Things to remember:

- The aim of the diary is to try to help our patients recovery.
- It will be our patient's choice to view their diary.
- Information in the diary will remain confidential and we will always protect patients' privacy and dignity.
- If you require any more information or think that a diary would be a good idea for your relative/friend in critical care then please approach the nurse looking after him/her.
- If considered appropriate for your relative, the nurse caring for him/her may approach you as the relative, to discuss use of a diary and to get it established.

Remember to remind your relative to come and collect the diary, or for them to ask us to forward it to them after discharge!

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You can request this information in a different format or another language.

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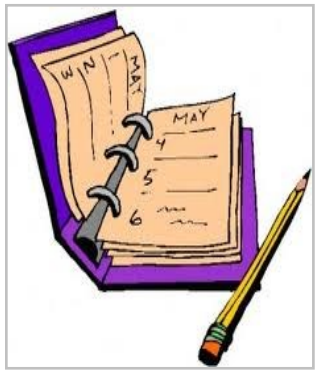
East and North Hertfordshire NHS
NHS Trust

Information for Relatives

Patient Diary

Critical Care Unit



Introduction

It has been found that patients cared for in the Critical Care Unit, be it long or short term, benefit from having a diary to 'fill the gap' of their period of ill health. Patient diaries are designed to help our patients with their recovery after admission to the Critical Care Unit.

What is a patient diary?

Patients who have been in the Critical Care Unit often remember very little of their stay. This is mainly because patients are usually sedated, are receiving strong pain killers or have an infection, all factors that can affect memory. Sometimes the things that patients do remember can be a little disjointed or confused. By keeping a diary for our patients, it can help them to understand what has happened to them, and help them make some sense of their critical care stay.

The diary involves having a small note book where entries can be made to explain episodes of care, the events of each day in the hospital and at home, and our patient's progress. It is kept at the patient's bedside and remains with the patient until he/she is discharged from the Critical Care Unit.

Who writes in the diary?

- Nurses
- Clinical support workers
- Doctors
- Physiotherapists
- Occupational therapists
- Most importantly, relatives and friends of our patients

What is written in them?

No medical jargon or confidential information will be written in the diary. The privacy and dignity of our patients is very important to us and an essential element of our care.

A Trust policy gives clear instructions as to what can and can't be included in the diaries and this is adhered to in order to protect the patient and provide guidance to the clinical team as to the diary contents.

Good things to write about include:

- Date of admission
- How long your friend/relative has been with us
- Brief description of the patient's condition and treatment
- Recent news
- Family updates i.e. who has visited and even football results!

What happens to the diary when your relative is discharged from critical care to a general ward?

- The diary stays with the patient until they are discharged from the Critical Care Unit.
- It will then be the patient's decision if they would like see/keep the diary.
- If he/she decides they do not wish to see it or keep it, it is then destroyed.

We can take a picture of your relative during their stay if you would like us to do so. This will be so your relative can understand how unwell they were during their stay and to make some sense of their memories and experiences. It may also help our patients understand their recovery process.