Patient Diaries.

Patient diaries have been shown to benefit patient in their recovery following ITU admission. They are a tool for 'filling in the blanks' and can help patients understand what happened to them during their time on the ICU. This can help patients understand things like why their recovery is taking a long time, why their families are so worried about them, why they are struggling to do simple tasks etc. They can also help patient to make sense of confused or frightening memories they may have.

Who should I start a diary for?
Ask yourself if you think it is likely that the patient will stay for longer than 3 days on the ITU. Are they likely to have gaps in their memory of this time? It is impossible to predict the length of stay for all patients with complete accuracy. Use your best judgement. If in doubt, ask.

Where do I get a diary?
New diaries are kept in the bottom draw of the filing cabinet under the main desk on the unit, the same filing cabinet as the book with the death notices in.

What do I do when starting a new diary?
In the draw with the diaries is a list recording the names of the patients and the number of the diary they have been given. This enables us to track the diaries and to locate them easily when returning them to the patients.

The diary number is on the back of the diary; please record this and the patient's name and hospital number on the form.

Write the patient's name and hospital number on the inside of the diary.

Write an introduction on the first page giving an explanation of why the patient came to the ITU.

If you have time, take a photograph of the patient on admission.

Explain to the family about the diary and encourage them to make entries. Guidelines for families regarding the diaries are available on the intranet. Look in the patient diaries folder on the red PC for the link. Please make sure the relatives have a copy.

At the end of your shift write an entry summarising the events of the day.

Hand over to the next shift that the patient has a diary.

Important points.

- Make your entries legible, it is extremely frustrating for patients to have information they can't access because they can't read the nurse's handwriting.

- Try and make an entry for every shift, even if it is short. Patients find gaps very difficult to deal with.

- Sign your entries.

- Write your entries in layman's terms. What you write in the diary is not a repeat of what you write in your care plan at the end of your shift. Write as if you were talking to the patient and telling them what happened that day.

- Encourage contributions from other members of the MDT and from the family.

- If you take a photo you must print it immediately and then delete the image. We are not allowed to store the digital images so if you are unable to print it straight away you must delete it. Put the printed photo in an envelope with the patients name, diary number and hospital number on it. Give the envelope to the Liaison nurse, Consultant nurse or shift leader.

- Diaries of patients who have left the unit are also kept in this drawer.

Returning dairies.

Usually dairies do not go with the patient when they go to the ward. The dairies are kept on the unit and returned subsequently either at follow up or by the nurses at a later date. If you think it would be appropriate for your patient to take the diary at the time of discharge, please discuss it with the nurse in charge or Consultant nurse.

If your patient has died, please offer the diary to the family before they leave the unit. It is very difficult to return diaries to the relatives of deceased patients if it is not done at this time. Please ensure the consent form is completed and a copy retained for our records.

If you are returning a diary please make sure a consent form is signed. The consent forms are in the back of the diary. Ask the patient to sign both copies of the consent form keep one copy for storing on G ICU (in the diary drawer) and give the other copy to the patient. If a member of the 'diary team' is not around please leave any completed consent forms in the audit office for the admin staff to file.

Diaries can only be given to the relatives when the patient is deceased. If the patient is alive, the relatives cannot take the diary.

If you have questions please ask Consultant Nurse, Liaison nurses, team leaders or a member of the aqua team.