Further information

Information on who to contact, i.e web sites / telephone numbers of other departments / organisations which may be of help.

How to contact us

Oxhey Ward
Watford General Hospital
West Hertfordshire Hospitals NHS Trust
Vicarage Road
Watford
Hertfordshire
WD18 0HB

Tel: 01923 436100
Ext: 8100 / 7271
Email: westherts.oxhey@nhs.net
westherts.coe-referral@nhs.net

If you need this leaflet in another language, large print, Braille or audio version, please call **01923 217 187** or email **westherts.pals@nhs.net**

Language | Large Print | Braille | Audio

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NHS
West Hertfordshire Hospitals
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A guide to...

Delirium Recovery Programme

Patient information

Oxhey ward

Watford General Hospital

Delirium Recovery Programme

What is delirium?

Delirium is a term used to describe a sudden onset of confusion with symptoms of fluctuating cognition and difficulty with concentration. Patients that are most at risk of developing a delirium are those with a known diagnosis of dementia or a long term cognitive impairment. Delirium can be caused by any medical illness such as infection, heart attack or stroke. The condition can also develop whilst a patient is in hospital because of a change to the person's environment and disruption to routine with no other medical cause identified.

Aim of the programme

The Delirium Recovery Programme identifies patients in the hospital that have potentially reversible causes of confusion. The programme helps the person to be discharged safely back to their own home with support to recover. The aim is to maximise the person's cognitive and physical abilities in their familiar home environment. To re-establish their daily routines initially with intensive 24-hour live in care to meet their specific care needs. Providing patients the opportunity to optimise the potential recovery from delirium and remain in their own homes.

What does the programme involve?

- The person is identified by Occupational Therapist (OT); Consultant Physician and Dementia Specialist Nurse as suitable i.e. has a reversible cause to their confusion.
- Ther family discharge planning meeting with multidisciplinary team provides the opportunity to meet the members of the team, discuss medical interventions, the programme and answer any questions.
- The OT writes a tailored care plan of the person's normal routine.

Key contact numbers

Oxhey ward	01923 436 100
Consultant Physician: Dr Cooray Dr Samji	
Dementia Specialist nurse (Katie Pardy)	07899 662521
Occupational Therapist	01923 217 271
Social Worker	0300 123 4042

Tips for preventing Delirium

- Make sure you drink plenty of fluids throughout the day. The Royal College of Nursing recommends you should drink no less 1.6 litres of fluid a day (unless advised otherwise by your doctor). This can be in the form of water, juice, milk on your cereal, yoghurt, soup and vegetables
- If concerned about getting up in the night limit your drinks after 7pm (especially caffeinated tea and coffee).
- Make sure you pass urine regularly; keep note of how often you go to the toilet and any smell when urinating
- Make sure you eat a well-balanced diet
- Prevent constipation, make sure your bowels open daily
- Make sure you take pain relief if you need it
- Make sure you get enough sleep
- Make sure your property is well lit
- Make sure your glasses and hearing aids are available and working well
- Make sure you remain active and mobile (with your walking aid if you have one) within your ability
- Keep orientated with calendars, diaries and large faced clocks

- The Care Agency will sometimes need to complete a home assessment before discharge. Please note the visit may be requested at short notice.
- On discharge the 24-hour live-in carer will meet the person at home with a care coordinator from the care agency to help settle the person at home. They will complete an assessment of needs at this time.
- The live-in care support can remain with the person in their house for up to three weeks. **The aim is to reduce** the live-in support after the first week, if it is safe to do so. This is to prevent full reliance on the carer and work towards a social services support care package.
- The live-in carer is legally required to have a two-hour break each day which is ideally covered by family.
- The live-in carer will require a food allowance which is usually between £5-10 per day, the cover of this will be discussed with family during the family meeting and on the care agency assessment.
- During the three weeks the OT and social worker will review the patient's progress at home and they will start to reduce the level of support provided by the carer in discussion with the person and their family.
- The aim by the end of the three weeks is for the care support to look like a package of care social services provide (visits one, two, three or four times per day).

The review process

Day 3-5:
OT review with the person and carer. This is to review / change the care plan and assess the person in their home and how they are settling. All aspects of function such as sleep, continence and nutrition will be discussed at this meeting and issues to focus on for ways to make the person more independent will be identified. Increasing the carer breaks during the day will be discussed and action taken as needed.

Day 7-10:
Joint OT and Social Work assessment. By this point a full week's sleep pattern will have been seen and discussion about removing the live-in carer will take place. This is the time when discharge planning is fully discussed with the person and their family, providing all have the opportunity to talk about onward plans. Family members are encouraged to attend this meeting.

Day 14-17:
OT review - this is the final review and social services then take over to start organising the package of care (if needed).

Please note that in the event of the patient not being safe and functionally able to stay at home an emergency care home placement will be arranged. The patient will not be readmitted to hospital.

On discharge on to the programme the patient's GP will receive a discharge summary providing a medical update and information on the programme. **At the end of three weeks the patient's full medical care returns back to the GP.**

Communication for patient, family and carer

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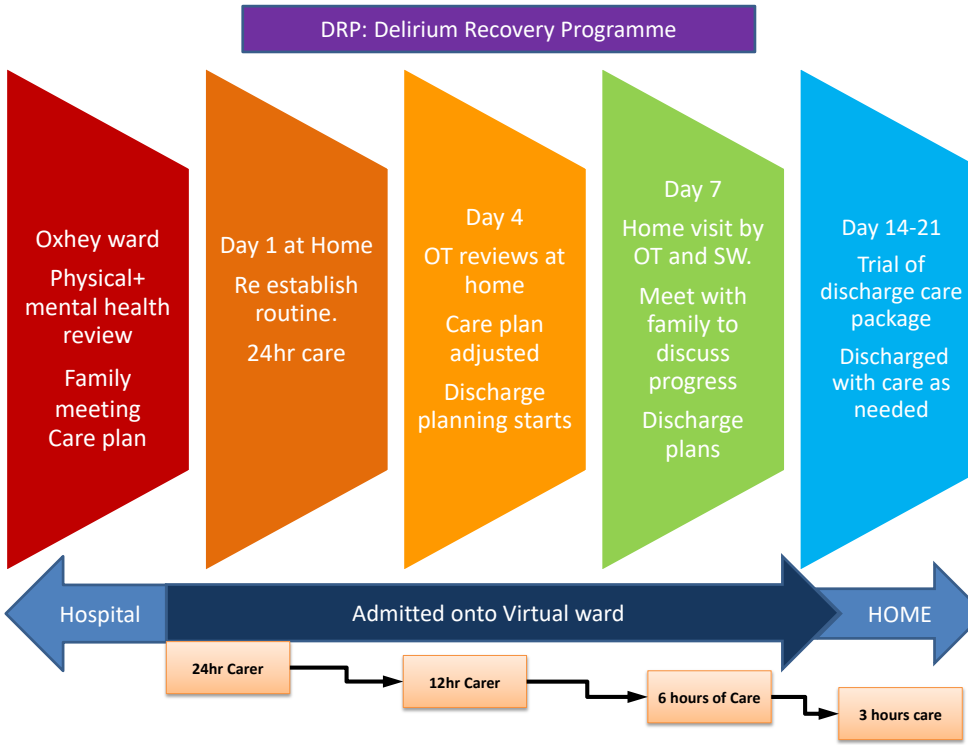
Communication for patient, family and carer



The role of the carer

- The carer in the home is there to **help** the person to get back to their previous activities and level of function – **NOT** to do it for them. Please note they are also not there to do housework such as hoovering, washing or cleaning – but will support the person if they would normally do this.
- The carer is the 'eyes and ears' of the hospital medical, therapy and social work teams.
- The carer does not make decisions about ongoing care needs.
- The carers write down all events over the time they are with the person.
- For repeat prescriptions the carer should contact the person's GP.
- Issues of concern - the carer should contact:

  Oxhey ward and ask to speak to nurse in charge or doctor. **Monday to Friday 9.00am to 5.00pm** -
- If the person needs "as required" antipsychotic medication, contact the ward for advice on giving it so that the team are aware of any incidents. Outside of these hours other medical advice should be sought from the GP. It is not anticipated that families will need to contact Oxhey ward.
- If the person becomes acutely unwell the live-in carer should call an ambulance. In the event the person is admitted to hospital during the three weeks **please inform** the medical staff that the person is on the Delirium Recovery Programme. This may reduce the length of time the person remains in hospital.

The role of the family

The key times for families to discuss care with the professionals will be at the review meetings (medical and therapy). The booklet also provides you with communication notes to also highlight any issues.

It is not anticipated that the family should provide any more support than they would normally provide the person and should visit as they normally would.

Social services

- The social worker will assess what care is needed when the programme ends which could include:
  - Permanent package of care
  - Direct payment
  - Day centre
  - Telecare equipment
- Any care that is put in place will be financially assessed to establish your contribution towards the care as per Hertfordshire County Council's charging policy. The social worker will explain this in more detail and provide you with the information.
- If the person is not managing at home, they may require residential care.
- If this is the case, they will be moved into urgent temporary residential care, whilst assessments are put in place for their long term care placement.
- This gives the person and family the chance to view and decide on the right long term residential home. The social worker will discuss the process in greater detail and the person and family will be fully involved throughout.