Day and Nightcare

WHO CARES? WE CARE.

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FULL HANDBOOK

Health conditions and care at home

Dementia, Parkinson's, stroke, falls, frailty, heart and lung conditions, continence, nutrition, wellbeing, sight and hearing.



16 guides in this handbook. The contents are on the next page.

A short guide to this handbook, with the key points of each guide: **www.dayandnightcare.co.uk/leaflets/brochure-health-conditions-short.pdf**

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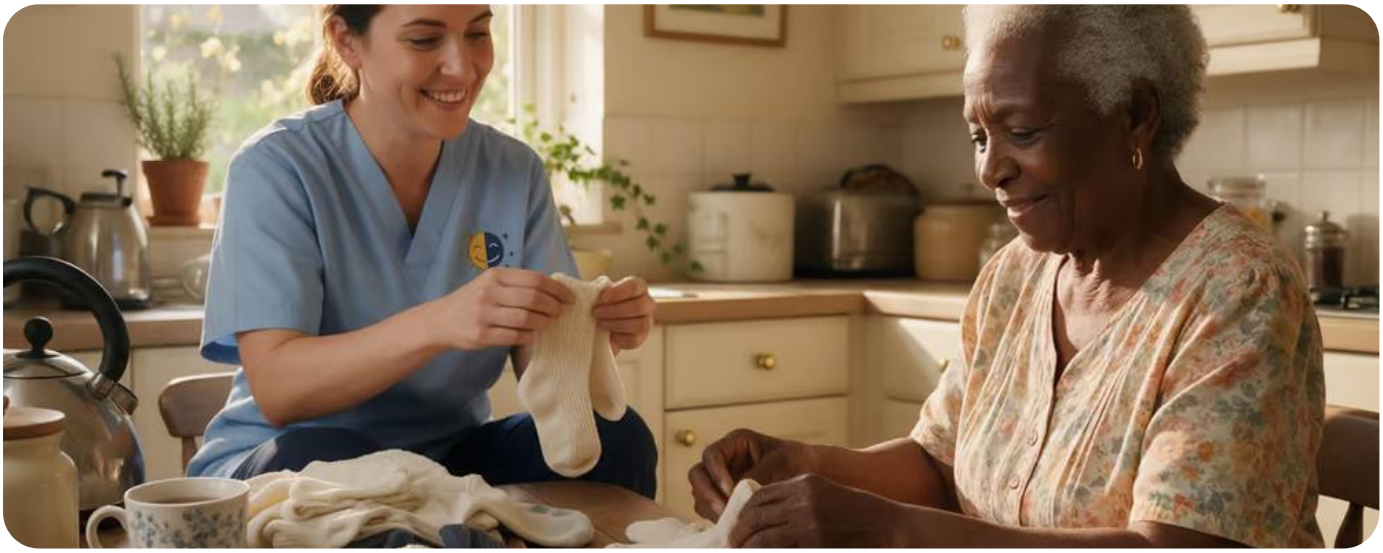
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Dementia care at home: a practical guide for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Many people with dementia can live well at home for a long time with steady routines, patient communication, a safe home and support that grows as their needs change. Start with a GP review and a free council care needs assessment, put Lasting Powers of Attorney in place while the person can still make them, and check every source of help with costs, from Attendance Allowance to NHS Continuing Healthcare.



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How dementia affects daily life at home

Dementia is a group of conditions, Alzheimer's disease and vascular dementia being the most common, that gradually affect memory, thinking, communication and everyday skills. Everyone's experience is different, but the Alzheimer's Society

describes three broad stages. They are only a rough guide, and people move through them at very different speeds.

- **Early stage:** mild memory lapses, repeating questions, losing track of appointments or bills. Most people manage much of their own life with some prompting. This is the time to plan ahead.
- **Middle stage:** often the longest. Confusion about time and place grows, people may not recognise familiar faces, and help is needed with washing, dressing, meals and medicines. Changes in mood, restlessness and unsettled evenings are common.
- **Later stage:** the person needs help with most things, may speak little, can have difficulty swallowing and becomes physically frail. Comfort, closeness and good personal care matter most.

Through every stage, the person is still themselves. Their history, likes and relationships do not disappear, and good care is built around them.

How to communicate with someone who has dementia

Communication changes, but connection remains possible. The NHS and dementia charities suggest:

- Speak clearly and calmly in short sentences, and give plenty of time for an answer.
- Offer simple choices ("tea or coffee?") rather than open questions.
- Turn down the television or radio, and sit at eye level, face to face.
- Use their name, a warm tone and, if they welcome it, a gentle touch on the hand.
- Listen for the feeling behind the words. Distress often signals an unmet need: pain, hunger, thirst, the toilet, boredom or being too hot or cold.
- Check glasses are clean and hearing aids are working; sight and hearing loss make confusion worse.

Why routines matter

A predictable day reduces anxiety. Keep getting up, meals, personal care, outings and bedtime at roughly the same times, in the same order. Build in things the person enjoys and is still good at, such as folding laundry, gardening, music they

love, looking at photographs or a daily walk. A simple life story book or "about me" sheet helps every carer, whether family or professional, know what matters to them.

Eating and drinking well

People with dementia often forget to eat, lose interest in food or do not notice thirst, which raises the risk of weight loss, constipation and urinary infections. Helpful habits include:

- Smaller meals and snacks through the day, using foods they have always liked.
- Finger foods if cutlery has become difficult.
- Drinks offered often, in a clear glass or brightly coloured cup that is easy to see and hold.
- Eating together, without rushing, in a calm room.
- Regular dental checks, because a sore mouth or loose dentures can stop someone eating.

If you notice coughing at meals, weight loss or refusal of food, speak to the GP, who can refer to a speech and language therapist or dietitian. Our guide to nutrition and hydration has more ideas.

Sundowning and unsettled nights

Many families notice that agitation, confusion or distress increases in the late afternoon and evening. This is often called sundowning. Possible causes include tiredness, hunger, pain, too little daylight, a noisy environment and a disrupted body clock. Things that often help:

- Plenty of daylight and activity earlier in the day, with only short naps.
- Closing curtains at dusk and covering unused screens and mirrors, as shadows and reflections can frighten.
- Less caffeine and alcohol in the afternoon and evening.
- A calm, familiar bedtime routine, a night light and a clear route to the toilet.

Disturbed nights are one of the main reasons family carers become exhausted. This is where night care or a live-in carer can make the biggest difference: someone is there to reassure, help to the toilet and settle the person again, so the family can sleep.

Walking about, getting lost and staying safe

Walking about can be a sign of restlessness, boredom or searching for something, such as “going home” or “going to work”. Rather than stopping it, try to understand it: a daily walk together often reduces the urge. To keep someone safe:

- Ask the council’s adult social care team about telecare, such as door sensors, falls detectors and GPS locators.
- Keep a recent photo and a short description ready. Many police forces run the Herbert Protocol, a form you fill in now so police can act quickly if someone goes missing.
- Consider cooker isolation valves, thermostatic taps and smoke alarms linked to a monitoring centre.
- Watch out for scams and doorstep callers; ask the bank about extra protections.

Mental capacity and Lasting Power of Attorney

A diagnosis does not mean someone has lost capacity. Capacity is about a specific decision at a specific time, and people must be helped to make their own decisions wherever possible.

A **Lasting Power of Attorney (LPA)** lets the person choose trusted people to make decisions if they no longer can. There are two types: property and financial affairs, and health and welfare. An LPA can only be made while the person has capacity, so it is worth doing soon after diagnosis. Registration with the Office of the Public Guardian costs £92 for each LPA, with reductions or exemptions for people on low incomes or certain benefits. Without an LPA, the family may need to apply to the Court of Protection for deputyship, which is slower and more expensive. See our guides to Lasting Power of Attorney and mental capacity and best interests.

Looking after yourself as a carer

Caring for someone with dementia is demanding, and family carers’ own health often suffers. You are entitled to a free **carer’s assessment** from the council, which can lead to breaks, practical help and training. Tell the GP practice you are a carer. Plan regular breaks before you reach crisis point, using day centres, sitting services or respite care. Check whether you can claim Carer’s Allowance, and see our carers’ assessment guide for what to ask for.

When needs increase

Signs that more support is needed include frequent falls, nights with little sleep for anyone, weight loss, incontinence that is hard to manage, distress when alone, or a family carer who is unwell or worn out. The options are more home care visits, regular night care, live-in care, or a care home.

Live-in care suits many people with dementia because it keeps them in familiar surroundings with a consistent carer, or a small team of regular carers, who learn their routines and moods. A care home may suit better when someone needs two people to move them at all hours, needs nursing care around the clock, or seems happier with more company. Our comparison of live-in care and care homes sets out the trade-offs honestly.

How dementia care is paid for

- **Attendance Allowance:** for people over State Pension age who need help with personal care or supervision. It is not means-tested and pays £76.70 or £114.60 a week, the higher rate when help is needed both day and night. See our Attendance Allowance guide.
- **Council funding:** a free care needs assessment, then a financial assessment. In England, people with capital over £23,250 usually pay in full; below £14,250, capital is ignored. The home is not counted when care is provided at home.
- **NHS Continuing Healthcare:** pays the full cost of care when needs are mainly health needs, assessed on the whole picture, not the diagnosis. Behaviour that is challenging, unpredictable or risky can count. See our NHS Continuing Healthcare guide.
- **Council tax:** someone certified by a doctor as having a severe mental impairment, and receiving a qualifying benefit such as Attendance Allowance, is disregarded. If they live alone, the bill can be reduced by 100%; if one other adult lives with them, a 25% discount may apply. Our council tax guide explains how to apply.

When to call the GP, 111 or 999

Dementia usually changes slowly, so a **sudden** change is a warning sign of something else, such as an infection, dehydration, a stroke or a side effect of medicine.

Call 999 if the person:

- Suddenly becomes much more confused, very drowsy or has difficulty speaking.
- Shows signs of a stroke: face drooping, arm weakness or slurred speech.
- Has fallen and may have hurt their head, neck, back or hip, or cannot get up.
- Is choking and it does not clear, or is struggling to breathe.

Ask for an urgent GP appointment or call NHS 111 (free, 24 hours) if they:

- Have signs of a urine infection, such as new agitation, shivering or more leaking than usual.
- Have barely eaten or drunk for a day, have dark urine or feel dizzy on standing.
- Start coughing or choking when eating or drinking.

Book a routine GP appointment for gradual changes in memory, mood, sleep or behaviour, weight loss, or a medication review.

How to get NHS and council help, step by step

1. **Memory concerns:** book a GP appointment. The GP checks for other causes and can refer to the local memory assessment service.
2. **After diagnosis:** ask who your named contact is. NICE recommends that everyone with dementia has a named health or social care professional coordinating their care. GP practices usually offer a dementia care review once a year.
3. **Care at home:** phone or apply online to the council's adult social care team for a free care needs assessment. Ask about an occupational therapist for equipment and about telecare.
4. **The family carer:** ask the council for a carer's assessment, and tell the GP practice you are a carer.
5. **Specific needs:** ask the GP or district nurse for referrals to the continence service, a speech and language therapist (eating or swallowing) or the falls service.
6. **Complex needs:** ask the GP, district nurse or social worker to complete an NHS Continuing Healthcare checklist.

Checklist: keep by the phone

- GP surgery, NHS 111 and the person's NHS number.
- A current list of medicines, allergies and conditions.
- Names and numbers of attorneys, family and carers.
- Who holds keys, and the key safe code holder.
- A recent photo and the Herbert Protocol form, if completed.
- Any hospital "about me" sheet or care plan.

Where to get support

- **Alzheimer's Society Dementia Support Line:** 0333 150 3456 (local rate). Monday to Wednesday 9am to 8pm, Thursday and Friday 9am to 5pm, weekends 10am to 4pm.
- **Dementia UK Admiral Nurse Dementia Helpline:** 0800 888 6678 (free). Weekdays 9am to 9pm, weekends and bank holidays 9am to 5pm.
- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.
- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.
- **Samaritans:** 116 123 (free), 24 hours a day, if you are struggling.
- **In Oxfordshire:** Dementia Oxfordshire, run by Age UK Oxfordshire, offers free dementia advisers for people with a diagnosis and their families.

What to do next

1. Ask the GP for a review and a medication check, and tell them you are the person's carer.
2. Request a free care needs assessment from the council's adult social care team, and a carer's assessment for yourself.
3. Make or register Lasting Powers of Attorney while the person can still do so.
4. Claim Attendance Allowance and apply for the council tax discount.
5. Ask whether an NHS Continuing Healthcare checklist should be completed.
6. Write a short "about me" sheet and keep a record of difficult days, nights and falls.

How we can help

Day and Nightcare has supported people at home since 2008. We provide fully managed live-in dementia care anywhere in England, from £1,550 a week, and home care visits, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England. We work with private, council, direct payment and NHS Continuing Healthcare funding. If you would like to talk things through, call us on 01865 715780 to arrange a free assessment and a written quote.

Common questions

Can someone with dementia carry on living alone?

Often yes, particularly in the earlier stages, if the right support is in place and the risks are understood. Warning signs that living alone is becoming unsafe include missed meals, weight loss, leaving the cooker on, getting lost, falling for scams or not taking medicines. A diagnosis alone does not mean someone must move or have care they do not want. If they can still make the decision, it is theirs; if they cannot, it is made in their best interests, involving the family and any attorney.

Is dementia care free on the NHS?

Usually not in full. Diagnosis, treatment and specialist nursing are free, but help with washing, dressing, meals and supervision is social care, which the council means-tests. NHS Continuing Healthcare pays for all care when needs are complex, intense or unpredictable enough, but a dementia diagnosis alone does not qualify. Attendance Allowance is not means-tested and many people with dementia are entitled to it.

Should I correct someone with dementia when they get things wrong?

Usually it is kinder not to. Arguing about facts, such as the day of the week or whether a parent is still alive, rarely helps and can cause real distress. Respond to the feeling behind the words instead: 'You sound worried, let's sit down together.' Gentle reassurance and a change of activity often work better than correction. Safety matters are different: you may need to step in calmly, without blame.

What is the difference between a waking night and a sleep-in?

With a waking night, a carer stays awake all night, ready to help with toileting, repositioning, medicines or distress. With a sleep-in, the carer sleeps in the home and is woken only occasionally. A sleep-in suits someone who wakes once or twice; a waking night suits someone who is up often, at risk of falls at night or who tries to leave the house. A care assessment can help you decide.

What if my parent refuses all help?

This is very common, and it is rarely about the help itself. People fear losing control or being moved from home. Start small and familiar, such as company for a walk or help with lunch, and introduce a carer as a helper rather than a nurse. Involve the GP if needed. If the person lacks capacity for this decision, a best interests decision can be made, but never by force, and always the least restrictive option.

Sources and further information

- NHS: Looking after someone with dementia
- NHS: Communicating with someone with dementia
- NHS: Coping with dementia behaviour changes
- NHS: Dementia, social services and the NHS
- Alzheimer's Society: Stages of dementia and progression
- Alzheimer's Society: Sundowning and dementia
- GOV.UK: Council Tax discounts for disabled people
- GOV.UK: Register a lasting power of attorney

Read next

PAYING FOR CARE AND REDUCING THE COST

NHS Continuing Healthcare: a guide for families

A plain-English guide to NHS Continuing Healthcare in England: who qualifies, the Checklist, the Decision Support Tool and its 12 domains, Fast Track, care at home including live-in care, reviews, appeals with template letters, retrospective claims and how to prepare evidence.

Read the guide →

LEGAL MATTERS AND PLANNING AHEAD

Lasting Power of Attorney: a guide for families

How Lasting Power of Attorney works in England and Wales: the two types, why to make one early, how to make and register it online or on paper, the £92 registration fee, the certificate provider, and what happens without one (deputyship and the Court of Protection).

Read the guide →

PAYING FOR CARE AND REDUCING THE COST

Council Tax discounts for dementia, disability and carers

How to reduce Council Tax when someone has dementia, a disability or a carer: the severe mental impairment disregard, single person discount, Disabled Band Reduction, carer disregards, Council Tax Reduction, empty-home exemptions, backdating, appeals and a letter to claim.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/dementia-care-at-home-guide/**

Parkinson's care at home: a guide for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Good Parkinson's care at home starts with medicines taken exactly on time, because late or missed doses can quickly make symptoms worse. Around that, a person can stay safer and more independent with help for movement and freezing, falls prevention, early swallowing checks, better nights and a team that includes a Parkinson's nurse, physiotherapist and speech and language therapist.



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How Parkinson’s affects daily life

Parkinson’s is a progressive condition of the brain. The best-known symptoms are tremor, slowness of movement and stiff muscles, but many people are more troubled by symptoms that others cannot see: tiredness, low mood or anxiety, poor

sleep, constipation, pain, problems with balance and, for some, memory difficulties.

Symptoms often change through the day. Many people have “on” times, when medicines are working well, and “off” times, when movement becomes slow or stuck. The same person may walk to the kitchen easily at ten o’clock and struggle to stand up at two. Good care follows these changes rather than assuming a fixed level of need.

There is no cure yet, but treatment and the right support can keep people active and independent for many years.

Why Parkinson’s medicines must be taken on time

Parkinson’s medicines replace or mimic dopamine, the chemical messenger the brain is short of. Each dose works for a limited time, so when a dose is late, symptoms can return quickly: stiffness, freezing, tremor, difficulty swallowing and a much higher risk of falling. Parkinson’s UK’s long-running “Get It On Time” campaign exists because this happens so often in hospitals and care settings.

At home, the aim is simple: every dose at the prescribed time, every day. Practical ways to achieve this:

- Write out a medicines chart with the exact times, not just “three times a day”.
- Use phone, watch or pill-timer alarms, and keep the next doses where they are easy to reach.
- Ask the Parkinson’s nurse or specialist how doses should be timed around meals, as protein can affect how some medicines work for some people.
- Order repeat prescriptions early and never let supplies run low.
- If swallowing tablets becomes difficult, ask the specialist about alternatives, such as patches or liquids.
- Never stop or reduce Parkinson’s medicines suddenly without medical advice.

Family and carers should also watch for side effects the person may not notice in themselves, such as hallucinations, confusion or impulsive behaviour, and report them early.

Movement, slowness and freezing

Freezing is when the feet feel glued to the floor, often when starting to walk, turning, going through doorways or in busy places. It usually lasts seconds but can cause falls. Techniques suggested by Parkinson's UK include:

- **Stop, think, plan, then go:** pause, take a breath and decide on the next step.
- **Weight shift:** gently rock from one foot to the other, then step.
- **Rhythm:** count out loud, hum a tune or march on the spot.
- **Visual cues:** strips of contrasting tape across doorways or turning spots give the feet a target.
- **Turn in a wide arc** rather than pivoting on the spot.

Carers should avoid pulling or rushing someone who is frozen; a calm word and a cue work better. A physiotherapist can teach techniques tailored to the person and advise on walking aids, as some aids can make freezing worse. An occupational therapist can suggest equipment for getting out of bed, chairs and the bath.

Preventing falls

Falls are a real risk in Parkinson's because of balance problems, freezing, low blood pressure on standing and night-time toilet trips. To reduce the risk:

- Stand up slowly, sitting on the edge of the bed for a moment first.
- Keep walkways clear, remove loose rugs and light the route to the toilet at night.
- Wear well-fitting shoes with low heels and good grip, not loose slippers.
- Avoid carrying things while walking, and avoid talking while walking if concentration is needed.
- Ask the GP or Parkinson's nurse to check lying and standing blood pressure if the person feels dizzy.

Our falls prevention guide covers home checks, exercise and alarms in more detail.

Swallowing and eating

Swallowing problems can develop gradually. Watch for coughing or choking when eating or drinking, a wet or gurgly voice, food sticking, drooling, taking much longer over meals, difficulty with tablets, weight loss or repeated chest infections.

Parkinson's UK advises seeing a speech and language therapist early, even before problems start. The GP or Parkinson's nurse can refer, and some services accept self-referral.

At mealtimes, sit fully upright, take small mouthfuls, eat slowly, avoid distractions and plan meals for "on" times when possible. Constipation is common in Parkinson's, so fibre, fluids and regular activity help. Our nutrition and hydration guide explains texture-modified diets.

Sleep and night-time problems

Sleep problems are common at every stage. People may struggle to turn over in bed, wake with stiffness or tremor when medicines wear off, need the toilet often, have restless legs or act out vivid dreams, known as REM sleep behaviour disorder. Daytime sleepiness then follows.

Helpful steps include a regular bedtime, short daytime naps, a cool bedroom, less caffeine later in the day, satin sheets or nightwear to make turning easier, and a commode or urinal by the bed. Mention night-time problems to the GP or specialist, because treatment can often help. If nights are disturbed for everyone, night care can give the family the rest they need.

Communication

Parkinson's can make the voice quieter and speech less clear, and it can reduce facial expression, so a person may look uninterested or unhappy when they are not. Speech and language therapists offer programmes such as Lee Silverman Voice Treatment (LSVT LOUD) to strengthen the voice.

Family members can help by facing the person, reducing background noise, allowing time, asking rather than guessing how they feel, and not finishing their sentences.

How live-in or night care can help

As Parkinson's progresses, many families find the hardest parts are medicines at exact times through the day and night, help during unpredictable "off" periods, and broken nights. A live-in carer is in the home all day, so medicine prompting or

administration can follow the chart to the minute, and help is there whether the person is “on” or “off”. A consistent carer also notices small changes, in swallowing, mood or mobility, that are easy to miss in short visits.

When to call the GP, 111 or 999

Call 999 if the person:

- Is choking and cannot breathe, cough or speak, and it does not clear.
- Has fallen and may have hurt their head, neck, back or hip, or cannot get up.
- Suddenly becomes very confused or drowsy, or shows signs of a stroke.

Contact the GP urgently or call NHS 111 (free, 24 hours) if:

- There are signs of a chest infection, such as fever, a new cough or breathlessness, especially if swallowing is difficult.
- Vomiting or illness means medicines cannot be taken or kept down.
- Doses have been missed and symptoms are much worse.

Contact the Parkinson’s nurse or GP about new hallucinations, worsening falls or dizziness, low mood, constipation that does not settle, or changes in how well medicines are working.

How to get NHS help, step by step

Most people with Parkinson’s are supported by a specialist (a neurologist or a doctor specialising in older people) and, in many areas, a Parkinson’s nurse, who helps adjust medicines and refers to other services. To build the rest of the team:

1. **Parkinson’s nurse:** ask the GP or specialist for a referral. Community Parkinson’s nurses cover set areas, so ask the GP surgery whether one covers your practice. If not, the Parkinson’s UK helpline can connect you with a local adviser.
2. **Physiotherapy:** ask the GP, specialist or Parkinson’s nurse for a referral for movement, balance and freezing. Some areas also run Parkinson’s exercise classes.
3. **Speech and language therapy:** ask the GP or Parkinson’s nurse for a referral for speech or swallowing; some services accept self-referral.
4. **Occupational therapy and equipment:** ask the council’s adult social care team for a care needs assessment, or ask the GP or hospital team.

5. **Falls service:** after any fall, ask the GP for a falls assessment; some areas let you refer yourself.
6. **Specialist review:** keep regular appointments with the specialist and take your diary of "on" and "off" times.

Checklist: a hospital bag for someone with Parkinson's

Tell staff on arrival that Parkinson's medicines are time-critical, and pack:

- All medicines in their original packaging.
- A written list of every medicine with the exact dose and time.
- The name and number of the Parkinson's nurse and specialist.
- A note of how the person is during "on" and "off" times.
- Glasses, hearing aids and phone charger.
- A family contact who can remind staff when doses are due.

Help with costs

- **Attendance Allowance** (over State Pension age) or **Personal Independence Payment** (under it), neither of which is means-tested.
- A free **care needs assessment** from the council, followed by a financial assessment.
- **Equipment and minor adaptations** costing £1,000 or less are free if the council assesses a need; larger changes may qualify for a means-tested Disabled Facilities Grant of up to £30,000 in England.
- **NHS Continuing Healthcare** may pay for all care if needs become complex in the later stages.
- **Carer's Allowance**, which a family member caring for at least 35 hours a week may be able to claim.

See our guides to Attendance Allowance and Personal Independence Payment.

Where to get support

- **Parkinson's UK Helpline:** 0808 800 0303 (free). Monday to Friday 9am to 6pm, Saturday 10am to 1pm. For people with Parkinson's, families and carers; the charity also runs local groups and exercise classes.
- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.

- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.
- **Samaritans:** 116 123 (free), 24 hours a day.

What to do next

1. Write an exact medicines timetable and set alarms for every dose.
2. Ask the GP or specialist for a referral to a Parkinson's nurse, physiotherapist and speech and language therapist if you do not have one.
3. Check the home for falls risks, especially the night-time route to the toilet.
4. Claim Attendance Allowance or PIP, and ask the council for a care needs assessment and a carer's assessment.
5. Keep a simple diary of "on" and "off" times, falls, sleep and side effects to share at appointments.

How we can help

Day and Nightcare supports people with Parkinson's through fully managed live-in care anywhere in England, from £1,550 a week, and home care visits, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England. Medicines support is agreed in each person's care plan, so the times that matter are written down for every carer. Call 01865 715780 to arrange a free assessment and a written quote.

Common questions

Can Parkinson's medicines be stopped if they cause side effects?
Not without specialist advice. Parkinson's medicines should never be stopped or cut down suddenly, because this can cause a serious reaction. If side effects appear, such as sickness, dizziness, hallucinations, unusual sleepiness or new compulsive behaviour like gambling or excessive shopping, write down what you notice and contact the Parkinson's nurse, specialist or GP promptly. They can often adjust the dose, timing or type of medicine safely.

Can someone with Parkinson's keep driving?

Often, for a time. A diagnosis of Parkinson's must be reported to the DVLA and to the car insurer, but it does not automatically mean giving up driving. The DVLA asks about the condition and the doctors involved, then decides whether the person is safe to drive. Some medicines can cause sudden sleepiness, especially when doses are being increased, so check with the specialist before driving after any change.

Is exercise safe for someone with Parkinson's?

Yes, and it is one of the most helpful things they can do. The NHS says regular exercise can ease stiffness and improve mood. People with milder symptoms may enjoy more vigorous activity such as cycling or brisk walking, while those with more advanced symptoms can benefit from walking, gentle stretching and strengthening exercises. A physiotherapist can suggest what is safe, and the GP should be consulted before starting anything new.

Does Parkinson's affect mood and memory?

It can. Depression and anxiety are common in Parkinson's and are treatable, so mention low mood, worry or loss of interest to the GP or Parkinson's nurse. Some people develop problems with memory and thinking, and some go on to develop dementia. Hallucinations can be caused by the condition or by medicines, so report them promptly rather than assuming they are part of ageing.

Is Parkinson's care paid for by the NHS?

Medical treatment, the Parkinson's nurse and therapies are free on the NHS. Day-to-day care at home is social care, which is means-tested by the council. In the later stages, needs can become complex enough for NHS Continuing Healthcare, which pays the full cost of care. Attendance Allowance (over State Pension age) or Personal Independence Payment (under it) can help with costs whatever your savings.

Sources and further information

- NHS: Parkinson's disease
- NHS: Parkinson's disease treatment
- Parkinson's UK: Managing your medication in hospital
- Parkinson's UK: Freezing

- Parkinson's UK: Eating, swallowing and saliva control
- Parkinson's UK: Parkinson's nurses
- NICE: Parkinson's disease in adults (NG71)

Read next

HEALTH CONDITIONS AND CARE AT HOME

Falls prevention for older people: a practical guide

Why older people fall and how to reduce the risk at home: common causes, home hazards, footwear, eyesight, medication reviews, strength and balance exercise, what to do after a fall, personal alarms, and the free help available from the NHS and the council.

Read the guide →

LIVING SAFELY AND WELL AT HOME

Managing medication at home: a guide for families and carers

How medicines support works at home: prompting versus administering, blister packs and their limits, MAR charts, safe storage, medication reviews with the GP or pharmacist, the free New Medicine Service, what paid carers can and cannot do, and a medicines list template.

Read the guide →

PAYING FOR CARE AND REDUCING THE COST

Personal Independence Payment (PIP): a guide for families

PIP helps people aged 16 to State Pension age with the extra costs of a long-term condition or disability. The 2026/27 rates, how the points work, how to claim step by step, example wording for the form, end-of-life rules and PIP at State Pension age.

Read the guide →

This page online: **www.dayandnightcare.co.uk/guides/parkinsons-care-at-home/**

Stroke recovery at home: the first weeks and beyond

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Recovery from a stroke usually continues for months after leaving hospital, and much of it happens at home. The first weeks are about safety, rest and rehabilitation, often with free reablement for up to six weeks. Keep practising what the therapists teach, take medicines to prevent another stroke, know the FAST signs, and expect a review of progress at about six months.



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The first weeks at home after a stroke

Coming home is a big step, and it can feel daunting for everyone. Hospital stays after a stroke are often short, so much of the recovery happens in the person's own home. Before discharge, the hospital team should agree a recovery plan, arrange

any equipment, and show the person and family how to manage safely. Ask for a copy of the plan and the discharge letter, and make sure you know who to call with questions.

In the early weeks it is normal for the person to tire very easily, to feel low or anxious, and to find that things they did without thinking now take effort and concentration. Some areas have an early supported discharge team that continues stroke therapy at home; others arrange community therapy or reablement. Our guides to leaving hospital and Discharge to Assess explain how this works.

A simple first-weeks checklist:

- Medicines: a clear list, a reliable routine and enough supply.
- Safety: a clear route to the bathroom, a commode or urinal if needed, and good lighting at night.
- Equipment: grab rails, a raised toilet seat, a shower chair or a walking aid, as advised by the occupational therapist.
- Contacts: the stroke team, GP, therapists and the Stroke Association helpline on one sheet by the phone.
- Rest: a daily routine with planned rest periods.

Rehabilitation and reablement

Rehabilitation helps the brain find new ways to do things, and it works best with regular practice. NICE guidance recommends that people who need it and are able to take part are offered at least three hours a day of rehabilitation therapy, on at least five days a week, across physiotherapy, occupational therapy, speech and language therapy and other therapies, and that therapy continues at a lower level for those who cannot manage this.

At home, recovery can be supported by:

- **Physiotherapy** for movement, balance and walking.
- **Occupational therapy** for everyday tasks such as washing, dressing and cooking, and for equipment.
- **Speech and language therapy** for communication and swallowing.
- **Reablement**, short-term practical support to rebuild skills and confidence, which in England is free for up to six weeks. See our reablement and intermediate care guide.

The exercises the therapists give are the most important part. Carers can help by encouraging practice little and often, and by letting the person do as much as they safely can for themselves, even when it is quicker to do it for them.

Mobility and moving safely

Many people have weakness or numbness on one side of the body. This affects balance, walking and getting in and out of bed, chairs and the bath. Some practical points:

- Follow the therapist's advice on how to stand, transfer and walk.
- Never pull on a weak arm or shoulder; support it on a cushion or armrest when sitting.
- If sight or awareness on one side is affected, ask the therapist which side to approach from and where to place drinks, the call bell and other everyday items.
- Wear supportive, well-fitting footwear and take extra care at night.

Falls are more likely after a stroke; our falls prevention guide explains how to reduce the risk.

Communication and aphasia

Aphasia is a language difficulty caused by damage to the brain. It can affect speaking, understanding, reading, writing and numbers, but it **does not affect intelligence**. The person still knows what they want to say. Other people may have dysarthria, where speech is slurred because of muscle weakness.

Ways to help:

- Find a quiet place, face the person and speak a little slower, in short sentences.
- Ask questions that can be answered "yes" or "no", or offer written choices.
- Give time, and do not finish sentences unless asked.
- Use gestures, pictures, writing and objects.
- Check you have understood by summing up what you think they said.
- Include them in conversations and decisions; do not talk over them.

Fatigue

Tiredness after a stroke is very common and is not ordinary tiredness: it can come on suddenly and is not always relieved by sleep. It can be caused by the brain healing, by emotional effects, by medicines or by poor sleep. It often improves over time. Pacing helps: break tasks into smaller steps, plan the most important activity for the time of day the person has most energy, and build in rest before exhaustion sets in. A simple diary of activity and tiredness can show patterns.

Mood and emotional changes

Most people experience emotional changes after a stroke, such as low mood, anxiety, frustration, irritability or emotionalism, where they cry or laugh suddenly. Depression is common and treatable. Talking therapies, including cognitive behavioural therapy, can help, and people can refer themselves to NHS Talking Therapies. Speak to the GP if low mood lasts more than a couple of weeks, if the person withdraws, or if you are worried about their safety. Family carers' mood matters too, so please look after yourself.

Preventing another stroke

Having had a stroke or TIA increases the risk of another, but much can be done:

- Take the prescribed medicines every day, which may include tablets for blood pressure, cholesterol and blood clotting.
- Have blood pressure checked regularly, at the GP surgery, a pharmacy or with a home monitor.
- Stop smoking; the NHS offers free support to quit.
- Keep alcohol within the NHS guideline of no more than 14 units a week, spread over several days.
- Eat a balanced diet with plenty of fruit and vegetables and less salt.
- Stay as active as safely possible.
- Keep diabetes and an irregular heartbeat (atrial fibrillation) under review with the GP.

When to call 999, 111 or the GP

Everyone in the home should know the signs of a stroke, remembered as **FAST**:

- **Face:** has the face dropped on one side? Can they smile?
- **Arms:** can they lift both arms and keep them there?
- **Speech:** is speech slurred or muddled?
- **Time:** call 999 straight away.

Call 999 for any FAST sign, even if it seems to settle, and do not drive the person to hospital yourself. Also call 999 if they suddenly become confused or drowsy, are choking and it does not clear, have chest pain or severe difficulty breathing, or have fallen and may be badly hurt.

Ask for an urgent GP appointment or call NHS 111 (free, 24 hours) if there are signs of a chest infection, coughing or choking when eating or drinking, signs of a urine infection, or new throbbing pain or swelling in one leg, which can be a blood clot (call 999 if this comes with breathlessness or chest pain).

Book a GP appointment about low mood, fatigue that is not improving, side effects of medicines, continence problems or blood pressure checks.

How to get NHS and council help, step by step

1. **Before discharge:** ask the ward for the recovery plan, the name of the community stroke or early supported discharge team, and when therapy will start.
2. **Therapy at home:** if nobody has been in touch within a few days, phone the number on the discharge letter, or ask the GP to chase the referral.
3. **Care and equipment:** ask the council's adult social care team for a care needs assessment and an occupational therapy assessment; ask for a carer's assessment too.
4. **Speech or swallowing:** ask the GP for a speech and language therapy referral if problems appear or return.
5. **Mood:** self-refer to NHS Talking Therapies, or ask the GP.
6. **Review:** expect a progress review at about six months, and ask the stroke team or GP if it is not offered.
7. **Driving:** check the DVLA rules before driving again.

How support at home helps recovery

For people who are struggling, a period of live-in care after hospital can make home the right place to recover: a carer is there to help the person practise their exercises, move safely, rest, eat well and take medicines, around the clock. For others, visits at key times of day or night care are enough. Care should aim to restore independence, with support reduced as the person improves.

Help with costs

- Reablement and intermediate care: free for up to six weeks.
- Attendance Allowance (over State Pension age) or Personal Independence Payment (under it), neither of which is means-tested.
- A free council care needs assessment, then a financial assessment, for longer-term care.
- Free equipment and minor adaptations costing £1,000 or less if the council assesses a need, and a means-tested Disabled Facilities Grant for larger changes.
- NHS Continuing Healthcare if needs are primarily health needs.

Where to get support

- **Stroke Association Support Helpline:** 0303 3033 100. Monday to Friday 9am to 5pm, Saturday 10am to 1pm. For stroke survivors, families and carers.
- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.
- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.
- **Samaritans:** 116 123 (free), 24 hours a day.

What to do next

1. Ask for a copy of the discharge plan and a named contact in the stroke or community team.
2. Check that therapy and reablement are arranged, and when they start.
3. Make the home safe before or on the day of discharge.
4. Claim Attendance Allowance or PIP and ask for a council care needs assessment and a carer's assessment.
5. Put the prevention medicines into a daily routine and book a blood pressure check.

6. Note the six-month review in the diary and ask for it if it does not happen.

How we can help

Day and Nightcare has provided Discharge to Assess care since 2014 and for several years ran Oxfordshire's Urgent Response service for several years, so we know how important the first weeks home are. We provide fully managed live-in care anywhere in England, from £1,550 a week, and home care visits, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England. Call 01865 715780 to arrange a free assessment.

Common questions

How long does recovery from a stroke take?

It is different for everyone. Most improvement tends to happen in the first weeks and months, but many people keep making progress for much longer, especially with regular practice. Some effects, such as tiredness or word-finding difficulties, can last. The NHS says you should have a review of your progress at about six months; if it is not offered, ask the stroke team or GP. Progress can be slow and uneven, so celebrate small gains.

Can someone drive again after a stroke?

Not straight away. Anyone with a car licence must stop driving after a stroke or TIA for at least one month, and only restart when a doctor says it is safe. If problems such as weakness, sight, balance, memory or understanding still affect them after a month, or they have had a seizure, they must tell the DVLA. Bus and lorry drivers must tell the DVLA and stop for at least a year.

Is care after a stroke free?

Some of it is. NHS treatment and therapy are free, and reablement or intermediate care arranged by the council or NHS is free for up to six weeks. Longer-term help with personal care is means-tested by the council. If needs are mainly health needs, NHS Continuing Healthcare may pay for all care. Attendance Allowance or PIP can help with costs whatever your savings.

Why does my relative suddenly cry or laugh since the stroke?

This can be emotionalism, a common effect of stroke in which a person laughs or cries suddenly, sometimes without feeling sad or happy. It is caused by damage to the brain, not by weakness of character, and it often improves with time. Gentle distraction can help in the moment. Tell the GP or stroke team, as treatment is available, and also watch for signs of depression, which is common too.

What is a TIA, and is it serious?

A transient ischaemic attack (TIA), sometimes called a mini-stroke, causes stroke symptoms that go away, often within minutes. It is a warning sign that a stroke may follow, so it needs urgent medical attention. If you notice stroke symptoms, call 999 even if they seem to have stopped. Treatment after a TIA can greatly reduce the risk of a full stroke.

Sources and further information

- NHS: Stroke recovery
- NHS: Stroke symptoms
- NHS: Preventing a stroke
- NICE: Stroke rehabilitation in adults (NG236)
- GOV.UK: Stroke and driving
- Stroke Association: Stroke Support Helpline
- Stroke Association: Fatigue after stroke

Read next

LEAVING HOSPITAL AND RECOVERY

Leaving hospital: what to expect and how to prepare

How hospital discharge works in England today: the discharge pathways, who the discharge team are, timing, transport, medicines and equipment, what families can do, and how to arrange private or live-in care quickly.

Read the guide →

LEAVING HOSPITAL AND RECOVERY

Reablement and intermediate care: free help to recover

Reablement and intermediate care help people recover after a hospital stay, a fall or an illness. Find out what is free (up to six weeks), who provides it, how goals are set, how to get it without a hospital stay, and what happens afterwards.

Read the guide →

LEAVING HOSPITAL AND RECOVERY

Discharge to Assess (D2A) explained for families

What Discharge to Assess (D2A) means in England: the four pathways, which care is free and for how long, what happens when the D2A period ends, assessments for council funding and NHS Continuing Healthcare, and how to plan ahead.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/stroke-recovery-at-home/**

Falls prevention for older people: a practical guide

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Falls are common in later life, but they are not an inevitable part of ageing and many can be prevented. The biggest differences come from strength and balance exercise, a medication review, regular eye tests, good footwear and a safer home. After any fall, tell the GP, because a falls assessment can find the cause and lower the chance of another.



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Why do older people fall?

Most falls have more than one cause. Common ones include:

- Muscles weakening with age and less activity.

- Balance problems, and conditions such as arthritis, stroke, Parkinson's or dementia.
- Low blood pressure, especially feeling dizzy on standing up.
- Side effects of medicines, particularly when someone takes several.
- Poor eyesight or hearing.
- Needing the toilet urgently, especially at night.
- Trip hazards at home, poor lighting and unsuitable footwear.
- Being unwell, for example with an infection or dehydration.
- Too much alcohol.

Around a third of people aged 65 and over, and around half of people aged 80 and over, fall at least once a year. The encouraging news is that many of the causes above can be reduced. NICE guidance asks health services to look at each person's own risk factors and offer help to reduce them, rather than relying on a simple score.

How to make the home safer

Walk through the home with fresh eyes, ideally at night as well as in the day.

- **Floors:** remove or secure loose rugs and mats, tidy trailing wires, and keep walkways clear of clutter.
- **Lighting:** use bright bulbs, light switches at the top and bottom of the stairs, and plug-in night lights or motion-sensor lights between bedroom and bathroom.
- **Stairs:** firm handrails on both sides, with nothing left on the steps.
- **Bathroom:** non-slip mats, grab rails by the toilet, bath and shower, and a shower seat if standing is tiring.
- **Bedroom:** a bed at the right height, a lamp within reach, and a commode or urinal if night-time trips are risky.
- **Kitchen:** everyday items stored between waist and shoulder height, so there is no climbing or bending low.
- **Outside:** clear, well-lit paths and a rail by the front step.

An occupational therapist can assess the home and recommend equipment. Our home safety checklist and equipment and home adaptations guide go into more detail.

Footwear and clothing

Shoes and slippers should fit well, fasten securely and have a thin, firm, non-slip sole. Backless slippers and worn-out shoes are common culprits. Trousers and dressing gowns should not trail on the floor. Swollen feet need properly fitting footwear, so ask the GP or a podiatrist if shoes have become hard to find.

Eyesight and hearing

Changes in vision affect balance and judging steps. NHS sight tests are free for everyone aged 60 and over, and opticians can visit at home if someone cannot leave the house unaccompanied because of illness or disability. Keep glasses clean, wear the right pair for the task, and take extra care on steps with bifocals or varifocals. Hearing loss also affects balance and awareness, so have hearing checked if it seems to be changing. See our sight and hearing loss guide.

Ask for a medication review

Some medicines can cause dizziness, drowsiness, low blood pressure or unsteadiness, including some sleeping tablets, sedatives, antidepressants and blood pressure medicines. The risk increases when several medicines are taken together. Ask the GP or pharmacist for a medication review, especially after a fall or if the person takes several medicines. Never stop a medicine without advice; there may be a safer dose or alternative. Our medication management guide has practical tips.

Strength and balance exercise

This is one of the most effective ways to prevent falls. The NHS advises older adults to be active every day, and to do activities that improve strength, balance and flexibility on at least two days a week. Ask the GP or local falls service about a strength and balance programme, which may be run in groups, at home or online. Gentle activities such as tai chi, dancing, gardening and walking all help. Sit less, and break up long periods in a chair.

If someone has not exercised for a while or has health conditions, speak to the GP before starting.

Nights and getting up safely

Many falls happen at night or when getting up. Encourage the person to sit on the edge of the bed for a moment before standing, to turn the light on first, and to use a walking aid if they have one. Keeping well hydrated in the day, rather than drinking a lot late in the evening, can reduce night-time toilet trips. If someone is often up in the night and unsteady, a waking night carer can be there to help.

What to do after a fall, and when to call 999 or 111

If you have fallen:

- Stay calm, take your time and check yourself for pain or injury.
- If you are not hurt and feel able, roll onto your side, get onto your hands and knees, crawl to a sturdy chair, put one foot flat on the floor and push up slowly. Then sit and rest.
- If you cannot get up, call for help using a phone or alarm, or shout or bang on the floor. Keep warm with anything to hand, keep moving your arms and legs, and change position about every 30 minutes.

If you find someone who has fallen, do not try to lift them yourself.

- **Call 999** if they may have injured their head, neck, back or hip, or cannot get up.
- **Call NHS 111** if they are in pain, may be injured or seem unwell.
- **See the GP** afterwards about any fall, or about worries with balance and walking. The GP can refer to a falls service, which may check strength, bones, eyesight, blood pressure and medicines, and arrange exercise and home safety checks.

Checklist: a falls plan for the home

- An alarm or mobile phone carried at all times, including to the bathroom and at night.
- A key safe, with the code held by family, carers and the alarm service.
- A list of who to call, in order, kept by the phone and given to the alarm service.
- A throw or blanket kept low down in the rooms used most.
- Practising how to get up from the floor, with a physiotherapist if possible.
- Daily contact: someone who checks in at an agreed time each day.

How to get NHS and council help, step by step

1. **Falls assessment:** after any fall, or if balance is worrying you, ask the GP for an assessment and a referral to the local falls service. In some areas you can refer yourself; the GP surgery can tell you how the local service works.
2. **Medicines:** ask the GP or a community pharmacist for a medication review.
3. **Eyes:** book a free NHS sight test with any optician (aged 60 and over); ask for a home visit if the person cannot go out unaccompanied.
4. **Hearing:** ask the GP for a hearing check and referral.
5. **Home and equipment:** ask the council's adult social care team for a care needs assessment, including an occupational therapist's home assessment, and ask about telecare.
6. **Larger adaptations:** ask the council about a Disabled Facilities Grant.

Personal alarms and telecare

A personal alarm, worn on the wrist or round the neck, lets someone call for help if they fall. Options include alarms that ring a family member's phone, alarms linked to a 24-hour monitoring centre, and automatic falls detectors that raise the alert even if the person cannot press the button. A key safe means responders can get in. Ask the council's adult social care team about local telecare services. Our technology and telecare guide compares the options.

How care at home can help

Care cannot remove every risk, and it should never take away someone's independence. But the right support can make a real difference: a carer can help with bathing and dressing safely, encourage exercises from the physiotherapist, make sure meals and drinks are taken, keep the home clear and be there at night. For people who have fallen several times or who are frail, live-in care means help is always close by. For others, a few home care visits at key times are enough.

Help with costs

- Free equipment and minor adaptations costing £1,000 or less, if the council assesses a need.
- A means-tested Disabled Facilities Grant of up to £30,000 in England for larger adaptations.

- No VAT on alarms and equipment designed for disabled people, for those who qualify.
- Attendance Allowance (£76.70 or £114.60 a week, not means-tested) for people over State Pension age who need help with personal care.

Where to get support

- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.
- **Independent Age Helpline:** 0800 319 6789 (free). Monday to Friday, 8.30am to 5.30pm.
- **NHS 111:** free, 24 hours a day, by phone or at 111.nhs.uk, for urgent advice after a fall.

What to do next

1. Tell the GP about any fall and ask for a falls assessment and a medication review.
2. Book a free NHS sight test if it has been more than two years.
3. Walk round the home and fix the quick wins: rugs, wires, lighting and the route to the toilet.
4. Ask about a local strength and balance programme.
5. Arrange a personal alarm and a key safe.
6. Ask the council for a care needs assessment if daily tasks have become risky.

How we can help

Day and Nightcare provides home care visits from one hour, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England, and fully managed live-in care anywhere in England from £1,550 a week. A regular carer can help someone stay active and move safely at home. Call 01865 715780 to arrange a free assessment.

Common questions

Why is a fall taken so seriously in later life?

Because a fall is often a sign that something else has changed, such as an infection, low blood pressure, a heart rhythm problem, a new medicine or weakening muscles. Falls can also lead to fractures, especially of the hip, and lying on the floor for a long time can cause pressure damage, dehydration and loss of confidence. Tell the GP about any fall, even if there was no injury, so the cause can be looked into.

Can fear of falling make things worse?

Yes. After a fall, many people understandably start doing less. But less movement leads to weaker muscles and poorer balance, which makes another fall more likely. The answer is usually more confidence, not less activity: a strength and balance programme, practising how to get up from the floor, a personal alarm and a safer home. Ask the GP about the local falls service.

Do personal alarms cost money?

It depends on the type. Basic alarms can be inexpensive to buy, while monitored alarms linked to a 24-hour response centre usually have an installation cost and a monthly charge. Some councils provide basic monitoring services after an assessment. People who are disabled or have a long-term illness do not pay VAT on alarms for their own use. If the home has a digital phone line, check the alarm is compatible.

Will we have to pay for grab rails and equipment?

Often not. In England, if the council assesses that someone needs equipment or a minor adaptation, such as grab rails, it must be provided free of charge as long as it costs £1,000 or less. Bigger changes, such as a level-access shower or stairlift, may qualify for a Disabled Facilities Grant of up to £30,000, which is means-tested. Ask the council's adult social care team for an assessment.

Should older people take vitamin D?

The NHS advises everyone to consider taking a daily vitamin D supplement in autumn and winter. People who are not often outdoors, for example because they are frail or housebound, or who live in a care home, are advised to take it all year round. Vitamin D helps keep bones and muscles healthy. Check with the GP or pharmacist first if the person takes other medicines or has kidney problems.

Sources and further information

- NHS: Falls
- NICE: Falls, assessment and prevention in older people (NG249)
- NHS: Personal alarms, security systems and keysafes
- NHS: Vitamin D
- GOV.UK: Falls, applying All Our Health
- GOV.UK: Disabled Facilities Grants
- legislation.gov.uk: Care and Support (Charging and Assessment of Resources) Regulations 2014, regulation 3

Read next

LIVING SAFELY AND WELL AT HOME

Home safety checklist for older people: room by room

A practical room-by-room home safety checklist for older people and their families, covering falls, fire, gas, electrics, heating and cold, the bathroom, stairs, the garden and doorstep scams, plus how to get a free home fire safety visit from your fire and rescue service.

Read the guide →

LIVING SAFELY AND WELL AT HOME

Equipment and home adaptations: what is free and how to get it

How to get equipment and home adaptations for an older or disabled person in England: occupational therapy assessments, free council and NHS equipment, Disabled Facilities Grants of up to £30,000, VAT relief, beds, hoists and stairlifts, and how to buy safely.

Read the guide →

LIVING SAFELY AND WELL AT HOME

Technology and telecare: alarms, sensors and smart help at home

A plain guide to personal alarms, fall detectors, telecare sensors, video calls, medication dispensers and smart home help for older people, with typical costs, council telecare schemes, VAT relief, and what the digital phone switchover means for alarms.

Read the guide →

All guides in the information centre **Check what help you could get**

This page online: **www.dayandnightcare.co.uk/guides/falls-prevention/**
Guide last reviewed 30 October 2026.

Frailty in later life: what it is and how to slow it

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Frailty describes how much reserve a person's body and mind have: someone living with frailty can be knocked off their feet by a minor illness, a fall or a change in medicines. It is not an inevitable part of ageing, and it can get better as well as worse. Regular activity, good nutrition, a medication review and planning ahead can slow it, and sometimes improve it.



IN THIS GUIDE

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What is frailty?

Frailty is a health state in which the body gradually loses its built-in reserves. In everyday terms, it is about resilience: how well someone bounces back from illness, injury or upheaval.

A fit older person with a urinary infection may feel unwell for a few days. Someone living with frailty may become confused, fall, stop eating and lose the ability to walk, all from the same infection. The trigger is small; the effect is large. That is why frailty matters, and why spotting it early helps.

Frailty is not the same as having several long-term conditions, although the two often go together. Nor is it a diagnosis that should change how a person is treated as an individual. It is a way of recognising who needs extra care to stay well.

Signs of frailty to look out for

Health professionals often describe five signs. Having three or more suggests frailty; one or two may mean someone is at risk.

- Losing weight without trying.
- Weakness, such as difficulty opening jars or getting out of a chair.
- Walking more slowly than before.
- Feeling exhausted much of the time.
- Being much less active.

Frailty also often shows itself through a fall, sudden confusion (delirium), a sudden loss of mobility, new incontinence, or side effects from medicines that were previously fine. If any of these happen, it is worth asking the GP whether frailty is part of the picture.

How frailty is identified

GP practices in England use a tool called the electronic frailty index, which looks at existing health records to flag people aged 65 and over who may be living with mild, moderate or severe frailty. A clinician then confirms it in person, often using the Clinical Frailty Scale. People with more complex needs may be offered a comprehensive geriatric assessment by a team specialising in older people's health, which looks at physical health, mood, memory, medicines, mobility, home and support together, and produces a plan.

If you are worried about a relative, it is reasonable to ask the GP: "Has Mum been assessed for frailty, and is there a plan?"

How to slow frailty: keep moving

Activity is the single most powerful tool. Muscles that are not used weaken quickly in later life, especially during illness or a hospital stay. The NHS advises older adults to be active every day, and to do activities that build strength, balance and flexibility on at least two days a week.

For someone who is frail, this can start very small:

- Standing up from a chair several times, using the arms if needed.
- Walking to the end of the garden or round the house a little further each day.
- Seated exercises with the radio on.
- Carrying shopping, gardening, or doing housework at their own pace.

Ask the GP or a physiotherapist about a safe programme, and about local strength and balance classes. Breaking up long periods of sitting matters too.

Eating well to build strength

Weight loss and poor appetite both speed up frailty. The NHS says that losing 5% to 10% of body weight over three to six months without trying is a sign of malnutrition. Helpful habits:

- Protein at every meal and snack, such as eggs, cheese, milk, yoghurt, fish, meat, beans or lentils.
- Small meals and snacks more often if appetite is poor.
- Full-fat milk and yoghurt rather than low-fat versions when someone is losing weight.
- Enough drinks through the day.
- A daily vitamin D supplement for people who are rarely outdoors, as the NHS recommends; ask the GP or pharmacist which one suits, especially if they take other medicines.

See our nutrition and hydration guide for practical ideas.

Ask for a medication review

People living with frailty are more sensitive to side effects, and medicines that once helped may now cause dizziness, confusion or falls. Ask the GP or practice pharmacist for a structured medication review. The aim is to check each medicine is

still needed, still helping and safe at its current dose, and to agree any changes with the person. Never stop medicines without advice.

Other ways to stay well

- **Vaccinations:** have the flu, COVID-19 and pneumococcal vaccines when offered, and the RSV vaccine if aged 75 or over.
- **Sight and hearing:** regular checks; poor senses add to falls and isolation.
- **Mood and company:** loneliness and low mood are linked with frailty, so staying connected matters. See our loneliness and wellbeing guide.
- **Recovering from setbacks:** after an illness or hospital stay, ask about reablement, which is free for up to six weeks and helps rebuild strength and confidence.

Planning ahead

Because frailty can make health change suddenly, it helps to think ahead while the person can say what matters to them. Useful steps include:

- Talking about what matters most: staying at home, avoiding hospital where possible, or having every treatment available.
- Making Lasting Powers of Attorney for finances and for health and welfare.
- Writing an advance statement of wishes and, if wanted, an advance decision to refuse specific treatments.
- Asking the GP about an emergency plan, such as a ReSPECT form where it is used locally.
- Keeping a list of medicines, conditions and contacts by the phone.

Our guides to advance care planning and Lasting Power of Attorney explain each step.

How care at home can help

In frailty, small changes are early warning signs: eating a little less, sleeping more, a bit more confused, slower on the stairs. A regular carer who knows the person well is often the first to notice and can raise concerns before they become a crisis. Care

at home can also make the healthy habits happen every day: preparing protein-rich meals, encouraging the physiotherapist's exercises, supporting medicines and keeping the person company.

For some people, a few home care visits are enough. For those whose frailty is more advanced, or who live alone and are at risk of falls, live-in care means a carer is in the home through the day and close by at night. A care home may suit better when someone needs nursing care around the clock.

Checklist: a simple monthly check-in

Families and carers can run through this once a month and take it to the GP if things are slipping:

- **Weight:** the same scales, the same time of day; is it falling?
- **Eating and drinking:** finishing meals? Drinking regularly? Pale urine?
- **Moving:** getting out of a chair, walking and managing stairs as well as last month?
- **Falls:** any falls, trips or near misses?
- **Mood and memory:** brighter, flatter or more confused than usual?
- **Medicines:** taken as prescribed? Any dizziness or drowsiness?
- **Sleep and continence:** any new problems?
- **Company:** how many days without seeing or speaking to anyone?

When to call the GP, 111 or 999

Call 999 if the person:

- Suddenly becomes confused, very drowsy or cannot be woken properly.
- Has severe difficulty breathing, chest pain or signs of a stroke.
- Has fallen and may have hurt their head, neck, back or hip, or cannot get up.

Contact the GP the same day or call NHS 111 (free, 24 hours) if there is:

- A sudden change in walking, eating, drinking or continence.
- Signs of infection, such as a temperature, shivering, a new cough or pain passing urine.

- Dizziness on standing that does not go away, or dark urine and drinking very little.

Book a routine GP appointment about weight loss, increasing tiredness, falls or concerns about medicines.

How to get NHS and council help, step by step

1. **Frailty review:** ask the GP whether frailty has been assessed and whether there is a care plan. For complex needs, ask about a referral to the older people's or frailty team.
2. **Medicines:** ask for a structured medication review with the GP or practice pharmacist.
3. **Strength and falls:** ask about the local falls service or a strength and balance programme.
4. **Eating:** if weight is falling, ask the GP to check for causes and refer to a dietitian.
5. **Support at home:** ask the council's adult social care team for a free care needs assessment, including equipment and telecare.
6. **Connection:** ask the GP practice about a social prescribing link worker, who can connect the person with local groups and services.
7. **Planning ahead:** ask the GP to talk through an emergency plan and record the person's wishes.

Where to get support

- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.
- **Independent Age Helpline:** 0800 319 6789 (free). Monday to Friday, 8.30am to 5.30pm.
- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.

Help with costs

- Attendance Allowance, £76.70 or £114.60 a week, for people over State Pension age who need help with personal care. It is not means-tested.
- A free council care needs assessment, followed by a financial assessment. The person's home is not counted when care is at home.

- Free equipment and minor adaptations costing £1,000 or less if the council assesses a need.
- NHS Continuing Healthcare if needs become mainly health needs.

What to do next

1. Ask the GP whether frailty has been assessed and whether there is a care plan.
2. Request a medication review.
3. Start a little daily activity and ask about strength and balance support.
4. Check weight monthly and boost protein and calories if it is falling.
5. Talk about wishes and put Lasting Powers of Attorney in place.
6. Ask the council for a care needs assessment and claim Attendance Allowance if eligible.

How we can help

Day and Nightcare has supported older people at home since 2008. We offer home care visits from one hour, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England, and fully managed live-in care anywhere in England from £1,550 a week. Call 01865 715780 to arrange a free assessment.

Common questions

Is frailty just another word for being old?

No. Frailty is a particular health state, not an age. Around 10% of people aged over 65 live with frailty, rising to between a quarter and a half of those over 85, which means many people in their eighties and nineties are not frail at all. Some younger people with several long-term conditions are. Frailty also says nothing about someone's intelligence or their right to make their own decisions.

Can frailty be reversed?

Sometimes, and it can almost always be slowed. The British Geriatrics Society describes frailty as a long-term condition whose severity can get better or worse. People with mild frailty have most to gain, but even those who are more frail can benefit from regular strength and balance activity, eating enough protein and calories, and stopping medicines that are no longer helping. Progress usually depends on keeping these habits going.

What is the Clinical Frailty Scale?

It is a nine-point scale that health professionals use to describe how fit or frail someone is, from very fit to terminally ill, based on how they managed in the weeks before an illness. Hospitals and GPs use it to help plan care and decide which treatments are likely to help. It is a starting point for a conversation, not a judgement, and families can help by describing how the person usually manages.

Does living with frailty mean someone cannot stay at home?

No. Many people living with frailty live at home, often with some support. Age UK stresses that frailty does not mean a person lacks capacity or cannot live independently. The right support at home, such as help with meals, washing, medicines and staying active, can reduce the risk of falls and hospital admissions. A care needs assessment from the council is a good first step.

What is a ReSPECT form?

ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. It records a person's wishes and clinical recommendations for an emergency in which they cannot speak for themselves, including whether CPR should be attempted. It is made through a conversation with a doctor or nurse, stays with the person at home and can be reviewed at any time. It is not legally binding, and it is used in many, but not all, areas of England.

Sources and further information

- Age UK: Understanding frailty
- British Geriatrics Society: Introduction to frailty
- NHS England: Electronic Frailty Index
- NHS: Physical activity guidelines for older adults

- NHS: Malnutrition
- Resuscitation Council UK: ReSPECT for patients and carers

Read next

HEALTH CONDITIONS AND CARE AT HOME

Falls prevention for older people: a practical guide

Why older people fall and how to reduce the risk at home: common causes, home hazards, footwear, eyesight, medication reviews, strength and balance exercise, what to do after a fall, personal alarms, and the free help available from the NHS and the council.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Nutrition and hydration in later life: a guide for families

Why older people are at risk of malnutrition and dehydration, the warning signs, practical ways to help someone eat and drink well, texture-modified diets and swallowing support, monitoring weight, and where to get help, from the GP and dietitian to meals at home.

Read the guide →

LEGAL MATTERS AND PLANNING AHEAD

Advance care planning: making your wishes known

A gentle guide to advance care planning in England: advance statements, advance decisions to refuse treatment, ReSPECT forms and DNACPR decisions, choosing your preferred place of care, and how to start the conversation with family and professionals.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/frailty-in-later-life/**

Heart failure and COPD at home: a guide for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Heart failure and COPD are long-term conditions that cause breathlessness and tiredness, but with the right treatment, routines and support many people live well at home for years. Learn the person's usual pattern, act early on warning signs such as sudden weight gain or worsening breathlessness, keep medicines and oxygen safe, and call 999 for severe breathing difficulty or chest pain.



IN THIS GUIDE

1. How heart failure and COPD affect daily life
2. How to manage breathlessness
3. Warning signs: heart failure
4. Warning signs: a COPD flare-up
5. Medicines and vaccinations
6. Home oxygen safety
7. Saving energy for what matters
8. Rehabilitation
9. Checklist: a daily record
10. How to get NHS help, step by step
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12. How care at home can help
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How heart failure and COPD affect daily life

Both conditions tend to follow a pattern of good days and bad days, with longer stable spells broken by flare-ups. Common effects at home include:

- Breathlessness when walking, washing, dressing or climbing stairs, and sometimes when lying flat.
- Tiredness that makes ordinary tasks feel exhausting.
- Swollen ankles and legs (more common in heart failure).
- A persistent cough with phlegm and frequent chest infections (more common in COPD).
- Poor appetite, weight changes and disturbed sleep.
- Anxiety, which often rises with breathlessness and can make it worse.

Neither condition can be cured, but treatment can control symptoms and many people stay stable for years. The aim of care at home is to keep the person comfortable and active, to spot problems early, and to avoid unnecessary hospital stays.

How to manage breathlessness

Breathlessness is frightening, for the person and for those watching. Practical techniques taught by NHS respiratory and heart teams include:

- **Positions:** sitting upright and leaning forward with forearms resting on the knees or a table, or standing and leaning on a wall or worktop, lets the breathing muscles work more easily.
- **Breathing control:** gentle, relaxed breathing with the shoulders down and supported.
- **Pursed-lip breathing:** breathing in through the nose and out slowly through pursed lips, as if whistling.
- **Paced breathing:** matching breaths to steps on the stairs or during activity.
- **Air movement:** many people find a cool flow of air on the face, from a handheld fan or an open window, eases the feeling of breathlessness.

Stay calm, speak gently and give the person time. A written breathlessness plan from the respiratory or heart failure nurse is invaluable for everyone in the home.

Warning signs: heart failure

Weigh the person every morning, after using the toilet and before breakfast, in similar clothing, and write the result down. A sudden rise in weight usually means fluid is building up. The heart failure team will give a personal threshold; the British

Heart Foundation's guidance suggests acting on a gain of more than 2kg over three days. Ask for an urgent GP appointment or contact NHS 111 if the person:

- Has suddenly gained weight.
- Is more breathless with everyday activity or when lying down.
- Has more swelling in the legs or tummy.
- Is coughing up frothy pink phlegm.

Warning signs: a COPD flare-up

A flare-up (exacerbation) is when symptoms become suddenly worse than usual: more breathless, coughing more, more phlegm or a change in its colour. Other signs include more wheeze, tiredness, swollen ankles and confusion. Follow the person's COPD self-management plan, which may include extra reliever inhaler use or starting a rescue pack, and let the GP or respiratory team know.

Medicines and vaccinations

- Give medicines exactly as prescribed, and keep a current list.
- Ask the pharmacist to check inhaler technique; many people do not get the full dose.
- Ask the team about the best time of day for water tablets (diuretics), so they do not disturb the night.
- Check with the GP or pharmacist before taking any over-the-counter remedy or supplement.
- Keep vaccinations up to date: the yearly flu vaccine, the pneumococcal vaccine, COVID-19 vaccines when offered, and the RSV vaccine for people aged 75 and over.

Our medication management guide explains prompting and administering medicines safely.

Home oxygen safety

Extra oxygen in the air makes fires start more easily and burn much more fiercely, so a lit cigarette or a flame can cause a serious fire. If someone uses oxygen at home:

- No smoking or e-cigarettes by anyone in the room, ever.

- Keep oxygen equipment well away from naked flames, gas cookers, fires and heaters.
- Ask the oxygen team about skin creams: emollients soaked into clothing and bedding can make fabric burn more easily.
- Keep tubing tidy to avoid trips, and store cylinders as the supplier advises.
- Contact the local fire and rescue service about a free home fire safety visit, and fit working smoke alarms.

Saving energy for what matters

Pacing lets people do more of what they enjoy. An occupational therapist can advise, and simple changes help:

- Sit down to wash, dress, shave and prepare food; a perching stool and shower seat make a big difference.
- Plan the day, spread out tiring tasks, and rest before becoming exhausted.
- Keep frequently used items within easy reach, between waist and shoulder height.
- Wear a towelling dressing gown after a shower instead of drying off with a towel.
- Eat smaller meals more often, as a full stomach can make breathing harder.

Rehabilitation

The NHS says everyone diagnosed with heart failure should be offered cardiac rehabilitation, with exercise, advice and support. For COPD, pulmonary rehabilitation is a programme of exercise and education, usually two or more group sessions a week for at least six weeks. Both improve how far people can walk, how they feel and their confidence. Ask the GP or specialist nurse for a referral.

Checklist: a daily record

A simple daily note helps the person, carers and the heart or lung team spot changes early. Each morning, record:

- Weight (heart failure), on the same scales at the same time.
- Ankle and leg swelling: better, the same or worse?
- Breathlessness compared with a usual day, and how many pillows were needed at night.

- Cough and phlegm: more than usual, or a change in colour?
- How often the reliever inhaler was needed, and whether a rescue pack was started.
- Medicines taken, and any missed doses.
- Appetite, sleep and how the person feels in themselves.

How to get NHS help, step by step

1. **Specialist nurse:** ask the GP for a referral to the local heart failure team or respiratory (COPD) team, if the person does not already have a named nurse.
2. **Self-management plan:** ask the nurse or GP for a written plan that says what to do on a bad day and when to call.
3. **Rehabilitation:** ask the GP, specialist nurse or hospital team for a referral to cardiac or pulmonary rehabilitation.
4. **Oxygen:** if oxygen might help, the GP or respiratory team can refer for the tests that decide whether it is needed.
5. **Vaccinations:** book flu, pneumococcal, COVID-19 and RSV vaccines through the GP surgery or a pharmacy when eligible.
6. **Support at home:** ask the council's adult social care team for a care needs assessment and an occupational therapist for equipment.
7. **Comfort and planning:** ask the GP or specialist nurse about the community palliative care team when symptoms become harder to manage.

When to call 111 or 999

Call 999 immediately if the person:

- Has severe difficulty breathing: gasping, choking or unable to get words out.
- Has chest pain or tightness, or pain spreading to the arms, back, neck or jaw.
- Has lips or skin turning very pale, blue or grey.
- Becomes suddenly confused, or collapses and is not responding normally.

Contact the GP urgently or NHS 111 (free, 24 hours) for the heart failure or COPD warning signs above, a suspected chest infection, or if you are struggling to manage at home. Do not drive someone who is seriously unwell to A&E yourself; call 999.

How care at home can help

Breathlessness often makes personal care, cooking and nights the hardest parts of the day. A carer can take on the tiring tasks so the person saves energy for what they enjoy, support medicines, help with daily weighing and keep a record, and notice early warning signs. Night-time breathlessness and anxiety are common, so night care or a live-in carer can bring real reassurance. If the illness becomes advanced, our page on end of life care at home explains how care can support comfort and family time.

Help with costs

- Attendance Allowance (£76.70 or £114.60 a week) over State Pension age, or Personal Independence Payment under it; neither is means-tested.
- A free council care needs assessment, followed by a financial assessment.
- NHS Continuing Healthcare for complex health needs, including the Fast Track route for people whose health is deteriorating quickly towards the end of life.

Where to get support

- **British Heart Foundation Heart Helpline:** 0808 802 1234 (free), staffed by cardiac nurses. Weekdays 9am to 5pm, except bank holidays.
- **Asthma + Lung UK Helpline:** 0300 222 5800. Monday to Friday 9am to 5pm, except bank holidays.
- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.
- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.

What to do next

1. Make sure there is a written self-management or breathlessness plan, and keep it by the phone.
2. Start a daily weight and symptom diary.
3. Check vaccinations and inhaler technique with the GP surgery or pharmacy.
4. Ask for a referral to cardiac or pulmonary rehabilitation.
5. If oxygen is used, book a free home fire safety visit.
6. Request a council care needs assessment if daily tasks have become exhausting.

How we can help

Day and Nightcare provides fully managed live-in care anywhere in England, from £1,550 a week, and home care visits, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England. We work with private, council, direct payment and NHS Continuing Healthcare funding. Call 01865 715780 to arrange a free assessment.

Common questions

What is the difference between heart failure and COPD?

Heart failure means the heart is not pumping blood around the body as well as it should; it does not mean the heart has stopped. Fluid can build up in the lungs, legs and tummy. COPD (chronic obstructive pulmonary disease) is a group of lung conditions, including emphysema and chronic bronchitis, that narrow the airways and damage the lungs. Both cause breathlessness and tiredness, and many older people live with both.

Will oxygen help with breathlessness?

Not necessarily. Home oxygen is prescribed for people whose blood oxygen level is too low, which is checked with tests. The NHS explains that long-term oxygen therapy treats low oxygen levels rather than breathlessness itself, and it is usually needed for at least 15 hours a day to help. Many breathless people have normal oxygen levels and are better helped by breathing techniques, positioning, rehabilitation and the right inhalers or medicines.

What is a COPD rescue pack?

A rescue pack is a supply of steroid tablets, and sometimes antibiotics, that a doctor or nurse may prescribe for someone with COPD to start at home if a flare-up begins. The COPD self-management plan should say exactly when to use it. Always tell the GP or respiratory team when the rescue pack has been used, so they can review treatment and replace it.

Should someone with heart failure drink less?

Only if their heart failure team advises it. Some people are asked to keep to a daily fluid limit, because extra fluid can build up when the heart is weak, but others are not. Restricting drinks without advice can lead to dehydration, dizziness and kidney problems, especially for people taking water tablets. Ask the team for a clear daily amount, and whether it changes in hot weather or illness.

Is palliative care only for the last days of life?

No. Palliative care focuses on comfort and quality of life, and it can start much earlier, alongside other treatment. For people with advanced heart failure or COPD, a palliative care team can help with breathlessness, anxiety, pain, equipment and support for the family, and help plan for the future. Ask the GP or specialist nurse about a referral when symptoms become harder to manage.

Sources and further information

- NHS: Heart failure
- NHS: Living with heart failure
- NHS: COPD treatment
- NHS: Living with COPD
- British Heart Foundation: Heart failure
- Asthma + Lung UK: COPD flare-ups
- NHS: RSV vaccine

Read next

LEGAL MATTERS AND PLANNING AHEAD

Planning end of life care at home: a gentle guide

How to plan end of life care at home in England: choosing to die at home, the team around you (GP, district nurses, hospice at home, live-in carers), just in case medicines, NHS Continuing Healthcare Fast Track, preparing practically and emotionally, and what to do when someone dies.

Read the guide →

LIVING SAFELY AND WELL AT HOME

Managing medication at home: a guide for families and carers

How medicines support works at home: prompting versus administering, blister packs and their limits, MAR charts, safe storage, medication reviews with the GP or pharmacist, the free New Medicine Service, what paid carers can and cannot do, and a medicines list template.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Frailty in later life: what it is and how to slow it

A plain guide to frailty in older people: what it means, the signs to look for, how GPs identify it, and practical ways to slow or improve it through activity, good nutrition, medication reviews and planning ahead, with the support and funding available at home.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/heart-failure-and-copd-at-home/**

Continence care with dignity: a guide for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Incontinence is common in later life, but it is not an inevitable part of ageing and it can often be improved or even cured. Start with the GP, who can look for causes such as infection, constipation or medicines and refer to the NHS continence service, which may supply products. Good care protects the skin, keeps routines regular and always puts the person's dignity first.



IN THIS GUIDE

1. Why bladder and bowel problems happen in later life
2. How to get NHS continence help, step by step
3. Treatments that can help
4. Checklist: a three-day bladder diary
5. Choosing continence products
6. Caring for the skin
7. Protecting dignity
8. Routines that help
9. Managing nights
10. When to call the GP, 111 or 999
11. Checklist: a continence care kit
12. How care at home can help
13. Where to get support
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Why bladder and bowel problems happen in later life

Incontinence means leaking urine or faeces without meaning to. It is common, and it is often hidden because people feel embarrassed. But it is a symptom, not a diagnosis, and there is usually a reason that can be looked into.

The main types of bladder leakage are:

- **Stress incontinence:** leaks when coughing, sneezing, laughing or lifting, usually because the pelvic floor muscles are weaker.
- **Urge incontinence:** a sudden, strong need to go, with leaks before reaching the toilet.
- **Overflow incontinence:** the bladder cannot empty fully, so it leaks often. In men, an enlarged prostate is a common cause.
- **Mixed incontinence:** a combination of stress and urge.

Many older people also leak because they cannot reach or use the toilet in time, for example because of slow walking, arthritis, or dementia making it hard to find the toilet or recognise the need to go.

Bowel incontinence is less common but very distressing. One of the most frequent causes in older people is constipation, when hard stool blocks the bowel and looser stool leaks around it.

Other common contributors are urinary infections, some medicines (water tablets, for example), not drinking enough, reduced mobility, stroke, Parkinson's, diabetes and the after-effects of childbirth or surgery.

How to get NHS continence help, step by step

1. **Book a GP or practice nurse appointment.** Say that you would like help with bladder or bowel control. If the person is housebound, ask whether the district nurse can visit.
2. **Keep a three-day bladder diary** beforehand (see the checklist below).
3. **Expect simple checks:** questions, a urine test, an examination, and a review of medicines that might be making things worse.
4. **Ask for a referral to the NHS continence service** (sometimes called the bladder and bowel service). Some areas accept self-referral, so check the local NHS website or ask the surgery.
5. **The continence assessment:** a specialist nurse looks at the causes, suggests treatment and, if products are needed, which type and size.
6. **Products and review:** if your area supplies them, products are delivered to the home. Ask how to reorder and when they will be reviewed, and ask for a review if needs change.

Treatments that can help

Depending on the cause, the GP or continence nurse may suggest:

- **Pelvic floor exercises,** ideally taught by a specialist physiotherapist or nurse.
- **Bladder training,** gradually lengthening the time between feeling the urge and going.
- **Treating constipation,** with diet, fluids, activity and, if needed, laxatives.
- **Medicines** for an overactive bladder or an enlarged prostate.
- **Referral to a specialist** for further tests.

Even when incontinence cannot be cured, it can usually be managed much better.

Checklist: a three-day bladder diary

For three days, write down:

- Every drink: the time, what it was and roughly how much.
- Every toilet visit: the time, and roughly how much urine was passed.
- Every leak: the time, and what was happening (coughing, rushing to the toilet, asleep).
- Pad changes, and how wet each pad was.
- Bowel movements and any accidents.

Choosing continence products

No single product suits everyone, and many people use a combination. Types include pads and pull-up pants, bed and chair protection, handheld urinals for men and women, toilet frames, commodes and, for some people, sheaths or catheters. Washable options are available too.

The right size and absorbency matter for comfort, skin health and dignity, because the wrong product can leak, rub or feel bulky. Ask the continence nurse to review the choice if leaks, soreness or discomfort continue, and plan different products for day, night and outings.

Caring for the skin

Urine and faeces irritate the skin quickly, and older skin is thin and easily damaged. To protect it:

- Change wet or soiled pads promptly, rather than waiting for set times.
- Wash gently with warm water and a pH-balanced cleanser or wipes designed for continence care, rather than ordinary soap.
- Pat the skin dry; do not rub.
- Use a barrier cream only as advised, in a thin layer, as thick layers can stop pads absorbing properly.
- Check daily for redness, soreness or broken skin, especially over the bottom, hips and heels.

Report red or broken skin to the district nurse promptly. Our guide to nutrition and hydration explains why eating and drinking well also protects the skin.

Protecting dignity

Continence care is one of the most personal kinds of help anyone can receive. Good care feels respectful and calm:

- Close doors and curtains, cover the person as much as possible, and only have the people present who need to be.
- Ask about preferences, including whether they would prefer a carer of the same sex.
- Use adult language: “pads” or “pants”, never “nappies”.
- Stay matter-of-fact after an accident; reassure and never scold.
- Let the person do as much as they can for themselves.
- Choose clothes that are easy to undo, such as elasticated waists.

Routines that help

- Offer regular toilet visits, for example after meals and before going out, rather than waiting to be asked.
- Watch for signs of needing to go, such as fidgeting or getting up suddenly.
- Make the toilet easy to find and use: a clear sign on the door, the door left open, good lighting, a raised seat and grab rails.
- Keep drinks regular through the day.
- Support regular bowel habits with fibre, fluids, activity and unhurried time on the toilet, ideally with the feet raised on a small step.

These simple steps help many people living with dementia stay dry and comfortable for longer.

Managing nights

Night-time toilet trips disturb sleep and are a common time for falls. Helpful steps:

- Drink less in the couple of hours before bed, while keeping up daytime drinks.
- Use the toilet just before going to bed.
- Light the route with night lights or motion-sensor lights.
- Keep a commode or urinal by the bed if walking at night is unsafe.
- Use a night-time pad with higher absorbency, and washable or disposable bed protection.

If someone needs help several times a night, a carer providing a waking night can help them to the toilet safely, change pads and bedding, and settle them again, so the family can sleep.

When to call the GP, 111 or 999

- **Call 999** if the person is suddenly confused, very drowsy or has difficulty speaking.
- **Call NHS 111 or go to A&E** if they cannot pass urine at all, or have severe tummy pain.
- **Ask for an urgent GP appointment or call NHS 111** (free, 24 hours) if someone aged 65 or over may have a urine infection, or has a high temperature or feels hot and shivery.
- **Book a GP appointment** about any new or worsening leakage, blood in urine or stools, a change in bowel habit, or constipation that does not improve.

Checklist: a continence care kit

- Pads or pants in the size and absorbency the nurse advised.
- A pH-balanced cleanser or continence wipes, soft cloths and towels.
- Barrier cream, if advised.
- Disposable gloves and bags for used products.
- Bed and chair protection.
- A change of clothes and bedding within easy reach.

- A small travel kit for days out.

How care at home can help

The right carer makes continence care feel ordinary and private. A consistent live-in carer gets to know someone's patterns, prompts at the right times, keeps skin healthy and notices changes early. Many people find it easier to accept this help from one familiar person than from several different visitors. Our page on types of care at home explains the options.

Where to get support

- **Bladder & Bowel UK confidential helpline:** 0161 214 4591, or email bbuk@disabledliving.co.uk. Specialist nurses and a product adviser can explain options and how to find your local service.
- **Your local NHS continence service,** through the GP, practice nurse or district nurse.
- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.
- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.

Help with costs

- NHS continence products after an assessment, depending on local policy.
- No VAT on incontinence products for people who are disabled or have a long-term illness.
- Attendance Allowance, £76.70 or £114.60 a week, for people over State Pension age who need help with personal care, including at night. It is not means-tested.
- Free equipment, such as a raised toilet seat, commode or grab rails, if the council assesses a need and it costs £1,000 or less.

What to do next

1. Book a GP or practice nurse appointment and start a three-day bladder diary.
2. Ask for a referral to the NHS continence service and a product assessment.
3. Set up a simple daily routine for drinks, toilet visits and skin checks.
4. Make the route to the toilet safe and well lit at night.
5. Claim Attendance Allowance if the person needs help day or night.

How we can help

Day and Nightcare has supported people at home since 2008. We provide home care visits from one hour, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England, and fully managed live-in care anywhere in England from £1,550 a week. If you would like to talk about the support your relative needs, in confidence, call 01865 715780 to arrange a free assessment.

Common questions

Are incontinence pads free on the NHS?

They can be, depending on where you live. Most local NHS continence services supply products after a continence assessment by a nurse or other health professional, often with a set number per day and home delivery. The rules vary between areas, so ask the GP or district nurse how to be referred. If you buy your own, people who are disabled or have a long-term illness should not be charged VAT on incontinence products for their personal use.

Should someone drink less to avoid accidents?

No, not during the day. Drinking too little makes urine more concentrated, which can irritate the bladder and make urgency worse, and it raises the risk of urinary infections, constipation and dizziness. Aim for regular drinks through the day. It can help to drink less in the couple of hours before bed and to cut down on tea, coffee, cola and alcohol, which can irritate the bladder.

How can I raise incontinence with my parent?

Choose a private, unhurried moment and be matter-of-fact. Many people feel deeply embarrassed and may have been hiding the problem for some time. You might say that it is very common, that it is often treatable, and that the GP can help. Focus on comfort and health rather than accidents, use the words they are comfortable with, and let them decide who is involved.

Does incontinence mean someone has to move into a care home?

Not on its own. Incontinence is one of the most common reasons families feel they cannot cope, but with a proper assessment, the right products, regular routines and help with personal care, most people can be cared for well at home. Night-time care can take the pressure off family carers. A care home may become the better choice when incontinence is one of several needs that require help around the clock and home care cannot meet them.

When is a catheter used?

A urinary catheter, a thin tube that drains the bladder, is used for specific medical reasons, such as when the bladder cannot empty properly. It is not usually the first answer to incontinence, because catheters carry a risk of infection and other problems. If someone has a catheter, the district nurse or continence team should explain how to care for it, and what signs of infection or blockage to look out for.

Sources and further information

- NHS: Urinary incontinence
- NHS: Incontinence products
- NHS: Bowel incontinence
- NHS: Urinary tract infections (UTIs)
- Bladder & Bowel UK: Promoting and maintaining continence
- GOV.UK: Reliefs from VAT for disabled and older people (Notice 701/7)

Read next

HEALTH CONDITIONS AND CARE AT HOME

Dementia care at home: a practical guide for families

How to support someone with dementia at home: the stages, communication, routines, eating and drinking, sundowning and nights, wandering and safety, Lasting Power of Attorney, support for carers and how care is funded, including NHS Continuing Healthcare and council tax.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Nutrition and hydration in later life: a guide for families

Why older people are at risk of malnutrition and dehydration, the warning signs, practical ways to help someone eat and drink well, texture-modified diets and swallowing support, monitoring weight, and where to get help, from the GP and dietitian to meals at home.

Read the guide →

LIVING SAFELY AND WELL AT HOME

Equipment and home adaptations: what is free and how to get it

How to get equipment and home adaptations for an older or disabled person in England: occupational therapy assessments, free council and NHS equipment, Disabled Facilities Grants of up to £30,000, VAT relief, beds, hoists and stairlifts, and how to buy safely.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/continence-care-with-dignity/**

Nutrition and hydration in later life: a guide for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Around one in ten people over 65 are malnourished or at risk of it, and dehydration often goes unnoticed because the sense of thirst fades with age. Watch for unplanned weight loss, loose clothes and dark urine; offer small, frequent meals the person enjoys and regular drinks; and ask the GP for help early, including a dietitian or speech and language therapist if eating or swallowing is difficult.



IN THIS GUIDE

1. Why older people are at risk
2. Warning signs to look out for
3. Practical ways to help someone eat well
4. Practical ways to help someone drink more
5. Food the person enjoys
6. Swallowing problems and texture-modified diets
7. Keeping an eye on weight
8. Checklist: an easy-food store cupboard
9. When to call the GP, 111 or 999
10. How to get NHS help, step by step
11. How care at home helps
12. Help with costs
13. Where to get support
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Why older people are at risk

Malnutrition means the body is not getting enough energy, protein, vitamins or minerals to stay healthy. Age UK estimates that around one in ten people over 65 are malnourished or at risk of malnutrition, and most of them live in their own

homes rather than in hospital or care homes. It is easy to miss, because it often creeps up slowly, and it can happen to people of any size: someone overweight can still be malnourished.

Common reasons include a smaller appetite, long-term conditions, pain, medicines, difficulty chewing or swallowing, reduced mobility, struggling with shopping or cooking, money worries, bereavement, loneliness and memory problems.

Dehydration is just as important. The sense of thirst becomes weaker with age, some people drink less to avoid trips to the toilet, and people who rely on others for drinks are at particular risk. Even mild dehydration can cause tiredness, dizziness, constipation, confusion and urinary infections, and it makes falls more likely.

Malnutrition and dehydration often go together, and both slow recovery from illness, weaken muscles and increase the risk of pressure damage to the skin.

Warning signs to look out for

Malnutrition:

- Losing weight without trying. The NHS describes losing 5% to 10% or more of body weight over three to six months as a key sign.
- Clothes, belts, rings or dentures becoming loose.
- Losing interest in food and drink, or leaving most of each meal.
- Tiredness, weakness and getting ill more often, or taking longer to recover.
- Food going out of date in the fridge, or an empty fridge.

Dehydration:

- Dark yellow, strong-smelling urine, or passing urine less often.
- A dry mouth, lips and tongue.
- Feeling dizzy or light-headed, headaches and tiredness.
- New or worse confusion.

Practical ways to help someone eat well

- **Little and often:** three small meals and two or three snacks a day are often easier than three large meals.

- **Fortify food:** add grated cheese, butter, cream, milk powder, eggs or nut butter to everyday dishes to boost energy and protein without increasing the portion.
- **Protein at every meal:** eggs, milk, cheese, yoghurt, fish, meat, beans or lentils help maintain muscle.
- **Nourishing drinks:** milky drinks such as hot chocolate, milky coffee or milkshakes between meals.
- **Make it appealing:** small portions on a plate with a coloured rim, favourite foods, and a calm, unhurried table.
- **Eat together:** company often improves appetite, and you can see how much is eaten.
- **Make it easier:** finger foods, adapted cutlery or plates from an occupational therapist, and well-fitting dentures.
- **Keep the mouth healthy:** regular dental checks and daily mouth care.
- **Stock up:** keep a few days of easy food in the cupboard and freezer.

Practical ways to help someone drink more

- Offer a drink with every activity: on waking, with medicines, at each meal, with visitors and before bed.
- Keep a drink within reach and in sight, in a cup or glass that is easy to hold.
- Offer variety: water, squash, tea, coffee, milk, soup, fruit juice with a meal.
- Include water-rich foods such as jelly, yoghurt, ice lollies, fruit and soup.
- If you are worried, keep a simple record of drinks for a few days.

Food the person enjoys

Eating is about pleasure, culture, memory and choice as well as nutrition. Ask what the person has always enjoyed, what they eat on special days, what their faith or culture means for food, and what they dislike. Favourite meals, familiar mealtimes and food from their own background can all lift appetite and mood. A small treat that is eaten is worth more than a “healthy” meal that is left.

Swallowing problems and texture-modified diets

Difficulty swallowing (dysphagia) is common after a stroke and in conditions such as Parkinson’s and dementia. The NHS lists signs including coughing or choking when eating or drinking, food coming back up, a feeling of food sticking, a gurgly

or wet voice after eating or drinking, and, over time, weight loss and repeated chest infections. If you notice these, ask for an urgent GP appointment or contact NHS 111.

A speech and language therapist (SALT) can assess swallowing and recommend the safest textures of food and thickness of drinks. In the UK these are described using the IDDSI framework, an international scale from 0 to 7: drinks range from thin (0) to extremely thick (4), and foods from liquidised (3) to regular (7). Follow the recommendation exactly every time, including for snacks and drinks given by visitors, and ask the SALT before changing anything.

Other good practice:

- Sit fully upright to eat and drink, and for at least a short time afterwards.
- Offer small mouthfuls, slowly, with no rushing and few distractions.
- Keep the mouth clean, because good oral care reduces the risk of chest infections.
- Ask the pharmacist about medicines that are hard to swallow; do not crush tablets without advice.

Our guides to Parkinson's care and stroke recovery cover swallowing in more detail.

Keeping an eye on weight

Weighing someone once a month, on the same scales, at the same time of day and in similar clothes, is the simplest way to spot a problem early. Write it down. If weighing is not possible, notice how clothes, rings and belts fit. Health professionals often use a screening tool called MUST (the Malnutrition Universal Screening Tool), developed by the British Association for Parenteral and Enteral Nutrition (BAPEN), which also offers a self-screening version online.

Checklist: an easy-food store cupboard

Keeping a few days of simple, nourishing food at home means there is always something to eat, even on a bad day:

- Long-life milk, milk powder and milky drink sachets.
- Porridge oats, breakfast cereal and crackers.
- Tinned fish, beans, soup and rice pudding.

- Custard pots, jelly and long-life desserts.
- Nut butter, cheese portions and eggs.
- Frozen ready meals, frozen vegetables and bread in the freezer.
- Small cartons of fruit juice and bottles of water.

When to call the GP, 111 or 999

- **Call 999** if someone is choking and cannot breathe, cough or speak and it does not clear, or has signs of severe dehydration such as confusion, cold or blotchy skin, or being very sleepy and hard to wake.
- **Ask for an urgent GP appointment or call NHS 111** (free, 24 hours) about signs of swallowing problems, or signs of dehydration such as dizziness on standing that does not go away, dark urine or passing much less urine than usual.
- **Book a GP appointment** about unplanned weight loss, poor appetite lasting more than a few days, or difficulty chewing.

How to get NHS help, step by step

1. **Weigh first:** take two or three monthly weights, or note how clothes fit, to show the GP.
2. **See the GP:** they can check for causes such as infection, medicines, constipation, low mood or dental problems, and may test blood.
3. **Dietitian:** if weight is falling or eating is difficult, ask for a referral. Supplement drinks are only prescribed when a clinician recommends them.
4. **Speech and language therapist:** if there is coughing, choking or a wet voice at meals, ask the GP for a referral; some services accept self-referral.
5. **Teeth and dentures:** book a dental check if eating is painful or dentures are loose.
6. **Help with meals:** ask the council's adult social care team for a care needs assessment, and an occupational therapist for adapted cutlery, plates and kitchen equipment.

How care at home helps

Many people eat better simply because someone is there. A carer can shop, cook meals the person likes, sit and eat with them, offer drinks through the day and notice when they are eating less. A live-in carer can prepare fresh meals and snacks

throughout the day and follow any texture-modified diet consistently, which is hard to achieve with short visits. For others, home care visits at mealtimes are enough.

Help with costs

- Attendance Allowance, £76.70 or £114.60 a week and not means-tested, can help pay for meals, shopping help or care.
- A free council care needs assessment may lead to support with meals and shopping, including meals delivered to the home.
- Prescribed supplement drinks are available on NHS prescription when a clinician recommends them.

Where to get support

- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year. It can point you to local lunch clubs and services.
- **Independent Age Helpline:** 0800 319 6789 (free). Monday to Friday, 8.30am to 5.30pm.
- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.
- **The council's adult social care team,** for meals and shopping support.

What to do next

1. Weigh the person and write it down; repeat monthly.
2. Look in the fridge and cupboards, and notice what is being eaten and drunk.
3. Introduce small meals, fortified food and regular drinks.
4. Book a GP appointment if weight is falling or eating or swallowing has changed.
5. Ask about lunch clubs, meals at home or care at mealtimes.

How we can help

Day and Nightcare provides home care visits from one hour across Oxfordshire, and fully managed live-in care anywhere in England from £1,550 a week, as well as waking nights and sleep-ins in Oxfordshire, and 24-hour care with carers working in shifts anywhere in England. Call 01865 715780 to arrange a free assessment.

Common questions

How much should an older person drink each day?

The NHS suggests 6 to 8 cups or glasses of fluid a day as a guide, and more in hot weather or during illness. Water, milk, tea and coffee all count, as does some fluid from food such as soup and yoghurt. Pale yellow urine is a good sign. If a doctor has advised a fluid limit, for example for heart failure or kidney disease, follow that advice instead.

Are nutritional supplement drinks a good idea?

They can help, but usually as a second step. Most dietitians start with 'food first': fortifying ordinary meals and adding nourishing snacks and milky drinks. If that is not enough, the GP, nurse or dietitian may prescribe supplement drinks, usually taken between meals so they do not spoil the appetite. Ask before buying them, especially if the person has diabetes or kidney problems.

Should older people follow low-fat, low-sugar advice?

Not always. Healthy eating advice for the general population may not suit someone with a small appetite or who is losing weight without trying. For them, full-fat milk and yoghurt, cheese, puddings and energy-dense snacks can be exactly what is needed. If someone has diabetes, heart disease or another condition affected by diet, ask the GP or dietitian for advice that balances both needs.

Why has my relative lost interest in food?

There are many possible reasons: illness, pain, side effects of medicines, constipation, a sore mouth or loose dentures, changes in taste and smell, low mood, loneliness, bereavement or dementia. Some people struggle with shopping and cooking, or feel it is not worth cooking for one. Mention a poor appetite to the GP, as several of these causes are treatable, and try eating together when you can.

What help is there with shopping and cooking?

Quite a lot. The council may arrange meals delivered to the home after a care needs assessment. Local Age UKs and community groups run lunch clubs, which combine a hot meal with company. Online supermarket deliveries, frozen and ready meals can be nutritious and convenient. Home care visits can include preparing meals and encouraging someone to eat, and a live-in carer can cook fresh food every day.

Sources and further information

- NHS: Malnutrition
- NHS: Dehydration
- NHS: Water, drinks and your health
- NHS: Swallowing problems (dysphagia)
- Age UK: Malnutrition signs, causes and prevention
- BAPEN: Introducing 'MUST'
- IDDSI: The IDDSI framework

Read next

HEALTH CONDITIONS AND CARE AT HOME

Frailty in later life: what it is and how to slow it

A plain guide to frailty in older people: what it means, the signs to look for, how GPs identify it, and practical ways to slow or improve it through activity, good nutrition, medication reviews and planning ahead, with the support and funding available at home.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Dementia care at home: a practical guide for families

How to support someone with dementia at home: the stages, communication, routines, eating and drinking, sundowning and nights, wandering and safety, Lasting Power of Attorney, support for carers and how care is funded, including NHS Continuing Healthcare and council tax.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Parkinson's care at home: a guide for families

Supporting someone with Parkinson's at home: why medicines must be taken on time, help with movement and freezing, preventing falls, swallowing, sleep and communication, when to get medical help, where to find support and how care can be funded.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/nutrition-and-hydration/**

Loneliness and wellbeing in later life: a guide for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Loneliness is common in later life, especially after bereavement, illness or giving up driving, and it affects both mood and physical health. Regular contact, activities that give the day purpose, befriending services and local groups can all help. Low mood that lasts more than two weeks is worth raising with the GP, because depression in older people is common and treatable.



IN THIS GUIDE

1. Why loneliness is common in later life
2. Signs that someone may be lonely or low
3. How to talk about loneliness
4. What helps: companionship and connection
5. Staying connected when getting out is hard
6. Activities and local groups
7. Checklist: a weekly connection plan
8. How to get help locally, step by step
9. Befriending and helplines
10. When to see the GP, call 111 or call 999
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Why loneliness is common in later life

Loneliness can affect anyone, but later life brings many of the changes that trigger it: losing a partner or friends, retiring, moving home, illness, reduced mobility, sight or hearing loss, giving up driving, becoming a carer, or family living far away. Age

UK's research suggests that nearly a million people aged 65 and over in the UK often or always feel lonely.

Loneliness is not a personal failing, and it is not just about being alone. It is linked with low mood, poorer sleep, less activity and poorer physical health, which is why it deserves to be taken as seriously as any other health concern.

Signs that someone may be lonely or low

People rarely say "I'm lonely". The signs are often indirect:

- Withdrawing from friends, family or activities they used to enjoy.
- Talking much more about the past, or saying things like "what's the point?"
- Phoning family very often, or hardly at all.
- Not looking after themselves or the home as before.
- Changes in sleep or appetite, or drinking more alcohol.
- Irritability, tearfulness or seeming flat.
- Physical complaints such as tiredness or aches without a clear cause.

Some of these are also signs of depression. The NHS advises seeing a GP if low mood has lasted more than two weeks, if someone is struggling to cope, or if things they have tried are not helping.

How to talk about loneliness

Loneliness can feel embarrassing to admit. Raise it gently and without judgement, in an everyday moment rather than a formal conversation. Ask open questions: "How have the days been since Dad died?" or "What do you miss most about driving?" Listen more than you advise, and build on what the person says matters to them rather than presenting a list of solutions.

What helps: companionship and connection

Regular, reliable contact makes the biggest difference, and quality matters more than quantity.

- **A rhythm of contact:** a daily phone call at the same time, a weekly visit, a standing lunch date.

- **Shared activity:** doing something together, such as a walk, a crossword, cooking or watching a match, is often easier than "just talking".
- **Purpose:** a role or responsibility, such as caring for a pet or plants, helping a grandchild with homework or volunteering, gives the day meaning.
- **Familiar places:** the same café, church, mosque, temple, library or market, where people know them.
- **Neighbours:** a friendly neighbour who calls in can be as important as family.

Staying connected when getting out is hard

- **Remove barriers:** check hearing aids and glasses; poor hearing and sight make conversation exhausting and isolating. See our sight and hearing loss guide.
- **Transport:** ask the council about community transport, dial-a-ride services and the Blue Badge scheme. People of State Pension age in England can get free off-peak bus travel.
- **Phone and video:** large-button phones, video calling and smart speakers can keep family in touch.
- **Letters and photos:** for some, cards, letters and printed photos mean more than messages on a screen.

Activities and local groups

What helps depends on the person's personality and interests. Options in most areas include:

- Lunch clubs and coffee mornings, often run by local Age UKs and faith groups.
- Interest groups such as choirs, gardening clubs, walking groups, book groups, and learning groups for people in later life.
- Men's Sheds and craft groups for people who prefer to make or fix things side by side.
- Re-engage, which organises regular tea parties for older people who live alone.
- Day centres, including specialist ones for people with dementia.
- Volunteering, which many people find gives them company and purpose.

Ask the GP practice about **social prescribing**. Link workers in GP practices across England can spend time with someone, find out what matters to them and connect them with local groups and services.

In Oxfordshire, Age UK Oxfordshire and the county council's Live Well Oxfordshire directory list local groups, activities and services.

Checklist: a weekly connection plan

Fill this in together and stick it on the fridge:

- **Every day:** who phones, and at what time?
- **Every week:** who visits, and on which day?
- **One regular activity:** a group, class, service or club, with transport arranged.
- **One outing:** shopping, a café, the library or a walk.
- **One neighbour or friend** who knows to look out for them.
- **Practical checks:** hearing aids and glasses working, phone charged, key numbers in large print by the phone.

How to get help locally, step by step

1. **Talk to the GP practice:** ask for a GP appointment if mood is low, and ask to see the social prescribing link worker.
2. **Talking therapies:** search "NHS Talking Therapies" on the NHS website with the person's postcode to find the local service and refer online or by phone.
3. **Befriending:** call the Age UK Advice Line or the local Age UK to ask about telephone or face-to-face befriending.
4. **Groups and transport:** ask the council, library or local Age UK about groups, day centres and community transport.
5. **Care and support:** ask the council's adult social care team for a free care needs assessment if getting out or managing at home has become hard.

Befriending and helplines

- **Telephone befriending:** Age UK and the Silver Line offer free regular calls with a volunteer.
- **Face-to-face befriending:** many local Age UKs arrange a volunteer to visit or go out with someone.
- **The Silver Line Helpline:** 0800 4 70 80 90, free, confidential and open 24 hours a day, every day, for people aged 55 and over.
- **Age UK Advice Line:** 0800 678 1602, free, 8am to 7pm, every day of the year.

- **Independent Age Helpline:** 0800 319 6789, free, Monday to Friday, 8.30am to 5.30pm.
- **Samaritans:** 116 123, free, 24 hours a day, every day, for anyone who is struggling.
- **Carers UK Helpline:** 0808 808 7777, Monday to Friday, 9am to 6pm, for family carers who feel isolated.

When to see the GP, call 111 or call 999

- **Call 999** if someone's life is at risk now, for example if they have seriously harmed themselves or are about to.
- **Call NHS 111 and choose the mental health option** (free, 24 hours) for urgent advice if someone talks about wanting to die or harming themselves, and you cannot reach the GP. Take it seriously and stay with them if you can.
- **Book a GP appointment** if low mood lasts more than two weeks, if sleep, appetite or interest in life have changed, if they are drinking more to cope, or if things they have tried are not helping.

The GP can check for physical causes, including side effects of medicines, discuss treatment and refer to services. People aged 18 and over can also refer themselves to NHS Talking Therapies for low mood, depression and anxiety without seeing the GP first; there is no upper age limit.

Looking after yourself too

Family carers are at high risk of loneliness themselves, especially when caring for a partner with dementia. Breaks, support groups and a carer's assessment from the council can help. Our guide to looking after yourself as a carer has more ideas.

How care at home can help

Care at home can bring companionship as well as practical help. A regular carer becomes a familiar face, someone to talk to, eat with and go out with, and can help the person keep up hobbies, faith, friendships and family contact. For people who are very isolated or anxious at home alone, live-in care means there is company throughout the day and someone close by at night. For couples, live-in care for couples means they can stay together at home.

Help with costs

- When assessing needs, councils in England must consider a person's wellbeing, including their relationships and their ability to take part in activities and use services in their community. Ask the council for a free care needs assessment.
- Attendance Allowance (£76.70 or £114.60 a week, not means-tested) can help pay for care and support if someone over State Pension age needs help with personal care.
- Many befriending services, lunch clubs and helplines are free or low cost.

What to do next

1. Gently ask how the person is feeling, and listen.
2. Set up a regular rhythm of calls or visits.
3. Check hearing aids, glasses and transport, the practical barriers to getting out.
4. Find one local group or activity that matches an existing interest, and offer to go along the first time.
5. Ask the GP practice about social prescribing, and see the GP if low mood lasts more than two weeks.
6. Consider befriending, or care at home that includes companionship.

How we can help

Day and Nightcare has supported people at home since 2008. We provide home care visits from one hour, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England, and fully managed live-in care anywhere in England from £1,550 a week. If you are lonely, or worried that someone else is, call 01865 715780 to talk it through and arrange a free assessment.

Common questions

What is the difference between loneliness and social isolation?

Social isolation describes having few contacts with other people, which can be measured. Loneliness is a feeling: the gap between the relationships someone has and the ones they want. A person can see people every day and still feel lonely, perhaps because they miss a partner who has died, while someone who lives quietly may feel content. Both matter, and the answer depends on what the person is missing.

Is depression a normal part of getting older?

No. Feeling sad after a loss is natural, but persistent low mood, losing interest in things, poor sleep, changes in appetite and feeling hopeless are not an expected part of ageing. Depression in older people is often missed, sometimes because it shows up as tiredness, aches or memory problems. It is treatable at any age, with talking therapies, medicines or both, so encourage the person to see the GP.

My parent will not go to groups. What else can help?

Many people dislike the idea of a 'group for older people', and that is fine. One-to-one contact often works better: a regular phone call, a telephone befriending volunteer, a neighbour who calls in, or someone to go with them to something they already enjoy. Activities built around an interest or a role, such as gardening, a choir, a faith community or volunteering, can feel very different from a social club.

Can technology help with loneliness?

It can help, but it works best alongside face-to-face contact rather than replacing it. Video calls let grandchildren and distant family be seen as well as heard. Simple tablets, large-button phones and smart speakers can make calls, music and audiobooks easy. Many local Age UKs, libraries and community groups offer free help with digital skills. Make sure hearing aids and glasses are working, as they make every kind of contact easier.

Can a carer provide companionship as well as care?

Yes, and for many people it is one of the most valued parts of care at home. A regular carer offers conversation, shared meals and help to get out and about, as well as practical support. A live-in carer provides company through the whole day. It works best when it adds to time with family and friends rather than replacing it, and when the carer helps the person keep up their own interests and connections.

Sources and further information

- NHS: Loneliness in older people
- NHS: NHS Talking Therapies
- Age UK: You are not alone in feeling lonely (2024)
- Age UK: Befriending services
- Age UK: The Silver Line Helpline
- NHS England: Social prescribing

Read next

HEALTH CONDITIONS AND CARE AT HOME

Sight and hearing loss in later life: a guide for families

Supporting someone with sight or hearing loss at home: adapting the home, communication tips, free NHS sight tests and hearing aids, registering as sight impaired, council sensory services, when to get urgent help, and the concessions and support available.

Read the guide →

SUPPORT FOR FAMILY CARERS

Looking after yourself as a carer: rest, support and breaks

Caring for someone you love can wear you down without you noticing. How to spot carer burnout, protect your sleep, take regular breaks, find emotional support and carers' groups, and get help from your GP and local carers' centre.

Read the guide →

CHOOSING LIVE-IN CARE

Types of care at home: live-in, visiting, night and respite care

The types of care at home in England explained simply: live-in care, visiting home care, sitting and companionship, waking nights and sleep-ins, 24-hour care, respite, reablement, Discharge to Assess and palliative care, who each suits and how to combine them.

Read the guide →

All guides in the information centre Check what help you could get

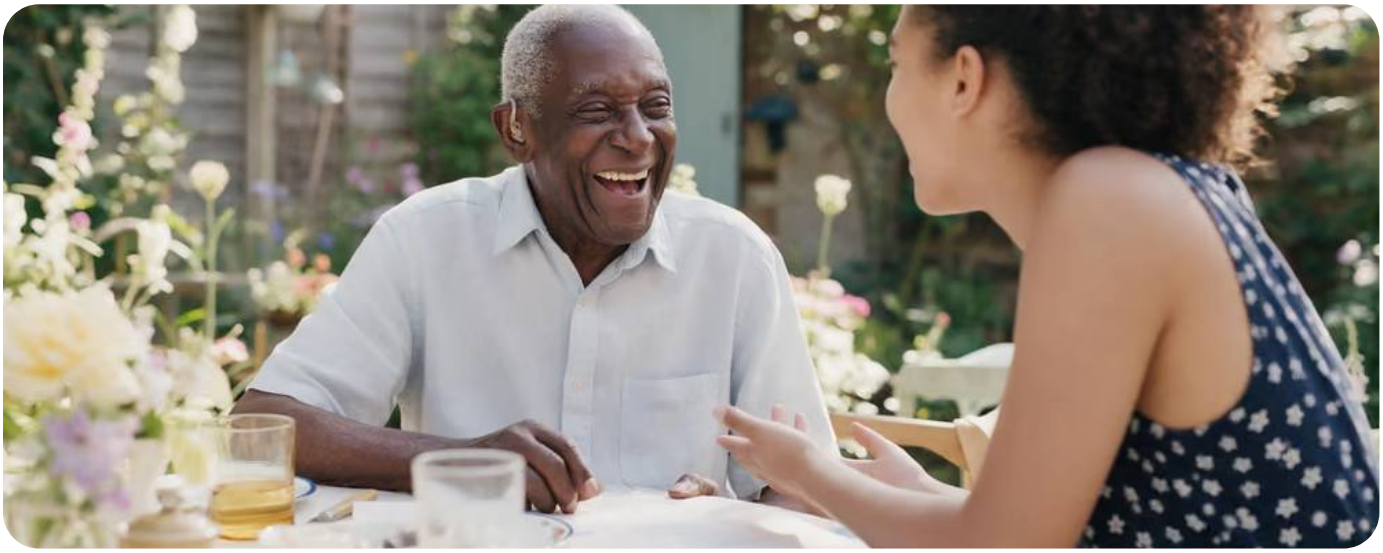
This page online: **www.dayandnightcare.co.uk/guides/loneliness-and-wellbeing/**

Sight and hearing loss in later life: a guide for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Sight and hearing loss are common in later life, but much can be done: free NHS sight tests from age 60, free NHS hearing aids on long-term loan, better lighting and contrast at home, and clear communication habits. If sight or hearing changes suddenly, get medical help straight away, and ask the council for a sensory assessment if daily life has become harder.



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How sight and hearing loss affect daily life

Both become more common with age, and both often develop so gradually that the person adapts without realising how much they are missing. Common causes of sight loss in later life include cataracts, age-related macular degeneration, glaucoma and diabetic retinopathy. Hearing loss is most often age-related, although a build-up of earwax can also muffle sound.

The effects reach into every part of life: reading post and medicine labels, cooking safely, recognising faces, using the phone, hearing the doorbell, following conversations and enjoying television. Sight and hearing loss also increase the risk of falls and can lead people to withdraw from company, so treating them is about safety and wellbeing as much as convenience.

Free NHS sight tests

NHS sight tests are free for everyone aged 60 and over, and for people with diabetes or glaucoma, people registered as sight impaired, and others. Most people should have their eyes tested every two years, or more often if the optician advises. A sight test is also a health check, and can pick up conditions such as glaucoma before the person notices symptoms.

If someone qualifies for a free test and cannot leave home unaccompanied because of physical or mental illness or disability, an optometrist can visit them at home.

Hearing tests and NHS hearing aids

Signs of hearing loss include asking people to repeat themselves, struggling in noisy places or on the phone, turning the television up louder than others like, and feeling tired from concentrating to listen. Family often notice before the person does.

The GP can check for earwax or infection and refer to the NHS hearing service. Some pharmacies and opticians offer free hearing tests, and RNID has a free online hearing check. Not all GP surgeries remove earwax; the NHS suggests olive or almond oil drops first, and advises never using cotton buds.

Hearing aids work best when worn every day, so that the brain gets used to them. Help with cleaning, changing batteries or charging, and putting them in, is something a carer can easily support.

Making the home easier with sight loss

- **Light:** bright, even lighting throughout, with extra task lights for reading, cooking and the stairs. Reduce glare with blinds or net curtains.
- **Contrast:** a coloured edge on each step, light switches and door handles that stand out from the wall, and crockery that contrasts with the food and the table.
- **Order:** keep things in the same places, and tell the person if anything has been moved.
- **Clear routes:** remove clutter and trailing wires, and keep doors fully open or fully shut.
- **Marking:** tactile "bump-on" dots on cooker dials, the microwave and washing machine settings.
- **Equipment:** magnifiers, talking clocks and watches, liquid level indicators for hot drinks, large-button phones and voice-controlled smart speakers. A low vision clinic, usually through the hospital eye service, can advise on magnifiers.

Equipment designed for people with sight loss, including low vision aids, can be bought without VAT by people who qualify.

Making the home easier with hearing loss

- A doorbell with a flashing light or a vibrating pager.
- An amplified telephone, or a phone that works with hearing aids.
- Subtitles on the television, or a television listener that sends sound straight to the person.
- Smoke alarms with flashing lights or vibrating pads.
- A hearing loop at home, which works with many hearing aids.

How to communicate with someone who has sight or hearing loss

With hearing loss, RNID's advice includes:

- Get the person's attention before you start speaking.

- Face them, in good light, without a window or lamp behind you, so they can see your lips and expressions.
- Speak clearly at a normal pace; do not shout.
- Reduce background noise, and talk one at a time.
- If they do not understand, rephrase rather than repeat the same words.
- Write down important details such as appointment times.

With sight loss:

- Say who you are when you come into a room, and say when you are leaving.
- Describe where things are, for example using a clock face for food on a plate.
- When guiding, offer your arm rather than pushing or pulling, and mention steps and doorways ahead.
- Do not move furniture or belongings without saying so.

When sight and hearing loss happen together

Some people have both sight and hearing loss, sometimes called dual sensory loss or deafblindness. It is more than the sum of its parts, because each sense can no longer make up for the other. In England, councils must make sure an assessment of a deafblind person is carried out by someone with specialist training. Deafblind UK's free helpline is 0800 132 320.

Registering as sight impaired

If sight loss cannot be corrected, a consultant ophthalmologist can complete a Certificate of Vision Impairment (CVI), certifying the person as sight impaired or severely sight impaired. Many eye clinics have an eye clinic liaison officer (ECLO) who can explain the process and offer emotional and practical support. The council then offers to add the person to its register and should arrange an assessment of the support they need to stay independent, which may include training in getting around safely, cooking and managing daily tasks.

How to get NHS help, step by step

For sight:

1. Book a sight test with any high-street optician and say the person is entitled to a free NHS test (for example, because they are 60 or over).

2. If they cannot leave home unaccompanied, ask for a home visit from a mobile optician.
3. If the optician finds a problem, they will refer to the GP or the hospital eye service.
4. At the eye clinic, ask to speak to the eye clinic liaison officer (ECLO), and ask about the low vision service for magnifiers and lighting advice.
5. If sight loss is certified, expect contact from the council. If nobody gets in touch, call the council's adult social care team, or the RNIB Helpline for help.

For hearing:

1. Book a GP appointment to check for earwax or infection and ask for a referral to the NHS hearing (audiology) service. Some areas accept self-referral; ask the GP surgery.
2. At the hearing assessment, ask about NHS hearing aids and equipment for the home.
3. After fitting, keep the follow-up appointment and ask how to get free batteries and repairs.

Checklist: daily hearing aid care

- Wipe the aids each day with a dry cloth or the wipes the hearing service recommends.
- Check batteries or charging every morning, and keep spares where they are easy to find.
- Keep aids away from water, heat and hairspray.
- Take them out at night and store them in their case, out of reach of pets.
- If an aid whistles, sounds weak or stops working, contact the hearing service that fitted it.

Council sensory services

Every council's adult social care team supports people with sight and hearing loss, often through a specialist sensory team. Ask for a care needs assessment. Equipment and minor adaptations costing £1,000 or less are free if the council assesses a need. Our equipment and home adaptations guide explains how to ask.

When to get urgent help

- **Call 999 or go to A&E** if someone suddenly cannot see from one or both eyes, or has sudden severe eye pain. Do not drive yourself.
- **Ask for an urgent GP appointment or contact NHS 111** (free, 24 hours) for flashing lights, new floaters or a dark shadow across vision, sudden blurred or double vision, a red and painful eye, or sudden hearing loss in one or both ears.
- **See an optician** about any gradual change in sight, and the GP about gradual hearing loss.

How care at home can help

A carer can make a real difference to independence: reading post and labels, supporting medicines, cooking safely, keeping the home well lit and clutter-free, helping with hearing aids and glasses, and going with the person to appointments. A consistent carer learns exactly how the person likes to communicate. For people who also live with frailty or dementia, live-in care means support is always at hand; for others, home care visits at key times are enough. Our falls prevention guide is also worth reading, as sensory loss raises the risk of falls.

Help with costs and concessions

- Free NHS sight tests from age 60, with home visits for those who qualify.
- Free NHS hearing aids, batteries and repairs.
- No VAT on low vision aids and other equipment for people who qualify.
- If registered severely sight impaired: an automatic Blue Badge, a half-price TV licence and Blind Person's Allowance.
- Attendance Allowance (£76.70 or £114.60 a week, not means-tested) if someone over State Pension age needs help with personal care, or Personal Independence Payment under State Pension age.

Where to get support

- **RNIB Helpline:** 0303 123 9999. Monday to Friday, 9am to 6pm.
- **RNID contact centre:** 0808 808 0123 (free), or text 07360 268 988. Monday to Friday, 8.30am to 5pm.
- **Deafblind UK Helpline:** 0800 132 320 (free). Monday to Thursday 9am to 5pm, Friday 9am to 4pm.

- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.

What to do next

1. Book a free NHS sight test, at home if needed.
2. Ask the GP about a hearing check and a referral to the NHS hearing service.
3. Improve lighting and contrast, starting with the stairs, kitchen and bathroom.
4. Agree simple communication habits with everyone who visits.
5. Ask the council for a sensory or care needs assessment.
6. If sight loss is significant, ask the eye clinic about certification and registration.

How we can help

Day and Nightcare provides fully managed live-in care anywhere in England, from £1,550 a week, and home care visits, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England. Call 01865 715780 to arrange a free assessment.

Common questions

Are NHS hearing aids really free?

Yes. NHS hearing aids are provided free as a long-term loan, and follow-up appointments, aftercare, batteries and repairs are free from the service that fitted them. There may be a charge if an aid is lost or damaged. NHS aids are usually the behind-the-ear type, and waiting times can be longer than privately. Start by asking the GP for a referral, or ask the local hearing service whether self-referral is possible.

What are the benefits of registering as sight impaired?

Registration is voluntary and confidential, and it can open doors. It gives access to the council's specialist support and can make it easier to claim benefits. People registered as severely sight impaired automatically qualify for a Blue Badge and can get a half-price TV licence, and they can claim Blind Person's Allowance, an extra tax-free allowance. Other concessions include free postage for some items through the Articles for the Blind scheme.

Are glasses free on the NHS for older people?

Not automatically. Being 60 or over gives a free NHS sight test, but not free glasses. People can get an NHS optical voucher towards glasses or contact lenses if they, or their partner, receive Pension Credit Guarantee Credit, income-based Jobseeker's Allowance or qualifying Universal Credit, or if they are named on an HC2 certificate. Those with an HC3 certificate may get partial help. Ask the optician to check entitlement before choosing frames.

What is Charles Bonnet syndrome?

Charles Bonnet syndrome is when someone who has lost a lot of their sight sees things that are not there, such as patterns, people or animals. It is caused by the brain reacting to the loss of visual information, not by mental illness or dementia, and the person usually knows the images are not real. It can be frightening, so reassurance helps. Mention it to the GP or optician to rule out other causes.

Is hearing loss linked to dementia?

Research suggests hearing loss may be one of the risk factors for dementia, which is one more reason to have hearing checked and to wear hearing aids if they are recommended. Hearing loss can also be mistaken for confusion or memory problems, because someone who mishears answers questions wrongly. If memory seems to be changing, a hearing test is a sensible first step alongside a GP review.

Sources and further information

- NHS: Free NHS eye tests and optical vouchers
- NHS: Vision loss
- NHS: Hearing loss
- NHS: Hearing aids and implants
- RNIB: Registering as sight impaired
- RNID: How to communicate with someone who is deaf or has hearing loss
- GOV.UK: VAT relief for disabled people

Read next

HEALTH CONDITIONS AND CARE AT HOME

Falls prevention for older people: a practical guide

Why older people fall and how to reduce the risk at home: common causes, home hazards, footwear, eyesight, medication reviews, strength and balance exercise, what to do after a fall, personal alarms, and the free help available from the NHS and the council.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Loneliness and wellbeing in later life: a guide for families

Loneliness and depression in later life: how to recognise them, the difference companionship makes, practical ways to stay connected, activities and local groups, befriending services and helplines, and when to see the GP, with simple steps families can take.

Read the guide →

LIVING SAFELY AND WELL AT HOME

Equipment and home adaptations: what is free and how to get it

How to get equipment and home adaptations for an older or disabled person in England: occupational therapy assessments, free council and NHS equipment, Disabled Facilities Grants of up to £30,000, VAT relief, beds, hoists and stairlifts, and how to buy safely.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/sight-and-hearing-loss/**

Dementia stages: how care needs change and what help fits

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Dementia is usually described in three broad stages: early, middle and later. Needs grow from prompts and planning ahead at first, to daily help with washing, meals, medicines and nights in the middle stage, to full-time personal care in the later stage. Plan for the next stage before it arrives, and arrange care around what the person needs now rather than the stage name.



IN THIS GUIDE

1. The three stages of dementia at a glance
2. The early stage: what changes and what help is needed
3. The middle stage: what changes and what help is needed
4. The later stage: what changes and what help is needed
5. A sudden change is not a new stage
6. Signs that needs are moving on
7. When live-in care helps, and when a care home may suit better
8. Words you can use
9. Where to get support
10. What to do next
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The three stages of dementia at a glance

Dementia is progressive: symptoms start mild and gradually become more severe, usually over several years. UK dementia charities describe three broad stages. They are a rough guide, not a timetable, and the Alzheimer's Society encourages families to focus on what the person needs now rather than which stage they are in.

Stage	Average length	What often changes	Help that usually fits
Early (mild)	About 2 years	Forgetting recent events, losing things, harder to plan, manage money or follow conversations	Prompts and routines, planning ahead, company, some help with tasks
Middle (moderate)	About 2 to 4 years	Confusion about time and place, help needed with washing, dressing and the toilet, restless evenings and nights	Daily personal care, medicines support, supervision, often live-in or night care
Later (severe)	About 1 to 2 years	Little speech, help with eating and drinking, swallowing problems, frailty, continence needs	Full-time personal care, pressure care, nursing input, end-of-life planning

Averages from the Alzheimer's Society. People move through the stages at very different speeds.

The early stage: what changes and what help is needed

In the early stage, symptoms affect daily life but the person can still do most things themselves or with a little support. Common changes include forgetting recent conversations, repeating questions, losing keys or glasses, finding it harder to plan meals or manage bills, struggling to find words and feeling anxious, low or less confident.

The most useful help at this stage is about keeping independence and planning ahead:

- **Do things together, not for them.** Taking over too early erodes confidence. Reminder lists, a large clock showing the day and date, and a regular routine help.
- **Make Lasting Powers of Attorney** for both property and finance and health and welfare, while the person can still do so. See our Lasting Power of Attorney guide.
- **Write an advance statement** about their wishes for future care. See advance care planning.

- **Tell the DVLA.** GOV.UK says drivers must tell the DVLA if they have dementia, online or on form CG1. Not telling the DVLA about a condition that affects driving can lead to a fine of up to £1,000.
- **Check benefits.** Attendance Allowance (£76.70 or £114.60 a week in 2026/27, not means-tested) is for people over State Pension age who need help or supervision. See our Attendance Allowance guide.
- **Ask about council tax.** Someone certified as having a severe mental impairment may be disregarded for council tax. See council tax discounts for care.

Many people in the early stage need no paid care at all. Where it helps, a few short home care visits a week for company, a walk or help with shopping can keep life on track.

The middle stage: what changes and what help is needed

The middle stage is often the longest. Memory and thinking problems become more noticeable, and the person starts to need help with everyday tasks. Typical changes include:

- confusion about the time of day, such as getting dressed in the middle of the night
- not recognising familiar people, or mistaking them for someone else
- needing prompts or practical help with washing, dressing and using the toilet
- mood changes, anxiety, suspicion (for example, believing things have been stolen) and sometimes hallucinations
- restlessness, walking about, following a carer from room to room, and agitation in the late afternoon and evening, known as sundowning
- disturbed sleep, which soon exhausts family carers

Help that usually fits the middle stage:

- **Daily personal care** at the person's own pace: laying clothes out, prompting, and hands-on help when needed.
- **Medicines support,** from prompting to administering, so doses are not missed or doubled. See medication management at home.
- **Meals and drinks** prepared and shared, because people often forget to eat or do not notice thirst.

- **Supervision and safety:** telecare, door sensors, and the Herbert Protocol, a form many police forces use if someone goes missing.
- **Night support** if the person is often up at night: a sleep-in, a waking night or a live-in carer.
- **A carer's assessment** for the main family carer, and regular breaks before they reach crisis point. See respite options.

People sometimes resist help at this stage. Our guide to dementia and refusing care suggests gentle ways forward.

The later stage: what changes and what help is needed

In the later stage, dementia affects almost every part of life and the person needs full-time care. They may speak very little, may not recognise close family, and often respond more to touch, music, voices and familiar smells than to words. Physical changes become important:

- **Eating and swallowing:** people need a lot of help to eat and drink, weight loss is common and swallowing can become difficult. Ask the GP for a speech and language therapy referral if there is coughing at meals.
- **Mobility:** walking becomes slower and less steady, then many people spend more time in a chair or bed. This raises the risk of falls, infections and pressure ulcers.
- **Continence:** loss of bladder and bowel control is common. See continence care with dignity.
- **Infections:** frailty makes chest and urine infections more likely.
- **Distress during personal care:** washing and dressing can feel frightening, so a calm, unhurried, familiar carer matters.

Help that usually fits: full-time personal care, repositioning and pressure care, a profiling bed and pressure-relieving equipment lent by the NHS, district nurse visits, and a plan for the end of life agreed with the GP. See planning end-of-life care at home. If needs have become complex, intense or unpredictable, ask for an NHS Continuing Healthcare assessment.

A sudden change is not a new stage

Dementia usually changes over months, not days. If someone becomes much more confused, drowsy, agitated or unwell over a day or two, it may be delirium, often caused by an infection, dehydration, constipation, pain or a new medicine. The NHS advises calling 999 or going to A&E if someone suddenly becomes confused. See our guide to sudden confusion and delirium.

Signs that needs are moving on

Use this checklist every few months, or after any hospital stay:

- Meals skipped, weight lost or fridge food going off.
- Medicines missed, doubled or found on the floor.
- Unwashed, wearing the same clothes, or new incontinence.
- Falls, near misses or bruises nobody can explain.
- Getting lost, leaving the house at night or leaving the cooker on.
- Phone calls to family at night, or distress when alone.
- A family carer who is exhausted, unwell or not sleeping.

Any of these is a good reason to ask the council for a new care needs assessment and to look again at the care in place.

When live-in care helps, and when a care home may suit better

Live-in care can work at every stage, but it is most often chosen in the middle and later stages. It keeps the person in familiar surroundings, which matters because moves can increase confusion, and gives them one consistent carer who learns their routines, moods and the signs that something is wrong. It can also support couples to stay together.

Be honest about nights. A live-in carer can help occasionally at night, but if the person needs help most nights, an extra waking night carer is needed. A care home or nursing home may suit better when someone needs two people to move them at all hours, needs nursing care around the clock, or seems happier with more people around. Our comparison of live-in care and care homes sets out the trade-offs.

Words you can use

Asking the GP for a review:

> "My mother, [name, date of birth], has dementia. Over the last [weeks or months] she has [stopped eating regular meals, started getting up at night, had two falls]. Please could we book a review of her health and medicines, and could you tell us whether she should be referred back to the memory service or for any other support?"

Asking the council for a new assessment:

> "I am writing about [name, address, date of birth]. Their needs have increased since their last assessment in [month]: [list the changes]. Please could you arrange a review of their care needs, and a carer's assessment for me as their main carer."

Where to get support

- **Alzheimer's Society Dementia Support Line:** 0333 150 3456. Monday to Wednesday 9am to 8pm, Thursday and Friday 9am to 5pm, weekends 10am to 4pm.
- **Dementia UK Admiral Nurse Dementia Helpline:** 0800 888 6678 (free). Monday to Friday 9am to 9pm, weekends 9am to 5pm. Email helpline@dementiauk.org.
- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.
- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.

What to do next

1. Write down what the person can still do well, and where they struggle now.
2. Book a GP review and ask whether the memory service should see them again.
3. Put Lasting Powers of Attorney and an advance statement in place if they are not already done.
4. Ask the council for a care needs assessment, and a carer's assessment for yourself.
5. Claim Attendance Allowance and check the council tax disregard.

6. Talk as a family about what will happen if nights or personal care become too much, before it happens.

How we can help

Day and Nightcare has supported people at home since 2008. We provide fully managed live-in dementia care anywhere in England, from £1,550 a week, and home care visits, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England, so support can grow as needs change. If you would like to talk through what would help at this stage, call us on 01865 715780 to arrange a free assessment and a written quote.

Common questions

How long do people live after a dementia diagnosis?

It varies widely. The Alzheimer's Society gives average life expectancy after diagnosis as about eight to ten years for Alzheimer's disease (shorter for people diagnosed in their 80s or 90s, and some people live 15 to 20 years), about five years for vascular dementia, about six years for dementia with Lewy bodies and about six to eight years for frontotemporal dementia. These are averages only. Age, the type of dementia and other conditions such as heart disease or diabetes all affect the pace.

At what stage does someone with dementia need 24-hour care?

There is no fixed point, but it is usually during the middle or later stage. The signs are that the person cannot safely be left alone, needs help with most personal care, is up and unsettled at night, or is at risk of falls, wandering or forgetting to eat and drink. At that point the realistic choices are live-in care, live-in care with extra night support, round-the-clock care in shifts, or a care home. A care needs assessment helps decide which fits.

Can someone in the later stage of dementia stay at home?

Often, yes, with the right support. Later-stage care at home usually involves a consistent carer, equipment such as a profiling bed and pressure-relieving mattress, visits from the district nurse and GP, and a plan for the end of life. A care home or nursing home may suit better when someone needs two people to move them day and night or constant nursing. NHS Continuing Healthcare may pay for care if needs become complex.

Does everyone with dementia go through the stages in order?

Broadly, yes, because dementia is progressive, but not neatly. Some symptoms, such as agitation or restlessness, can appear for a while and then fade, while memory, thinking and language problems tend to stay and slowly worsen. People also have good days and bad days. Different types start differently: memory loss is common early in Alzheimer's disease but uncommon early in frontotemporal dementia. In the later stage, the different types tend to look more alike.

When should we start planning for the later stages?

As early as possible, ideally soon after diagnosis. Lasting Powers of Attorney can only be made while the person has the mental capacity to make them, and an advance statement records their wishes about care, where they want to live and what matters to them. Planning early means decisions later on are made the way the person would have wanted, and it gives the family time to look at care options calmly rather than in a crisis.

Sources and further information

- Alzheimer's Society: The progression and stages of dementia
- Alzheimer's Society: The middle stage of dementia
- Alzheimer's Society: The later stage of dementia
- NHS: Coping with dementia behaviour changes
- GOV.UK: Dementia and driving
- GOV.UK: Attendance Allowance, what you'll get

Read next

HEALTH CONDITIONS AND CARE AT HOME

Dementia care at home: a practical guide for families

How to support someone with dementia at home: the stages, communication, routines, eating and drinking, sundowning and nights, wandering and safety, Lasting Power of Attorney, support for carers and how care is funded, including NHS Continuing Healthcare and council tax.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Sundowning: evening agitation in dementia and how to help

Why some people with dementia become confused, anxious or restless in the late afternoon and evening, the common triggers, the routines and home changes that help, what to say in the moment, and when to call the GP, NHS 111 or 999.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

When someone with dementia refuses care: a guide for families

What to do when a parent or partner with dementia says no to help: why people refuse, how mental capacity and best interests work, gentle approaches and words that often help, introducing a carer, refusing washing or medicines, and when safety means acting.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/dementia-stages-and-what-help-is-needed/**

Sundowning: evening agitation in dementia and how to help

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Sundowning is confusion, anxiety or agitation that builds in the late afternoon and evening in some people with dementia. It is often linked to tiredness, unmet needs such as hunger, thirst, pain or needing the toilet, too little daylight and a noisy or shadowy home. A steady daily routine, a calm evening and looking for the need behind the distress help most; if confusion or behaviour changes suddenly, get urgent medical help, because it may be delirium.



IN THIS GUIDE

1. What sundowning looks like
2. What causes sundowning
3. Keep a diary for one to two weeks
4. A daytime routine that makes evenings easier
5. Setting up the home for the evening
6. What to do and say in the moment
7. When it carries on into the night
8. Looking after yourself
9. When to seek help
10. What to tell the GP
11. Where to get support
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What sundowning looks like

Sundowning describes changes in behaviour that start in the late afternoon or early evening. The name is a little misleading: it is not always linked to the sun setting, and it can begin at any time from mid-afternoon. Families often notice that

the person:

- becomes anxious, tearful or frightened for no clear reason
- paces, fidgets, tries to leave the house or keeps packing a bag
- asks to “go home”, or to collect children who are now grown up
- becomes suspicious, shouts or pushes away help
- sees or hears things that are not there, sometimes continuing into the night
- is more muddled about where they are or who people are

For the person, these feelings are real and often frightening. For the family, evenings can become the hardest part of the day.

What causes sundowning

Nobody knows exactly why sundowning happens, but the Alzheimer’s Society and Dementia UK list factors that make it more likely:

- **Tiredness** at the end of the day, for the person and for those around them.
- **Unmet needs** the person cannot put into words: hunger, thirst, pain, needing the toilet, feeling too hot or cold.
- **Too little daylight** and too little activity earlier in the day.
- **Too much noise or bustle,** such as television, cooking, visitors and children home from school all at once.
- **A disrupted body clock,** which happens in some types of dementia, including dementia with Lewy bodies.
- **Shadows, reflections and dim light,** which can be misread as people or threats.
- **Evening cues,** such as lights going on or people settling down, that make the person feel they are in the wrong place.
- **Poor sight or hearing,** anxiety or depression.
- **Side effects of medicines.**

Different causes need different answers, so the first step is to work out which ones apply.

Keep a diary for one to two weeks

The NHS suggests keeping a diary for a week or two to spot patterns. Note each evening:

- the time the unsettled behaviour started and how long it lasted
- what happened in the hour before: visitors, a nap, a meal, a phone call, the television
- what the person said or did, and what they seemed to be feeling
- whether they had eaten, had a drink, been to the toilet and been outside that day
- what helped, and what made it worse

After a fortnight, patterns often jump out: a long afternoon nap, no drink since lunch, or the six o'clock news.

A daytime routine that makes evenings easier

- **Get daylight early.** Time outdoors in the morning or early afternoon helps set the body clock. If going out is hard, a favourite chair by a window helps.
- **Keep active.** A walk, gardening, folding laundry, music or seated exercise during the day can improve sleep and reduce evening restlessness.
- **Keep naps short** and earlier in the day.
- **Plan the late afternoon.** Have a calm, familiar activity ready for the time trouble usually starts: a drink and a snack, favourite music, looking at photographs, a simple task.
- **Offer drinks and food regularly.** Hunger and thirst are easy to miss.
- **Cut down caffeine and alcohol** in the afternoon and evening.
- **Keep to the same order of events** each evening: tea, a wash, nightwear, a drink, bed.

Setting up the home for the evening

- Close curtains or blinds as it starts to get dark, and put lights on before the room becomes gloomy. In winter, after the clocks go back, this means doing it earlier.
- Keep lighting even. Shadows and dark corners can look like people.
- Cover mirrors or a blank television screen if reflections cause alarm.
- Turn down background noise, and keep evening visits small and calm.
- Use a clock that shows the day, date and whether it is morning or evening.
- Put a night light on the route to the toilet, and keep the route clear.

What to do and say in the moment

When someone is distressed, reasoning rarely helps. The aim is to help them feel safe.

- Stay calm, speak slowly and use short sentences. Sit down beside them rather than standing over them.
- Check for a need first: "Are you cold? Shall we go to the toilet? Would you like a cup of tea?"
- Respond to the feeling, not the facts. Avoid contradicting or arguing.
- Offer a gentle change of scene: another room, a short walk, some music.
- If they are becoming angry, give them space and come back in a few minutes.

Words that often help:

> "You're safe. I'm here with you. Let's sit down together and have a cup of tea."

> "You sound worried. Tell me what's on your mind."

> "Your children are fine. Tell me about when they were little."

When it carries on into the night

Disturbed nights are one of the main reasons family carers become exhausted. If the person wakes and walks about, keep the house safe: a night light, a clear route to the toilet, and door sensors or other telecare from the council's adult social care team. If there is a risk they might leave the house, ask your local police force about the Herbert Protocol, a form you fill in now to help police act quickly if someone goes missing.

Night care can give the family their sleep back: a sleep-in carer who can be woken occasionally, or a waking night carer for someone up and needing help through the night.

Looking after yourself

When to seek help

Call 999 or go to A&E if the person suddenly becomes confused, very drowsy or has difficulty speaking, or shows signs of a stroke. The NHS treats sudden confusion as an emergency.

Ask for an urgent GP appointment or call NHS 111 (free, 24 hours) if:

- evening agitation has started or worsened over a few days, without sudden confusion (sudden confusion needs 999 or A&E, as above)
- there are signs of a urine infection: the NHS says older or frail people and people with dementia may become agitated or confused, leak urine more than usual, or have new shivering or shaking
- they have barely eaten or drunk, have dark urine or seem unusually tired
- they seem to be in pain

Book a routine GP appointment if sundowning is a regular pattern, to check for pain, constipation, poor sleep, low mood and medicine side effects. Take your diary.

What to tell the GP

- When the evening changes started, and whether they came on suddenly or gradually.
- What the diary shows: times, triggers and what helps.
- Any recent illness, fall, constipation, change in eating or drinking.
- Any new or changed medicines, including ones bought over the counter.
- How nights are going for the person and for you.

See our guide to sudden confusion and delirium for the signs that something more urgent is going on.

Where to get support

- **Dementia UK Admiral Nurse Dementia Helpline:** 0800 888 6678 (free). Monday to Friday 9am to 9pm, weekends 9am to 5pm. Email helpline@dementiauk.org.

- **Alzheimer's Society Dementia Support Line:** 0333 150 3456. Monday to Wednesday 9am to 8pm, Thursday and Friday 9am to 5pm, weekends 10am to 4pm.
- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.
- **Samaritans:** 116 123 (free), 24 hours a day.

What to do next

1. Start a simple evening diary tonight and keep it for one to two weeks.
2. Plan more daylight and activity in the morning, and a calm activity for late afternoon.
3. Close curtains and put lights on before dusk, and quieten the house in the evening.
4. Book a GP review to check for pain, infection, constipation and medicine side effects.
5. Ask the council about telecare, a carer's assessment and breaks for you.

How we can help

Day and Nightcare provides fully managed live-in dementia care anywhere in England, from £1,550 a week, and home care visits, sleep-ins and waking nights across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England. A consistent carer who knows the person's evening routine can make a real difference to how the end of the day feels. To talk it through, call us on 01865 715780 and we can arrange a free assessment.

Common questions

Is sundowning a sign that dementia is getting worse?
Not necessarily. Sundowning can happen at any stage of dementia, although the Alzheimer's Society says it is more common in the middle and later stages. It may come and go over weeks or months, and some people never have it. What matters is a sudden change: if evening confusion appears out of the blue or becomes much worse over a day or two, it may be delirium caused by an infection, pain or a medicine, and needs urgent medical help. The NHS advises calling 999 or going to A&E if someone suddenly becomes confused.

How common is sundowning?

Dementia UK estimates that about one in five people with dementia experience sundowning. It is more common in the middle and later stages, and can be more frequent after a move, a room change or in a busy household in the evening. Not everyone with dementia has it, and someone who does may not have it every evening, which is why a short diary of good and bad evenings is so useful.

Is there medication for sundowning?

Usually not for sundowning itself. Dementia UK says it is best managed with routines and changes to the environment. Doctors first look for treatable causes, such as pain, infection, depression or side effects of medicines. If distress or aggression continues despite everything else, the NHS says a specialist may prescribe an antipsychotic medicine for a short time. Talk to the GP before trying any sleep remedy, including ones bought over the counter.

My dad wants to 'go home' every evening, but he is at home. What should I say?

Try not to argue or correct him. 'Home' often means a feeling of safety, comfort or an earlier time in life, rather than a building. Respond to the feeling instead: 'You want to go home. Tell me about home.' Talking about the house he grew up in, offering a warm drink or going for a short walk together often settles the urge better than explaining that he already lives there.

Can a live-in carer help with sundowning?

Yes, often a great deal. A live-in carer keeps the day's routine steady, gets the person outside in daylight, notices the early signs of an unsettled evening and knows what calms them. A carer the person knows, already there in the evening, is often less unsettling than a change of visiting carers at teatime. If the person is up and needing help most nights, a waking night carer may be needed as well, so that everyone can rest.

Sources and further information

- Alzheimer's Society: Sundowning and dementia
- Dementia UK: Sundowning
- NHS: Coping with dementia behaviour changes
- NHS: Sudden confusion (delirium)

- NHS: Urinary tract infections (UTIs)

Read next

HEALTH CONDITIONS AND CARE AT HOME

Dementia care at home: a practical guide for families

How to support someone with dementia at home: the stages, communication, routines, eating and drinking, sundowning and nights, wandering and safety, Lasting Power of Attorney, support for carers and how care is funded, including NHS Continuing Healthcare and council tax.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Dementia stages: how care needs change and what help fits

The early, middle and later stages of dementia explained for families in England: what usually changes at each stage, how long each tends to last, the help and funding that fit, when live-in care works well and when a care home may suit better.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Sudden confusion and delirium in older people: what to do

How to tell delirium from dementia, the common causes of sudden confusion in older people such as infections, dehydration, constipation and medicines, when to call 999 or NHS 111 and what to say, how to help in hospital and at home, and how to lower the risk.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/sundowning-and-evening-agitation/**

When someone with dementia refuses care: a guide for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

When someone with dementia refuses help, it is usually fear of losing control, or not recognising their own difficulties, rather than stubbornness. If they can make the decision themselves, it is theirs, even if it seems unwise; if they cannot, help can be arranged in their best interests, choosing the option that restricts them least. Starting small, framing help around what matters to them and giving it time works far more often than pressure.



IN THIS GUIDE

1. Why people with dementia refuse help
2. First, ask: can they make this decision?
3. Approaches that often work
4. Gentle words to try
5. Introducing a carer step by step
6. When they refuse washing or personal care
7. When they refuse medicines
8. When refusal puts them at risk
9. Mistakes to avoid
10. Where to get support
11. What to do next
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Why people with dementia refuse help

“No” is rarely about the help itself. Common reasons include:

- **Fear of losing independence,** or of being “put in a home”.

- **Not recognising the problem.** Dementia can affect a person's awareness of their own difficulties, so help feels unnecessary or insulting.
- **Embarrassment** about needing help with washing, dressing or the toilet.
- **Not understanding** what is being offered, who the stranger is or why they are there.
- **Wrong time, wrong approach:** too tired, in pain, rushed, cold, or asked in front of others.
- **A bad past experience** with carers, hospitals or being told what to do.
- **Low mood,** which can sap the will to wash, eat or see people.

Working out which reason applies is the key to what will help.

First, ask: can they make this decision?

The Mental Capacity Act 2005 starts from the assumption that every adult can make their own decisions. A dementia diagnosis does not change that. Capacity is about **one decision at one time**: someone may be able to decide what to wear, but not understand the risks of living without help at home.

- **If they can make the decision,** their refusal must be respected, even if it seems unwise. You can still keep offering, keep the door open and try again later.
- **If they cannot,** the decision is made in their best interests by whoever is responsible for it, taking into account their past and present wishes, values and beliefs, consulting family, and choosing the least restrictive option.
- **If there is a registered health and welfare Lasting Power of Attorney,** the attorney makes the decision when the person cannot.

Even when someone lacks capacity, care is never forced as a first step. Our guide to mental capacity and best interests explains assessments and how to be involved.

Approaches that often work

- **Start small and familiar.** Help with the garden, shopping or lunch is easier to accept than "a carer for personal care".
- **Lead with what matters to them.** Staying at home, keeping the dog, getting to church, seeing grandchildren.
- **Talk about practical benefits,** not about what they can no longer do.
- **Frame help as shared.** "It would help me" is often true, and easier to hear.

- **Use someone they trust.** A GP, nurse, faith leader or old friend may be listened to where family are not.
- **Choose the moment.** A good time of day, after a meal, when nobody is rushed.
- **Offer choices, not questions.** "Shall Sarah come on Tuesday or Thursday?" rather than "Do you want a carer?"
- **Give it time.** Let the idea settle and come back to it in a few days.
- **Use a trial.** The Alzheimer's Society suggests asking an agency about a trial period, or building visits up gradually.

Gentle words to try

Introducing the idea:

> "I worry about you when I'm at work. Would you let someone pop in at lunchtime, just so I know you're all right? It would really help me."

Introducing a carer as a helper:

> "This is Anna. She's going to help with a few jobs around the house and keep you company for a bit."

Offering help with washing:

> "The water's nice and warm. Would you like to start with your hands or your face?"

When they say they don't need help:

> "I know you manage really well. This is just so things are a bit easier for both of us."

Bringing in the GP's voice:

> “Dr Patel said it would be good to have someone help with your tablets. Shall we give it a try for a month?”

Avoid words that sound clinical or permanent, such as “care package”, “personal care” or “from now on”.

Introducing a carer step by step

1. Tell the care provider what the person enjoys, what upsets them, and what to call them.
2. Arrange the first visit when you can be there, framed as a visitor or helper.
3. Keep early visits short and social: a cup of tea, a walk, a shared job.
4. Let personal care come later, once trust has grown.
5. Keep the same carer wherever possible.
6. Step back gradually, so the person gets used to the carer without you.

When they refuse washing or personal care

The Alzheimer’s Society suggests trying to find out why: they may have forgotten the steps, think they have already washed, feel cold or exposed, or be frightened of the bath. Practical ideas:

- Change the time of day, or try a wash at the basin or a bed bath instead of a bath or shower.
- Warm the room and towels, and cover the parts of the body not being washed.
- Offer simple choices, such as which towel or which clothes.
- Ask whether they would prefer a male or female carer.
- If they resist, stop and try again a little later.

Respect their choices about how often they wash, while making sure hygiene is enough to keep them well: the Alzheimer’s Society says the face, bottom and genitals should be washed daily to prevent infection.

When they refuse medicines

- Never force tablets. Note what was refused and when.

- Ask why: difficulty swallowing, a bad taste, side effects or not understanding what the tablet is for.
- Ask the GP or pharmacist about liquid versions, patches, different timings or stopping medicines that are no longer needed.
- Tell the GP promptly if an important medicine is being missed.

Never hide medicines in food or drink on your own: the questions below explain the formal process. See also medication management at home.

When refusal puts them at risk

Sometimes refusal leads to real danger: not eating, unsafe heating, falls, scams or serious self-neglect. The Care and Support Statutory Guidance recognises self-neglect, which covers neglecting personal hygiene, health or surroundings, as a possible safeguarding issue, and the council will consider whether the person can protect themselves.

If you believe the person is at risk, contact the council's adult social care team or their safeguarding team, and speak to the GP. You can say:

> "I am concerned about [name, address, date of birth], who has dementia and lives alone. They are refusing all help, and [describe the risks: weight loss, no heating, falls, unpaid bills]. I don't think they understand the risks. Please could you arrange an assessment, considering whether they have capacity to refuse and whether there is a risk of self-neglect?"

In an emergency, call 999.

Mistakes to avoid

- Arguing about whether they need help, or listing their failures.
- Springing a carer on them without warning.
- Calling help "temporary" if it is not, or making promises you cannot keep.
- Asking yes-or-no questions that invite a no.
- Giving up after the first refusal.
- Carrying on alone until you are exhausted.

Where to get support

- **Alzheimer's Society Dementia Support Line:** 0333 150 3456. Monday to Wednesday 9am to 8pm, Thursday and Friday 9am to 5pm, weekends 10am to 4pm.
- **Dementia UK Admiral Nurse Dementia Helpline:** 0800 888 6678 (free). Monday to Friday 9am to 9pm, weekends 9am to 5pm.
- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.
- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.

What to do next

1. Write down what the person is refusing, when, and what you think the reason is.
2. Ask the GP to check for pain, infection, low mood and medicine side effects.
3. Check whether there is a Lasting Power of Attorney, and make one if the person still can.
4. Ask the council for a care needs assessment, and a carer's assessment for yourself.
5. Start with one small, appealing piece of help and build from there.

How we can help

Day and Nightcare has supported people at home since 2008. We provide home care visits from one hour, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England, and fully managed live-in dementia care anywhere in England from £1,550 a week. Our free assessment is a chance to talk about the person, what matters to them and how help could be introduced gently. Call us on 01865 715780.

Common questions

Can we make a parent with dementia accept care?

Not simply because the family thinks it is best. If the person has the mental capacity to decide about their care, they can refuse, even if others think it unwise. If they lack capacity for that decision, care can be arranged in their best interests, involving them as much as possible and choosing the least restrictive option. Restraint is only lawful when it is needed to prevent harm and is proportionate. Significant restrictions the person objects to may need legal authorisation.

What if they refuse a council care needs assessment?

Under section 11 of the Care Act 2014, the council does not have to assess someone who refuses. But it must still assess if the person lacks capacity to refuse and an assessment would be in their best interests, or if they are experiencing, or at risk of, abuse or neglect, which can include self-neglect. If they refuse now, the duty to assess comes back if they later ask, or if their needs or circumstances change.

Can medicines be hidden in food or drink?

Only after a formal process, never on your own. CQC guidance says hiding medicines (covert administration) is only likely to be appropriate when the person actively refuses, lacks the capacity to understand the consequences, and the medicine is essential. It must be a best interests decision involving the prescriber, a pharmacist's advice, the care team and family, recorded in writing, agreed for each medicine and reviewed regularly. Crushing some tablets can make them dangerous.

Who decides whether someone with dementia lacks capacity?

The person who needs the decision to be made. For a care package that is often a social worker; for medicines, the prescriber; for everyday care, the carer helping at the time. Capacity is assessed for one decision at one time, so someone may be able to choose their meals but not to understand the risks of living without help. If a registered health and welfare Lasting Power of Attorney covers the decision, the attorney decides when the person cannot.

Why will Mum accept help from a carer but not from me?

This is very common and nothing to feel hurt by. Many people find it easier to accept intimate help, such as washing, from a professional than from their own child or partner, because it protects their dignity and the family relationship. A trained carer also arrives fresh, without the history of earlier disagreements. It often frees the family to go back to being a daughter, son or partner rather than a carer.

Sources and further information

- legislation.gov.uk: Mental Capacity Act 2005
- legislation.gov.uk: Care Act 2014, section 11 (refusal of assessment)
- Alzheimer's Society: Support and care when a person won't accept their diagnosis
- Alzheimer's Society: When a person with dementia doesn't want to change their clothes or wash
- CQC: Covert administration of medicines
- GOV.UK: Care and support statutory guidance

Read next

LEGAL MATTERS AND PLANNING AHEAD

Mental capacity and best interests: a guide for families

How the Mental Capacity Act 2005 works in England and Wales: the five principles, how capacity is assessed, best interests decisions, deprivation of liberty after the 2026 Supreme Court ruling, the position on LPS, and how to support someone to decide.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Dementia care at home: a practical guide for families

How to support someone with dementia at home: the stages, communication, routines, eating and drinking, sundowning and nights, wandering and safety, Lasting Power of Attorney, support for carers and how care is funded, including NHS Continuing Healthcare and council tax.

Read the guide →

LEGAL MATTERS AND PLANNING AHEAD

Lasting Power of Attorney: a guide for families

How Lasting Power of Attorney works in England and Wales: the two types, why to make one early, how to make and register it online or on paper, the £92 registration fee, the certificate provider, and what happens without one (deputyship and the Court of Protection).

Read the guide →

All guides in the information centre **Check what help you could get**

This page online: **www.dayandnightcare.co.uk/guides/dementia-and-refusing-care/**

Sudden confusion and delirium in older people: what to do

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Delirium is a sudden change in a person's thinking and alertness that develops over hours or a day or two, and it needs urgent medical attention. It is usually caused by another problem, such as an infection, dehydration, constipation, pain or a new medicine, and is much more common in older people and people with dementia. The NHS advises calling 999 or going to A&E if someone suddenly becomes confused; many people improve once the cause is treated.



IN THIS GUIDE

1. What delirium is
2. Delirium or dementia?
3. Common causes of sudden confusion
4. When to call 999, NHS 111 or the GP
5. What to say when you call
6. While you wait for help
7. Helping someone with delirium in hospital
8. Recovery at home after delirium
9. Lowering the risk of delirium at home
10. Where to get support
11. What to do next
12. How we can help
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What delirium is

Delirium is a sudden change in a person’s mental state. Families often describe it simply: “She’s not herself.” It usually develops over hours or a day or two and is often the first sign that someone is becoming physically unwell. Signs include:

- being less alert, easily distracted or unable to follow a conversation
- not knowing where they are, or mixing up day and night
- seeing or hearing things that are not there, or believing things that are not true
- sudden restlessness, agitation or uncharacteristic anger
- becoming unusually sleepy, withdrawn or quiet
- suddenly struggling with things they could do yesterday, such as walking or eating
- symptoms that come and go through the day, often worse in the evening

There are three types. **Hyperactive** delirium is the restless, agitated kind that is easy to spot. **Hypoactive** delirium makes people quiet, sleepy and withdrawn, and is easily mistaken for tiredness. **Mixed** delirium switches between the two. In older people, the hypoactive and mixed types are the most common, so a parent who is suddenly drowsy and not eating needs as much attention as one who is agitated.

Delirium or dementia?

	Delirium	Dementia
How it starts	Suddenly, over hours or a day or two	Slowly, over months or years
Day to day	Changes markedly, even hour to hour	Fairly consistent from day to day
Alertness and attention	Often reduced or swinging	Usually normal until the later stages
Outlook	Often improves when the cause is treated	Long-term and progressive
Urgency	A medical emergency	Needs planned support

Someone can have both. Dementia is the biggest single risk factor for delirium, and a person with dementia who suddenly becomes much more confused should be treated as possibly having delirium until a clinician has checked.

Common causes of sudden confusion

Delirium is usually the brain's reaction to another problem, and there is often more than one cause. The NHS, the Alzheimer's Society and Dementia UK list:

- **Infections,** especially urine and chest infections.
- **Dehydration** and not eating enough.
- **Constipation** or being unable to pass urine.
- **Pain,** which people with dementia may not be able to describe.
- **Medicines:** a new medicine, a changed dose, or several medicines together, particularly strong painkillers and sedatives.
- **Surgery,** especially hip surgery, and anaesthetics.
- **Stroke or mini-stroke (TIA),** a head injury after a fall, or low blood sugar in people with diabetes.
- **Alcohol,** or stopping alcohol suddenly.
- **Low oxygen** from lung or heart problems.
- **Unfamiliar, noisy or poorly lit places,** such as a hospital ward, and poor sleep.

The NHS also warns about carbon monoxide poisoning, especially if other people in the home feel unwell too.

When to call 999, NHS 111 or the GP

Call 999 straight away if they also:

- are very drowsy, hard to wake or have difficulty speaking
- show signs of a stroke: face drooping, arm weakness or slurred speech
- have blue, grey, pale or blotchy skin, lips or tongue, cold skin, or are breathing fast or struggling to breathe
- have fallen and may have hurt their head

Ask for an urgent GP appointment or call NHS 111 (free, 24 hours) if you are unsure, or if:

- they are 65 or over and have symptoms of a urine infection
- they seem dehydrated: dark urine, peeing less, dizziness on standing that does not go away, or unusual tiredness

- they are a little more muddled than usual and you cannot tell whether it is sudden

Book a routine GP appointment for changes in memory or thinking that have come on gradually. That is a different problem and needs a planned assessment.

What to say when you call

> "My father is 84 and has dementia. Since yesterday afternoon he has become much more confused than his normal and very sleepy. Normally he knows who I am, walks with a frame and chats. He's had a temperature since this morning and hasn't drunk much. He takes [number] medicines and started a new one on [date]."

Have ready:

- a list of their medicines, or the packets, including any new or changed ones
- what is normal for them, and when the change started
- any recent fall, illness, operation, constipation or change in drinking
- their NHS number and GP surgery
- any advance care plan, "about me" sheet or Lasting Power of Attorney

While you wait for help

The NHS advises:

- Stay with them, tell them who you are and where they are, and keep reassuring them.
- Use simple words and short sentences.
- Do not ask lots of questions while they are confused.
- Do not stop them moving around unless they are in danger.
- Gather their medicines to take with you.

Helping someone with delirium in hospital

- Tell staff clearly what the person is normally like. They have only seen them unwell.

- Bring glasses, hearing aids (with batteries), dentures and familiar things such as photographs.
- Help them eat and drink, and keep a note of how much.
- Remind them gently where they are and why, without arguing.
- Ask what is causing the delirium and what is being done about it.

If you feel the person is getting worse and your concerns are not being acted on, ask for an urgent review. Under **Martha's Rule**, being introduced across acute hospitals in England, families can call a dedicated hospital number to ask for a rapid review by a different team. Each hospital has its own number: look for posters on the ward or ask staff. You might say:

> "I'm worried my mother is getting worse. This is not her normal. I'd like to ask for a Martha's Rule review."

Recovery at home after delirium

Recovery can take days, weeks or sometimes months. Expect good and bad days. At home:

- Keep the routine calm and familiar, with daylight, regular meals and drinks, and good sleep.
- Encourage gentle activity as soon as it is safe.
- Ask the GP for a follow-up, including a review of medicines.
- If memory or thinking has not returned to normal after a few weeks, ask the GP whether a memory assessment is needed.
- Ask about reablement if they are less able than before.

See our guide to leaving hospital for help with the journey home.

Lowering the risk of delirium at home

Based on NICE's recommendations for people at risk:

- Drinks within reach all day, and help to drink at mealtimes. Pale urine is the aim.
- Regular meals, fibre and fluids to prevent constipation.
- Glasses clean and worn, hearing aids working.

- A clock and calendar easy to see, and a calm, well-lit home.
- Daily movement, even seated exercises.
- A regular bedtime and a quiet night.
- Pain asked about and treated, including in people who cannot say they are in pain.
- A medicines review with the GP or pharmacist, especially for anyone on several medicines.
- Infections treated promptly.

People most at risk, according to NICE, are those aged 65 or over, people with memory problems or dementia, people with a hip fracture and people who are severely ill. Poor sight or hearing and a previous episode of delirium add to the risk.

Where to get support

- **NHS 111:** free, 24 hours, by phone or online.
- **Dementia UK Admiral Nurse Dementia Helpline:** 0800 888 6678 (free). Monday to Friday 9am to 9pm, weekends 9am to 5pm.
- **Alzheimer's Society Dementia Support Line:** 0333 150 3456. Monday to Wednesday 9am to 8pm, Thursday and Friday 9am to 5pm, weekends 10am to 4pm.
- **Age UK Advice Line:** 0800 678 1602 (free). 8am to 7pm, every day of the year.

What to do next

1. Write a short "what's normal for Mum" note and keep it with the medicines list.
2. Learn the signs of a urine infection and dehydration in older people.
3. Make sure drinks, glasses and hearing aids are part of every day.
4. Ask the GP or pharmacist for a medicines review if several medicines are taken.
5. If someone suddenly becomes confused, call 999 or go to A&E.

How we can help

A carer who sees someone every day is often the first to notice that they are "not themselves". Day and Nightcare provides home care visits from one hour, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in

shifts anywhere in England, and fully managed live-in care anywhere in England from £1,550 a week, including support after a hospital stay. Call us on 01865 715780 to arrange a free assessment.

Common questions

Why do doctors keep asking what my parent is normally like?
Because delirium is recognised by comparing the person with their usual self. Staff in A&E or on a ward have only ever seen them unwell, so they may not know that a quiet, muddled, sleepy person is normally chatty and sharp. NICE asks clinicians to look for recent changes reported by the person, a carer or a relative. Telling staff clearly what has changed, and when, is one of the most useful things a family can do.

How long does delirium last?
Usually days, but sometimes longer. The Alzheimer's Society says symptoms often improve within a few days of the cause being treated, though serious infections can take longer, and some people, particularly older people after major surgery, take weeks or months to get their memory and thinking back. In people who already have memory problems, prolonged or severe delirium can speed up decline. Delirium does not itself cause dementia.

Can a urine infection cause confusion in older people?
Yes. The NHS says older or frail people and people with dementia with a urinary tract infection may become agitated or confused, leak urine more than usual, or have new shivering or shaking. Anyone aged 65 or over with symptoms of a urine infection should have an urgent GP appointment or call NHS 111. Call 999 if they are confused, drowsy or having difficulty speaking. But not all confusion is a urine infection, so do not assume: let a clinician look for the cause.

How common is delirium in hospital?
Very common. NICE says about 20% to 30% of people on medical wards in hospital have delirium, and between 10% and 50% of people having surgery develop it. Older people, people with dementia, people with a hip fracture and people who are severely ill are most at risk. It is often missed, especially the quiet, sleepy kind, which is why families who know what the person is normally like have such an important role.

What is the 4AT test?

The 4AT is a short screening test, taking about two minutes, that doctors and nurses use to help spot delirium. The Alzheimer's Society explains that it covers four things: how alert the person is, whether they know basic facts such as their age and where they are, whether they can concentrate on a simple task, and whether there has been a sudden change. It supports a clinician's judgement rather than replacing it, and your account of the change matters.

Sources and further information

- NHS: Sudden confusion (delirium)
- NHS: Urinary tract infections (UTIs)
- NHS: Dehydration
- NICE: Delirium, prevention, diagnosis and management in hospital and long-term care (CG103)
- Alzheimer's Society: Delirium
- Dementia UK: Delirium
- NHS England: Martha's Rule

Read next

HEALTH CONDITIONS AND CARE AT HOME

Dementia care at home: a practical guide for families

How to support someone with dementia at home: the stages, communication, routines, eating and drinking, sundowning and nights, wandering and safety, Lasting Power of Attorney, support for carers and how care is funded, including NHS Continuing Healthcare and council tax.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Nutrition and hydration in later life: a guide for families

Why older people are at risk of malnutrition and dehydration, the warning signs, practical ways to help someone eat and drink well, texture-modified diets and swallowing support, monitoring weight, and where to get help, from the GP and dietitian to meals at home.

Read the guide →

LEAVING HOSPITAL AND RECOVERY

Leaving hospital: what to expect and how to prepare

How hospital discharge works in England today: the discharge pathways, who the discharge team are, timing, transport, medicines and equipment, what families can do, and how to arrange private or live-in care quickly.

Read the guide →

All guides in the information centre **Check what help you could get**

This page online: **www.dayandnightcare.co.uk/guides/sudden-confusion-and-delirium/**

Preventing pressure ulcers at home: a guide for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Pressure ulcers, also called pressure sores or bed sores, are damage to the skin and the tissue beneath it caused by staying in one position for too long, and most can be prevented. The essentials are changing position regularly, checking the skin every day, keeping it clean and dry, eating and drinking well, and using the right mattress and cushion, which the NHS usually lends free after an assessment. Report any patch that does not fade when pressed to the GP or district nurse promptly.



IN THIS GUIDE

1. What pressure ulcers are and where they form
2. Who is most at risk
3. A daily skin check: what to look for
4. Changing position: how often and how
5. Keeping skin clean and dry
6. Eating and drinking
7. Equipment and how to get it from the NHS
8. When to call the district nurse, GP or NHS 111
9. Words you can use
10. If you are worried about the care someone is getting
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What pressure ulcers are and where they form

A pressure ulcer is an injury to the skin and the tissue underneath, caused by pressure, or pressure combined with the skin being dragged, over a period of time. They usually form over bony parts of the body:

- heels and ankles
- the base of the spine (tailbone) and buttocks
- hips
- elbows and shoulder blades
- the back of the head and the ears, in someone lying in bed

They usually develop gradually, but the NHS says they can appear within a few hours. Without care, a discoloured patch can become a blister, then an open wound that reaches muscle and bone. Nurses describe pressure ulcers in categories, from category 1 (the skin is unbroken but has a discoloured patch that does not fade when pressed) to category 4 (a deep wound reaching muscle or bone). Deep ulcers can take months to heal, so prevention matters.

Who is most at risk

The NHS lists people who:

- have difficulty moving, or spend most of the day in a bed or chair
- have had a pressure ulcer before
- have recently been seriously ill or had surgery
- are underweight
- have swollen, sweaty or broken skin, often linked to incontinence
- have poor circulation or fragile skin
- have reduced feeling, for example after a stroke, with diabetes or a spinal condition

Significant memory problems also increase the risk, because the person may not shift position or say when they are uncomfortable. If you think someone is at risk, the NHS suggests asking the GP for a risk assessment so a prevention plan can be put in place.

A daily skin check: what to look for

Check the skin once a day, ideally while helping with washing or dressing, and pay most attention to the bony areas listed above. Look for:

- a patch of skin that is discoloured: red on white skin, or purple or blue on black or brown skin

- a patch that does not change colour when you press it gently with a finger
- skin that feels warm, spongy or hard compared with the skin around it
- pain, tenderness or itching in one spot
- a blister, broken skin or a shallow wound

Check under and around anything that presses on the skin, such as oxygen tubing, a catheter, splints or tight footwear. Write down what you find, with the date, so changes are easy to spot.

Changing position: how often and how

Pressure is relieved only when the weight comes off the area. NICE recommends that people at risk change position frequently and at least every six hours, and people at high risk at least every four hours. The district nurse sets the right frequency for each person and it should be written in the care plan.

- **In bed:** turn from back to side to other side in a regular pattern, keeping weight off any red area.
- **Heels:** these are especially vulnerable. Ask the nurse how best to keep pressure off them.
- **Sitting:** someone sitting for long periods needs a suitable pressure-relieving cushion and should change position or stand regularly if they can.
- **Encourage movement:** small shifts of weight, standing and short walks all help, if safe.
- **Do not drag:** sliding someone across the sheets damages the skin. Use slide sheets and the moving and handling methods shown by a nurse or occupational therapist.
- **At night:** if turning is needed through the night, plan who will do it. This often decides the type of care needed.

Keeping skin clean and dry

- Wash gently with warm water and a mild cleanser, pat dry rather than rub, and dry carefully between skin folds.
- Change wet or soiled pads and clothing promptly. Moisture from urine, faeces or sweat makes skin much more likely to break down.
- Use a barrier cream if the nurse or GP recommends one.

- Do not massage or rub red areas. NICE advises against it.
- Keep bedding smooth and free of crumbs and creases.

Our guide to continence care with dignity covers products and skin care.

Eating and drinking

Healthy skin needs enough food, protein and fluid. Weight loss, a poor appetite or not drinking enough all raise the risk and slow healing. Offer drinks regularly and keep them within reach, aiming for pale urine. If someone is losing weight or eating little, ask the GP for a nutrition check and, if needed, a dietitian referral. See nutrition and hydration.

Equipment and how to get it from the NHS

Equipment is not a substitute for changing position, but it helps. Common items:

- **Pressure-relieving mattress:** NICE recommends a high-specification foam mattress for adults at high risk. Some people need an electric air mattress.
- **Pressure-relieving cushion** for anyone who sits for long periods or uses a wheelchair.
- **Profiling bed,** which raises and lowers and helps with turning and sitting up.
- **Heel protection,** slide sheets and other moving and handling aids.

How to get it: ask the GP practice to refer the person to the district (community) nursing team, or ask the occupational therapist or hospital team if they are being discharged. Equipment assessed as needed is usually lent free through the local community equipment service. See equipment and home adaptations.

If the mattress needs electricity, join the Priority Services Register with your energy supplier and the local electricity network operator. Ofgem says members can get priority support in an emergency and, where possible, advance notice of planned power cuts. Ask the nurse what to do if the power goes off, and report power cuts by calling 105, the free national power cut number.

When to call the district nurse, GP or NHS 111

Contact the GP or district nurse (non-urgent, but soon) if you think someone has a pressure ulcer or a patch that does not fade when pressed.

Ask for an urgent GP appointment or call NHS 111 (free, 24 hours) if a sore area shows any of these signs, which the NHS lists:

- hot, swollen or red skin around it (on brown or black skin it can look purple or blue)
- pus coming from it
- a high temperature
- severe or worsening pain

Words you can use

Asking the GP practice for a district nurse:

> "My father, [name, date of birth], is mostly in bed or his chair now. There's a red patch on his tailbone that doesn't fade when I press it. Please could the district nursing team visit to assess his skin and whether he needs a pressure-relieving mattress and cushion?"

Asking about the plan:

> "How often does he need turning, day and night? Could that be written in his care plan, and could someone show us how to move him safely?"

If you are worried about the care someone is getting

Raise concerns with the care provider and the district nurse first. Ask to see the care plan and the record of repositioning and skin checks. The government's safeguarding protocol on pressure ulcers says families should be involved and listened to, and that carers can ask for training in preventing pressure ulcers and spotting the early signs. If you believe the person is being neglected, contact the council's adult social care team to raise a safeguarding concern. See safeguarding and scams.

How live-in and night care help

A carer who is in the home all day can help someone change position regularly, check their skin while helping them wash and dress, keep drinks and snacks coming and spot early changes before they become wounds. Be honest about nights: a live-in carer can help occasionally at night, but if someone needs turning several times every night, a waking night carer is usually needed as well. See night care.

Checklist: pressure care at home

- Daily skin check of heels, hips, tailbone, elbows and ears, written down.
- Position changed as often as the care plan says, day and night.
- Pressure-relieving mattress and cushion in place and working.
- Skin kept clean and dry; pads changed promptly; no rubbing.
- Drinks within reach; meals and weight watched.
- Slide sheets used; nobody dragged across the bed.
- District nurse and GP numbers by the phone.
- Priority Services Register joined if equipment uses electricity.

What to do next

1. Check the person's skin today, especially heels and the base of the spine.
2. Ask the GP practice for a pressure ulcer risk assessment or district nurse visit.
3. Agree how often they need to change position, and who will help at night.
4. Ask for an assessment for a pressure-relieving mattress and cushion before buying anything.
5. Review eating, drinking and continence care.

How we can help

Day and Nightcare provides home care visits from one hour, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England, and fully managed live-in care anywhere in England from £1,550 a week, funded privately, by councils (including direct payments) or by NHS Continuing Healthcare. If someone you care for is spending more time in bed or a chair and you would like to talk about support at home, call us on 01865 715780 to arrange a free assessment and a written quote.

Common questions

Are pressure ulcers the same as bed sores?

Yes. Pressure ulcers, pressure sores, pressure injuries and bed sores are different names for the same thing: damage to the skin and the tissue underneath caused by pressure over time. Despite the name, they do not only happen in bed. People who sit for long periods in a chair or wheelchair are also at risk, and medical devices such as oxygen tubing, catheters or splints can cause pressure damage where they press on the skin.

Can pressure ulcers be treated at home?

Many can, usually by the district nursing team. The NHS says treatment depends on how severe the ulcer is and can include changing position and moving regularly, specialist mattresses and cushions, dressings, creams, cleaning the wound and antibiotics if it is infected. Severe ulcers, or ones that do not heal with other treatment, may need surgery. Keep to the care plan the nurse sets, and report any change in the wound or in how the person feels.

What does a pressure ulcer look like on darker skin?

The NHS says early pressure damage usually looks red on white skin, but on black or brown skin it may look purple or blue, and redness can be hard to see. Feel as well as look: an area that is warmer or cooler than the skin around it, spongy or hard, or painful or itchy can be an early warning. Report it promptly, describing what you can feel as well as what you can see.

Is sore skin from incontinence the same as a pressure ulcer?

Not quite. Skin damage caused only by moisture, such as urine, faeces or sweat, is called moisture-associated skin damage, and nurses record it separately from pressure ulcers. But moist skin breaks down much more easily under pressure, and damage caused by moisture and pressure together is counted as a pressure ulcer. Both need prompt attention: change pads quickly, clean and dry the skin gently, and ask the nurse or GP about a barrier cream.

Does a pressure ulcer mean someone has been neglected?

Not necessarily. Pressure ulcers can develop despite good care, particularly in people who are very ill, frail or near the end of life. But they can also be a sign that care has not been planned or delivered properly. If you are worried, talk to the care provider and the district nurse first. If you think the person is being neglected, you can raise a safeguarding concern with the council's adult social care team.

Sources and further information

- NHS: Pressure ulcers (pressure sores)
- NICE: Pressure ulcers, prevention and management (CG179)
- GOV.UK: Safeguarding adults protocol, pressure ulcers and raising a safeguarding concern
- Ofgem: Join your supplier's Priority Services Register
- NHS: Dehydration

Read next

LIVING SAFELY AND WELL AT HOME

Equipment and home adaptations: what is free and how to get it

How to get equipment and home adaptations for an older or disabled person in England: occupational therapy assessments, free council and NHS equipment, Disabled Facilities Grants of up to £30,000, VAT relief, beds, hoists and stairlifts, and how to buy safely.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Continence care with dignity: a guide for families

Bladder and bowel problems in later life: common causes, how to get an NHS continence assessment and products, protecting the skin, keeping dignity at the centre, helpful routines, managing nights and when to see a GP, with sources of support and help with costs.

Read the guide →

HEALTH CONDITIONS AND CARE AT HOME

Nutrition and hydration in later life: a guide for families

Why older people are at risk of malnutrition and dehydration, the warning signs, practical ways to help someone eat and drink well, texture-modified diets and swallowing support, monitoring weight, and where to get help, from the GP and dietitian to meals at home.

Read the guide →

All guides in the information centre **Check what help you could get**

This page online: **www.dayandnightcare.co.uk/guides/pressure-ulcer-prevention/**

MS and MND care at home: a guide for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

MS and MND are progressive neurological conditions that affect people very differently: MS often changes slowly over many years and most people live into old age, while MND usually progresses over months or years and shortens life. Good care at home is built around a specialist team, equipment provided in good time, planning ahead while the person can still decide, and care that grows with their needs, including live-in care when help is needed throughout the day.



IN THIS GUIDE

1. How MS and MND affect daily life
2. The specialist team and how to reach it
3. Planning ahead
4. Equipment and adaptations
5. Care at home as needs grow
6. MS: relapses and when to get help
7. MND: breathing, swallowing and urgent help
8. Help with costs
9. Where to get support
10. What to do next
11. How we can help
12. Common questions
13. Sources and further information

How MS and MND affect daily life

Multiple sclerosis (MS) affects the brain and spinal cord. Common symptoms include extreme tiredness (fatigue), vision problems, numbness or tingling, balance problems, muscle stiffness and spasms, bladder and bowel problems, and difficulties with memory or concentration. Many people first have relapsing

remitting MS, with flare-ups followed by recovery, which often becomes secondary progressive MS over time. Primary progressive MS worsens gradually from the start. MS is most common in people aged 20 to 50, and the NHS says most people live into old age, although life expectancy is a few years shorter on average. Some people need little help for many years; others need a lot.

Motor neurone disease (MND) affects the nerves that control muscles. It usually starts with weakness in the hands, legs or feet, or with speech and swallowing, and gradually spreads. Over time people may need a wheelchair, help with every aspect of personal care, a feeding tube, breathing support at night and a communication aid. Some people also have changes in mood, thinking or behaviour. The NHS describes MND as usually life-shortening, and it most often begins after the age of 50.

Because MND can change quickly, the most important principle is to plan one step ahead. With MS, the challenge is often unpredictability: care needs to flex with good and bad days.

Much of this guide also applies to other progressive neurological conditions. See our guide to Parkinson's care at home.

The specialist team and how to reach it

For MS, NICE recommends that everyone has a single point of contact who knows MS services, usually an MS specialist nurse, and a comprehensive review of their care at least once a year. The wider team includes a neurologist, physiotherapist, occupational therapist, and as needed a speech and language therapist, continence specialist, dietitian and psychologist.

For MND, NICE recommends care from a specialist multidisciplinary team, with coordinated assessments at the team's clinic usually every two to three months. The MND Association has developed MND care centres and networks across England, Wales and Northern Ireland, including one in Oxford. Not everyone attends one, as many hospitals provide good MND services.

How to get the team in place:

1. Ask the neurologist or GP who the specialist nurse is, and get a direct phone number and email.

2. Ask for referrals to physiotherapy, occupational therapy, speech and language therapy and a dietitian.
3. Ask for a council care needs assessment, and a carer's assessment for the main family carer.
4. For MND, ask early about the palliative care team: it supports quality of life, not just the last days.
5. Ask what to do out of hours or in an emergency, including if equipment fails. NICE says people with MND should be given this information.

Planning ahead

Talking about the future early, while the person can make and communicate their own decisions, protects their choices.

- **Lasting Powers of Attorney** for health and welfare and for property and finance. See our Lasting Power of Attorney guide.
- **An advance statement** of wishes, and if wanted an **advance decision to refuse treatment**. See advance care planning.
- **For MND,** NICE recommends discussing preferences for end-of-life care at diagnosis, if breathing changes significantly, and when a feeding tube (gastrostomy) or breathing support (non-invasive ventilation) is planned. Feeding tubes are best discussed early, as later placement carries more risk.
- **Voice banking:** the MND Association suggests early conversations with a speech and language therapist about recording the person's voice so a communication aid can sound like them.

Equipment and adaptations

NICE says people with MND should get equipment, adaptations and wheelchairs **without delay**, because needs can change quickly. Equipment that is commonly needed includes:

- walking aids, then manual and powered wheelchairs from the NHS wheelchair service
- a profiling bed, pressure-relieving mattress and cushion
- a riser-recliner chair, shower chair, commode and grab rails
- a hoist and slings, with training in how to use them

- communication aids, environmental controls and adapted phones or tablets
- for MND, a suction machine and breathing equipment if prescribed

Equipment and minor adaptations costing £1,000 or less are free from the council if an assessment shows they are needed. Larger works, such as a level-access shower or a through-floor lift, may be funded by a means-tested Disabled Facilities Grant of up to £30,000 in England. Start with an occupational therapy assessment. See equipment and home adaptations and pressure ulcer prevention.

If any equipment needs electricity, join the Priority Services Register with your energy supplier and electricity network operator.

Care at home as needs grow

Care usually builds in steps: a few visits a week, then daily home care, then live-in care when help is needed throughout the day, with night care added if nights are busy.

Live-in care suits many people with MS or MND because one consistent carer learns exactly how they like to be moved, positioned, fed and helped to communicate, which matters greatly when speech becomes difficult. It also keeps the family together at home, and it can flex around MS fatigue and relapses.

Be honest about the limits:

- If every transfer needs two people, a second carer will be needed at those times.
- If help is needed most nights, for example turning or breathing support, a waking night carer is needed as well as the live-in carer.
- A hospice or nursing home may suit better if symptoms become very hard to manage at home.

MS: relapses and when to get help

NICE describes a relapse as new symptoms, or old symptoms getting worse, lasting more than 24 hours, after at least a month of being stable, when there is no infection or other cause.

- **Contact the MS nurse** promptly if you think a relapse has started. NICE says relapses that affect the person's ability to do their usual tasks should be assessed and treatment offered as early as possible, and within 14 days.

- Infections, especially urine and chest infections, can make MS symptoms worse, so the team will check for them first.
- Heat, stress and illness can bring on MS fatigue.
- A relapse is a good moment to ask for extra care: NICE says social care needs should be checked and the person referred for assessment if needed.

MND: breathing, swallowing and urgent help

NICE lists signs that breathing muscles may be weakening, including breathlessness, breathlessness when lying flat, a weak cough, repeated chest infections, disturbed or unrefreshing sleep, daytime sleepiness and morning headaches. Tell the MND team promptly about any of these, and about coughing or choking when eating or drinking, or weight loss.

Call 999 if someone is struggling to breathe or is choking and it does not clear. Keep a copy of any emergency plan, advance decision and DNACPR form where ambulance crews will see it.

Help with costs

- **Personal Independence Payment (PIP)** for people under State Pension age: daily living £76.70 or £114.60 a week, and mobility £30.30 or £80.00 a week. It is not means-tested. See our PIP guide.
- **Special rules for end of life:** if a doctor or nurse has said the person might have 12 months or less to live, call the PIP claims line on 0800 917 2222 (Monday to Friday, 9am to 5pm) and ask to make a special rules claim. Ask the healthcare professional for form SR1. The higher daily living rate is paid and there is no face-to-face assessment.
- **Attendance Allowance** for people who first claim after State Pension age. See our Attendance Allowance guide.
- **Council funding** after a care needs assessment and a financial assessment.
- **NHS Continuing Healthcare**, including Fast Track for rapidly deteriorating conditions.
- **Carer's Allowance** for a family member caring for 35 hours a week or more. See Carer's Allowance.

- **MND Association Support Funds:** cost of living, everyday living, technology and innovation, and wellbeing funds. Some must be applied for by a health or social care professional.
- **MS Society:** some local groups offer grants, and the charity runs a legal advice service.

Where to get support

- **MS Society MS Help:** 0808 800 8000 (free). Monday to Friday, 9am to 5pm, except bank holidays. Email helphub@mssociety.org.uk.
- **MS Trust Helpline:** 0800 032 38 39 (free). Weekdays 10am to 4pm, except bank holidays. Email helpline@mstrust.org.uk.
- **MND Association, MND Connect:** 0808 802 6262. Monday to Friday, 9am to 4pm. Email mndconnect@mndassociation.org.
- **Carers UK Helpline:** 0808 808 7777. Monday to Friday, 9am to 6pm.
- **Samaritans:** 116 123 (free), 24 hours a day.

What to do next

1. Get the specialist nurse's direct number, and ask what to do out of hours.
2. Ask for occupational therapy and equipment assessments now, ahead of need.
3. Make Lasting Powers of Attorney and talk about future wishes.
4. Claim PIP or Attendance Allowance, using the special rules if they apply.
5. Ask the council for a care needs assessment and a carer's assessment.
6. Ask whether an NHS Continuing Healthcare Checklist should be completed.

How we can help

Day and Nightcare provides fully managed live-in care anywhere in England, from £1,550 a week, and home care visits, waking nights and sleep-ins across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England. We work with private, council, direct payment and NHS Continuing Healthcare funding. If you would like to talk about care at home for someone with MS or MND, call us on 01865 715780 to arrange a free assessment and a written quote.

Common questions

Is someone with MS or MND protected at work?

Yes. GOV.UK says people with multiple sclerosis automatically meet the definition of disability under the Equality Act 2010 from the day they are diagnosed. People with other progressive conditions, such as MND, can also be classed as disabled, assessed in the usual way. Employers must then make reasonable adjustments, such as changed hours or equipment, and must not treat the person unfairly because of their condition. Family carers can ask their own employer about flexible working.

Can someone with MND be cared for at home until the end of life?

Many people can, if that is what they want. It needs a specialist team, equipment arranged early, palliative care support, a clear plan for emergencies and enough care at home, often including nights. NHS Continuing Healthcare, including the Fast Track route for someone whose condition is deteriorating rapidly, can pay for care at home. A hospice or nursing home may suit better if symptoms become hard to manage at home, and that is a valid choice too.

Does NHS Continuing Healthcare pay for care for MS or MND?

It can, but not because of the diagnosis. Eligibility depends on whether the person's needs are mainly health needs, judged on how complex, intense and unpredictable they are. People in the later stages of MND often have complex needs, such as breathing support, swallowing problems and a high risk of choking, which may qualify. People with advanced MS may qualify too. Ask the GP, specialist nurse or social worker for a Checklist assessment.

Can a live-in carer help with tube feeding or breathing equipment?

Sometimes. Some health tasks, such as feeding through a gastrostomy tube, can be delegated by an NHS nurse to a care worker who has been trained and checked as competent, with the nurse keeping clinical responsibility. This is agreed for each person and each task. Other tasks remain with nurses. Ask the specialist team and any care provider exactly which tasks would be delegated, who trains the carers and who to call if something goes wrong.

Do people with MS or MND have to tell the DVLA?

Yes, in most cases. GOV.UK says you must tell the DVLA if you have motor neurone disease. For MS, car and motorcycle drivers must tell the DVLA if the condition will affect their driving; bus, coach and lorry drivers must always tell the DVLA. You can report online or on form CN1. You can be fined up to £1,000 for not telling the DVLA about a condition that affects driving.

Sources and further information

- NHS: Multiple sclerosis
- NHS: Motor neurone disease
- NICE: Multiple sclerosis in adults, management (NG220)
- NICE: Motor neurone disease, assessment and management (NG42)
- MS Society: MS Help
- MND Association: MND Connect helpline
- MND Association: Care centres and networks
- GOV.UK: Claiming PIP if you're nearing the end of life

Read next

HEALTH CONDITIONS AND CARE AT HOME

Parkinson's care at home: a guide for families

Supporting someone with Parkinson's at home: why medicines must be taken on time, help with movement and freezing, preventing falls, swallowing, sleep and communication, when to get medical help, where to find support and how care can be funded.

Read the guide →

LIVING SAFELY AND WELL AT HOME

Equipment and home adaptations: what is free and how to get it

How to get equipment and home adaptations for an older or disabled person in England: occupational therapy assessments, free council and NHS equipment, Disabled Facilities Grants of up to £30,000, VAT relief, beds, hoists and stairlifts, and how to buy safely.

Read the guide →

PAYING FOR CARE AND REDUCING THE COST

Personal Independence Payment (PIP): a guide for families

PIP helps people aged 16 to State Pension age with the extra costs of a long-term condition or disability. The 2026/27 rates, how the points work, how to claim step by step, example wording for the form, end-of-life rules and PIP at State Pension age.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/ms-and-mnd-care-at-home/**