QI & SERVICE MANAGERS

Audit the delirium detection system, not just the form

Help improvement teams measure whether recognition leads to appropriate assessment, clinical action and continuity without using a single score rate as a crude target.

Define the audit question and denominator

- Specify the setting, patient group, time period and opportunities being measured.
- Define eligibility from the agreed pathway and record exclusions transparently.
- Separate general inpatient settings from critical care and postoperative recovery, where different assessment tools are recommended.

Measure detection reliability

- Was new or fluctuating change observed and documented when present?
- When indicators were identified, was the appropriate delirium assessment completed and interpretable?
- Were baseline information, communication barriers, item responses, score, time and assessor recorded sufficiently to understand the result?

Measure what happened next

- Did a result suggesting delirium lead to timely clinical assessment and a documented conclusion?
- Were urgent threats and possible multiple causes considered, with investigations tailored to the clinical presentation?
- Were cause-directed actions, supportive care, distress assessment and person or family communication documented?

Measure continuity and recovery planning

- Was delirium visible in handovers, referrals and the discharge summary?
- Was current status compared with baseline, with unresolved issues and follow-up responsibilities made explicit?
- Was the diagnosis communicated to primary care and the next care setting?

Interpret and improve responsibly

- Examine trends over time and stratify findings by pathway, setting and relevant case mix.
- Review a sample of records to test clinical quality, not only data-field completion.
- Use findings to identify the next process problem, test a change and re-audit.
- Review balancing measures chosen for the local change, such as staff burden, inappropriate repeat assessment, use of sedating medicine or restrictive interventions, falls and reported distress. Interpret them with clinical context rather than as league-table targets.

Safety box - do not turn a positive-score rate into a league table: A single percentage can reflect case mix, pathway scope, incomplete assessment or missed detection. It is not, by itself, a standard of good care. Audit data support improvement; they do not validate individual clinical decisions or replace clinical review.

Verified official sources

- NICE CG103: daily observation, assessment, diagnosis and documentation
- SIGN 157 on Right Decisions: detecting and documenting delirium
- SIGN 157 on Right Decisions: screening and monitoring tools
- Official 4AT user guide
- Official 4AT frequently asked questions

Use and review: UK-focused general education. This resource supports but does not replace clinical assessment, individual advice or current local guidance. Prepared from source materials curated by Professor Alasdair MacLullich, University of Edinburgh; AI-assisted production. Professor MacLullich led development of the 4AT and reports no financial interest in its uptake. Final named human clinical approval is required before use in patient care. Independent resource; not an official University of Edinburgh or NHS publication.