COMMUNITY & CARE-HOME TEAMS

Care-home and community response to a new change

Help care-home, care-at-home and community staff recognise a possible delirium, obtain timely clinical assessment and provide safe supportive care while the cause is being assessed and treated.

Confirm that something has changed

- Compare alertness, attention, thinking, perception, behaviour, mobility, eating and drinking with the person's usual state.
- Ask when the change began and whether it has fluctuated. Include quiet changes such as withdrawal, slow responses and reduced movement.
- Seek observations from family, carers and staff who know the person well. Record what they report and the source of the baseline.

Treat sudden confusion as urgent

- Assess the immediate clinical state within the staff member's competence and follow the setting's emergency pathway without delay.
- Seek immediate medical help for sudden confusion. Escalate severe deterioration, difficulty rousing, acute instability or immediate danger to emergency services as required.
- Do not assume the change is dementia progression, a urinary infection, ageing or "behaviour" without clinical assessment.

Support assessment and handover

- If competent to do so and this fits the local pathway, use the 4AT when delirium is suspected. A concerning score prompts clinical assessment; it is not the final diagnosis.
- Prepare a concise handover: usual baseline, time course, fluctuation, observations, recent illness or injury, falls, pain, food and fluid intake, bladder and bowel changes, and recent medicine changes or missed doses.
- Have the current medicine record and relevant care information available. State what has already been tried and whether it helped.

Provide supportive care while help is arranged

- Stay with the person when needed, approach calmly, use short sentences and offer repeated reassurance.
- Make glasses, hearing aids and familiar orientation cues available. Reduce avoidable noise and unfamiliar demands.
- Address comfort, food, fluids, toileting and safe movement within the person's current care plan and level of assistance.

Continue the plan after the first contact

- Record the clinical advice, who is responsible for each action, the escalation plan and when the person will be reviewed.
- Observe for further change and report deterioration promptly. Do not let an apparently clearer period close the assessment when the history is strongly fluctuating.
- If delirium is diagnosed, communicate it across shifts, services and transfers. Monitor recovery and make follow-up responsibilities explicit if symptoms or functional change persist.

Safety box - familiarity must not delay escalation: NHS advice is to get medical help immediately when someone suddenly becomes confused. Follow the local emergency pathway and do not wait for a routine visit. A familiar environment may support the person, but any decision to remain in place or transfer requires clinical assessment of the whole situation.

Verified official sources

- NHS: sudden confusion and immediate action
- NICE CG103: hospital and long-term care recommendations
- Official 4AT user guide
- SIGN 157 on Right Decisions: purpose and audience across care settings
- SIGN 157 on Right Decisions: non-pharmacological treatment
- NHS inform: delirium

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.