DISCHARGE TEAMS

Five essentials for a delirium discharge summary

Ensure the delirium episode, unresolved issues and recovery plan remain visible across transitions of care.

1. Diagnosis and course

- State delirium clearly rather than using a vague label such as “confusion”.
- Record when the change began, how it fluctuated and how the diagnosis was reached.
- State whether delirium is resolved, improving, persistent or uncertain at discharge.

2. Causes and clinical actions

- List confirmed and suspected contributors, including where more than one was present.
- Summarise key treatment and the response; identify important unresolved questions.
- Record any recurrence or deterioration that would require prompt reassessment.

3. Current cognition, function and support

- Compare cognition, alertness and function with the person’s pre-illness baseline.
- Describe current mobility, falls risk, eating and drinking, sleep, communication and sensory needs.
- State the support, rehabilitation or supervision now required.

4. Medicines and follow-up

- Explain relevant medicines started, stopped or changed, why, and who will review them.
- Specify follow-up for persistent symptoms, unresolved causes, distressing memories or functional recovery. Name the receiving person or service and review timeframe. If these cannot yet be confirmed, name who will secure them and by when.
- If cognitive impairment remains, arrange appropriate later review rather than assuming it is dementia.

5. Communication and safety-netting

- Send the diagnosis and plan to primary care and the next care setting, and include it in handover information.
- Explain the episode and recovery uncertainty to the person and family or carers in accessible language.
- State whom to contact for ongoing concerns and that sudden new confusion needs urgent medical help.

Safety box - do not let delirium disappear at the doorway: Persistent or worsening delirium requires renewed assessment for causes and an explicit follow-up plan. Do not treat discharge as proof of recovery, and do not make a new dementia label solely from cognition measured during unresolved delirium.

Verified official sources

- NICE CG103: documentation, treatment and unresolved delirium
- SIGN 157 on Right Decisions: documentation across transfers of care
- SIGN 157 on Right Decisions: recovery, referral and follow-up
- NHS inform: delirium duration and recovery
- NHS: urgent help for sudden confusion

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.