MANAGERS & LEADERS

Is your hospital genuinely delirium-sensitive?

Give clinical and operational leaders a practical whole-system check of delirium prevention, detection, response and continuity.

Leadership and pathway

- Is there a named clinical lead and multidisciplinary ownership across emergency, medical, surgical and care-transition pathways?
- Does current policy distinguish observation for change, episodic delirium assessment, critical-care tools and final clinical diagnosis?
- Are escalation, cause assessment, supportive care, distress management and follow-up connected in one usable pathway?

Reliable detection

- Are staff trained to recognise drowsy and withdrawn presentations as well as agitation?
- Can they establish baseline from family, carers and records and document acute change or fluctuation?
- Is the 4AT available at the point of care when indicated, with the appropriate alternative in critical care and postoperative recovery?

Reliable response

- Does a result suggesting delirium trigger clinical assessment rather than end the process?
- Are urgent threats, multiple causes, medicines and fundamental care needs reviewed without imposing a universal test panel?
- Are cause-directed treatment, supportive care, rehabilitation and communication delivered together?

Care environment and workforce

- Can teams provide glasses, hearing support, orientation, hydration, nutrition, mobility, sleep support and pain care reliably?
- Are unnecessary ward moves and avoidable overnight disruption reduced?
- Are family and carers treated as partners in baseline history, reassurance and care planning?

Governance and continuity

- Are delirium diagnosis and status visible in notes, handovers, discharge summaries and primary care communication?
- Do audits examine both completion and the quality of action after a concerning result?
- Are patient, family and staff experiences used alongside process data to improve the pathway?

For each domain, record a local red/amber/green rating, the evidence checked, a named action owner and a review date. A colour without an action is not an improvement plan.

Safety box - a completed field is not proof of safe care: Leadership assurance should test the full pathway from recognition to action and transition, not only whether a form was ticked. Review documentation and selected cases, account for setting and case mix, and require clinical oversight of any pathway or audit change.

Verified official sources

- NICE CG103: prevention, diagnosis and management recommendations
- SIGN 157 Right Decisions toolkit: purpose, audience and governance
- SIGN 157 on Right Decisions: detecting delirium
- SIGN 157 on Right Decisions: non-pharmacological risk reduction
- Official 4AT user guide

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.