HEALTH & CARE STAFF

Hypoactive delirium: recognise the quiet change

Help staff detect and respond to delirium when the person is sleepy, withdrawn or moving less rather than visibly agitated.

Notice what is easy to miss

- Look for new withdrawal, slow answers, reduced speech, worsened concentration, sleepiness, reduced movement, poorer mobility or reduced appetite.
- Notice reduced engagement with care or a person who seems unusually passive. Do not assume that quietness means comfort or recovery.
- Ask staff across shifts and family or carers whether this is different from the person's usual state.

Establish change from baseline

- Record the timing and fluctuation of the change in alertness, cognition, communication and function.
- Check for hearing, vision, language or communication barriers, but do not let these delay assessment of a credible acute change.
- If dementia and delirium are difficult to distinguish, address possible delirium first.

Assess rather than label

- Use the 4AT when indicators of delirium are present and the practitioner is competent to do so. Use the NICE-recommended alternative in critical care or the recovery room after surgery.
- A drowsy person is not automatically "unable to assess" with the 4AT; its scoring allows for people who cannot engage because they are unwell or inattentive.
- Interpret the score with the history and clinical picture. A detection tool does not make the final diagnosis by itself.

Look for causes and distress

- Arrange prompt clinical assessment and consider multiple causes, including acute illness, medicines or withdrawal, pain, dehydration, constipation, urinary difficulty and impaired oxygenation.
- Ask about hallucinations, frightening beliefs or fear in a simple, non-confrontational way. Distress may be present without agitation.
- Start cause-directed treatment and supportive care while the assessment continues.

Protect function and follow the course

- Support orientation, sensory aids, hydration, nutrition, comfort, safe movement and daytime engagement according to the care plan.
- Watch for further reduction in alertness, mobility, eating, drinking or ability to participate in care.
- Handover the baseline, observed fluctuation, current causes and outstanding actions. Review recovery rather than judging from one quiet encounter.

Safety box - drowsiness can be a warning sign: New marked sleepiness, difficulty rousing the person or a rapid fall in responsiveness needs urgent clinical assessment. Do not record hypoactive delirium as ordinary tiredness, low mood, dementia progression or "settled behaviour" without assessing the acute change and possible causes.

Verified official sources

- NICE CG103: indicators, assessment and treatment
- Official 4AT user guide
- SIGN 157 on Right Decisions: detecting delirium
- SIGN 157 on Right Decisions: non-pharmacological treatment
- NHS inform: delirium symptoms and treatment

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.