CLINICAL TEAMS

Multidomain treatment of delirium

Help teams treat the causes of delirium while also creating the conditions for brain recovery, preventing complications and supporting the person through distress.

Check urgency and define the change

- Assess the person's immediate clinical state and respond to physiological instability or another time-critical presentation.
- Establish the usual level of alertness, cognition, communication and function. Describe what changed, when it changed and how it has fluctuated.
- Use a recommended delirium assessment when indicated. The final diagnosis remains a clinical decision.

Find and treat the causes

- Use the history, examination, observations and clinical context to identify possible causes. More than one cause is common.
- Review acute illness, injury, pain, oxygenation, hydration, nutrition, bladder and bowel function, sleep, recent procedures and the care environment.
- Reconcile medicines, including recent starts, stops, dose changes, missed doses and possible withdrawal. Choose investigations from the clinical picture rather than a fixed panel.

Support brain recovery

- Communicate calmly, explain what is happening and reorient gently. Involve family or carers where helpful and acceptable to the person.
- Make glasses, hearing aids, dentures, communication aids and mobility aids available and usable.
- Support food, fluids, comfort, sleep, daytime activity and movement in line with the person's clinical plan. Reduce avoidable noise, disruption and moves.

Address distress and prevent complications

- Look for fear, hallucinations, pain, urinary retention, constipation, thirst or another unmet need. Distress may be hard to see in hypoactive delirium.
- Use verbal and non-verbal de-escalation first where possible. Any medicine decision requires individual assessment and current prescribing guidance.
- Prevent avoidable immobility, falls, pressure damage, dehydration, malnutrition and isolation. Begin suitable rehabilitation without waiting for cognition to be fully normal.

Review the whole plan

- Record the current formulation, actions, response, remaining uncertainty and escalation plan. Give every open clinical or supportive-care action a named owner and next review time. Reassess if the person deteriorates or does not improve as expected.
- Share the diagnosis and plan with the person, family or carers and the multidisciplinary team in understandable language.
- Monitor recovery. If delirium persists, re-evaluate possible causes and arrange appropriate follow-up.

Safety box - treat the person, not a checklist: Do not delay urgent treatment while completing a cause sweep. Supportive care does not replace treatment of acute illness, and a medicine does not treat delirium's underlying causes. Escalate new instability, marked reduction in responsiveness or rapid deterioration through the setting's emergency pathway.

Verified official sources

- NICE CG103: recommendations
- SIGN 157 on Right Decisions: non-pharmacological treatment
- SIGN 157 on Right Decisions: non-pharmacological risk reduction
- SIGN 157 on Right Decisions: medicines optimisation
- 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.