CLINICAL TEAMS

Recognising delirium: look for change from usual

Help staff recognise a new or fluctuating change that may be delirium, including quieter presentations that are easily missed.

Look for an acute or fluctuating change

- Ask whether alertness, attention, thinking, perception or behaviour has changed over hours or days.
- Notice fluctuation: a person may appear clearer at one contact and substantially different at another.
- Treat a credible concern from family, carers or staff who know the person as clinically important information.

Do not look only for agitation

- Delirium may present with restlessness, fear, suspiciousness, hallucinations or disorganised speech.
- It may instead present with drowsiness, withdrawal, slow responses, reduced movement, poor concentration or reduced appetite. This quieter pattern is often called hypoactive delirium.
- Mixed presentations can move between quieter and more active states.

Establish the usual baseline

- Find out the person's usual cognition, communication, alertness and level of function.
- Use more than one source where possible: the person, family or carers, care records, referral information and staff observations.
- Check that hearing, vision, language or communication difficulties are not obscuring the assessment.

Record and assess

- Document the observed change, its timing, fluctuation and the source of baseline information.
- If indicators of delirium are present, arrange assessment with the appropriate tool and a clinical evaluation.
- If delirium and dementia are difficult to distinguish, address possible delirium first.

Safety box - act on sudden change: New confusion or a marked change in alertness may signal serious acute illness and needs prompt clinical assessment. A detection tool supports recognition; it does not by itself make the final diagnosis. Follow the setting's emergency response if the person is acutely unstable or difficult to rouse. NICE recommends CAM-ICU or ICDSC rather than 4AT in critical care or the recovery room after surgery.

Verified official sources

- NICE CG103: recommendations
- SIGN 157 on Right Decisions: detecting delirium
- Official 4AT user guide
- 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.