NURSES & CARE STAFF

Shift-by-shift supportive care for delirium

Turn person-centred, non-drug delirium care into practical actions at every shift and handover.

At the start of the shift

- Read the person's baseline, current causes, care plan, risks and communication needs.
- Check that glasses, hearing aids, mobility aids, call bell and orientation cues are available as appropriate.
- Find out what reassures the person, what may trigger distress and how family or carers wish to help.

At every contact

- Approach calmly, introduce yourself and explain one step at a time using short, clear language.
- Allow time for a response; avoid rapid questioning, confrontation or repeatedly testing the person.
- Reorient gently and offer reassurance without arguing about a distressing belief or perception.

Support essential needs

- Look for pain, thirst, hunger, toileting needs, constipation, urinary difficulty and other discomfort.
- Support food, fluids, mobility and meaningful activity in line with the current clinical and assistance plan.
- Promote daytime engagement and avoid unnecessary immobility or isolation. Review whether catheters, cannulas, monitoring leads or other devices are still needed and escalate concerns to the responsible clinician.

Make the environment help

- Keep the setting calm, well lit for the time of day and easy to understand.
- Reduce avoidable noise, overnight disruption and unnecessary moves between rooms or wards.
- Use familiar objects, routines and people where possible.

Handover what matters

- Report new or fluctuating changes in alertness, attention, cognition, function or behaviour.
- Share unmet needs, successful calming approaches, family information and outstanding clinical actions.
- Record concern and escalate it; do not dismiss a change as simply difficult behaviour. If any restrictive intervention has been used or considered, hand over the reason, alternatives tried, monitoring and review plan in line with law and local policy.

Safety box - supportive care does not replace medical care: A new or worsening change requires clinical assessment for underlying causes. Adapt food, fluids, mobility and activity to the person's current safety plan and level of assistance. Seek urgent help for marked drowsiness, acute instability or immediate danger.

Verified official sources

- NICE CG103: prevention and initial management recommendations
- SIGN 157 on Right Decisions: non-pharmacological treatment
- SIGN 157 on Right Decisions: non-pharmacological risk reduction
- NHS: supporting someone with sudden confusion while help is arranged

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.