

Improving the care for older people

Delirium toolkit









© Healthcare Improvement Scotland 2019 First published April 2016

This document is licensed under the Creative Commons
Attribution-Noncommercial-NoDerivatives 4.0 International
Licence. This allows for the copy and redistribution of this
document as long as Healthcare Improvement Scotland is fully
acknowledged and given credit. The material must not be remixed,
transformed or built upon in any way. To view a copy of this
licence, visit https://creativecommons.org/licenses/by-nc-nd/4.0/

Contents

Introduction	4
Delirium risk reduction	6
Delirium management: summary pathway	7
Identifying delirium	8
4AT single assessment tool	9
4AT guidance notes	10
TIME bundle	11
TIME bundle guidance	12
4AT combined assessment tool	13
Delirium learning resources	14

Introduction

Delirium is an acute deterioration in mental status arising over hours or days.

Illness, surgery and medications can all cause delirium. It often starts suddenly, but usually lifts when the condition causing it gets better. It can be frightening – not only for the person who is unwell – but also for those around him or her.

Delirium is a serious medical emergency and statistics suggest that the prevalence of delirium in people on medical wards in hospital is about 20-30%, while 10-50% of people having surgery develop delirium. People who develop delirium may need to stay longer in hospital or in critical care, have more hospitalacquired complications, such as falls and pressure ulcers, be more likely to need to be admitted to long term care if they are in hospital, and are more likely to die¹. Delirium is a recognised problem in older people that is frequently overlooked or misdiagnosed and is very distressing to individuals and to their families and carers.

In collaboration with the Scottish
Delirium Association, NHS Education
for Scotland and colleagues across
NHSScotland, Healthcare Improvement
Scotland has developed a range of tools
and resources to support improvements
in the identification and immediate
management of delirium. This toolkit has
been produced to provide easy access to
all of these tools and resources. The tools
included here have been tested by small
teams in test sites across NHSScotland
and feedback from staff has informed
their development.

Who is at risk of delirium?

Any patient can develop delirium, but certain factors can increase the risk. These include:

- older people the risk increases with age.
- older people taking multiple medicines.
- people with dementia.
- people who are dehydrated.
- people with an infection.
- severely ill people.
- people who have had surgery, especially hip surgery.
- people who are nearing the end of their life.
- people with sight or hearing difficulties.
- people who have a temperature.
- older people with constipation or urinary retention.

How can I help someone with delirium?

You can help someone with delirium feel calmer and more in control if you:

- stay calm.
- talk to them in short, simple sentences.
- check that they have understood you. Repeat things if necessary.
- try not to agree with any unusual or incorrect ideas, but tactfully disagree or change the subject. Reassure them. Remind them of what is happening and how they are doing.
- remind them of the time and date.
- make sure they can see a clock or a calendar.
- try to make sure that someone they know well is with them. This is often most important during the evening, when delirium often gets worse. If they are in hospital, bring in some familiar objects from home.
- make sure they have their glasses and hearing aid.
- help them to eat and drink.
- have a light on at night so that they can see where they are if they wake up.

Delirium risk reduction

Evidence suggests that approximately 30–40% of cases of delirium are preventable¹. A range of strategies may help reduce the risk of delirium in an older person. Guidelines have outlined the following preventative interventions² that may help you play your part in reducing the risk of delirium for the people in your care.

Clinical factor	Preventative intervention
Cognitive impairment or disorientation	 Provide appropriate lighting and clear signage. A clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk. Reorientate the person by explaining where they are, who they are, and what your role is. Introduce cognitively stimulating activities (for example, reminiscence). Facilitate regular visits from family and friends.
Dehydration or constipation	 Encourage the person to drink. Consider offering subcutaneous or intravenous fluids if necessary. Seek advice if necessary when managing fluid balance in people with comorbidities (for example, heart failure or chronic kidney disease).
Нурохіа	Assess for hypoxia and optimise oxygen saturation if necessary.
Immobility or limited mobility	 Encourage the person to: mobilise soon after surgery walk (provide walking aids if needed - these should be accessible at all times). Encourage all people, including those unable to walk, to carry out active range-of-motion exercises.
Infection	 Look for and treat infection. Avoid unnecessary catheterisation. Implement infection control procedures in line with 'Infection control' (NICE clinical guideline 2).
Multiple medications	 Carry out a medication review for people taking multiple drugs, taking into account both the type and number of medications.
Pain	 Assess for pain. Look for non-verbal signs of pain, particularly in people with communication difficulties. Start and review appropriate pain management in any person in whom pain is identified or suspected.
Poor nutrition	 Follow the advice given on nutrition in 'Nutrition support in adults' (NICE clinical guideline 32). If the person has dentures, ensure they fit properly.
Sensory impairment	 Resolve any reversible cause of the impairment (such as impacted ear wax). Ensure working hearing and visual aids are available to and used by people who need them.
Sleep disturbance	 Avoid nursing or medical procedures during sleeping hours, if possible. Schedule medication rounds to avoid disturbing sleep. Reduce noise to a minimum during sleep periods*.

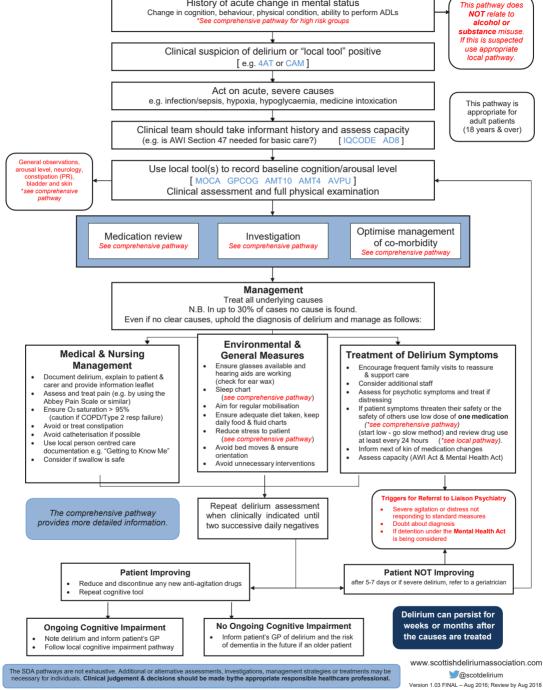
^{*} See 'Parkinson's disease' (NICE clinical guideline 35) for information about sleep hygiene.

 $^{^1\} https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5801894$

² SIGN 157 - Diagnosis and Management of Delirium, March 2019

Delirium management: summary pathway

THINK DELIRIUM History of acute change in mental status cognition, behaviour, physical condition, ability to pe



Identifying delirium

The 4 'A's Test or 4AT is an assessment tool for delirium and cognitive impairment. The 4AT tool (www.the4at. com) is designed to be used by any health professional at first contact with the patient, and at other times when delirium is suspected. It incorporates the Months Backwards test and the Abbreviated Mental Test - 4 (AMT4), which are short tests for cognitive impairment. The 4AT is rapid to administer. As an assessment tool it does not provide a formal diagnosis but a positive score should trigger more formal assessment.

Through testing of detection methods and initiation of the TIME bundle (see page 11), we have also created a combined tool to detect, manage, and review delirium through the repeat assessment.

These tools are the start of a process to manage the medical emergency delirium. The tools aim to help clinicians to follow appropriate care pathways and help plan ongoing care and assessment to ensure safe, effective, person-centred delivery of care for older people every time.

It is important to involve families or carers in identifying delirium. You may want to consider using the Single Question to Identify Delirium (SQID) which simply asks relatives or carers, "Do you think [name of patient] has been more confused, sleepy or drowsy?"

This simple question can help identify change and help keep families and carers involved.



4AT single assessment tool

Name:	Date	
Date of birth:	Zero time	
CHI number:		
Practitioner name:	Practitioner signature:	
Designation:		
[1] Alertness	/ lice in the little in the li	
This includes patients who may be markedly druing assessment) or agitated/hyperactive. Of or gentle touch on shoulder. Ask the patient to	oserve the patient. If asleep, attempt to	wake with speech
Normal (fully alert, but not agitated, throughou	t assessment)	0
Mild sleepiness for <10 seconds after waking, t	nen normal	0
Clearly abnormal		4
TO 11171		
[2] AMT4	and the state of t	
Age, date of birth, place (name of the hospital of No mistakes	or building), current year.	
1 mistake		0
2 or more mistakes/untestable		2
2 of more mistakes/untestable		2
[3] Attention		
Ask the patient: "Please tell me the months of To assist initial understanding one prompt of "		
Achieves 7 months or more correctly		0
Starts but scores < 7 months / refuses to start		1
Untestable (cannot start because unwell, drow	sy, inattentive)	2
[4] Acute change or fluctuating course		
Evidence of significant change or fluctuation in	: alertness, cognition, other mental fund	ction (eg.
paranoia, hallucinations) arising over the last 2		
No		0
Yes		4
#AT Score 4 or above: possible delirium +/- cognitive impa I-3: possible cognitive impairment	irment	

4AT guidance notes

The 4AT is an assessment tool designed for rapid and sensitive initial assessment of cognitive impairment.

Items 1-3 are rated solely on observation of the patient at the time of assessment.

Item 4 requires information from one or more sources, for example your own knowledge of the patient, other staff who know the patient (for example ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

A score of 4 or above suggests delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis.

A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required.

A score of 0 does not definitively exclude delirium or severe cognitive impairment: more detailed testing may be required depending on the clinical context.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item.

AMT4 (Abbreviated Mental Test - 4):

This score can be extracted from items in the AMT10 if the latter is done immediately before.

Attention: the Months Backwards test assesses attention, the main cognitive deficit in delirium; most patients with delirium will show deficits. Other types of cognitive impairment, for example dementia, can also lead to deficits on this test

Acute change or fluctuating course:

Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/ or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

TIME bundle

	Name: Date of birth:		Date Zero time	
L	CHI number:			
Pra	ctitioner name:	Practitioner sign	nature:	
Des	signation:			
	itiate TIME within 2 hours itial and write time of completion)	Assessed/ sent	Results seen	Abnormality found
	Think exclude and treat possible triggers			
	NEWS (think sepsis six)			
	Blood glucose			
т	Medication history (identify new medications/change of dose/medication recently stopped)			
	Pain review (Abbey Pain Scale)			
	Assess for urinary retention			
	Assess for constipation			
	Investigate and intervene to correct underl	ying causes		
	Assess Hydration and start fluid balance chart			
	Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose)			
I	Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see sepsis six)			
	ECG (ACS)			
м	Management Plan			Completed
	Initiate treatment of ALL underlying causes for			
E	Engage and Explore (complete within 2 hours or if fa			
	Engage with patient/family/carer – explore if Ask: How would you like to be involved?			
	Explain diagnosis of delirium to patient and f (use delirium leaflet)			
	Document diagnosis of delirium			

TIME bundle guidance

First 2 hours

Within 2 hours or if family/carer not present within 24 hours

Triggers

Severe illness

Trauma/surgery

Pain

Infection/sepsis

Dehydration

Нурохіа

Hypoglycaemia

Medications

Alcohol and drugs withdrawal

Urinary retention/constipation

Investigate

FBC, U&Es, CRP, LFTs, Glucose, Mg, Ca, PO₄ urinalysis Consider ABG

Culture, urine, sputum, wounds. Consider blood culture (Sepsis Six), CXR

Always carry out routine observations (EWS) including AVPU and Think Glucose

Start fluid balance

Think about hydration status

Manage

First and foremost treat underlying causes

Manage sepsis

Refer to delirium management: comprehensive pathway for complete care guidance*

DO NOT USE RESTRAINT

AVOID

ANTIPSYCHOTIC MEDICATIONS
- these may worsen delirium or contribute to the risk of falls and immobility (see delirium comprehensive pathway)*

Engage

Families and carers can give you a history of change. Always speak to them to obtain history and baseline function.

Families and friends can help reorientate.

Always document delirium diagnosis.

Reassure families and carers.

^{*}Delirium comprehensive pathway can be found at www.scottishdeliriumassociation.com

4AT combined assessment tool

Practitioner name: Practitioner signature: P		Name:	•	Dato			
Practitioner name: Practitioner signature: Designation: II Alertness This includes patients who may be markedly drowsy (eq. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient if saleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Normal fully alert, but not agitated, throughout assessment) 0							
Practitioner name: Practitioner signature: Designation: 11 Alertness This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated//byperactive. Observe the patient. If saleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Normal fully later, but not agitated throughout assessment) Mild sleepiness for <10 seconds after waking, then normal Question Q				Zero time:			
Practitioner name: Practitioner signature: Designation: II Alertness This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient, if asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Normal (fully alert, but not agitated, throughout assessment) 0 Mild sleepiness for <10 seconds after waking, then normal 0 10 (Clearly abnormal) 10 (Clearly abnormal) 11 (Clearly abnormal) 12 (ANTA) 12 (ANTA) 13 (Clearly abnormal) 14 (Clearly abnormal) 15 (Clearly abnormal) 16 (Clearly abnormal) 16 (Clearly abnormal) 17 (Clearly abnormal) 18 (Clearly abnormal) 19 (Clearly abnormal) 10 (Clearly abnormal) 11 (Clearly abnormal) 11 (Clearly abnormal) 12 (Clearly abnormal) 15 (Clearly abnormal) 16 (Clearly abnormal) 16 (Clearly abnormal) 16 (Clearly abnormal) 16 (Clearly abnormal) 17 (Clearly abnormal) 18 (Clearly abnormal) 19 (Clearly abnormal) 19 (Clearly abnormal) 10 (Clearly abnormal) 10 (Clearly abnormal) 10 (Clearly abnormal) 11 (Clearly abnormal) 11 (Clearly abnormal) 12 (Clearly abnormal) 13 (Clearly abnormal) 14 (Clearly abnormal) 15 (Clearly abnormal) 16 (Clearly abnormal) 16 (Clearly abnormal) 17 (Clearly abnormal) 18 (Clearly abnormal) 19 (Clearly abnormal) 10 (Clearly abnormal) 11 (Clearly abnormal) 11 (Clearly abnormal) 12 (Clearly abnormal) 13 (Clearly abnormal) 14 (Clearly		CHI number:					
Designation: (1) Alertmess This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Normal (fully alert, but not agitated, throughout assessment) O O O			_				
Designation: 11) Alertness This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Normal (fully alert, but not agitated, throughout assessment) 0)r:	actitioner name:	Practitioner signatu	re.			
This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If askep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Normal (fully alert, but not agitated, throughout assessment) O (Illy) alert, but not agitated assessment a		ictitioner name.	Tractitioner signatu				
This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient if saleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Normal (fully alert, but not agitated, throughout assessment) 0 Clearly abnormal 2 Jan 19 Jan)e	signation:					
This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Normal (Iuliy) alert, but not agitated, throughout assessment) 0 Clearly abnormal 2 Jan 19 J							
hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Normal (fully alert, but not agitated, throughout assessment) 0 0. Mild sleepiness for <10 seconds after waking, then normal 0 0. Clearly abnormal 4 4 21, AVT4 Age, date of birth, place (name of the hospital or building), current year No mistakes 0 1 12 or more mistakes/untestable 1 2 2 3 Attention Ask the patient. Please tell me the months of the year in backwards order, starting at December. To assist initial understanding one prompt of "What is the month before December?" is permitted. Achieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start because unwell, drowsy, inattentive) 2 1 4 Acute change or fluctuating course Evidence of significant change or fluctuation in alectrones, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No Yes 1 1 Total If scored 4 or more this is possible delirum -/- cognitive impairment. More detailed cognitive impairment. Sent the seen of the found of the	_						
Mild sleepiness for <10 seconds after waking, then normal Age, date of birth, place (name of the hospital or building), current year	hy	peractive. Observe the patient. If asleep, at	tempt to wake with speech or gentle touch on shou		nent) or agita	ted/	
Clearly abnormal 2) AMT4 2) AMT4 Age, date of birth, place (name of the hospital or building), current year No mistakes 0 Inistake 1 2 Or more mistakes/untestable 2 2 To more mistakes/untestable 3) Attention Ask the patient-"Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted. Achieves 7 months or more correctly Starts but scores < 7 months / refuses to start 1 Untestable (cannot start because unwell, drowsy, inattentive) 2) Actue the hange or fluctuating course Fuldence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No Yes 1 Total If scored 4 or more this is possible delirium +/- cognitive impairment. More detailed cognitive assessment and informant history taking see required If scored 4 or more this is possible triggers NEWS (think Sepsis Six) Blood glucose Medication history (identify new medications/change of dose/medication recently stopped) Pair review (Abbey Pain Scale) Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptomisgins of infection (skin, chest, urine, CNS) and perform appropriate cultures/impairments/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/impairments/signs of infection (skin, chest, urine, CNS) and perform appropriate Completed Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours of if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	No	rmal (fully alert, but not agitated, through	out assessment)				0
Age, date of birth, place (name of the hospital or buildingl), current year No mistakes 1	Mil	d sleepiness for <10 seconds after waking,	then normal				0
Age, date of birth, place (name of the hospital or building), current year No mistakes 1 mistake 2 or more mistakes/untestable 3 Attention SAsk the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted. Achieves 7 months or more correctly 1 octators but scores < 7 months / refuses to start 1 threstable (cannot start because unwell, drowsy, inattentive) 2 (1) Acute change or fluctuating course Verdence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No Yes 1 octal If scored 4 or more this is possible delirium +/- Cognitive impairment. More detailed cognitive impairment. More detailed cognitive assessment and informant history taking are required informant incompletion) Think exclude and treat possible triggers NEWS (think Sepsis Six) Blood glucose 7 Medication history (identify new medications/change of dose/medication recently stopped) Pain review (Abbey Pain Scale) Assess for uninary retention Assess for constipation Investigate and intervene to correct underlying causes Assess for uninary retention Assess for constipation Investigate and intervene to correct underlying causes Assess shall and a start fluid balance chart Bloods (FBC, U&E, Ca, LTTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above the proper of the proper of this is usual behaviour. EAsk: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	Cle	arly abnormal					4
No mistakes 0 0 I mistake 1 1 2 or more mistakes/untestable 1 2 2 or more mistakes/untestable 2 2 3) Attention Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted. Achieves 7 months or more correctly 0 0 Starts but scores < 7 months / refuses to start 1 1 Untestable (cannot start because unwell, drowsy, inattentive) 2 2 (4) Acute change or fluctuating course Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No Yes 0 0 Total If scored 4 or more this is possible delirum +/- cognitive impairment More detailed cognitive impairment More detailed cognitive impairment More detailed cognitive impairment More detailed cognitive assessment and informant history taking are required If scored 4 or more this is possible of the completion	[2]	AMT4					
I mistake 2 or more mistakes/untestable 3 or more mistakes/untestable 3 Attention Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted. Achieves? months or more correctly 0 Starts but scores < 7 months / refuses to start 1 turtestable (cannot start because unwell, drowsy, inattentive) 4 Acute change or fluctuating course Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No 0 Yes 1 Total If scored 4 or more this is possible delirum +/- cognitive impairment. More detailed cognitive impairment. More detailed cognitive impairment. More detailed cognitive impairment. More detailed cognitive wastesment and informant history taking are required Initiate TIME within 2 hours Initiate TIME within 2 hours Initiate time of completion) Think exclude and treat possible triggers NEWS (think Sepsis Stx) Blood glucose 7 Medication history (identify new medications/change of dose/medication recently stopped) Pain review (Abbey Pain Scale) Assess for constipation Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	Ag	e, date of birth, place (name of the hospita	l or building), current year				
2 or more mistakes/untestable 2 3 Attention Ack the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted. Achieves 7 months or more correctly 0 Starts but scores < 7 months / refuses to start 1 Untestable (cannot start because unwell, drowsy, inattentive) 2 Al Acute change or fluctuating course Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No 0 Overs 1 Total If scored 4 or more this is possible delirium +/- cognitive impairment. More detailed cognitive impairment. If scored 0 delirium or severe cognitive impairment. If scored 4 or more this is possible if (4) information incomplete. If scored 4 or more this is possible if (4) information incomplete. If scored 4 or more this is possible if (4) information incomplete. Assessed M Results Seen. Assessed M Results Abnormality found If scored 4 or more this is possible if (4) information incomplete. Assessed M Results Seen. Assesse	No	mistakes					0
Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted. Achieves 7 months or more correctly O Starts but scores < 7 months / refuses to start 1 Untestable (cannot start because unwell, drowsy, inattentive) 2 (4) Acute change or fluctuating course Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No O Yes Total If scored 4 or more this is possible delirium +/- cognitive impairment. More detailed cognitive assessment and informant history taking are required If scored 4 or more this is possible if (4) information incomplete impairment. More detailed cognitive assessment and information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still possible if (4) information incomplete impairment unlikely flut delirium still pos							
Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted. Achieves T months or more correctly Starts but scores < 7 months or more correctly 1 Untestable (cannot start because unwell, drowsy, inattentive) 2 (4) Acute change or fluctuating course Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No Yes 1 Total If scored 4 or more this is possible delirium the last 24 hours. More detailed cognitive assessment and informant history taking arc required If scored 4 or more this is possible informant history taking arc required If scored 1 or more this is possible informant history taking arc required If scored 1 or more this is possible informant history taking arc required If scored 4 or more this is possible informant history taking arc required If scored 4 or more this is possible informant history taking arc required If scored 4 or more this is possible informant history taking arc required If scored 5 or more this is possible informant history taking arc required If scored 4 or more this is possible informant history taking arc required If scored 6 or more this is possible informant history taking arc required If scored 6 or more this is possible informant history taking arc required If scored 6 or more this is possible informant history taking arc required If scored 6 or more this is possible informant history taking arc required If scored 6 or more this is possible informant history taking arc required If scored 6 or more this is informant history taking arc required If scored 6 or more this is unable to be involved? If scored 6 or more this is usual behaviour. Ask: How would you like to be involved? Explain daily and carers - explore if this is usual behaviour.							2
To assist initial understanding one prompt of "What is the month before December?" is permitted. Achieves 7 months or more correctly 1 Untestable (cannot start because unwell, drowsy, inattentive) 2 41 Acute change or fluctuating course Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No 0 Yes 1 Total If scored 4 or more this is possible delirium the last 24 hours. No 1 Total If scored 1 or more this is possible delirium the last 24 hours are severe cognitive impairment. More detailed cognitive impairment. More detailed cognitive impairment. Initiate TIME within 2 hours Initiate TIME within 2 hours NEWS (think Sepsis Six) Blood glucose Think exclude and treat possible triggers NEWS (think Sepsis Six) Blood glucose Pain review (Abbey Pain Scale) Assess for urinary retention Assess for urinary retention Assess for urinary retention Assess for constipation Investigate and intervene to correct underlying causes Assess for urinary retention Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (REQ. U.B.E. Ca. I.F.S. CRP. Mg. Glucose) Lock for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Assess for constipation Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers – explore if this is usual behaviour.							
Achieves 7 months or more correctly Achieves 7 months / refuses to start Intrestable (cannot start because unwell, drowsy, inattentive) Achieves 6 ginificant change or fluctuating course Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No Yes If scored 1-3 possible cognitive impairment. More detailed cognitive assessment and informant history taking are required If scored 0 delirium or severe cognitive impairment. More detailed cognitive assessment and informant history taking are required If scored 0 delirium or severe cognitive impairment. More detailed cognitive assessment and informant history taking are required Assessed/ Results seen Abnormality found IThink exclude and treat possible triggers NEWS (think Sepsis Six) Blood glucose The Medication history (identify new medications/change of dose/medication recently stopped) Pain review (Abbey Pain Scale) Assess for urinary retention Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engag							
Starts but scores < 7 months / refuses to start Untestable (cannot start because unwell, drowsy, inattentive) 2			"what is the month before December?" is permitte	ea.			
Untestable (cannot start because unwell, drowsy, inattentive) 4) Acute change or fluctuating course Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No Yes 10 17 17 18 18 scored 4 or more this is possible delirium 4/- cognitive impairment. More detailed cognitive assessment and informant history taking are required 19 seen 10 seen 10 seen 10 seen 10 seen 10 seen 10 seen 11 scored 4 or more this is possible delirium 6/- cognitive impairment. More detailed cognitive assessment and informant history taking are required 10 seen 11 seen 12 seen 13 seen 14 seen 15 scored 0 delirium or severe cognitive impairment. More detailed cognitive assessment and informant history taking are required 14 information incomplete) 15 seen 16 scored 0 delirium or severe cognitive impairment. More detailed cognitive assessment and informant history taking are required 16 scored 0 delirium or severe cognitive impairment. More detailed cognitive assessment and informant history taking are required 16 scored 0 delirium or severe cognitive impairment. More detailed cognitive assessment and informant history taking are required 17 scored 0 delirium or severe cognitive impairment. More detailed cognitive assessment and informant history taking are required 18 scored 1-3 possible cognitive impairment. More detailed cognitive assessment and informant and are required 18 scored 1-3 possible cognitive impairment. More detailed cognitive impairment. More detailed cognitive assessment and informant history taking are required 18 scored 0 delirium or severe cognitive impairment. More detailed cognitive assessment and informant history taking are required 18 scored 1-3 possible cognitive impairment. More detailed cognitive assessment and informant and are severe cognitive impairment. More detailed cognitive assessment and informant and are severe cognitive impairment. Asse		·					
A served of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No			<u> </u>				-
Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours. No Yes Total If scored 4 or more this is possible delirium #/- cognitive impairment. More detailed cognitive impairment. More detailed cognitive assessment and informant history taking are required Initiate TIME within 2 hours or if family/carer not present within 24 hours) Initiate TIME within 2 hours or if family/carer not present within 24 hours Initiate TIME within 2 hours or if family/carer not present within 24 hours Initiate treatment of ALL underlying causes found above Initiate treatment of ALL underlying causes found acrers – explore if this is usual behaviour. Ask: How ould you like to be involved? Initiate treatment of ALL underlying causes found acrers (use delirium leaflet)		· · · · · · · · · · · · · · · · · · ·	wsy, matternave,				_
Assessed Results (4) information incomplete) Initiate TIME within 2 hours (14) informant history taking are required Think exclude and treat possible triggers NEWS (think Sepsis Six) Blood glucose Teal Medication history (identify new medications/change of dose/medication recently stopped) Pain review (Abbey Pain Scale) Assess for urinary retention Assess for urinary retention Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	-		in: alertness, cognition, other mental function (eg. r	paranoia, hallucin	nations)		
Total If scored 4 or more this is possible delirium +/- cognitive impairment. More detailed cognitive assessment and informant history taking are required Initiate TIME within 2 hours impairment. Initiate TIME within 2 hours impairment informant history taking are required Initiate TIME within 2 hours impairment unlikely (but delirium still possible if (4) information incomplete) Initiate TIME within 2 hours impairment unlikely (but delirium still possible if (4) information incomplete) Initiate TIME within 2 hours impairment unlikely (but delirium still possible if (4) information incomplete) Initiate TIME within 2 hours impairment unlikely (but delirium still possible if (4) information incomplete) Initiate TIME within 2 hours Initiate TIME within 3 hours or if family/carer not present within 24 hours Initiate TIME within 3 hours or if family/carer not present within 24 hours Initiate TIME within 4 hours or if family/carer not present within 24 hours Initiate TIME within 4 hours or if family/carer not present within 24 hours Initiate TIME within 4 hours or if family/carer not present within 24 hours Initiate TIME within 4 hours or if family/carer not present within 24 hours Initiate TIME within 4 hours or if family/carer not present within 24 hours Initiate TIME within 4 hours or if family/carer not present within 24 hours Initiate TIME within 4 hours or if family/carer not present within 24 hours Initiate TIME within 4 hours or if family/carer not present within 24 hours Initiate TIME within 4 hours or if family/carer not present within 24 hours Initiate TIME within 4 hours or if family and carers (use delirium leaflet)				,	,		
if scored 4 or more this is possible delirium +/- cognitive impairment. More detailed cognitive assessment and informant history taking are required Initiate TIME within 2 hours (initial and write time of completion) Think exclude and treat possible triggers NEWS (think Sepsis Six) Blood glucose T Medication history (identify new medications/change of dose/medication recently stopped) Pain review (Abbey Pain Scale) Assess for urinary retention Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTS, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	No						0
if scored 4 or more this is possible delirium +/- cognitive impairment. More detailed cognitive assessment and informant history taking are required Initiate TIME within 2 hours (initial and write time of completion) Think exclude and treat possible triggers NEWS (think Sepsis Six) Blood glucose T Medication history (identify new medications/change of dose/medication recently stopped) Pain review (Abbey Pain Scale) Assess for urinary retention Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTS, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	Yes	<u> </u>					4
Initiate TIME within 2 hours (initial and write time of completion) Think exclude and treat possible triggers NEWS (think Sepsis Six) Blood glucose T Medication history (identify new medications/change of dose/medication recently stopped) Pain review (Abbey Pain Scale) Assess for urinary retention Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes of family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)			Total				
Think exclude and treat possible triggers			More detailed cognitive assessment and	impairment unli	kely (but deliriu	m still possi	
Think exclude and treat possible triggers	ni	tiate TIME within 2 hours		Assessed/	Poculto	Abnor	nality
NEWS (think Sepsis Six) Blood glucose Medication history (identify new medications/change of dose/medication recently stopped) Pain review (Abbey Pain Scale) Assess for urinary retention Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)		tial and write time of completion)				fou	nd
Blood glucose Medication history (identify new medications/change of dose/medication recently stopped) Pain review (Abbey Pain Scale) Assess for urinary retention Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)			rs				
Medication history (identify new medications/change of dose/medication recently stopped) Pain review (Abbey Pain Scale) Assess for urinary retention Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)							
Pain review (Abbey Pain Scale) Assess for urinary retention Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	т		tions/change of dose/medication recently stopped	d)			
Assess for constipation Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)			,	-,			
Investigate and intervene to correct underlying causes Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)							
Assess hydration and start fluid balance chart Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)							
Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glucose) Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) EGG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)						T	
Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see Sepsis Six) ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)							
ECG (ACS) Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)		Bloods (FBC, U&E, Ca, LFTs, CRP, Mg, Glu					
Management Plan Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 24 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. E Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	,		kin, chest, urine, CNS) and perform appropriate				
Initiate treatment of ALL underlying causes found above Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. E Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	,	Look for symptoms/signs of infection (s cultures/imaging depending on clinical					
Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours) Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	1	Look for symptoms/signs of infection (s cultures/imaging depending on clinical ECG (ACS)					land and the
Engage with patient, family and carers – explore if this is usual behaviour. Ask: How would you like to be involved? Explain diagnosis of delirium to patient, family and carers (use delirium leaflet)	ı	Look for symptoms/signs of infection (s cultures/imaging depending on clinical ECG (ACS) Management Plan	assessment (see Sepsis Six)			Comp	leted
	ı	Look for symptoms/signs of infection (s cultures/imaging depending on clinical ECG (ACS) Management Plan Initiate treatment of ALL underlying cau	assessment (see Sepsis Six) uses found above			Comp	leted
Document diagnosis of delirium		Look for symptoms/signs of infection (scultures/imaging depending on clinical ECG (ACS) Management Plan Initiate treatment of ALL underlying cat Engage and Explore (complete within 2 Engage with patient, family and carers- Ask: How would you like to be involved	assessment (see Sepsis Six) uses found above hours or if family/carer not present within 24 hours explore if this is usual behaviour.			Comp	leted

Delirium learning resources

Learnpro modules

NHS Education for Scotland, in collaboration with colleagues from across NHSScotland, has developed a range of learning resources to support staff and enhance their knowledge and understanding of delirium. Although the Improving Care for Older People programme focuses on acute general hospital care, it is essential that all staff working across health and social care are able to recognise delirium, seek medical advice, provide appropriate support and take steps to reduce the risk of delirium. To support the diversity of learning needs across the workforce the learning resources consist of two modules, which are accessible on Learnpro as well as an interactive mobile application available on iOS and android.

- The module 'An Introduction to Delirium' provides the baseline knowledge and skills required by all staff working in health and social care settings including in a person's own home.
- The module 'Delirium: Prevention,
 Management and Support' has been
 designed to enhance the knowledge
 and skills of all health professionals
 working across all care sectors. It
 will enable them to feel confident of
 their ability to identify, treat, prevent
 and provide appropriate support
 to people with delirium and their
 families and carers.

The mobile application is available to all staff, but is specifically aimed at health professionals who use or potentially could value learning using smart phone/tablet technology.

Education videos

Healthcare Improvement Scotland has produced a series of videos to help educate and raise awareness of delirium. The videos include Professor Alasdair MacLullich, University of Edinburgh, helping to explain what delirium is, the focus and importance of our work, and how our programme is helping to improve the care of older people in acute care. You can view the video gallery by searching for 'OPAC video gallery' at http://ihub.scot/delirium-toolkit

Staff, patients' and families' experiences report

In conjunction with University of West of Scotland, we also produced a report to provide details of a project undertaken to explore staff, patients' and families' experiences of episodes of delirium in an acute hospital setting.

We were keen to explore what it felt like to both give and receive care during an episode of delirium to:

- enhance our learning about caring for patients and family during an episode of delirium
- help us to improve communication, and
- contribute to the development of a guidance document for the delirium bundle.

This is a qualitative study which highlights the importance of continued engagement with everyone involved during these episodes. You can find the report at http://ihub.scot/delirium-toolkit

The Improvement Hub Healthcare Improvement Scotland

Edinburgh OfficeGyle Square
1 South Gyle Crescent

Glasgow Office
Delta House
50 West Nile Street

Edinburgh Glasgow EH12 9EB G1 2NP

0131 623 4300 0141 225 6999

www.ihub.scot/delirium-toolkit

