AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

FACT SHEET
for clinicians

Delirium

Clinical Care Standard

The goal of the *Delirium Clinical Care Standard* is to improve the prevention of delirium in patients at risk and the early diagnosis and treatment of patients with delirium, in order to reduce its incidence, severity and duration.

1 Early identification of risk

A patient with any key risk factor for delirium is identified on presentation and a validated tool is used to screen for cognitive impairment, or obtain a current score if they have known cognitive impairment. Before any planned admission, the risk of delirium is assessed and discussed with the patient, to enable an informed decision about the benefits and risks.

2 Interventions to prevent delirium

A patient at risk of delirium is offered a set of interventions to prevent delirium and is regularly monitored for changes in behaviour, cognition and physical condition. Appropriate interventions are determined before a planned admission or on admission to hospital, in discussion with the patient and their family or carer.

3 Patient-centred information and support

A patient at risk of delirium and their family or carer are encouraged to be active participants in care. If a patient is at significant risk or has, delirium, they and their family or carer are provided with information about delirium and its prevention in a way that they can understand. When delirium occurs, they receive support to cope with the experience and its effects.

4 Assessing and diagnosing delirium

A patient with cognitive impairment on presentation to hospital, or who has an acute change in behaviour or cognitive function during a hospital stay, is promptly assessed using a validated tool by a clinician trained to assess delirium. The patient and their family or carer are asked about any recent changes in the patient's behaviour or thinking.

A diagnosis of delirium is determined and documented by a clinician working within their scope of practice.

5 Identifying and treating underlying causes

A patient with delirium is offered a set of interventions to treat the causes of delirium, based on a comprehensive assessment that includes relevant multidisciplinary consultation.

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6 Preventing complications of care

A patient with delirium receives care to prevent functional decline, dehydration, malnutrition, falls and pressure injuries, based on their risk.

7 Avoiding use of antipsychotic medicines

Antipsychotic medicines are not recommended to treat delirium. Behavioural and psychological symptoms in a patient with delirium are managed using non-drug strategies.

8 Transition from hospital care

Before a patient with persistent or resolved delirium leaves hospital, an individualised comprehensive care plan is developed collaboratively with the patient and their family or carer. The plan describes the patient's post-discharge care needs and includes strategies to help reduce the risk of delirium and related complications, a summary of changes in medicines and any other ongoing treatment. This plan is provided to the patient and their family or carer before discharge, and to their general practitioner and other regular clinicians within 48 hours of discharge.