

The patient still has delirium.

What should we do today?

Patient: _____ Date/time: _____ Reviewer: _____

New deterioration needs prompt assessment. Do not wait to complete this checklist.

☐ 1. What has changed?

Improving, persisting or worsening? Compare alertness, attention, cognition, perception and behaviour with the previous review and usual baseline. Ask the nurse about the night; review staff and family observations. Use structured assessment to help judge recovery.

☐ 2. What is driving the delirium now?

Revisit each cause and the response to treatment; consider new causes. Review physiology and relevant investigations. Check pain, urinary retention, constipation and intake. Review drugs actually received, as-required doses, changes and omissions; assess benefit, harm and continuing need.

☐ 3. Are we supporting recovery and relieving distress?

Check food, fluids and swallowing; the assistance required; sleep, mobility, glasses and hearing aids. Ask about distress and observe discomfort. Explain, reassure and involve familiar people. Record what helps. Review any medication used for distress or risk of harm.

☐ 4. Are we preventing complications?

Pressure areas and repositioning; swallowing, oral care and aspiration risk; dehydration and malnutrition; falls, toileting and supervision. Look for complications already present. Check that the plan is being carried out with nurses and therapists.

☐ 5. Does everyone understand the plan?

Explain to the patient and support participation in decisions. Ask what the family has noticed and agree the next update. Record the clinical conclusion, actions, responsibility, review time and triggers for earlier reassessment. Plan discharge and follow-up when relevant.

Today's conclusion and priorities: _____

Action	Who	Review time

Earlier reassessment if: _____ Family update - who/when: _____

Feel free to adapt and use without permission.

Suggested prompts for ongoing care, used with clinical judgement and local guidance.

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