Delirium Academy

TEACHING COMPANION

Delirium example cases

Twenty short cases for discussion and self study

Use this booklet alongside the free courses at deliriumacademy.com. Begin with Delirium in 30, then use the cases to practise decisions you may meet at work.

For support staff, students and healthcare professionals who care for adults in hospital, care homes and the community.

Each case has a short story, questions to consider and learning points. The online modules provide fuller teaching, assessment and answer feedback.

Start with Delirium in 30

Then select safety, causes, distress or persistent delirium.
deliriumacademy.com

Free courses and teaching resources
deliriumacademy.com

How to use the cases

Ten minutes at a handover

Choose one case. Read the story aloud and cover the page below the pause line. Ask each person for an answer before discussing the learning points. Finish with what staff would do in this service.

Working on your own

Read the story, write or say your answers, then compare them with the teaching. Note one action or question for your next shift. Allow about five minutes, or longer where useful.

A longer teaching session

Select three cases for a discussion of 30 to 45 minutes. For mixed groups, ask what each role would do and whom they would contact. Each page can be printed as an individual handout.

Learning at the right level

Complete Delirium in 30 first. Cases 1–10 introduce recognition and everyday care. Cases 11–20 add clinical assessment and more complex decisions. Support staff can contribute observations and escalation plans throughout. Clinical decisions require appropriate competence and authority.

Assessment resources

For cases 11 and 12, use the official 4AT form and user guide. The AMT4 asks age, date of birth, place and current year. In intensive care, use the assessment and training specified by your service.

About the cases

All the stories were written for teaching. Use them alongside the Academy modules, clinical training and local guidance.

Official 4AT instructions · Academy educator resources

Choose the decision to discuss

Start with the basic cases or choose a relevant situation. Each case links to further learning.

Basic

Intermediate

Less conversation at breakfast

Mrs Malik, 82, lives in a care home. She usually talks with staff while eating breakfast. This morning she keeps closing her eyes and has left her tea untouched. When a care worker asks about breakfast, she answers after a long pause, then loses track of the question. Yesterday she ate and talked as usual. She is calm and asks for nothing. A colleague suggests letting her sleep until lunchtime.

Level: Basic

Care home

Team discussion: all staff

Questions

1. What are the risks of waiting until lunchtime?
2. What would you report, to whom, and how soon?

Decide your answers before reading on

Recognising hypoactive delirium

New drowsiness, slow responses and difficulty following a conversation may indicate delirium. A person with delirium may be withdrawn rather than restless. When delirium is present with reduced activity, this is called hypoactive delirium.

Report the new change promptly and arrange urgent clinical assessment through the local pathway. Describe what you have seen and when it started.

Check immediate safety. If she is difficult to wake, has abnormal breathing or appears seriously unwell, use the emergency response route. Do not wait for a delirium test.

Apply this

Practise a report that includes the change, its timing and the help needed now. In my workplace I would contact: _____

Further learning

Delirium in 30

deliriumacademy.com/introduction-to-delirium/

Sources: NICE, NHS, A1. See pages 24–25.

Her daughter notices first

Mrs Patel, 76, is in hospital with an infection. She gives her name and knows she is in hospital. Her daughter says that yesterday her mother could discuss the family's plans, but today she keeps losing the thread. During the visit, Mrs Patel asks several times why she is there. A member of staff says that she seemed fine earlier.

Level: Basic

Hospital ward

Team discussion: all staff

Questions

1. What would you ask the daughter, and where would you record it?

2. A colleague says Mrs Patel seemed fine earlier and her answers are correct. How would you respond?

Decide your answers before reading on

Knowing the person's usual abilities

Ask about usual attention, thinking, alertness and everyday abilities, as well as the time of the new change. Record concrete examples.

A person may answer orientation questions correctly and still have delirium. Symptoms also fluctuate.

Take the concern seriously, assess for delirium and arrange clinical review. A reassuring earlier encounter does not remove the need to act on new information.

Apply this

Ask someone who knows the person: "How is she different from her usual self?"

Further learning

Delirium in 30

deliriumacademy.com/introduction-to-delirium/

Sources: NICE, 4AT, A1. See pages 24–25.

Dementia and a new change

Mr Lewis, 87, has dementia. He usually needs help with washing but enjoys music and eats with little prompting. Over one afternoon he becomes sleepy, needs repeated encouragement to eat and struggles to follow familiar instructions. The evening handover describes him as “confused, as usual”. His regular care worker says this is a marked change.

Level: Basic

Care home

Team discussion: all staff

Questions

1. What is missing from the handover?
2. How should the team respond?

Decide your answers before reading on

Delirium in a person with dementia

Dementia increases vulnerability to delirium. Both conditions may be present at the same time.

Describe the new change relative to the person’s usual abilities. A label such as “confused” gives too little information.

Arrange prompt assessment of possible delirium and underlying illness. If it is difficult to distinguish delirium from dementia, manage possible delirium first while seeking further information.

Apply this

Rewrite the handover using his usual abilities and the changes seen this afternoon.

Further learning

Delirium in 30

deliriumacademy.com/introduction-to-delirium/

Sources: NICE, A1. See pages 24–25.

A normal conversation at lunchtime

At lunchtime, a student nurse finds Mrs Grant, 71, alert. She recognises the nurse and explains why she came to hospital. The student then reads the notes. At 08:00 Mrs Grant struggled to stay awake and said she was at home. Night staff recorded several episodes of disorientation after surgery. The student is asked to update the record and wonders whether to write that the confusion has resolved.

Level: Basic

Hospital ward

Team discussion: all staff

Overnight
Several episodes of disorientation

08:00
Drowsy; says she is at home

Lunchtime
Alert; explains admission

Questions

1. What should the student write in the record?
2. What should be arranged for this evening and tonight?

Decide your answers before reading on

Fluctuation

Record what was observed and when, including the morning and lunchtime findings. A period of better attention does not establish that delirium has resolved.

Use observations across the day and night, alongside information from the person and people who know them.

Continue clinical assessment, treatment of causes and supportive care. Record when symptoms occur and review for sustained improvement.

Apply this

Give a handover that includes both the improvement and the earlier changes.

Further learning

Delirium in 30

deliriumacademy.com/introduction-to-delirium/

Sources: NICE, 4AT, A4. See pages 24–25.

The hearing aid is missing

Mr Davies, 79, gives unrelated answers during a bedside assessment. His hearing aid is in a bag, switched off. The room is busy and several people speak at once. His niece says that he normally follows conversation well with the aid. She is also concerned that he has been unusually drowsy since this morning.

Level: Basic

Assessment area

Team discussion: all staff

Questions

1. What can you improve before asking further questions?
2. Which concern still needs assessment?

Decide your answers before reading on

Communication and sensory needs

Check hearing and visual aids, reduce competing noise and speak clearly, one person at a time. Ask about preferred language and communication needs.

A missing hearing aid may explain the unrelated answers. It does not explain new drowsiness. Seek clinical assessment of the reported change.

Document which communication supports were used, the responses observed and the relative's account. Repeat assessment as clinically indicated.

Apply this

Ask what would help this person understand and respond before continuing.

Further learning

Delirium in 30

deliriumacademy.com/introduction-to-delirium/

Sources: NICE, 4AT. See pages 24–25.

Sudden confusion at home

A community care worker arrives at the home of Mr Jones, 78. He is usually able to manage a conversation, but today he is disorientated and repeatedly asks where he is. His partner says the change began an hour ago. The care worker's next visit is due shortly.

Level: Basic

Home visit

Team discussion: all staff

Questions

1. How urgent is this change?
2. What should the worker report?

Decide your answers before reading on

Urgent assessment

Sudden confusion needs urgent medical help. In the UK, NHS public advice is to call 999 or go to A&E for sudden confusion. Follow the local emergency route in other countries.

Stay with the person if safe, provide reassurance and seek help. Avoid leaving the concern for a later routine visit.

Report the onset, usual abilities, current symptoms and any signs of serious illness. A delirium assessment tool should never delay emergency care.

Apply this

Identify the emergency contact route used by your service.

Further learning

Delirium in 30

deliriumacademy.com/introduction-to-delirium/

Sources: NHS, NICE. See pages 24–25.

A restless patient after surgery

Mr Campbell, 68, had abdominal surgery this morning. That evening he becomes restless, pulls at his bedding and tries to get out of bed. He struggles to follow the nurse's explanation. He grimaces when he moves and says he needs to pass urine. He has received several medicines today. A colleague suggests asking for something to settle him.

Level: Basic

Surgical ward

Team discussion: all staff

Questions

1. What needs attention now, alongside keeping him safe?

2. Which clues suggest possible causes, and what else needs assessment?

Decide your answers before reading on

Looking for causes and unmet needs

Assess immediate safety and acute illness. New restlessness with impaired attention may indicate delirium. Treatment of pain and other urgent problems proceeds alongside assessment.

Look for causes and contributors, including pain, urinary retention, constipation, infection, low oxygen, dehydration and medicine effects. More than one may be present.

De-escalation and treatment of causes are the first approach. An appropriately skilled health professional reviews medicines; prescribing changes require an authorised prescriber. Review the response to treatment.

Apply this

Describe the symptoms without using "difficult" or "non-compliant".

Further learning

Safety, distress and agitation

deliriumacademy.com/safety-distress-and-agitation/

Sources: NICE, A2, A3, MEDICINES. See pages 24–25.

Food and drink within reach

Mrs Brown, 84, is recovering from a fracture. Her water is beyond reach and she struggles to open food packaging. She has a documented swallowing plan. At night she is woken repeatedly by ward activity. She uses glasses but they are still at home. She has no new change today. A colleague says delirium is only a concern once someone becomes confused.

Level: Basic

Orthopaedic ward

Team discussion: all staff

Questions

1. How would you respond to the colleague?

2. Which changes can the team make today, and what needs an individual care plan?

Decide your answers before reading on

Prevention and everyday care

Prevention combines several measures: hydration and nutrition, mobility, sleep, pain care, sensory aids, orientation and medicine review.

Offer help that follows the swallowing plan and any fluid restriction. Position food and drink safely and check whether assistance is needed.

Support safe movement within the mobility plan. Reduce avoidable night disturbance and help obtain the person’s glasses. Continue to observe for new changes.

Apply this

Choose two actions within your role and record who will address the other needs.

Further learning

Delirium in 30

deliriumacademy.com/introduction-to-delirium/

Sources: NICE, COCHRANE. See pages 24–25.

Frightened by people in the room

Mr Wilson, 74, has delirium. When several staff approach his bed, he says that strangers are trying to hurt him. He becomes more frightened as they come closer. His wife says he finds a familiar voice reassuring. He appears uncomfortable when moving in bed. The nurse needs to check his observations.

Level: Basic

Hospital ward

Team discussion: all staff

“You’re going to hurt me. Stay away.”

Words from this example case

Questions

1. What could the nurse say and do before approaching again?
2. What needs assessment alongside the fear?

Decide your answers before reading on

Responding to distress

Acknowledge the fear and offer reassurance. Introduce yourself, explain what you are doing and use short, calm sentences. Avoid arguing about the experience.

Reduce noise and the number of people speaking. Offer a familiar person’s support when appropriate and wanted.

Assess pain and other causes of distress, alongside illness and immediate safety. De-escalation and treatment of causes are the first approach.

Apply this

Practise a reassuring opening sentence and one explanation before providing care.

Further learning

Safety, distress and agitation

deliriumacademy.com/safety-distress-and-agitation/

Sources: NICE, A3. See pages 24–25.

Explaining the diagnosis

A clinician has diagnosed delirium in Mrs Chen, 80. Her son has been told that she is “confused” but does not know why. He is frightened that the change is permanent. Mrs Chen is able to follow a short conversation this afternoon and asks what happened to her.

Level: Basic

Hospital ward

Team discussion: all staff

Questions

1. What would you explain first?
2. What would you avoid promising?

Decide your answers before reading on

Patient and family information

Use the word delirium and explain it in ordinary language: a change in thinking, attention or alertness that usually develops over hours or days, often with illness or medicine effects.

Explain the causes and treatment established by the clinical team and what the family can do to help. Ask the responsible clinician to clarify anything you do not know. Check understanding and offer written information, such as deliriumsupport.com.

Recovery varies. Some people improve quickly and others need longer. Avoid promising a fixed recovery time. Give a contact route for questions and concerns.

Apply this

Give a two-sentence explanation, then ask what the person or family would like to know.

Further learning

Delirium in 30

deliriumacademy.com/introduction-to-delirium/

Sources: NICE, A1, A4, SUPPORT. See pages 24–25.

The first score was zero

Level: Intermediate

Acute medical unit

Team discussion: clinical assessment

Mr Ali, 75, is fully alert throughout an initial 4AT assessment. He answers all AMT4 questions correctly and recites the months backwards from December to June correctly. No evidence of acute change has yet been found from the available information. The initial score is recorded as 0, with the history documented as incomplete. His daughter then arrives. She describes new episodes of disorientation and markedly impaired attention during the past day.

Questions

1. Which 4AT item should you reconsider?
2. The score of 0 is already in the record. What should happen to it?

Decide your answers before reading on

New information changes assessment

Use the new history to reassess Item 4: acute change or fluctuating course. Significant change within the last 2 weeks that is still evident within the last 24 hours scores 4.

With the other three items still scoring 0, the updated total is 4. This suggests possible delirium, with or without cognitive impairment, and requires clinical assessment.

Record the revised result and its source. A screening result supports assessment; the clinician makes the diagnosis.

Apply this

Explain to a colleague why the initial result should be updated.

Further learning

4AT assessment and cases

the4at.com/4atcases

Sources: 4AT, NICE. See pages 24–25.

Too drowsy for the questions

Mrs Evans, 81, is in the emergency department. Emergency assessment and treatment have started. She is clearly abnormally drowsy and is unable to attempt the AMT4 or months backwards. A colleague suggests leaving the 4AT blank until she is more awake. There is no reliable history yet about her usual abilities or when the change began.

Level: Intermediate

Emergency department

Team discussion: clinical assessment

Questions

1. Using the official form, how should a nurse trained in the 4AT score Items 1, 2 and 3?

2. What should you do about the missing history?

Decide your answers before reading on

Untestable cognitive items

Clearly abnormal alertness scores 4 on Item 1. When the person is untestable because of drowsiness, AMT4 scores 2 and months backwards scores 2.

These three items total 8. Continue to seek evidence for Item 4 and document that the history is incomplete. Absence of available history is not proof that no change occurred.

Continue urgent clinical care and diagnostic assessment. Do not postpone treatment to complete the score. Follow the official user guide for the full assessment.

Apply this

State the evidence for each score rather than assigning a number from a general impression.

Further learning

4AT assessment and cases

the4at.com/4atcases

Sources: 4AT, NICE. See pages 24–25.

No shared language

Mrs Hassan, 70, speaks little English. Staff have no interpreter present. Her son reports a sudden change in her conversation and behaviour since yesterday. She is awake and looking around, but does not respond meaningfully to questions in English. Someone suggests recording the cognitive items as normal because of the language barrier.

Level: Intermediate

Assessment area

Team discussion: all staff

Questions

1. How should the assessment be made more reliable?
2. What needs action while this is arranged?

Decide your answers before reading on

Language and test interpretation

Arrange an appropriate interpreter and use an official translated assessment where available. Establish hearing, vision, usual cognition and communication needs.

Do not record an unperformed cognitive test as normal. Follow the official user guide, document the limitation and interpret the findings in context.

The reported sudden change still needs urgent clinical assessment. Communication support should be arranged alongside care, without delaying treatment of serious illness.

Apply this

Record both the concern and the communication support needed.

Further learning

4AT assessment and cases

the4at.com/4atcases

Sources: 4AT, NICE. See pages 24–25.

Several possible causes

Mr Anderson, 83, develops delirium during treatment for pneumonia. He is improving on antibiotics, but remains inattentive. A nurse notices pain on movement, poor fluid intake and no recorded bowel movement for several days. A new medicine may also be causing sedation. A colleague says the continuing confusion is probably a urine infection.

Level: Intermediate

Medical ward

Team discussion: all staff

Questions

1. How would you respond to that suggestion?
2. How will you judge the response to changes in care?

Decide your answers before reading on

More than one cause

One identified cause does not exclude others. The clinical team reassesses illness, oxygenation, pain, hydration, bowel and bladder problems, medicines and other findings. Confusion alone does not establish a urinary tract infection.

Allocate each action to an appropriate team member and record who will review the person and when. Avoid adding medicines without reviewing the current medicines.

Follow the clinical course, function and distress. Delirium can continue after an initial cause improves and should prompt further review.

Apply this

Write a short plan with actions, named roles and a review time. Compare the reasoning with case 7.

Further learning

Identifying triggers of delirium

deliriumacademy.com/identifying-triggers-of-delirium/

Sources: NICE, A2, A4, IDSA. See pages 24–25.

Hallucinations and Parkinson’s disease

Mrs Fraser, 78, has Parkinson’s disease and develops delirium during an acute illness. She sees insects on her blanket and is frightened. Staff have begun reassurance, reduced stimulation and assessment of pain and other needs. A colleague asks whether haloperidol should be prescribed if distress continues.

Level: Intermediate

Hospital ward

Team discussion: clinical assessment

“Get those insects off my blanket.”

Words from this example case

Questions

1. Which history changes the medication decision?
2. What should the team do next?

Decide your answers before reading on

Medication risk and distress

Haloperidol must not be used in Parkinson’s disease or dementia with Lewy bodies. Escalate to a clinician with suitable expertise and follow local guidance.

Continue to assess and treat causes of delirium and distress. Medication decisions require an individual assessment of benefit, risk and alternatives.

For patients in whom haloperidol is appropriate, UK guidance limits its use to specific circumstances after de-escalation is ineffective or inappropriate, with the lowest dose for the shortest time and appropriate monitoring.

Apply this

Include Parkinson’s disease prominently in the clinical handover and medicine review.

Further learning

Safety, distress and agitation

deliriumacademy.com/safety-distress-and-agitation/

Sources: MHRA, NICE, A3. See pages 24–25.

A younger man, confused after surgery

Mr Miller, 42, becomes inattentive and disorientated two days after major surgery. He has severe pain and appears physically unwell. A colleague says that delirium is an older person's condition.

Level: Intermediate

Surgical ward

Team discussion: all staff

Questions

1. How does his age affect the response?
2. What needs assessment?

Decide your answers before reading on

Age and clinical context

Delirium can occur in younger adults. New changes in attention and awareness during illness need urgent assessment at any adult age.

The clinical team assesses signs of serious illness, including abnormal observations, and looks for causes using the history, examination and appropriate investigations. Report new observations and concerns promptly.

Ask about prescribed medicines, alcohol and other substances without assumptions. Withdrawal may need urgent specialist treatment and a specific local pathway.

Apply this

Describe the new changes and request assessment without making an age-based assumption.

Further learning

Identifying triggers of delirium

deliriumacademy.com/identifying-triggers-of-delirium/

Sources: NICE, A1, A2. See pages 24–25.

Choosing an assessment in intensive care

Level: Intermediate

Critical care

Team discussion: clinical assessment

Mrs Taylor, 64, is in intensive care. Her sedation was reduced today and her alertness has varied since. Her Richmond Agitation-Sedation Scale (RASS) score is recorded each shift. A nurse who recently moved from a medical ward reaches for the 4AT form she used there.

Questions

1. Which delirium assessment should be used here, and who is trained to do it?

2. What from ward practice still applies?

Decide your answers before reading on

Delirium assessment in critical care

Awareness of change, attention to causes, supportive care and communication remain relevant. Critical care assessment requires the appropriate local training and pathway.

NICE recommends the Confusion Assessment Method for the ICU (CAM-ICU) or Intensive Care Delirium Screening Checklist (ICDSC) in critical care and the recovery room immediately after surgery, instead of the 4AT. Follow the instrument's requirements.

RASS assesses agitation and sedation. Its score is not a delirium diagnosis and must not be numerically converted into a 4AT score.

Apply this

Identify the delirium assessment method and training used in your critical care service.

Further learning

Safety, distress and agitation

deliriumacademy.com/safety-distress-and-agitation/

Sources: NICE, 4AT. See pages 24–25.

Fluctuating attention and a treatment decision

Mr Stewart, 77, has delirium and needs a discussion about a proposed treatment. At one point he follows an explanation, but later he is distracted and struggles to retain it. His daughter asks whether a delirium diagnosis means that staff should make every decision for him.

Level: Intermediate

Hospital ward

Team discussion: clinical assessment

Questions

1. How can the team support his involvement?
2. Who should assess the specific decision?

Decide your answers before reading on

Supporting involvement in decisions

A diagnosis alone does not settle a person's ability to make every decision. Capacity is the ability to make the particular decision at the time it is needed. Legal processes differ by country or legal system.

Provide communication support and simple explanations. For a decision that can safely wait, consider a time when attention is better. Urgent treatment should follow the appropriate local legal and clinical process.

An appropriately skilled clinician should assess and document the decision in question, involve the person as far as possible and follow local policy for family involvement.

Apply this

Identify your local source of advice on capacity and urgent treatment.

Further learning

Safety, distress and agitation

deliriumacademy.com/safety-distress-and-agitation/

Sources: NICE, CAPACITY. See pages 24–25.

Still affected after the infection improves

Mrs Robertson, 85, has completed treatment for an infection. A week later, her attention still varies and she needs much more help dressing than before. Her family has been told that the blood tests are better. They ask why she has not returned to her usual self.

Level: Intermediate

Rehabilitation ward

Team discussion: all staff

Treatment completed
Infection treated

One week later
Attention varies; needs more help dressing

Next review
What should be assessed?

Questions

1. What should the team reassess?
2. How would you explain the uncertainty?

Decide your answers before reading on

Persistent delirium

Delirium may persist after treatment of the initial illness. Review for continuing or new causes, medication effects and unmet care needs.

Assess thinking, alertness and function over time. Avoid diagnosing a new permanent dementia solely from performance during active delirium.

Explain what has improved, what remains affected and the plan for review and rehabilitation. Some people have prolonged symptoms or lasting difficulties.

Apply this

List the information you need from the team before explaining the review plan and contact route to the family.

Further learning

Persistent delirium

deliriumacademy.com/persistent-delirium/

Sources: NICE, A4. See pages 24–25.

Going home after delirium

Mr Green, 73, is going home after an admission complicated by delirium. His attention has improved, but he still needs support with medicines and meals. A short course of an antipsychotic was started in hospital. The team is preparing his discharge letter.

Level: Intermediate

Hospital to home

Team discussion: all staff

Draft discharge letter

Diagnosis: infection, treated.

Medicines: usual medicines plus an antipsychotic started in hospital.

Follow-up: none stated.

Questions

1. What is missing from this draft?
2. What should the person and family know?

Decide your answers before reading on

Continuity of care

Record the delirium diagnosis, its course, likely causes, treatment and current cognitive and functional needs. Share the plan with the receiving team.

Review medicines before discharge. Specify the indication, review arrangements and planned stopping of any medicine used for acute distress. Avoid unintended long-term prescribing.

Explain recovery, support arrangements, warning signs and who to contact. Arrange follow-up appropriate to the person’s remaining needs.

Apply this

List the information for the delirium paragraph, marking details the team must confirm. Alternatively, practise reporting the omissions to the discharge team.

Further learning

Persistent delirium

deliriumacademy.com/persistent-delirium/

Sources: NICE, A4, MHRA. See pages 24–25.

Clinical sources

NICE · NICE CG103: Delirium, recommendations (updated 2023)

nice.org.uk/guidance/cg103

4AT · Official 4AT user guide

the4at.com/userguide

NHS · NHS: Sudden confusion (delirium)

nhs.uk/symptoms/confusion

MHRA · MHRA: Haloperidol, reminder of risks in older people with acute delirium

gov.uk/drug-safety-update (search haloperidol delirium)

COCHRANE · Burton et al. Non-pharmacological interventions for preventing delirium in hospitalised non-ICU patients. Cochrane, 2021

doi.org/10.1002/14651858.CD013307.pub3

MEDICINES · NICE NG5: Medicines optimisation, recommendation 1.4.2

nice.org.uk/guidance/ng5

CAPACITY · NICE NG108: Decision-making and mental capacity (England and Wales context; use applicable local law elsewhere)

nice.org.uk/guidance/ng108

IDSA · IDSA 2019 guideline on asymptomatic bacteriuria, recommendation V

idsociety.org/practice-guideline/asymptomatic-bacteriuria

Source identifiers on each case refer to these pages. Clinical sources checked 20 September 2026.

Continue learning

A1 · Delirium Academy: Delirium in 30 (developed from Introduction to delirium)

deliriumacademy.com/introduction-to-delirium/

A2 · Delirium Academy: Identifying triggers of delirium

deliriumacademy.com/identifying-triggers-of-delirium/

A3 · Delirium Academy: Distress in delirium

deliriumacademy.com/distress-in-delirium/

A4 · Delirium Academy: Persistent delirium

deliriumacademy.com/persistent-delirium/

SUPPORT · Delirium Support: Information for patients, families and carers

deliriumsupport.com/

Safety, distress and agitation

Complete Delirium in 30 first, then use the safety module to practise responses to distress and severe agitation. It covers patient and staff safety, including critical care examples.

deliriumacademy.com/safety-distress-and-agitation/

Illustrated cases

A separate resource for discussion and learning.
deliriumacademy.com/cases/

Reuse and version

 Version 1.1, 20 September 2026. Teaching durations are estimates.