A shared foundation in delirium care

Delirium Academy curriculum · Adult health and care staff · September 2026

Purpose and audience

Give staff a common understanding of delirium and a clear first response. Delirium in 30 is an introduction for healthcare professionals, students and support staff who care for adults. It covers recognition, assessment, immediate care, prevention and recovery. Responsibilities differ by role: everyone can notice and report change; diagnosis, prescribing and other clinical decisions require the appropriate competence.

Start with Delirium in 30

Complete the 30-minute foundation first. It introduces a person whose thinking and behaviour have changed, then explains what delirium is and what staff should do. Staff unfamiliar with healthcare terms can first take the optional eight-minute New to healthcare course. The preparation course is selected by learning need, rather than qualification.

Six foundation outcomes

Recognise a new or fluctuating change in attention, alertness, thinking or behaviour, including drowsiness and reduced engagement.

Establish the person’s usual state with the person, family or familiar staff; recognise that delirium and dementia can coexist.

Report concern promptly, recognise an emergency, and explain the role and limits of delirium assessment. Use the official 4AT instructions when assessment is part of your role.

Explain why the team treats possible causes, often more than one, while recognising and responding to distress, including in someone who speaks or moves very little.

Recognise increased vulnerability and support prevention through safe mobility and rehabilitation, hydration, nutrition, sleep, sensory aids, comfort and appropriate medicine review.

Explain delirium to the person and family; monitor change, communicate the care plan and arrange appropriate continuing care and follow-up.

How learning is checked

Short cases and questions connect knowledge to decisions. Learners complete ten assessment questions, read answer feedback and may retry. A certificate records completion of the course requirements. It does not establish competence to diagnose, prescribe or carry out a clinical procedure. No registration is needed.

For local teaching

Ask each learner to identify the person they would contact about a new change and describe one useful observation. Allow discussion time in addition to the course duration.

Develop the response to delirium

Follow-on learning · Complete Delirium in 30 first

Safety, distress and agitation in delirium · 35 minutes

For staff who need further teaching on safety. Recognise immediate danger in the first minute, call help, and protect patients and staff. Look for pain, a full bladder, fear and other causes, and use therapeutic engagement and de-escalation. Prevent falls, pressure ulcers, choking and dehydration in drowsy delirium. Explain consent and decision-specific capacity, the exceptional place of restraint and the limited use of medicines. Discuss hard calls: a person leaving at night, a relative asking for sedation, not enough staff, being hurt at work, a report of harm and the last days of life. Review and hand over after an episode. ICU examples use specialist team assessment and current PADIS guidance without detailed drug regimens.

Choose further learning for the staff group

Identifying triggers of delirium: assess possible causes systematically; consider acute illness, medicines and withdrawal, pain, retention, constipation and other contributors. Reassess when delirium persists or changes.

Distress in delirium: understand fear, hallucinations, delusions and the patient’s experience; improve communication, comfort and family involvement. Use this for a fuller discussion of the patient’s experience.

Communication in delirium care: practise introductions, explanations, reassurance and listening; adapt to distress, sensory loss and language needs.

Persistent delirium: continue assessment, care and rehabilitation; recognise incomplete recovery and plan transfer, discharge and follow-up.

4AT learning resources: practise the official assessment and interpretation with cases. Distinguish a test result from diagnosis. Use the appropriate specialist tools in ICU.

Example cases and illustrated cases: discuss recognition, dementia, communication, prevention, causes, safety, recovery and different care settings. These are parallel teaching resources, rather than an additional compulsory module.

Topics to include across the programme

Patient and family experience; hypoactive and mixed presentations; delirium with dementia; medicine effects; illness and surgery; intensive care; care homes and care at home; distressing memories; continuing symptoms; rehabilitation; discharge communication and recurrence prevention. These topics reflect the Academy modules, the delirium care guide and the family book’s subject coverage.

Extend locally where the role requires it

Add supervised assessment, clinical investigation and prescribing; withdrawal management; end-of-life care; local consent and capacity law; safeguarding; practical de-escalation and restraint training; and specialist ICU practice. Adapt communication for sensory impairment, language differences, learning disability and neurodiversity. Paediatric delirium needs a separate curriculum.

Make the learning usable in your service

Educator guide · Local application and sources

A manageable teaching sequence

Before learning: choose the staff group and relevant modules. Add local emergency contacts, escalation routes and role expectations. Check access to videos and provide the written alternatives.

Independent learning: use Delirium in 30, then the safety module where relevant. Together these take about 65 minutes; optional preparation adds eight minutes. These are planned durations, not time limits.

Group application: allow a further 15–20 minutes for two cases, a short handover rehearsal and a discussion of the local response. Use the slide notes and case booklet.

At work: arrange observation and feedback for tasks requiring clinical skills. Use the service's existing process to record course completion and practical assessment separately.

Use the wider frameworks at the appropriate level

The Delirium Core Model offers a provisional shared account of recognition, physical care, psychological care, prevention, communication and recovery. Use it to organise teaching, with its draft status stated. ACE-T is a possible additional structure for the early nursing response and team communication; introduce it where the service adopts the tool and its local pathway. Neither needs to be a prerequisite or an extra compulsory course. Use current clinical guidance for decisions.

Review learning and delivery

Ask staff what they would do in a new case, how long the course took and which terms were unclear. Check whether local escalation and follow-up arrangements are understood. Review teaching after feedback or guidance changes. Improvements in patient outcomes require evaluation; course completion alone does not demonstrate them.

Guidance used

The curriculum uses the subject coverage of the sources below, adapted to an introductory programme. It is not accreditation or a claim of equivalence to an undergraduate or specialist curriculum.

Sources

Copeland C, Fisher J, Teodorczuk A. Development of an international undergraduate curriculum for delirium using a modified delphi process. Age and Ageing 2018;47:131–137. doi:10.1093/ageing/afx133.

British Geriatrics Society: Delirium in Older People, published course outcomes.

MacLullich A. Guide to delirium care: the4AT.com/deliriumguide.

NICE CG103: Delirium; Australian Delirium Clinical Care Standard (2021); SCCM PADIS guidelines (2018 and 2025 focused update).

Academy modules and the earlier introduction module; Delirium Core Model v0.2 (working draft, August 2026); Book 1 chapter topics. Source review and curriculum preparation: 20 September 2026; safety module entry updated 22 September 2026.