

Delirium in 30: learning outcomes set against guidance and training standards

This document sets the six foundation outcomes of Delirium in 30 against five documents: NICE CG103, SIGN 157, the Australian Delirium Clinical Care Standard (2021), the Care Certificate standards (2025) and the Dementia Training Standards Framework (2026). Use it in course approval documents, training needs analyses and local audit.

The wording in the right-hand column is quoted from each source. "..." marks a shortened quotation. The guidelines describe care for patients; the mapping shows which recommendations each outcome prepares staff to act on. The training standards describe what staff should know or do.

Limits of the mapping. The Care Certificate (2025) does not mention delirium, so its links are indirect: reporting concerns, recognising distress and early signs of deterioration. NICE CG103 has no recommendation on staff education; its only training wording is in recommendation 1.4.3. SIGN 157 refers to staff education only in its implementation section (10.1). The Dementia Training Standards Framework addresses delirium in people living with dementia. The Australian standard was quoted from its web page; the PDF edition was not compared. Delirium in 30 is an introduction: it prepares staff to recognise, report and support, and does not by itself meet requirements for competence in assessment, diagnosis or prescribing.

Outcome 1

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

Document	Reference	Wording in the source
NICE CG103	1.3.2	"Be particularly vigilant for changes that may indicate hypoactive delirium, which are often missed, such as withdrawal, slow responses, reduced mobility and movement, worsened concentration and reduced appetite."
NICE CG103	1.5.1	"Observe, at least daily, all people in hospital or long-term care for recent (within hours or days) changes or fluctuations indicating delirium ..."
SIGN 157	1.2.3	"Patients may present with cognitive impairment, but drowsiness to the point that the patient is not speaking, severe agitation, or psychotic features such as hallucinations or delusions may be the most prominent features."
Australian standard	QS2	"Monitor patients regularly, at least daily for changes in cognition and behaviour, and for clinical deterioration."
Care Certificate	5.6b	"Recognise the signs that an individual is in pain, discomfort or emotional distress. This could include: verbal reporting from the individual; non-verbal communication; changes in behaviour"
Care Certificate	9.4a	"Describe how to recognise early indicators of mental health deterioration"
DTSF 2026	1.1.17 (Tier 1)	"Recognise the signs and symptoms of delirium and how they differ from dementia."
DTSF 2026	5.1.4 (Tier 1)	"Understand that sudden changes in behaviour and cognition may indicate delirium and a change in physical health."

Outcome 2

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

Document	Reference	Wording in the source
NICE CG103	1.3.1	"... These may be reported by the person at risk, or a carer or relative ..."
NICE CG103	1.6.3	"If there is difficulty distinguishing between the diagnoses of delirium, dementia or delirium superimposed on dementia, manage the delirium first."
SIGN 157	1.1.1	"Family members can provide background information on patient history, changes in behaviour and early warning signs."
Australian standard	QS4	"Seek information about the patient's usual mental status from the patient or their family or carer, general practitioner, or other primary care provider or similar."

Document	Reference	Wording in the source
Care Certificate	9.1c	"Explain what is meant by the term dementia"
DTSF 2026	3.2.10 (Tier 2)	"Understand how to differentiate between dementia, delirium, depression and other conditions presenting with similar symptoms, and be aware that people can have dementia as well as any of these other conditions."

Outcome 3

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.

Document	Reference	Wording in the source
NICE CG103	1.6.1	"If indicators of delirium are identified, a health or social care practitioner who is competent to do so should carry out an assessment using the 4AT tool. In critical care or in the recovery room after surgery use the Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) or Intensive Care Delirium Screening Checklist (ICDSC) instead of the 4AT."
NICE CG103	1.6.2	"If the assessment described in recommendation 1.6.1 indicates delirium, a healthcare professional with the relevant expertise should make the final diagnosis."
NICE CG103	1.5.2	"Ensure that any changes that may indicate delirium are documented in the person's record or notes."
SIGN 157	1.1	"Delirium is among the most common of medical emergencies."
SIGN 157	2.1 / 3.1 (R)	"The 4AT tool should be used for identifying patients with probable delirium in emergency department and acute hospital settings."
SIGN 157	3.1 (GPP)	"A formal assessment and diagnosis must be made by a suitably trained clinician whenever patients with probable delirium are identified."
Australian standard	QS4	"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. ..."
Care Certificate	1.2e	"Explain how and when to escalate any concerns they might have in line with organisational policy or ways of working"
Care Certificate	5.4b	"Report any concerns they have to the relevant person. ..."
Care Certificate	9.3b	"Describe how to report concerns associated with any unmet needs which may arise from mental health conditions or dementia through agreed ways of working"
DTSF 2026	3.2.6 (Tier 2)	"Be able to apply basic screening tools to support early recognition of delirium when it is within the scope of practice."

Outcome 4

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.

Document	Reference	Wording in the source
NICE CG103	1.7.1	"In people diagnosed with delirium, identify and manage the possible underlying cause or combination of causes."
NICE CG103	1.7.3	"If a person with delirium is distressed or considered a risk to themselves or others, first use verbal and non-verbal techniques to de-escalate the situation. ... Distress may be less evident in people with hypoactive delirium, who can still become distressed by, for example, psychotic symptoms."
SIGN 157	2.3 / 6 (R)	"... Systematically identify and treat potential causes (medications, acute illness, etc), noting that multiple causes are common. ... Specifically detect, assess causes of, and treat agitation and/or distress, using non-pharmacological means only if possible ..."
Australian standard	QS5	"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."
Australian standard	QS7	"Antipsychotic medicines are not recommended to treat delirium. Behavioural and psychological symptoms in a patient with delirium are managed using non-drug strategies."
Care Certificate	5.6c	"Take appropriate steps to remove or minimise factors, including environmental factors, which may be causing pain, discomfort or emotional distress to the individual. ..."

Document	Reference	Wording in the source
DTSF 2026	3.2.9 (Tier 2)	"Identify common causes and risk factors for delirium in people living with dementia."
DTSF 2026	5.2.3 (Tier 2)	"Be able to communicate effectively with a person who is experiencing delirium, using person-centred approaches to reduce distress."

Outcome 5

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

Document	Reference	Wording in the source
NICE CG103	1.2.1	"When people first present to hospital or long-term care, assess them for the following risk factors. ... Age 65 years or older. Cognitive impairment (past or present) and/or dementia ... Current hip fracture. Severe illness ..."
NICE CG103	1.4.2	"Give a tailored multicomponent intervention package ... provide a multicomponent intervention tailored to the person's individual needs and care setting ..."
NICE CG103	1.4.3	"The tailored multicomponent intervention package should be delivered by a multidisciplinary team trained and competent in delirium prevention."
SIGN 157	2.2 / 4.2 (R)	"The following components should be considered as part of a package of care for patients at risk of developing delirium: orientation and ensuring patients have their glasses and hearing aids; promoting sleep hygiene; early mobilisation; pain control; prevention, early identification and treatment of postoperative complications; maintaining optimal hydration and nutrition; regulation of bladder and bowel function; provision of supplementary oxygen, if appropriate."
SIGN 157	2.2 / 5.1 (R)	"All patients at risk of delirium should have a medication review conducted by an experienced healthcare professional."
Australian standard	QS2	"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. ..."
Australian standard	QS6	"A patient with delirium receives care to prevent functional decline, dehydration, malnutrition, falls and pressure injuries, based on their risk."
Care Certificate	8.1e	"Explain how to identify and report changes or risks relating to nutrition and hydration needs"
DTSF 2026	4.2.4 (Tier 2)	"Be able to contribute to care plans that include delirium prevention and management strategies for people living with dementia."
DTSF 2026	8.2.1 (Tier 2)	"Be able to support environmental and psychosocial initiatives to prevent or manage delirium."

Outcome 6

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

Document	Reference	Wording in the source
NICE CG103	1.6.4	"Ensure that the diagnosis of delirium is documented both in the person's record or notes, and in their primary care health record."
NICE CG103	1.8.1	"Offer information to people who are at risk of delirium or who have delirium, and their family and/or carers, which: informs them that delirium is common and usually temporary; describes people's experience of delirium; ..."
SIGN 157	3.1 (GPP)	"Where delirium is detected, patients and their family/carers should be informed of the diagnosis (see section 9)."
SIGN 157	8 (GPP)	"Ensure that delirium is noted in the discharge letter for the primary care team."
Australian standard	QS3	"... 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. ..."
Australian standard	QS8	"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. ..."
Care Certificate	9.4e	"Explain ways to engage with and signpost individuals living with a mental health condition or dementia and their families and carers to other services and support"
DTSF 2026	9.2.2 (Tier 2)	"Be able to support families, carers and supporters in understanding delirium and its impact on the person living with dementia."

Sources

Short name	Document, version and where it was read
NICE CG103	NICE. Delirium: prevention, diagnosis and management in hospital and long-term care (CG103). Published 28 July 2010, last updated 18 January 2023. nice.org.uk/guidance/cg103
SIGN 157	Scottish Intercollegiate Guidelines Network. Risk reduction and management of delirium (SIGN 157). March 2019; revalidated 2022. sign.ac.uk . R = recommendation; GPP = good practice point.
Australian standard	Australian Commission on Safety and Quality in Health Care. Delirium Clinical Care Standard, 2021. Quoted from the official web page at safetyandquality.gov.au/clinical-care-standards/delirium . QS = quality statement.
Care Certificate	Care Certificate standards, updated March 2025 (Skills for Care and Skills for Health). skillsforcare.org.uk
DTSF 2026	Dementia Training Standards Framework, February 2026 update (Skills for Care with Skills for Health). skillsforcare.org.uk . Tier 1 applies to everyone; Tier 2 to those providing direct care and services for people living with dementia.

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