Delirium discharge and handover templates

Use these editable forms of words after an individual clinical assessment. Replace every bracket, remove alternatives that do not apply and check the completed document. Record findings and arrangements that have actually been established. These teaching templates are not patient records. Module and guidance: https://deliriumacademy.com/communication-in-delirium-care/

Clinical discharge letter

For the clinician responsible for the discharge summary

Diagnosis: [delirium / suspected delirium / delirium superimposed on established dementia]. Onset: [date or best estimate and source]. Most recent assessment: [date, time, clinical findings and relevant tool results]. At transfer delirium was [resolved / still present / suspected]. Its recent course was [improving / unchanged / worsening / fluctuating / uncertain]. Persistent delirium can also be improving.

Usual baseline: [thinking, communication, daily activities, mobility and support], according to [person or record, date]. Current state: [attention, alertness, symptoms and fluctuation, daily activities and help required]. Evidence for improvement or resolution: [clinical findings and comparison with baseline].

Contributors identified or suspected: [list, stating uncertainty]. Treatment and response: [details]. Outstanding questions or results: [item; action needed; responsible clinician or service; deadline].

Communication: [preferred name and language; interpreter or sensory/communication aids; approaches that help; approaches to avoid]. Distress and relevant safety concerns: [observations, patient's own words where useful, actions and response]. Capacity or consent: [specific decision, assessment date and outcome, support used, relevant legal documentation or authorised representative where applicable].

Medicines: [medicine and dose; started/changed/stopped; reason; intended duration; monitoring; who will review; date; stopping or reduction plan where relevant]. Reconcile with the final prescription. Do not assume a medicine should be stopped abruptly because it was started during delirium.

Destination and support confirmed: [service, tasks, visit times or other arrangements, equipment and contact details]. Needs between visits or overnight: [assessment and plan]. Patient/carer views and feasible contribution: [details]. Unresolved support issues and action before transfer: [details].

Follow-up: [specific problem; responsible service/person; requested action; urgency and date]. Status: [appointment confirmed / referral sent and receipt checked / action still required]. If no response by [date], [named service/person] will [action].

Information discussed with: [patient and, with appropriate consent or authority, others; date; interpreter/format if relevant]. Written delirium information and personalised contact plan provided: [details]. Receiving services informed: [who, when, how; receipt checked for urgent actions].

Short paragraph for a discharge summary

Choose the wording that fits the clinical assessment

Delirium has resolved

During this admission, [name] had delirium associated with [known/suspected contributors]. On [date], [findings] supported resolution, with [comparison with usual baseline]. [Any remaining cognitive, emotional or functional problems] require [plan]. The episode, medicine changes and advice about further sudden changes were discussed with [person]. Follow-up: [specific arrangements].

Delirium is improving but remains present

[Name] has improving delirium associated with [contributors]. At assessment on [date/time], [remaining features and daily support needs] were present. [Name] will receive [confirmed support]. [Service] will review [specific issue] on/by [date; booking status]. New deterioration requires urgent reassessment through [local route]. Medicine review and outstanding actions: [details].

Persistent delirium without clear improvement

[Name] has persistent delirium, with [current findings] on [date/time]. There has been no clear improvement over [observed interval]. [Assessment of ongoing or new contributors and current diagnostic uncertainty]. Current support needs are [details]. [Named service] will reassess [specific issues] on/by [date; confirmation status]. [Escalation and transfer arrangements].

The diagnosis remains uncertain

[Name] developed [observed changes and onset]. Delirium is suspected; [remaining uncertainty] requires [assessment/action]. Current needs are [details]. [Responsible service] has been asked to [specific action and urgency], with [confirmation or outstanding arrangement]. The diagnostic uncertainty and contact plan were explained to [person].

Information to give the person and family

Complete together in plain language; offer an accessible format

You [have / have had] [delirium / changes that may be delirium]. This affected [describe their symptoms]. The team found [what is known about the cause]. At present, [what has improved and what still needs help].

The help arranged is: [who will do what and when, including evenings or nights if needed]. You told us that you or those close to you can manage: [agreed contribution]. We have also arranged: [other support].

Your medicines have changed as follows: [plain explanation consistent with the prescription]. For questions about these changes, contact [service and number]. Review: [who and when; whether confirmed].

The next review is [details and booking status]. It will cover [thinking, day-to-day activities, medicines or other specific needs]. If you have not heard by [date], contact [service and number].

If there is new sudden confusion or a sudden worsening, seek urgent medical assessment now. Follow the local contact plan below. For collapse, severe breathing difficulty, new stroke symptoms or new difficulty waking the person, call the local emergency number immediately. In hospital, call staff immediately and use the hospital emergency response. In a care home, tell staff as well as calling emergency help. Do not delay emergency help while seeking a particular staff member.

Local contact plan, completed and checked by the team

Emergency number: [number]. Urgent assessment route during the day: [service and number]. Out of hours: [service and number]. Non-urgent questions: [service and number].

If using the telephone or arranging help is difficult, the agreed way to get help is: [accessible contact method and support actually arranged]. The person or service checking outstanding appointments or results is: [name/role, contact and deadline]. Check that the person can use the plan and confirm any help needed before discharge.

Delirium can take time to improve. Some people have continuing difficulties. Tell the reviewing team about ongoing problems with thinking, sleep, distress or everyday activities. New deterioration needs assessment; do not assume it is part of recovery.

Information offered: [Delirium Support leaflet or web page; other local information]. Questions still to discuss: [patient/family priorities].

Spoken handover with colleagues

When handing over, identify the person and yourself, describe the change, and state what needs to happen next. Use the relevant identifiers and current observations required by your local handover process. Speak discreetly. Include the patient where appropriate and avoid discussing them as though they are absent.

These are short teaching examples. Replace the names and details with the actual findings. They are openings for a conversation; give the additional clinical information the receiving colleague needs.

1. At a shift change

“Mrs Grant still has delirium. She is more alert than yesterday but loses track of conversation. Her daughter says she usually manages her own medicines. She needs help with drinks and one instruction at a time. The medical team will review her this morning. Please hand over any new change straight away.”

Add the current observations, treatment, outstanding tasks and named staff responsible. Do not describe someone simply as “confused”.

2. Reporting a new change to the nurse or doctor

“I'm concerned about Mr Reid. At breakfast he was talking as usual. Since ten o'clock he has said very little and keeps losing track of what I'm asking. This is a new change. Can you assess him now?”

Give the current observations and any other symptoms, if available. Assessment should not wait until a full set of observations or a delirium score has been obtained.

3. Calling for immediate help

“I need emergency help at [precise location]. Mrs Ali is newly difficult to wake. She was speaking to me earlier.”

Use the local emergency response immediately. Follow the responder's instructions and provide observations as available. Do not delay the call to complete a longer handover.

4. When the first request has not led to a review

“I reported this change at ten o'clock. Mr Reid has not yet been assessed and I remain concerned. Who can review him now? If you are unable to come, I will contact the next clinician through our escalation route.”

Escalate according to urgency. A message left or a referral sent does not establish that someone has accepted responsibility.

5. Passing on an approach that helps

“Mrs Ali became frightened when several of us spoke at once. She followed better when one person spoke from in front of her, with her hearing aids in. Please explain before touching her and pause after each sentence. If she pulls away, stop when safe and check what is troubling her.”

Describe what happened and what helped. Avoid labels such as “difficult” or “uncooperative”. Record successful approaches for colleagues on later shifts.

6. Raising a concern at the team meeting

“Mr Brown walked to the bathroom with me, but he needed repeated prompts to use his frame. His attention still fluctuates. Before we agree discharge, can we review what help he needs between visits and overnight? His daughter has said she is unable to stay.”

A successful task during one assessment may not represent what the person can manage throughout the day. Ask the relevant team members to agree a feasible plan with the person and carers.

7. Handover to a ward or care home receiving the person

“I'm calling about Mrs Grant's planned transfer. Her delirium has improved but is still present. She needs [specific support], including [needs overnight]. The written handover includes her current assessment, medicine changes and review plan. Can your team provide this support from arrival? Is there anything we need to resolve before she moves?”

Confirm the receiving team's actual arrangements. A document sent does not establish that the destination can provide the required care.

8. Agreeing who will follow up an outstanding action

“The referral to [service] was sent today, but the review is not confirmed. We need an agreed time for [specific assessment]. Who will check the referral has been received and arrange the next step? Let's record the responsible person and deadline in the handover.”

Use the same approach for outstanding results and medicine reviews. Set the urgency from the clinical situation. Resolve any outstanding action that is essential for safe discharge before transfer.

9. The receiving colleague confirms the plan

“I'll assess Mr Reid now and update you afterwards. Please use the emergency response immediately if he becomes difficult to wake or develops another emergency sign. Who should I contact when I've seen him?”

The person receiving the handover should confirm the action and timing, ask about missing information, and explain any delay. Record the agreed plan and escalate again if the response is inadequate or the person deteriorates.

Example case and abbreviated wording

Teaching example only

Mrs Grant had delirium during treatment for pneumonia. Her daughter described previously independent management of medicines. At discharge, the team found improved alertness but continuing difficulty following medicine instructions. Support and a review were arranged before transfer.

“Mrs Grant developed delirium during this admission, with pneumonia identified as a contributor. On the day of discharge, she was more alert but remained inattentive during conversation and needed help to follow medicine instructions. Her daughter described independent medicine management before this illness. Delirium remained present. The discharge team confirmed medicine support through the receiving care service. The community team accepted a request to review cognition, daily activities and the support plan within the agreed interval. The actual dates, named services and contact numbers are recorded in the completed clinical handover.”

This is an abbreviated illustration of the wording. The full template above requires actual dates, service details, medicine changes and contact arrangements before use as a clinical discharge summary.

Sources and reuse

NICE CG103, assessment, diagnosis and information/support: https://www.nice.org.uk/guidance/cg103/chapter/Recommendations

NICE QS63, communication of a delirium diagnosis at transfer: https://www.nice.org.uk/guidance/qs63/resources/delirium-in-adults-pdf-2098785962437

SIGN 157, delirium management and information: https://rightdecisions.scot.nhs.uk/m/1728/sign-guidelines-delirium.pdf

Scottish guidance on consent and capacity: https://www.gov.scot/collections/adults-with-incapacity-forms-and-guidance/

Patient and family downloads, including editable sheets: https://deliriumsupport.com/staff-resources/