|  |  |
| --- | --- |
| Age (years) |  |
| Gender (M/F) |  |
| Dementia (N/probable/Y) |  |
| Specialty (Choose one of: Acute medicine/ Geriatric medicine/ Other medicine/ Stroke/ Other surgery/ General surgery/ Orthopaedic surgery) |  |
| Clinical Frailty Scale (1-9) – This should be recorded for their status 2 weeks prior to admission; use all available information including functional history by clerking doctor and/or OT assessment – *use guide overleaf* |  |
| Delirium screening performed in first 48 hours? (N/Y) |  |
|  | If so, who by? (Choose one of: Junior doctor FY1-CT2/ Geriatric SpR or consultant/ Other medical SpR or consultant/ Surgery SpR or consultant/ Nurse, AHP, or other) |  |
| Delirium diagnosis in notes? (N/Y) |  |
|  | If yes, duration (days)? |  |
| If yes, Incident (not present on admission), or prevalent (present on admission? |  |
| If yes, subtype? None/ Hyperactive/ Mixed/ Hypoactive |  |
| If no, proceed to full retrospective assessment (not necessary if delirium diagnosed) |
| Delirium present in retrospective assessment? (N/Y) – *use guide overleaf* |  |
|  | If yes, duration? (days) |  |
| If yes, Incident or prevalent? |  |
| If yes, subtype? None/ Hyperactive/ Mixed/ Hypoactive |  |
| Length of stay (or time to death if inpatient death) |  |
| Inpatient mortality (N/Y) |  |
| Discharge destination? (New care home\*/ previous care home/ own home/ rehabilitation)\*Care home can be residential or nursing |  |
| If delirium diagnosis in notes, was this included on discharge documentation? (N/Y) |  |



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **a** | A disturbance in; i) Attention- reduced ability to direct, focus, sustain, and shift attention FROM: 20-1, MOYB (if done), comments including ”distractible”, “inattentive”, or similar  | **Yes** | No | ? |
|  |  OR ii) Awareness (reduced orientation to the environment) FROM: comments including “drowsy”, “agitated”, or similar |
| **b** | The disturbance; i) Develops over a short period of time (usually hours to a few days)  |  |  |  |
|  |  Ii) Represents a change from baseline attention & awareness  iii) tends to fluctuate in severity during the course of the day FROM: documentation as new problem by medical staff, or relative concern | **Yes** | No | ? |
| **c** | An additional disturbance in cognition (e.g. memory deficit, disorientation, language, visuospatial ability, or perception). FROM: AMTS, MOCA (if done), comments of “confusion”, or similar | **Yes** | No | ? |
| **d** | Exclusions- The disturbance in criteria A and C are; i) Better explained by another pre-existing, established, or evolving neurocognitive disorder, or ii) Occur in the context of a severely reduced level of arousal such as coma. FROM: History suggestive of progressive condition on admission OR severely obtunded patient e.g. in the context of Type 2 respiratory failure requiring ICU admission | Yes | **No** | ? |
| **e** | There is evidence from the history, physical examination or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal, or exposure to a toxin, or is due to multiple aetiologies. FROM: Acute illness/precipitant of any description (should be yes for all patients) | **Yes** | No |  |
|  |  |
|  | **Probable Delirium Diagnosis – all items a,b,c and e ‘yes’, plus d ‘no’** | **Yes** | **No** |  |
|  | Possible delirium diagnosis – if any ‘?’ or e ‘no’ | Yes | No |  |