Appendix A: Scope

1 Guideline title

Delirium: diagnosis, prevention and management of delirium.

1.1 Short title

Delirium.

2 Background

a) The National Institute for Health and Clinical Excellence ('NICE' or 'the Institute') has commissioned the National Collaborating Centre for Nursing and Supportive Care to develop a clinical guideline on the diagnosis, prevention and management of delirium for use in the NHS in England and Wales. This follows referral of the topic by the Department of Health (see section 6 of this document). The guideline will provide recommendations for good practice that are based on the best available evidence of clinical and cost effectiveness.

b) The Institute's clinical guidelines support the implementation of National Service Frameworks (NSFs) in those aspects of care where a Framework has been published. The statements in each NSF reflect the evidence that was used at the time the Framework was prepared. The clinical guidelines and technology appraisals published by the Institute after an NSF has been issued have the effect of updating the Framework.

c) NICE clinical guidelines support the role of healthcare professionals in providing care in partnership with patients, taking account of their individual needs and preferences, and ensuring that patients (and their carers and families, if appropriate) can make informed decisions about their care and treatment.

3 Clinical need for the guideline

a) Delirium, sometimes called 'acute confusional state' is characterised by a disturbance of consciousness and a change in cognition that develops over a short period of time.

b) Although the clinical presentation of delirium differs considerably from patient to patient, there are several characteristic features that help make the diagnosis. The standard criteria for delirium, are described in the 'Diagnostic and Statistical Manual of Mental Disorders' [DSM IV] (1994):

- disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.
- a change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a pre-existing, established, or evolving dementia.
- the disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.
- there is evidence from the history, physical examination, and laboratory findings that: (1) the disturbance is caused by the direct physiological consequences of a general medical condition, (2) the symptoms in criteria (a) and (b) developed during substance intoxication[1], or during or shortly after, a withdrawal syndrome, or (3) the delirium has more than one aetiology".

c) Features of delirium are recent onset of fluctuating awareness, impairment of memory and attention, and disorganised thinking. Additional features may include hallucinations and disturbance of sleep-wake cycle. There are three clinical subtypes of delirium: hyperactive (characterised by hallucinations, delusions, agitation, and disorientation), hypoactive (sleepy state, uninterested in activities of living, often unrecognised or labelled as dementia) or mixed (patients can move between the two subtypes). Delirium may be present when a person is admitted to hospital (prevalent delirium) or develop during an admission (incident delirium).

d) The prevalence of delirium in hospitalised medically ill patients ranges from 10 to 31%. Most delirium occurs in the first 7 to10 days of admission or within days of surgery. Up to 50% of postoperative patients develop delirium, with patients at increased risk if they have had cardiac surgery, hip surgery or transplantation. Delirium is also commonly reported to occur in nursing homes, but is uncommon in community populations.

e) There is often difficulty in distinguishing whether a patient has delirium without dementia, has dementia alone, or has delirium with pre-existing dementia. Delirium, which has acute onset, is potentially preventable and treatable compared with dementia, which is ongoing. The severity of delirium symptoms fluctuates over a 24-hour period; this does not occur in dementia (with the exception of vascular dementia, Lewy body and Parkinson's disease dementia). Duration of symptoms of delirium has been reported to range from less than 1 week to more than 2 months.

[1] Refer to 4.1.2 c.

f) The causes of delirium can include a general medical condition and drugs (including psychoactive, opioids or anticholinergic types) and surgery. Typically, delirium occurs in patients who have one or more risk factors, and who then experience a precipitating factor. Some groups are more at risk, for example, people with dementia, people with a severe acute illness and older people (older than 65 years). Precipitating factors include acute illness (for example, urinary infection, lower respiratory tract infection), unrelieved pain, sleep deprivation and environmental factors. In a patient with several risk factors, a small precipitant (such as a change in medication) can trigger delirium.

g) Diagnosis of delirium may be made by examining changes in cognitive function. In addition to quick assessment methods, established instruments include the confusion assessment method, used to detect delirium, and the mini-mental state examination, used to monitor the development and resolution of delirium.

h) There is a significant burden associated with this condition. Consequences of delirium may include increased length of stay in hospital or in ICU, poor functional and cognitive recovery after hospital admission, earlier onset or progression of dementia, increased hospital acquired complications (nosocomial infection, falls, pressure sores, and incontinence), new admission to long-term care and death.

i) There is a need for guidance to improve methods of appropriate identification, diagnosis, prevention and management of delirium. Failure to diagnose delirium, or misdiagnosis (mainly as dementia), can lead to inappropriate treatment being given. Delirium is often preventable and improvements in care practices and other treatments are needed. The improved management of delirium has the potential to generate cost savings.

4 The guideline

a) The guideline development process is described in detail in two publications that are available from the NICE website (see 'Further information'). 'The guideline development process: an overview for stakeholders, the public and the NHS' describes how organisations can become involved in the development of a guideline. 'The guidelines manual' provides advice on the technical aspects of guideline development.

b) This document is the scope. It defines exactly what this guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health (see section 6 of this document).

c) The areas that will be addressed by the guideline are described in the following sections.

4.1 Population

4.1.1 Groups that will be covered

a) Adult patients (18 years and older) in a hospital setting

b) Adults (18 years and older) in long-term residential care.

4.1.2 Groups that will not be covered

a) Children and young people (younger than 18 years).

b) People receiving end-of-life care.

c) People with intoxication and/or withdrawing from drugs or alcohol, and people with delirium associated with these states.

4.2 Healthcare setting

a) The guideline will be relevant to NHS staff responsible for patients in hospital (including critical care) and long term residential care settings (including primary care health care professionals).

4.3 Clinical management

a) Assessment of risk factors and consideration of precipitants to identify people at high risk of developing delirium.

b) Diagnosis of delirium in acute, critical and long term care. This will take into consideration people presenting with learning disability, linguistic or communication problems.

c) Pharmacological and non pharmacological interventions to reduce the risk of delirium and its consequences.

d) Pharmacological and non pharmacological interventions for people with delirium to reduce the severity and duration and to prevent deterioration and major consequences of delirium including dementia.

e) Guideline recommendations will normally fall within licensed indications; Use outside a licensed indication may be recommended, including those licensed for other conditions, if clearly supported by evidence. The guideline will assume that prescribers will use a drug's summary of product characteristics to inform their decisions for individual patients.

f) The Guideline Development Group will take reasonable steps to identify ineffective interventions and approaches to care. If robust and credible recommendations for re-positioning the intervention for optimal use, or changing the approach to care to make more efficient use of resources can be made, they will be clearly stated. If the resources released are substantial, consideration will be given to listing such recommendations in the 'Key priorities for implementation' section of the guideline.

4.4 Status

4.4.1 Scope

This is the final version of the scope. The consultation period is 16 April to 14 May 2008.

NICE has published the following related guidance which may be referred to in this guideline:

- Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital. NICE clinical guideline 50 (2007). Available from www.nice.org.uk/CG050.
- Infection Control: prevention of healthcare-associated infection in primary and community care NICE clinical guideline 2 (2003). Available from www.nice.org.uk/CG2.

- Nutrition Support in adults: Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition. NICE clinical guideline 32 (2006). Available from www.nice.org.uk/CG032.
- Dementia: supporting people with dementia and their carers in health and social care. NICE clinical guideline 42 (2006). Available from www.nice.org.uk/CG042.
- Drug Misuse: opioid detoxification. NICE clinical guideline 52 (2007). Available from www.nice.org.uk/CG0452.
- Alcohol Use Disorders. Two guidelines are currently in preparation (exact titles to be confirmed). One will cover acute alcohol withdrawal and the treatment of physiological diseases associated with alcohol. The other will cover the management of planned detoxification and the psychological treatment of dependency.
- Surgical Site Infection. NICE clinical guideline in development.
- Schizophrenia (update). NICE clinical guideline in development
- Alzheimer's disease - donepezil, galantamine, rivastigmine (review) and memantine for the treatment of Alzheimer's disease. NICE technology appraisal 111 (2007). Available from www.nice.org.uk/TA111.
- Schizophrenia - the clinical effectiveness and cost effectiveness of newer atypical antipsychotic drugs for schizophrenia. NICE technology appraisal 43 (2002). Available from www.nice.org.uk/TA43.

5 Further information

Information on the guideline development process is provided in:

- 'The guideline development process: an overview for stakeholders, the public and the NHS'.
- 'The guidelines manual'.

These booklets are available as PDF files from the NICE website (www.nice.org.uk/guidelinesmanual). Information on the progress of the guideline will also be available from the website.

6 Referral from the Department of Health

"Remit: To prepare a clinical guideline on the diagnosis, prevention and management of delirium"