National Institute for Health and Clinical Excellence

Delirium
Guideline Consultation Comments Table
11 November 2009 – 6 January 2010

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
1	SH	College of Occupational Therapists	9	FULL / NICE	General	General	There needs to be a bigger acknowledgement of the man power and falls risk that are attached to this condition.	Thank you for your comment. NICE is not mandated to advice on workforce implementations of clinical guidance. The falls risk has been assessed as far as is possible within the limited evidence base. Falls risk is an explicit adverse consequence of delirium that has been included in the health economics model.
2	SH	College of Occupational Therapists	10	FULL / NICE	General	General	Screening for predisposing risk factors for Delirium should be a routine check for all pre-assessment clinics for surgery. Occupational therapy services in pre-assessment clinics are well placed to complete cognitive assessments to facilitate and contribute to such a process.	Thank you for your comment. Advising risk factor screening in all surgical pre-assessment clinics is problematic because many surgical procedures are low risk for delirium (e.g. cataract surgery, angioplasty, and hernia repair). Although, the role of Occupational Therapist input in such clinics is laudable, this

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								aspect is a care provider issue
3	SH	College of Occupational Therapists	11	FULL / NICE	General	General	I am surprised the guidance does not include more around managing the environment for patients with delirium e.g. the use of tele-care falls, pressure monitors and pagers, the use of low beds such as the Protean and falls mats ,orientation boards, etc. management techniques such as allowing relatives open visiting, volunteer companion observer schemes which have been trailed. Issue of safe footwear etc	Thank you for your comment. These are important points but relate more directly to existing NICE falls prevention guidance rather than delirium.
4	SH	College of Occupational Therapists	2	NICE	1.3.3.1	11	There needs to be an understanding that reminiscence work needs to be carried out by a trained healthcare professional. Occupational Therapy is well placed to deliver this treatment.	Thank you for your comment. Section 1.3.3 states: "The tailored multicomponent intervention package should be delivered by a multidisciplinary team trained and competent in delirium prevention. The tailored package should address the clinical indicators in recommendations 1.3.3.1–1.3.3.9.".
5	SH	College of	4	NICE	1.3.3.6	13	Actions should as the RED tray	Thank you for your comment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Occupational Therapists					system and protected meal time need to be spelled out here. Furthermore The need for a clutter free environment especially the table that they are eating from and correct positioning to reach food is equally important. This affects all service areas including acute hospital care.	We agree that the clinical support systems to encourage adequate food intake in vulnerable people are very important. They are dealt with in the NICE Topic Guidance on nutrition that has been cross-referred to.
6	SH	College of Occupational Therapists	5	NICE	1.3.3.7	13	An essential statement on having an assessment of gait needs top be clearly pointed out. It is not acceptable to assume that persons with delirium have no gait difficulties.	Thank you for your comment. We have not assumed that people with delirium 'have no gait difficulties' – but these recommendations refer to actions that are desirable for people at risk of delirium.
7	SH	College of Occupational Therapists	6	NICE	1.3.3.7	13	Assessment of falls risk and appropriate management plans should be completed.	Thank you for your comment. These are important points but relate more directly to existing NICE falls prevention guidance rather than delirium.
8	SH	College of Occupational Therapists	8	NICE	1.3.3.9	13/general	Use of low lying beds needs to be considered and the falls risk with persons who have delirium and sleep disturbances.	Thank you for your comment. These are important points but relate more directly to existing NICE falls prevention guidance rather than delirium.
9	SH	College of Occupational	7	NICE	1.3.3.9	13	Sleep patterns are often disturbed through purposive walking	Thank you for your comment. Please refer to

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Therapists					(wandering) these need to be acknowledged and supervised where appropriate.	recommendations 1.3.3.1-1.3.3.10 (these relate to actions desirable to prevent the onset of delirium). Therefore supervision of wandering does not fall into this category.
10	SH	College of Occupational Therapists	15	FULL	3.2 ?	59	Preventative interventions recommend include: soft lighting – needs to be clearly defined as if too soft can create shadows which can be very disorientating – refer to Pocklington Trust work?? Also suggests cognitively stimulating activities and cites 'structured reminiscence' as an example – this infers that a member of staff will be available to provide which will often not be practicable within an acute hospital setting, so perhaps suggest provision of activities that people can access / use independently, eg newspapers, crosswords, suduko. In terms of more structured activity, what about Cognitive Stimulation Therapy as recommended within the NICE Dementia Clinical Guideline? It should also recommend that people are encouraged / enabled to perform daily living activities within	Thank you for your comments. We agree about the 'soft lighting' and have amended the wording of the recommendation (1.3.3.1) to say 'appropriate' lighting. The developers feel that adding examples such as 'sudoku' is too much detail for inclusion in this broad national guideline. However, we have changed the wording of the recommendation to 'reminiscence' rather than structured reminiscence. We did not look at evidence for cognitive stimulation therapy and therefore have not made a recommendation based on this.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							their own routines as much as possible (ie getting dressed in their own clothes etc).	
11	SH	College of Occupational Therapists	14	FULL	3.1.5	57	Again, no mention of environmental factors / use of cues as example of non pharmacological intervention?	Thank you for your comment. We have added wording to the recommendation (1.6.2) about maintaining the care environment as part of delirium treatment.
12	SH	College of Occupational Therapists	17	FULL	4.15.2	77, line 2	Should say physical and sensory impairments, not disabilities	Thank you for your comment. We agree and have amended the wording of the recommendation accordingly.
13	SH	College of Occupational Therapists	16	FULL	4.4	63	Mobility: also need to provide people with appropriate walking aids AND have them accessible at all times.	Thank you for your comment. We agree and have amended the wording of the recommendation accordingly.
14	SH	Alzheimers Society	4	FULL	4.5 Indicators: daily observations	63	In this bullet point, the guidance must again highlight the need to assess for both delirium and dementia – a healthcare professional who is trained to distinguish between the two (and understand the links between them) must be involved (please see comment 2 on this form for more information).	Thank you for your comment. We have amended recommendations 1.1.1 and 1.5.1 to include dementia. We have also added a new recommendation 1.6.6 to assess again for dementia, as part of the recommendations we have cross-referred to the NICE dementia guideline. These changes have also been incorporated into the algorithm / care pathway.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
15	SH	Alzheimers Society	5	FULL	4.6 Diagnosis (specialist clinical assessment)	64	As previously discussed in this response, sections 4.3 and 4.5 of the guidance must highlight that the assessment process should involve assessing for dementia or dementia superimposed on delirium. Section 4.6 must build on this and make reference to the need to formally diagnose whether dementia is present or not, and give appropriate actions to take following a positive diagnosis of dementia. In particular, if dementia is diagnosed, the professional should be referred to the NICE guideline on dementia and ensure that delirium prevention interventions are employed.	Thank you for your comment. We have amended recommendations 1.1.1 and 1.5.1 to include dementia. We have also added a new recommendation 1.6.6 to assess again for dementia, as part of the recommendations we have cross-referred to the NICE dementia guideline. These changes have also been incorporated into the algorithm / care pathway.
16	SH	Alzheimers Society	6	FULL	4.7 Treatment of delirium	64	• **The careful management of delirium in an intensive care setting, to reduce the risk of the subsequent development of dementia, must be incorporated.** • **Dementia is a costly and growing problem for the health and social care system**	Thank you for your comment. We have amended recommendations 1.1.1 and 1.5.1 to include dementia. We have also added a new recommendation 1.6.6 to assess again for dementia, as part of the recommendations we have cross-referred to the NICE dementia guideline. These

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							and is a government priority. It is therefore vital that this aspect of the dementia/delirium relationship is addressed. The increased risk of dementia is acknowledged in the introductory text (for example statement 4.1, page 60 of the full guideline) but is not given adequate attention in the body of the guideline (in particular, section 4.7, treatment of delirium). The careful management of delirium, to reduce the risk of the subsequent development of dementia, must be incorporated. This section must explicitly state that the treatment of delirium must include interventions to prevent the subsequent development of dementia. In particular, there is a very high risk of the development of dementia for patients in an intensive care setting and much work on intervention techniques has been done. It is important that this is shared in the guideline. Delirium in intensive care is	changes have also been incorporated into the algorithm / care pathway. Population representativeness is always a bit subjective but whilst exclusion of people with dementia in long term care would certainly make the population unrepresentative, exclusion of people with dementia in, say ICU, would not necessarily make the population unrepresentative owing to the fact that the expected proportion of people with dementia in ICU would be likely to make up a significantly lower proportion of the casemix (whereas in long-term care about 2/3 of the 'residents' usually have dementia)

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							associated with deterioration in cognitive function - termed ITU accelerated dementia. The Alzheimer's Society believes that this is a particularly important area for investment and has funded a project to promote the screening for, and management of, delirium in intensive care. Dr Valerie Page, Consultant in Critical Care at Watford General Hospital, led the project. In the US there are protocols for managing delirium in intensive care, which mitigate the risk of developing dementia. The purpose of the Alzheimer's Society funded project was to collaborate with researchers from the US to adapt these protocols so that they are suitable for the UK NHS environment, and practice and embed them through workshops. This includes working with the ITUs in Hertfordshire and Bedfordshire to assist them in implementing the screening test. It is vital that UK clinicians have an understanding of the risk of	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							dementia resulting from delirium in intensive care and are able to implement protocols to mitigate this risk. The guideline must therefore incorporate this.	
17	SH	Alzheimers Society	7	FULL	4.8 Information giving and support	65	It is important that this information explicitly discusses the link between delirium and dementia. It is very helpful if families can recognise and report delirium in people with dementia.	Thank you for your comment. We have amended recommendations 1.1.1 and 1.5.1 to include dementia. We have also added a new recommendation 1.6.6 to assess again for dementia, as part of the recommendations we have cross-referred to the NICE dementia guideline. These changes have also been incorporated into the algorithm / care pathway.
18	SH	College of Occupational Therapists	18	FULL	6.2.1.2	93, line 10	Suggests that sensory overload is a risk factor, I would suggest likewise for sensory deprivation.	Thank you for your comment. The non pharmacological risk factor review examined the evidence for sensory deprivation as a risk factor for delirium and not sensory deprivation. Therefore we cannot make a recommendation on sensory deprivation as a risk factor.
19	SH	St Helens and Knowsley NHS Trust	17	Algorithm	General	General	The algorithm refers to hospital and long-term care equally however a	Thank you for your comment. We agree there are particular

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							number of the recommendations don't really apply to long-term care. In the long term care setting use of the CAM score and prescription of pharmacological treatment would require increased input from, and investment in, primary care or domiciliary geriatric/psychiatric services and there is no evidence for the clinical or cost-effectiveness of this approach.	issues relating to the diagnosis and management of delivery in long-term care. However patients require optimum care in both settings and our recommendations apply equally. How they are implemented locally is an issue for local providers.
20	SH	Intensive Care Society	9	Appendix	H	33	Suggestions for further areas of research completely exclude the intensive care setting. This is a rich source however of current and future research and an extremely important area for management of delirium, with many unanswered questions: eg are non-pharmacological interventions effective in this population? What is the role of sedative agents used in ICU on the incidence of delirium? Is there a role for ICU follow up clinics in the prevention of adverse sequelae of delirium? etc.	Thank you for your comment. We appreciate that the Intensive Care Society will be disappointed that there is not a specific research recommendation directly relevant to their population group. The final list of the research recommendations were arrived at through a system of consensus voting by the GDG. In developing this guideline, the GDG became aware of the substantial research agenda in relation to ICUs prevention and treatment of delirium and would be delighted to see this funded in the future.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
30	SH	Welsh Assembly Government	5	Delirium algorithm "pharmacological treatment"	(1.3.1) (1.6.4)	1	In view of all of the concerns detailed above I would like to suggest something which might assist the Clinician. The Algorithm appears to be designed primarily for a working age adult who develops delirium following sepsis or trauma in CCU and thus the "simplistic" alternative pharmacological treatment alternatives are suggested of either olanzapine or haloperidol. In fact this is a relatively rare scenario for delirium in clinical practice where it is usually seen in an individual with dementia or in an elderly frail individual with a different differential diagnosis of depression and/or behavioural symptoms secondary to the dementia and a multiplicity of physical health problems which might include parkinson's disease or stroke disease which would influence one's choice for the psychotropic drug used. I have thus enclosed an Appendix which is entitled "Algorithm for pharmacological treatment of delirium for those with an underlying dementia and/or are over 65 years old" . This algorithm could be	Thank you for your comment. We have now amended the recommendation on use of pharmacological treatment and added an additional recommendation to cover Parkinson's Disease and Lewy body dementia (recommendation 1.6.5).

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							inserted as an additional step advising the Clinician to consult this Algorithm prior to starting any psychotropic drugs in this population.(see enclosed)	
33	PR	NETSCC, HTA Referee 1	1	Full			**1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** No comments	Thank you.
34	PR	NETSCC, HTA Referee 1	29	Full	Passim		**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** I have included these above under validity Multivariate is used where multivariable is meant. Multivariate means multiple variables on the left hand side. I realize I am fighting a losing battle on this one.	Thank you for your comment. We have used the terminology as reported in the papers.
35	PR	NETSCC, HTA Referee 1	30	Full			**3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the**	Thank you for your comment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							important aspects of the evidence reflected? No comments	
36	PR	NETSCC, HTA Referee 1	31	Full			**3.2 Are any important limitations of the evidence clearly described and discussed?** No comments	Thank you for your comment.
37	PR	NETSCC, HTA Referee 1	32	Full	Passim		**4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** The graphics have been inserted in different ways and so look different for no apparent reason. I think getting the colours uniform would be helpful as otherwise the reader starts to wonder whether some important information is being coded thereby.	Thank you for your comment, we have amended the guideline document accordingly, to ensure the graphics are uniform throughout.
38	PR	NETSCC, HTA Referee 1	33	Full			**4.2 Please comment on whether the research recommendations, if included, are clear and justified** Based on the rest of the report one could justifiably call for more, better research on almost any aspect here. The proposals do seem justified	Thank you for your comment.
39	PR	NETSCC, HTA	34	Full			**Section five – additional**	Thank you for your comment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Referee 1					**comments** No comments	
40	PR	NETSCC, HTA Referee 2	1	Full			**1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** No, the review is very comprehensive in scope and thorough in presentation. Some relatively minor areas following the detailed comments	Thank you for your comment.
41	PR	NETSCC, HTA Referee 2	2	Full			**2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).** The methods are vigorous and it is likely that the relevant literature (as defined by the scope) has been identified. The comments that follow are about the way these are handled and presented.	Thank you for your comment.
42	PR	NETSCC, HTA Referee 2	3	Full			Clarification of exclusions – polypharmacy and dementia are mentioned early in the report as	Thank you for your comment. We are unable to locate from this comment where in the full

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						39	exclusions but then pop up later, rightly The approach to these important "co-morbid" issues needs to be clearer. Similarly the issue of withdrawal of drugs/alcohol which on admission – in the presence of other factors may be of importance. Further clarification of delirium and end of life is also needed – for clinical recommendations prospectively it will not always be clear that delirium is part of an end of life stage as this might only be realised retrospectively	guideline we have excluded polypharmacy and dementia. We are glad you agree polypharmacy and dementia are important factors to be considered in the presence of delirium, as stated under section 2.4.2 entitled '*Appraisal of methodological quality of studies of prognostic factors'* in the Methodology chapter (chapter 2) and in section 7.4.2 under the heading '*Confounders take* Delirium due to withdrawal of drugs/alcohol and delirium at end of life are outside of the scope of this guideline.
43	PR	NETSCC, HTA Referee 2	10	Full	2.4.10 5.2.2	43 81	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** Justification of where and when fixed/random effects models are used is needed. Is the approach to sensitivity analysis consistent with the whole document? (Section 2.4.10 in particular, 5.2.2 consequences of exclusion of ICD 10).	Thank you for your comment. The methodology chapter (chapter 2) has been amended accordingly. We have been consistent in our approach to sensitivity analyses as these have been undertaken as outlined in the *Sensitivity analyses* section (within section 2.2 entitled *Clinical effectiveness review methods)*. With reference to section 5.2.2 (now within

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								section 5.3), the decision to exclude studies using ICD-10 for the assessment of delirium was made in order to be consistent with the findings from the diagnostic test accuracy review.
44	PR	NETSCC, HTA Referee 2	12	Full			No further comment in the time frame and area of expertise	Thank you for your comment.
45	PR	NETSCC, HTA Referee 2	13	Full			**3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?** The recommendations are sound, and the reservations about strength of evidence are clearly stated. The parallels and overlaps with dementia are not really that clear. The guidelines cannot be seen in isolation from guidelines in other areas. Although this is acknowledged early in the document the text should recognize this more as clinicians are dealing with people, many of whom will	Thank you for your comment. We have amended recommendations 1.1.1 and 1.5.1 to include dementia. We have also added a new recommendation 1.6.6 to assess again for dementia, as part of the recommendations we have cross-referred to the NICE dementia guideline. These changes have also been incorporated into the algorithm / care pathway.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							have dementia as well, not single conditions.	
46	PR	NETSCC, HTA Referee 2	14	Full			**3.2 Are any important limitations of the evidence clearly described and discussed?** Yes there is comprehensive discussion of limitations.	Thank you for your comment.
47	PR	NETSCC, HTA Referee 2	15	Full			**4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** On the whole the report is excellent and there is a clear trail from evidence to recommendations.	Thank you for your comment.
48	PR	NETSCC, HTA Referee 2	16	Full			It needs careful proof reading.	Thank you for your comment. The document has been proof-read again and there will be several further 'proof reads' before publication.
49	PR	NETSCC, HTA Referee 2	17	Full	Chapter 6		Tables and figures, particularly Section 6, do not work –have not printed and need careful checking to ensure they are the relevant findings. The laborious presentation of single findings where there are no	Thank you for your comment. We agree that the guideline needs editing and synthesising. We have done this where possible and where timelines will allow.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							more to present should be reconsidered. The text could contain these findings and a summary table across topics be provided instead with these findings but which makes clear these are from individual studies. The combined presentation could also make it clear which studies have provided gaps of findings. My opinion is that this would assist the synthetic sections more than cumbersome presentation of so many individual figures.	
50	PR	NETSCC, HTA Referee 2	18	Full			The lists of studies in Section 5 could be presented in a more digestible format in simple tables.	Thank you for your comment. The guideline has been amended accordingly.
51	PR	NETSCC, HTA Referee 2	19	Full			It is surprising in Section 5 that there is not a clearer statement on the need to see in papers what the health care setting is. Some health care provision is for a defined population, others are not. Although this is information which appears to be extracted there was not a recognition of this. Each paper should have some indication of how representative the reader felt the admissions would be of the type of	Thank you for your comment. The tables in appendix E provide further information on the representativeness of the studies. We have now inserted a sentence into section 5.6.4 of the guideline document outlining this.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							patient from the population.	
52	PR	NETSCC, HTA Referee 2	20	Full	Through-out	Throughout	The proof did not include forest plots that could be viewed. Magnifying the forest plots on the .pdf showed inverted and upside down images. Makes for difficult assessment of the document.	Thank you for your comment. There was a corruption in the pdf document. We have now amended this.
53	PR	NETSCC, HTA Referee 2	22	Full			Tables in Ch 7 and 8 are all in bold	Thank you for your comment, the guideline document has been amended accordingly.
54	PR	NETSCC, HTA Referee 2	35	Full			**4.2 Please comment on whether the research recommendations, if included, are clear and justified.** Yes, although it is a shame this opportunity to highlight the need for research into ward management (e.g. environment, structures to minimize ward moves in those at risk) was not included.	Thank you for your comment. We agree this is important, however there are many areas of research that need to be conducted, but we felt the ones we highlighted were most important.
55	PR	NETSCC, HTA Referee 2	38	Full			I do not like the use of occurrence in the text without qualification each time since the meaning is so different across studies and grouped studies. If terms are defined more clearly there is less likelihood of lumpin inappropriately or misinterpretation of the findings.	Thank you for your comment. We agree the term 'occurrence' is less than ideal but this is the terminology widely used in epidemiology papers in this topic area. We have defined the term 'occurrence rate' in section 5.2.1 to set the context for how this term would be used in relation to epidemiology of delirium.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								The tables in appendix E show what occurrence rate means with regards to each study, as the methods of delirium assessment are included in the tables (frequency of assessment). We have also now inserted a sentence into the guideline document (in the results section 5.6) to clarify the use of occurrence rate. The sentence explains that the meaning of occurrence varied between studies and refers to the tables in appendix E. We have already noted in the guideline document that for comparison with HES data we used total delirium and for calculating that, a specific definition was used (see paragraph titled 'total delirium' in section 5.2.1).
56	PR	NETSCC, HTA Referee 2	39	Full			It would be helpful to note in the discussion on area of terminology whether the infectious disorder terms had been considered or relapsing-remitting conditions (time spent with condition over time in	Thank you for your comment. This is an innovative proposal but we were constrained by the methods used in the studies included in the review.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							denominator population at risk). It is worth considering, if not done already, whether such measures might be more informative and helpful than the vague 'occurrence'.	
57	PR	NETSCC, HTA Referee 2	43	Full			Chapters 1-8 and 12 are those which we have reviewed with most attention.	Thank you for your comment.
58	SH	Alzheimers Society	1	Full	General	General	• **People with dementia are a core group within hospitals and long-term care facilities.** • **Dementia and delirium are closely linked - research suggests that two thirds of cases of delirium occur in people with dementia.** • **Therefore, in order to successfully identify, diagnose, prevent and manage delirium in hospitals and long-term care facilities overall, the relationship between dementia and delirium must be fully addressed.** • **Alzheimer's Society believes that the guideline is currently weak because it does not**	Thank you for your comment. We have amended recommendations 1.1.1 and 1.5.1 to include dementia. We have also added a new recommendation 1.6.6 to assess again for dementia, as part of the recommendations we have cross-referred to the NICE dementia guideline. These changes have also been incorporated into the algorithm / care pathway.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							adequately address this relationship. Dementia must be a core thread throughout the guideline if it is to meet its aims of diagnosing, preventing and managing delirium. • **Effectively meeting the guideline aims by integrating dementia throughout would also support the health and social care system to meet the challenge of dementia. Dementia is a health and social care priority, as identified by the National Dementia Strategy for England (2009) and initiatives such as the NICE quality standards in dementia, and it is vital to support this agenda through the guideline.** There are currently 700,000 people with dementia in the UK and this is forecast to increase to 940,110 by 2021 and 1,735,087 by 2051 (Alzheimer's Society, 2007). People with dementia are significant	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							users of health and social care services. Two thirds of care home residents have some form of dementia (Alzheimer's Society, 2007) and up to one quarter of hospital beds are occupied by people with dementia aged over 65 years at any one time (based on figures from Department of Health, 2001 and Holmes and House, 2000). Delirium in a person with dementia is very common (Fick et al., 2002). Research suggests that two thirds of cases of delirium occur in people with dementia (Cole, 2004) and this is likely to increase in the future (Fick et al., 2002). In particular: 1. Dementia is the most important risk factor for delirium (Lindesay, 2002). 2. Delirium superimposed on dementia leads to increased risk of long-term cognitive impairment and dementia (Cole, 2004), increased rates of hospitalisation within 30 days (Levkoff et al., 1992) and higher mortality rates	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							(Pisani et al, 2002). 3. Delirium superimposed on dementia is often unrecognised (National Audit Office, 2007) and can go untreated and unmanaged. Clinicians must be able to distinguish between the two. 4. Delirium is associated with the subsequent development of dementia. In particular, there is a significant chance of this happening in an intensive care setting. The draft guideline does not give dementia the prominence and attention it needs. Given the relationship between delirium and dementia it is essential that dementia is fully addressed in a NICE guideline that aims to effectively prevent and manage delirium. In addition, effectively meeting the guideline aims by integrating dementia throughout would also support the health and social care system to meet the challenge of dementia, which is a health and	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							social care priority. Numerous reports have found that dementia is a costly and growing problem for the health and social care system, for example the National Audit Office (2007) and the King's Fund (2008). Such evidence led to dementia becoming a health and social care priority and the National Dementia Strategy for England (Department of Health, 2009) was published in 2009. The Strategy sets out a five-year transformational plan under four themes: raising awareness and understanding, early diagnosis and support, living well with dementia (improving the quality of care in the acute setting and long term care) and making the change (such as developing the skills of the workforce). Following the launch of the Strategy, there has been an increasing focus on dementia. For example, NICE are developing dementia quality standards and the Royal College of Psychiatrists are running a national audit of dementia in general hospitals, beginning in	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							March 2010. This guideline should also be supporting the health and social care system to meet the challenges presented by dementia. It presents a valuable opportunity to identify, prevent and manage both delirium and dementia, and the relationship between them, which must be taken. The comments below discuss how the relationship between dementia and delirium can be more fully integrated into the guideline, particularly into the recommendations.	
59	SH	British Geriatrics Society & Royal College of Physicians	1	Full	General	General	The guidance is welcome if long. We presume that a briefer more accessible version will ultimately be produced. However, it is helpful to have access to the review process undertaken by the GDG. We appreciate that there is a general lack of good quality evidence, however it would be useful if, when produced, the guidelines weighted the recommendations given	Thank you for your comment. As per all NICE guidelines, 4 versions of the guideline will be produced. The **full guideline** (containing all the recommendations and the underlying evidence); the **NICE guideline** (presenting the recommendations in a format suited to implementation by health professionals and NHS

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							according to the strength of the evidence. The target population is clearly defined, although many will wish to extrapolate as the guidance given is surely likely to be as relevant to those receiving long-term care at home as in a care home.	bodies); the **quick reference guide** (presenting recommendations in a suitable format for health professionals); **understanding NICE guidance** (written using suitable language for people without specialist medical knowledge). NICE recommendations are phrased according to the standards set in the NICE Guidelines Manual, and no longer give a grading for strength of recommendations. However, the phrasing used is aimed at giving an indicator of the strength of recommendation. For example, a 'weaker' recommendation may use the words 'consider giving' rather than 'give' (which would indicate a 'strong' recommendation ie. based on strong evidence). The guideline also relates to people in long-term care and so extrapolation of the evidence is intended.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
60	SH	European Delirium Association	16	Full	General	General	I could not find any clear references to what should be done for older patients who have recovered from delirium. (1) Many of these patients will have undiagnosed dementia (50% undiagnosed in the UK in general). Delirium presents a quantitatively important opportunity to detect undiagnosed dementia. All older patients who have recovered from delirium should be considered at high risk of dementia and screened for this in an appropriate setting (GP, outpatient clinic, or even in hospital if the patient has recovered from the delirium. I think this is an important aspect of delirium management which is increasingly being recognised in clinical practice. (2) Patients who have recovered from delirium may be very stressed or upset by their experience: should there be a recommendation about the GP or other healthcare professional following this up?	Thank you for your comment. The Guideline Development Group discussed routine follow up for patients recovering from delirium (including the older person) and felt that there was insufficient evidence and experience for a specific recommendation in this area. It was considered that the most appropriate course of action would be to empower and encourage patients and carers to discuss residual issues with their health care professionals. This has been incorporated in the 'Information and support' recommendation (1.7.1), final bullet point.
61	SH	European Delirium Association	17	Full	General	General	I am not sure why persistent delirium is not covered by the guideline, because this is very important and the content overlaps	Thank you for your comment. We have amended the guideline to emphasise that people who do not fully recover from delirium

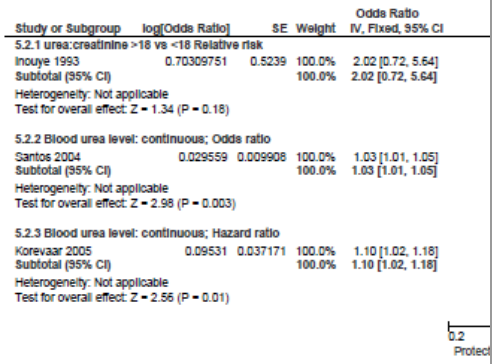
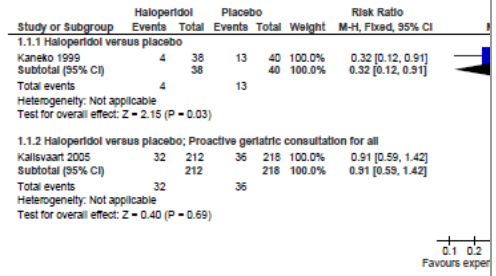
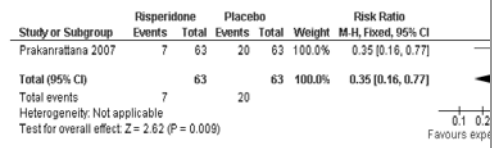
Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							well with general delirium content.	should be assessed for dementia. We have added a new recommendation 1.6.6 to assess again for dementia, as part of the recommendations we have cross-referred to the NICE dementia guideline. These changes have also been incorporated into the algorithm / care pathway.
62	SH	European Delirium Association	19	Full	general	general	Please be aware that commenting on a 450 page in its entirety document is difficult for most working clinicians and academics.	Thank you for your comment we appreciate the time and effort taken.
63	SH	European Delirium Association	20	Full	general	general	The document is clearly a major scholarly effort to collect, appraise and catalogue a vast amount of information, for which we should all be very grateful	Thank you for your comment.
64	SH	European Delirium Association	21	Full	general	general	My main criticism is that the guidance fails to convey the difficulty of delirium assessment in acute general hospital settings. Firstly, we need to stress to importance of underlying dementia, which makes diagnosis hard, and very reliant on a collateral history that can be difficult to obtain (not least as care home staff and relatives sometimes do not	Thank you for your comment. We have amended recommendations 1.1.1 and 1.5.1 to include dementia. We have also added a new recommendation 1.6.6 to emphasise that people who do not fully recover from delirium should be assessed for dementia and as part of the recommendations we have

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							recognise what they are seeing). Secondly, the type of dementia that predominates in general hospitals is vascular dementia. Distinguishing a step in the stepwise progression of VaD from delirium can be impossible (the same goes for DLB). Thirdly, a lot of delirium is very transient (about 40% resolves within 24h). A lot of the rest is quite persistent (30% at 3 months). Fourthly, delirium is not diagnosable in severe dementia. Finally (an aside) much 'depression' seen in general hospitals is delirium. The delirium guidance has to put greater emphasis on context. I would argue that you cannot separate delirium and dementia guidelines when aimed at acute general hospitals: the are joined at the hip.	cross-referred to the NICE dementia guideline. These changes have also been incorporated into the algorithm / care pathway. This reorientation of the guideline should result in a more thorough assessment for dementia that is consistent with the Dementia NICE guidance, thus distinguishing the dementia type (Alzheimer's, vascular etc) and considering the possibility of depression.
65	SH	Intensive Care Society	1	Full	General	General	It is heartening that the GDG have included studies relating to intensive care, as it is a vitally important yet under-recognised issue for intensivists, and was originally not going to be included in the guidance.	Thank you for your comment.
66	SH	Intensive Care Society	2	Full	General	General	One of the difficulties for intensive care practitioners is recognition of	Thank you for your comment. We will highlight this in the

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							hypoactive delirium. I think that the distinction between hypo- and hyper- active delirium should be highlighted further	introduction of the guideline and have now added wording to recommendations 1.2.1 and 1.6.3 regarding hypoactive delirium.
67	SH	Intensive Care Society	3	Full	General	General	Because of the variable quality of many of the studies it appears that the GDG clinical expertise is sometimes used in judging important interventions. This should be explicitly stated (or excluded) in the section describing the methods of evaluation.	Thank you for your comment. The evidence to recommendations sections of the evidence review explicitly states where GDG expertise was sought in light of limited evidence.
68	SH	Royal College of Psychiatrists	7	full	general	general	It is very thorough and shows scholarship; in general we think it is a good piece of work.	Thank you for your comment.
69	SH	St Helens and Knowsley NHS Trust	18	Full	General	General	The document does not sufficiently make clear that a greater proportion of patients have a hypoactive delirium that is missed on casual observations where the fluctuations can be subtle. It is only recognised on testing but has important implications for consent. There is no evidence for drug therapy in this group. By far the greatest proportion of delirium in critical care patients is hypoactive and that is why it is not recognised.	Thank you for your comment. We have now added wording to recommendations 1.2.1 and 1.6.3 to alert healthcare professionals that hypoactive delirium could be missed and have highlighted changes in behaviour that may be indicative of hypoactive delirium.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
70	SH	Tees Esk & Wear Valleys NHS Trust	1	Full			Page 364 onwards describe the trials on Pharmacological interventions but Page 55 – onwards on recommendations, the use of haloperidol and olanzepine is not very comprehensive and also state that they do not have marketing authorisation in the u.k, a statement which is not clear. I cannot, unless I have missed this, the management of delirium in acute hospital and the need to work collaboratively with the Older People Psychiatrist.	Thank you for your comment. We have now incorporated the evidence to recommendation section to follow on from the evidence review in order to make, what we hope, a more comprehensive and easily readable document. Where we have indicated drugs do not have a marketing authorisation in the UK, it is to indicate that haloperidol and olanzapine are not licensed for treatment of delirium We have, where possible, highlighted the need for a multidisciplinary team appropriate (or an appropriate team in long term care settings) in caring for people with delirium. However, the need to work collaboratively with Older People Psychiatrist which you have highlighted is a healthcare provider issue dictated by local workforce and expertise availabilities.
71	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	1	Full	General	General	This is a comprehensive and wide ranging review and in general is a good piece of work that will advance	Thank you for your comment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							care for patients in both the NHS and long term care organisations alike. All comments that follow should be considered against the backdrop that the UKCPA support this piece of work and recognise the significant effort that has been expended in producing it.	
72	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	18	Full	General	General	On numerous occasions, decisions have been drawn from "GDG Expertise". Whilst this is the role of the GDG, we note that on occasion similar grades of evidence have been included or excluded based on the expert opinion of a small group without further clarification. Using a hierarchical and systematic approach to evidence, expert opinion is the lowest form of evidence, and yet it is used to affirm the results of a clinical trial, or overturn it. For example: Maintaining good hydration is recommended (based on GDG expertise)	Thank you for your comment. When developing the recommendations we have, where available, used the best available evidence. The apparent confusion in the examples you cite is because although the quantitative results point in a particular direction, they need to be interpreted against methodological quality aspects of the studies.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							Figure 6.11: dehydration as a risk factor: incidence of delirium  Study or Subgroup log[Odds Ratio] SE Weight Odds Ratio IV, Fixed, 95% CI 5.2.1 urea:creatinine >18 vs <18 Relative risk Inouye 1993 0.70309751 0.5239 100.0% 2.02 [0.72, 5.64] Subtotal (95% CI) 100.0% 2.02 [0.72, 5.64] Heterogeneity: Not applicable Test for overall effect: Z = 1.34 (P = 0.18) 5.2.2 Blood urea level: continuous; Odds ratio Santos 2004 0.029559 0.009908 100.0% 1.03 [1.01, 1.05] Subtotal (95% CI) 100.0% 1.03 [1.01, 1.05] Heterogeneity: Not applicable Test for overall effect: Z = 2.98 (P = 0.003) 5.2.3 Blood urea level: continuous; Hazard ratio Korevaar 2005 0.09531 0.037171 100.0% 1.10 [1.02, 1.18] Subtotal (95% CI) 100.0% 1.10 [1.02, 1.18] Heterogeneity: Not applicable Test for overall effect: Z = 2.56 (P = 0.01) 0.2 Protect Whilst pharmacological prophylaxis is not recommended.  Haloperidol Placebo Risk Ratio Study or Subgroup Events Total Events Total Weight M-H, Fixed, 95% CI 1.1.1 Haloperidol versus placebo Kaneko 1999 4 38 13 40 100.0% 0.32 [0.12, 0.91] Subtotal (95% CI) 38 40 100.0% 0.32 [0.12, 0.91] Total events 4 13 Heterogeneity: Not applicable Test for overall effect: Z = 2.15 (P = 0.03) 1.1.2 Haloperidol versus placebo; Proactive geriatric consultation for all Kallsvaart 2005 32 212 36 218 100.0% 0.91 [0.59, 1.42] Subtotal (95% CI) 212 218 100.0% 0.91 [0.59, 1.42] Total events 32 36 Heterogeneity: Not applicable Test for overall effect: Z = 0.40 (P = 0.69) 0.1 0.2 Favours exper Figure 10.1: number of patients with delirium  Risperidone Placebo Risk Ratio Study or Subgroup Events Total Events Total Weight M-H, Fixed, 95% CI Prakanrattana 2007 7 63 20 63 100.0% 0.35 [0.16, 0.77] Total (95% CI) 63 63 100.0% 0.35 [0.16, 0.77] Total events 7 20 Heterogeneity: Not applicable Test for overall effect: Z = 2.62 (P = 0.009) 0.1 0.2 Favours expe	

PLEASE NOTE: Comments received in the course of consultations carried out by the Institute are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that the Institute has received, and are not endorsed by the Institute, its officers or advisory committees.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							The UKCPA generally support the above decisions, however a few lines of explanation would increase the transparency of the decision making process and make the guideline less vulnerable to charges of bias.	
73	SH	West Hertfordshire Hospitals NHS Trust	1	Full	General	General	The term mental status is not used and I believe this is a singularly appropriate way to describe brain function with regard to an acute deterioration. Cognitive status is more associated with dementia-type conditions. In this way the very common delirium on top of dementia can be presented as different to dementia i.e. a change in mental status on top of cognitive impairment. Clinicians also could then view "mental status" as a vital sign, which is an important goal.	Thank you for your comment. The term cognitive impairment was preferred by the Guideline Development Group because: a) There is a relevant research evidence base in relation to delirium for this term. b) It can be quantified and measured in routine care. c) It underpins the inter-relationship between delirium and dementia.
79	PR	NETSCC, HTA Referee 2	21	Full		3	Lines 19-21 appear to be inserted in error	Thank you for your comment, the guideline document has been amended accordingly.
81	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	2	Full	Abbreviations	10	The abbreviation "ACS" is taken by another common medical condition and should not be used	Thank you for your comment. We have removed the abbreviation 'ACS' in order to remove any confusion.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
82	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	3	Full	Glossary	22	The stated definition for "Prevalent delirium" could include patients with dementia who are not actually delirious because it "cannot be determined when the delirium began"	Thank you for your comment. It is generally possible to provide a timeline for delirium onset by careful informant history taking, even in patients with dementia. This is why the GDG have emphasised the 'Indicators of delirium' (recommendation 1.2.1 and 1.4.1) as a useful, non-specialised method to improve delirium recognition.
84	SH	European Delirium Association	10	Full	TABLE	59	1. Constipation repeated 2. Hypoxia not mentioned 3. (Re 1.3.3.7): falls risk should be mentioned; many patients are unsafe to walk around and so this caveat should be given. 4. Some grouping of similar types of factors would make this table more coherent.	Thank you for your comment. We have removed the repeated 'constipation' and added a new recommendation about hypoxia (1.3.3.3). For recommendation on limited mobility/immobility (1.3.3.7 consultation version, new version 1.3.3.5) we did not feel the need to add about risk of falls, this is covered in the NICE falls guideline which we have added to the list of related NICE guidance at the beginning of the guideline document. We did not wish to further group

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								the factors because we felt it would make it more complicated for the user to read and implement the actions.
85	PR	NETSCC, HTA Referee 2	36	Full		67	**5 Additional comments** Illness severity clarification required.	Thank you for your comment. We have clarified this section and the guideline document has been amended accordingly.
86	PR	NETSCC, HTA Referee 2	11	Full		134	Make the use of OR consistent through text. I do not think beta co-efficients and P values are needed if OR with 95% CI have been given (e.g. Page 134).	Thank you for your comment. We have reported beta-coefficients and/or p values if these were the only values reported in the studies. Although these values may have been subsequently calculated to an odds ratio or to calculate confidence intervals, for clarity we have chosen to include the original values as reported in the studies.
87	PR	NETSCC, HTA Referee 2	32	Full		204	Wrong forest plot given for Figure 8.1 (shows mortality, rather than dementia)	Thank you for your comment. The forest plot has been amended.
88	PR	NETSCC, HTA Referee 1	26	Full		320 et seq	Why not synthesise sensitivity and specificity here? There are methods available for doing this. Note that they are usually negatively correlated as some of the figures here suggest.	Thank you for your comment. We were aware that there are methods to synthesise sensitivity and specificity and also that these should not be used lightly. In view of the variation in quality as discussed in the text and

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								small number of studies we decided not to synthesise measures of test accuracy.
89	SH	European Delirium Association	3	Full	1.2	27	Re: "There are three clinical subtypes ..." (line 36). Some patients with delirium show no motor changes. That is, not all delirium can be classified under this three-category model. It should be stated that some patients with delirium do not show changes in arousal.	Thank you for your comment. We have endeavoured to produce a guideline rather than a medical text to improve delirium management. We have therefore kept the descriptions of the clinical sub-types in keeping with traditional terminology to avoid confusion and guideline disengagement.
90	SH	European Delirium Association	4	Full	1.2	28	Line 5: Failure to diagnose delirium can also lead to medical emergencies being missed, ie. appropriate assessment and treatment can be omitted. This is very important and should stated alongside the equally important point about giving inappropriate treatment.	Thank you for your comment, we agree and have modified the text accordingly.
91	SH	Royal College of Psychiatrists	5	Full	1.6	28-29	The complete exclusion of alcohol and drug intoxications and withdrawal states from such an otherwise comprehensive work seems to be a serious omission, as these are very common.	Thank you for your comment. Alcohol and drug intoxications are outside the scope of this guideline.
92	SH	College of Occupational	12	Full	1.6	28	Excludes those receiving 'end-of-life' care – how this is defined,	Thank you for your comment. We have taken 'end of life care'

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Therapists					especially within long-term residential care settings?	to describe people in their last few days of their life.
93	SH	Royal College of Nursing	3	full	1.6	28	The exclusion of patients with alcohol/drug withdrawal should be reconsidered as there are a number of patients in acute settings with ACS. At some point in their stay this causes significant problems for not only the patient but also other patients, their families and the health care staff.	Thank you for your comment. Alcohol and drug withdrawal are outside the scope of this guideline.
94	SH	Royal College of Speech and Language Therapists	1	Full	1.7		The study group does not appear to include any AHPs. This is very disappointing and would appear inappropriate given the very welcome emphasis on rehabilitation for adults presenting with delirium.	Thank you for your comment. A GDG is never designed to represent the interest of any specific interest group, nor could all be represented. The GDG members do not represent a professional body. The developers are mindful of the need for ensuring that a broad range of experience and knowledge is represented on the group. This has to be balanced with the need to ensure that the GDG is a workable size and as such enables individuals to contribute effectively. When convening the guideline development group the developer's have followed the

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								principles outlined in the NICE Guidelines Manual.
95	SH	Royal College of Speech and Language Therapists	2	Full	2		While the evidence gathering appears very rigorous in it's adherence to Cochrane data review guidance, there is no attempt to scope the grey literature. This is unfortunate particularly in relation to long term care settings where there is a dearth of literature and indeed research, but where indications from the grey literature, at least to guide setting the research agenda, may be useful.	Thank you for your comment. The search strategy for clinical and health economic evidence has been conduced systematically in accordance with the NICE Guidelines Manual (NICE 2009).
96	SH	British Geriatrics Society & Royal College of Physicians	2	Full	1.6.4	8	We are surprised that haloperidol and olanzapine are recommended when they do not have a license for treating delirium and that risperidone, which does have a license, is not recommended.	Thank you for your comment. Evidence relating to risperidone was not included as the studies were mainly of poor or inappropriate study design. The GDG made the recommendation on haloperidol and olanzapine based on the available evidence and a footnote was included in the recommendation (1.6.4) stating that these drugs do not have UK marketing authorisation for this indication. This footnote was agreed by the MHRA.
97	SH	British Pain Society	1	Full	1.3.3.4	62	The British Pain Society welcome the inclusion of the assessment and	Thank you for your comment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							treatment of pain as an intervention to prevent Delirium	
98	SH	British Pain Society	2	Full	1.3.3.4	62	We welcome the inclusion of an action to identify pain, but would like to see the guidelines go further in asking practitioners not just to look for signs of pain but, in addition, to carry out an appropriate pain assessment using a recognised pain assessment tool appropriate to the individual patient. For older people and those with cognitive impairment The assessment of pain in older people: National Guidelines (2007) A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS. (available from http://www.britishpainsociety.org/pub_professional.htm#assessmentpop) may be helpful.	Thank you for your comment. The optimal management of delirium encompasses several associated and substantial clinical topics. The developers feel that this is too much detail for inclusion in this broad national guideline
99	SH	British Pain Society	3	Full	1.3.3.4	62	We would suggest that the statement 'If people have been prescribed pain relief, ensure they receive it.' Is open to misinterpretation as it omits to define any action in the absence of an appropriate prescription. Could we suggest 'Appropriate pain management should be instigated in	Thank you, we agree with insertion of this new text into the recommendation, and the guideline documents have been amended accordingly.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							any person in whom pain is identified or suspected.'	
100	SH	Derbyshire Mental Health Services NHS Trust	1	Full	1.3.3.4	62	Is there evidence of an appropriate assessment tool – can NICE recommend one?	Thank you for your comment. Recommending an appropriate pain assessment tool is outside the remit of this guideline.
101	SH	Royal College of Nursing	6	full	2.11	53	Should the NICE guidance on falls not be included in this list?	Thank you for your comment. We have added NICE guidance on falls to this list.
102	PR	NETSCC, HTA Referee 1	2	Full	2.3.1	31	**2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).** English language restriction is mentioned here but cf page 33 where it is lifted for some studies. Some justification needs to be made of why these decisions were taken and the language of studies included should be reported.	Thank you for your comment. Thank you for highlighting this inconsistency regarding inclusion of foreign language studies. This has been amended in the full guideline document.
103	SH	St Helens and Knowsley NHS Trust	19	Full	1.3.3.8	63	Sensory impairment is mentioned briefly in interventions. The greatest evidence for psychological problems is associated with hearing. However, noise disturbance is in the sleeping section. Daytime noise (eg	Thank you for your comment. We agree that intrusive day time noise should be minimised. However, recommendations were not made to this effect because:

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							white noise from oxygen flow humidifiers) is probably a more important impairment to hearing and sound prevention measures as building, design and working practices alter stress levels during the day. While noise can disrupt sleep and in some settings may be important for many acutely ill patients, there are many other factors that have been shown to be more significant (eg in ICU it is ventilatory related dysynchrony with the patient or drugs). Patients can close their eyes but not their ears. Similarly, hearing is the only realistic mode of information delivery to patients where the correct interpretation of the spoken word is central.	a) The relevant evidence base refers to only optimising sleep. b) Recommending a quite calm noise free environment is maybe too aspirational in context on acute hospital ward. We agree it is more achievable in the home environment of the residential care setting.
104	PR	NETSCC, HTA Referee 1	4	Full	2.4.10	43	Random effects methods are not a panacea for dealing with heterogeneity and basically ignore it rather than trying to explain it. Surely some mention and indeed use should be made of meta regression?	Thank you for your comment. We have added a reference to meta-regression methods in this section.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
110	PR	NETSCC, HTA Referee 1	3	Full	2.4.1.1	33	Non English RCTs mentioned here only (cf page 31)	Thank you for your comment. The full guideline document has been amended accordingly to ensure the literature search section and the methods sections are consistent on this issue.
111	SH	Royal College of Nursing	4	full	2.4.1.2	34	The exclusion of patients at end of life is a concern as this patient group although at the end of their life can still develop physiological problems leading to delirium that need to be prevented and managed to ensue that the patient has a comfortable dignified death.	Thank you for your comment. End of life care is outside the scope of this guideline. We were unfortunately unable to cover all areas and focused upon those that stakeholders and GDG members initially suggested as critical areas to address.
114	PR	NETSCC, HTA Referee 1	5	Full	2.4.13.5	48	Two types of reporting bias are mentioned but only one described. The term has become more closely associated with outcome reporting bias and other sorts of selective reporting from within studies rather than publication bias which refers to the whole study (and which might more generally be referred to as small study bias).	Thank you for your comment. The guideline has been amended accordingly.
117	PR	NETSCC, HTA Referee 2	4	Full	2.4.4.3	38	The use of DSM systems is explained carefully but the ICD is not introduced properly and this needs to be addressed.	Thank you for your comment. The two diagnostic systems are more fully described in appendix I. We have added a sentence into the section that you mention

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								which refers to the appendix.
118	SH	European Delirium Association	5	Full	3.1	55	This could be more emphatic: "Be aware that people in hospital or long-term care ARE at HIGH risk of delirium, which can have serious consequences (such as increased risk of dementia and/or death) and, for OLDER people in hospital, GREATLY INCREASES their risk of new admission to long-term care."	Thank you for your comment. Not all people are at high risk; some will have low risk by virtue of none of the risk factors listed in recommendation 3.1.1.
119	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	4	Full	3.1	55	"Awareness of delirium and its consequences" needs greater prominence (i.e. be section 3.1.1)	Thank you for your comment, Where possible the words 'Think Delirium' have been added and these have been put in capital letters and centralised to increase prominence.
120	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	6	Full	3.1	58	The algorithm needs a lot more work. Delirious patients need to be screened for the "right" sort of delirium that is covered by the scope: need a step to screen out withdrawal, intoxication or end of life delirium. Almost all comments received suggest that healthcare workers who have read this draft guideline did not know that withdrawal / intoxication is excluded,	Thank you for your comment. For clarity we have added wording into the introduction of both the FULL and NICE versions of the guideline as to which groups the guideline covers and which it excludes (as has been detailed in the guideline scope, Appendix A).

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							so this needs to be made absolutely crystal clear where ever possible.	
121	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	7	Full	3.1	58	In the Risk assessment No->Diagnostic indicators No -> End box: these patients never had delirium and thus "or delirium treated successfully" can be removed	Thank you for your comment, we have amended the algorithm accordingly.
122	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	8	Full	3.1	58	Delirium diagnosed (DSM IV/CAM) should also have CAM-ICU and ICDSC in the box.	Thank you for your comment. The algorithm has been amended to include CAM-ICU. However, as we have not reviewed the evidence for ICDSC we will not be amending the algorithm to include this test.
123	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	9	Full	3.1	58	"Is delirium causing distress?" to whom? The patient themselves (the answer is almost always yes if so), the healthcare team? The patient's relatives? This needs significant clarification (Cross reference with Order Number 21)	Thank you for your comment, we have amended the algorithm and it is explicit in the recommendation that the 'distress' is to themselves or at risk to themselves or others (recommendation 1.6.4)
124	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	10	Full	3.1	58	"Persistent delirium" is defined in the guidance as "delirium in patients who met the full criteria for delirium at the discharge interview, or who had full delirium during the hospitalisation and partial symptoms at discharge" (page 36, lines 30-32).	Thank you for your comment. We agree and have added a new recommendation to cover this (1.6.5.).

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							Persistent delirium is within the remit "*To prepare a clinical guideline on the diagnosis, prevention and management of delirium*" as it is a "subpopulation of patients with delirium" (page 125, lines 21-23) and is not specifically excluded in the scope. It should therefore be covered by this guidance or specifically excluded by changing the scope.	
125	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	11	Full	3.1	58	According to the algorithm, delirium that has not yet been treated with pharmacological therapy but does not "cause distress" is persistent delirium. This does not fit with the cited definition for persistent delirium.	Thank you for your comment, we have amended the algorithm accordingly.
126	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	12	Full	3.1	58	According to the algorithm, delirium that does not respond to 7 days of pharmacological therapy is persistent delirium. This does not fit with the cited definition for persistent delirium and is still within the scope of the document. Practical guidance on what to do with patients who do not respond after 7 days of pharmacological therapy is needed here, such as referral to a liaison psychiatrist or similar professional	Thank you for your comment, we have amended the algorithm accordingly.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							with experience of dealing with complex delirium cases.	
127	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	13	Full	3.1	59	Sleep disturbance: Would add a bullet point "Perform medical/nursing procedures during waking hours if they would interfere with sleep". May not be absolutely evidence based but is pragmatic.	Thank you for your comment, we have amended the recommendation accordingly to make it more explicit.
130	SH	West Hertfordshire Hospitals NHS Trust	15	Full	3.2	58	This algorithm is overly complicated more so at the top. The insert Treatment arm is not needed. The "identify and treat cause" needs to be emphasised.	Thank you for your comment, we have amended the algorithm accordingly.
131	SH	West Hertfordshire Hospitals NHS Trust	16	Full	3.2	58	The patients suffering hypoactive delirium or mixed with minimal agitation may indeed be suffering distress, we cannot tell. Bruera (Cancer 2009) study showed that of 72 patients who remembered a delirious episode 81% remembered it as distressing – regardless of motoric subtype. Breitbart similarly is shortly to publish findings that 50% of patients with hypoactive delirium have hallucinations. I appreciate there is little evidence other than case series and reports to back the use of antipsychotics in delirium. Within delirium experts as is known there are 2 schools of	We understand the reasonable arguments presented here, but were reluctant to recommend a widespread increase in the use psychotropic medications on the basis of limited evidence base. For this reason, we prioritised a research recommendation to address this. We have modified the algorithm to reconsider the underlying causes for people with non-resolving delirium, if they are not agitated and still delirious after

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							thought, one that they treat the symptoms only and one that they rebalance the neurotransmitters neither with the research to back them up. I am concerned, however, that by saying if the patient is not agitated and they are still delirious after non-pharmacological interventions they are to be considered as having persistent delirium. At the very least the arrow should be redirected to finding and addressing any precipitating cause. There may be something the clinician has not thought important enough a trigger that they can change and improve the patients mental status. This has been my experience – uncovering a previously unsuspected infection after thinking a patient was depressed. My understanding is that once a patient has delirious symptoms for 3 months then the chance of recovery is very slim. Until that 3 months is up then I believe it is incumbent on us to do all we can – that may require a short course of antipsychotics.	non-pharmacological interventions.
132	SH	European Delirium	22	Full	3.2	59	'Range of motion exercises' is an	Thank you for your comment,

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Association					American term not used by British physiotherapists. In fact, I am not sure what it means. It conjures up a vision of someone waggling arms or legs about in an inaccurate lay presumption about what physiotherapy entails. Please check this wording with a UK physiotherapist.	'range of motion' is also a term commonly used within the UK NHS.
134	SH	European Delirium Association	6	Full	3.1.2	56	The term 'sudden' is too specific: perhaps say 'rapid (over hours, days, or weeks)'	Thank you for your comment. We agree, and have replaced 'sudden' with 'recent' which we feel is a more appropriate term (in clinical practice this is what we usually ask people). We will put hours and days in brackets, but we feel that 'weeks' is more suggestive of dementia than delirium.
135	SH	European Delirium Association	7	Full	3.1.2	56	Re the cognitive function bullet, shouldn't all patients with impaired cognitive function as assessed by objective testing also be assessed for delirium?	Thank you for your comment. Our care pathway does imply that people with impaired cognitive function would be checked for these indicators of prevalent delirium.
136	SH	Royal College of Speech and Language Therapists	5	Full	3.1.3		The specification of an individually tailored package to manage the delirium and ensure maximum possible recovery is very welcome. The centrality of communication to	We agree with this comment and believe it has already been satisfactorily addressed by ensuring that patient/carer information is a unifying theme

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							such a package needs to be emphasised. If a person is experiencing communication difficulty then they will have difficulty engaging in any form of verbally mediated intervention re reminiscence (which is specified in the document). It is essential that such people are supported by speech and language therapists who have the expertise to address specific communication pathologies and are able to advise the multi-disciplinary team on making interventions accessible to individuals with communication difficulties.	across the whole pathway, by interventions to minimise cognitive impairment/disorientation (recommendation 1.3.3.1) and by emphasising the need for continuity of care in the care environment (1.3.1) and initial management recommendations (see recommendation 1.6.2).
137	SH	College of Occupational Therapists	13	Full	3.1.3	56	Recommends: avoiding room changes, ensure familiar health care professionals, but no mention of environmental factors / cues as preventative measure?	Thank you for your comment The care environment (recommendation 1.3.1) is a stand alone recommendation but designed to compliment the Multicomponent Preventative Intervention.
138	SH	European Delirium Association	8	Full	3.1.3	56	Line 21 'Avoids room changes unless the patient's clinical care requires this'	Thank you for your comment. We feel that use of the words 'unnecessary' which are already stated in the recommendation already covers this. However we have reworded the

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								recommendation to make the message clearer.
139	SH	Royal College of Speech and Language Therapists	4	Full	3.1.4		Diagnosis of delirium should be by a trained and competent healthcare practitioner. SLT's would potentially have a very valuable role here particularly where patients are experiencing communication difficulties that may affect verbally mediated assessments.	Thank you for your comment. NICE recommendations make recommendations on treatment and processes of care rather than specifying roles of different healthcare professionals.
140	SH	European Delirium Association	23	Full	3.4.1	56 (inter alia)	CAM: the guidance shows touching faith in the CAM. People who have actually used it know it is very difficult to use in practice (a comment frequently made by others as well). If you can diagnose delirium clinically, you can use the CAM. If not (and that is where the problem lies) then you will struggle to apply it. I think this aspect of the guidance should be played down, as the recommendation is unlikely to be useful in routine practice.	Thank you for your comment. We have worded the recommendation to say clinical assessment 'based on' the CAM or DSM-IV.
141	SH	European Delirium Association	9	Full	3.1.5	57	Line 4 I do not think that treating the cause(s) is best classified as a non-pharmalogical intervention. Vigorous treatment of acute medical causes, etc., often involves drug treatment,eg. antibiotics, and therefore heading 3.1.5 is potentially	Thank you for your comment. We have changed the title of this section to 'initial treatment'

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							misleading. I suggest that 'Prompt management of the possible underlying cause or causes, should be heading on its own, and that non-pharmacological interventions for delirium symptoms is a different heading.	
142	SH	Royal College of Speech and Language Therapists	6	Full	3.1.5	57	There is a very welcome reference to ensuring effective communication. In the case of an adult with delirium, who may or may not have other communication pathologies, access to SLT is essential to ensure that maximum possible communication is achieved. SLT will also benefit the multi-disciplinary team by guiding them to achieve the most effective level of communication possible.	Thank you for your comment. The implementation of this guideline (who, how, when) is a local health care provider issue dictated by local workforce and expertise availabilities. The type of communication and re-orientation we are referring to does not usually require the input from a speech and language therapist.
143	SH	Royal College of Speech and Language Therapists	7	Full	3.1.5	62	There is a reference to managing poor nutrition. Again this is very welcome. Reference should be made to SLT intervention for eating and swallowing difficulties as these may be 'temporary' in the case of passing delirium eg after surgery but may be very complex in the case of an adult with delirium associated with a dementing process.	Thank you for your comment. These are all useful points and these aspects are dealt within the cross-referenced NICE Clinical Guidance on Nutrition. ['Nutrition support in adults' (NICE clinical guideline CG 32).

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
144	SH	College of Mental Pharmacists	11	FULL	3.1.6	57	(NB Also applies to NICE document) When recommending the use of olanzapine and haloperidol; the evidence-based dosages should also be included with the codicil for reduction in doss for older patients; possible contra-indications for people with dementia with Lewy Bodies or care in those with Parkinson's disease plus the need for monitoring and what that entails	Thank you for your comment. We have now amended the recommendation on the use of pharmacological treatment and added an additional recommendation to cover Parkinson's Disease and Lewy body dementia. NICE do not usually include doses in recommendations (the BNF dosages apply) unless there is specific evidence for a particular dose that is not typically used in clinical practice.
145	SH	European Delirium Association	18	Full	3.1.6	57	With regard to : **3.1.6 Pharmacological interventions "**If non-pharmacological approaches are ineffective, consider giving short-term (for 1 week or less) haloperidol or olanzapine ***if people with delirium are distressed or a risk to themselves or others***." The conclusion that pharmacotherapy should be reserved for patients in distress is out of keeping with the populations in the quoted studies where no such stipulation in recruitment was made. In addition, a significant number of	Thank you for your comment. We understand the reasonable arguments presented here, but were reluctant to recommend a widespread increase in the use psychotropic medications on the basis of limited evidence base. For this reason, we prioritised a research recommendation to address this deficiency in the evidence base. We have modified the algorithm to reconsider the underlying causes for people with non-

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							studies have indicated that recognising levels of distress in delirium is complex, especially in patients with quieter presentations (e.g. hypoactive delirium) – a considerable number of these patients experience considerable distress, psychotic symptoms etc as evidenced by follow-up assessment of those who recover from delirium (e.g. Breitbart et al, 2002; O'Malley et al, 2008) Perhaps this stipulation should be removed or amended as the evidence indicates that clinicians are unreliable in detecting distress in delirium patients.	resolving delirium, if they are not agitated and still delirious after non-pharmacological interventions.
146	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	5	Full	3.1.6	57	There is no practical guidance here on when to instigate pharmacological interventions. How long does the team wait for non-pharmacological measures to work before reaching for the medication? If the delirium worsens does that reduce the threshold for reaching for medications? (cross reference with Order Number 20). Some practical guide on when to escalate for senior review would be prudent. Some guidance on what to do if 7 days of pharmacotherapeutic	Thank you for your comment. We believe we have provided clear guidance about when to initiate pharmacological measures (when the patients are distressed or at risk of injuring themselves or the care staff). We have now amended the guidance to include a re-evaluation of the causes of delirium in the situation of a non-resolving delirium (recommendation 1.6.6).

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							intervention is ineffective is required, should all interventions be stopped? Continued? Patient referred to a specialist service?	
150	SH	European Delirium Association	31	Full	4.15	76-7	This section (on information giving) was not very convincing.	Thank you for your comment. The developers feel the 'evidence to recommendation' section on information giving captures the key GDG debate and interpretation of the evidence, thereby linking the evidence to the recommendation. We have moved this section to follow directly on from the evidence. The limitations have been taken into consideration when developing the research recommendations.
152	SH	College of Mental Pharmacists	13	FULL	4.2	60	Should this include: 1. the start/withdrawal of CNS active medication, and 2. trauma. Trauma has not been referred to in this document but can be a major implicating factor in onset of delirium	Thank you for your comment. 1. With reference to start of CNS active medication, this has been examined in the Risk factors: pharmacological review, for example drugs started postoperatively. However, there was limited evidence. Withdrawal of CNS active medication did not appear to be reported as a risk

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								factor for delirium. 2. We have referred to the most important trauma situation – namely hip fracture within the risk factor assessment recommendation.
153	SH	European Delirium Association	11	Full	4.2	60	Line 18: "if cognitive impairment is suspected, confirm it using a standardised...". This is at odds with the general consensus that all older patients in hospital should be screened for cognitive impairment using a standard tool. I strongly disagree that this should only be done when cognitive impairment is 'suspected' because this relies on the clinical judgement of often very inexperienced staff. Objective testing in all patients on admission is essential; repeat testing is appropriate when cognitive impairment is suspected.	Thank you for your comment. The view of the GDG was that, in rapid throughput settings like A&E / Medical Assessment Unit, it would be impractical to adopt cognitive screening on all patients, many of whom (e.g. ankle sprains) would be at low risk of delirium. For this reason we have given greater priority to identifying patients at high risk of delirium (recommendation 1.1.1) and also improving the recognition of delirium through clinical indicators (recommendation 1.2.1.)
154	SH	College of Mental Pharmacists	12	FULL	4.2	59 In table under 1.3.3.5	Please use 'medicines'' not drug's e.g. "Carry out a medicines review"	Thank you for your comment. The NICE style guide states that we should use the term 'drugs' in preference to medicine or medication, however in mental health guidelines we are advised to use the term 'medication' if stakeholders strongly prefer this,

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								because of connotations relating to drug misuse. We therefore have amended the wording of the recommendations accordingly with the words 'medication', where we felt appropriate, but we will not use medicine or agent.
157	SH	College of Mental Pharmacists	26	FULL	4.14.1	74	Under first heading sentence two; please replace 'drugs' with medication. Line 19	Thank you for your comment. The NICE style guide states that we should use the term 'drugs' in preference to medicine or medication, however in mental health guidelines we are advised to use the term 'medication' if stakeholders strongly prefer this, because of connotations relating to drug misuse. We have therefore amended the guideline document and used the term medication where we feel it is appropriate.
159	SH	European Delirium Association	32	Full	4.16.1	77	Risperidone in dementia. It has a warning on use, but is still commonly used, and there is a lot to say for its continued use in delirium. There is the best evidence of any antipsychotic for relief of aggressive agitation in dementia – the best of a bad bunch perhaps. The discussion	Thank you for your comment. The evidence we reviewed examining the use of risperidone for the prevention of delirium was not representative of the intervention or the population. The GDG considered the

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							on risk of stroke is wholly disproportionate. We are talking about using it for a week or 2 in a semi-critical clinical scenario, many instances of which will be complicated by progression of vascular dementia anyway.	benefits and risks for antipsychotics. They felt that the possible increased risk of stroke could not be discounted. In light of adverse events associated with these medications for longer term use the GDG emphasised the need for short-term anti-psychotic medication use.
160	SH	Alzheimers Society	2	Full	4.3 Indicators of prevalent dementia	61	• **The delirium assessment process must include an assessment for dementia and delirium superimposed on dementia.** This section highlights that if any of the indicators listed are present, including worsened cognitive function, a healthcare professional who is trained and competent in the diagnosis of delirium should carry out a clinical assessment to confirm the diagnosis. Alzheimer's Society fully supports this, however, we believe that the guideline would be far stronger if the relationship between dementia and delirium was incorporated in this	Thank you for your comment. We have amended recommendations 1.1.1 and 1.5.1 to include dementia. We have also added a new recommendation 1.6.6 to assess again for dementia, as part of the recommendations we have cross-referred to the NICE dementia guideline. These changes have also been incorporated into the algorithm / care pathway.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							section. An NAO (2007) report found that older people with dementia often present to acute care with delirium. However, the presence/diagnosis of dementia may lead to delirium being overlooked and misdiagnosed as dementia (NAO, 2007). Delirium superimposed on dementia is therefore often unrecognised and can go untreated and unmanaged. Conversely, dementia can also be misdiagnosed as delirium. • It is therefore vital to incorporate dementia into this section. • The healthcare professional must be aware that the symptoms of delirium can be similar to dementia and either condition can be wrongly labelled as the other. • The assessment process must include tests for both and professionals must be able to distinguish between the two or recognise when both are present. • Useful resources that the	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							section could reference include: o A new web-based BMJ Learning dementia module has been developed to help clinicians in the diagnosis of dementia and the distinction of conditions such as delirium o If dementia is present, the guideline should point to the NICE guideline on dementia for further information.	
161	SH	College of Mental Pharmacists	14	FULL	4.3	61	Under perception; should delusions be added as these can be common especially persecutory in older people	Thank you for your comment. We agree that delusions can be a feature of delirium but may not be easily recognised by non-specialist staff for whom these indicators are intended. We therefore have not added this to the recommendation.
162	SH	College of Mental Pharmacists	21	FULL	4.10.2	68	Also evidence for ensuring pointers to time of day are followed; e.g. brighter light during day; lower night and closing of curtains at night.	Thank you for your comment. We have amended the recommendation to read 'appropriate lighting'.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
163	SH	European Delirium Association	26	Full	4.11.2	69	Did the economic model consider additional staffing for multi-component prevention? I think it is speculative and optimistic to assume that staffing levels are not important in implementing this.	Thank you for your comment. We considered additional staffing time and cost for the application of multi-component prevention. A description of the additional staffing time and cost is given in section 16.2.7.
164	SH	College of Mental Pharmacists	22	FULL	4.11.2	70	Under 'polypharmacy effects' please use "medicines review' e.g." advised recommending a medicines review that addressed the type of medication as well as….supported the principle that if clinicians added a new agent another should…"	Thank you for your comment. The NICE style guide states that we should use the term 'drugs' in preference to medicine or medication, however in mental health guidelines we are advised to use the term 'medication' if stakeholders strongly prefer this, because of connotations relating to drug misuse. We therefore have amended the wording of the recommendations accordingly with the words 'medication', where we felt appropriate, but we will not use medicine or agent.
165	SH	European Delirium Association	27	Full	4.11.2	70	Pain. It would be worth mentioning that most analgesics beyond paracetamol are potent causes of delirium, which leaves the clinician with a big dilemma. The guidance should produce a list of suggestions, and a caveat on making delirium	Thank you for your comment. We intended this to be covered by the polypharmacy recommendation (1.3.3.7) and by the phrase 'appropriate pain management' in the pain

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							worse when treating pain.	recommendation. However we have added the words 'and reviewed' to the recommendation (1.3.3.6) to ensure that this is understood and implemented.
166	SH	European Delirium Association	28	Full	4.11.2	70	Polypharmacy. The last line (stop a drug if you start one) is just plain silly. The guidance is to minimise all drug use. Every drug, started, continued or stopped should be assessed on is own merits. Is NICE really suggesting that to treat pneumonia you have to stop the donepezil, antihypertenive or analgesic?	Thank you for your comment. Our intention is to challenge the creeping incremental increase in drug burden common in older people. To suggest that patients would have to have donepezil discontinued if they developed pneumonia is a misinterpretation. We have amended the text to state "new long-term drug".
167	SH	College of Mental Pharmacists	23	FULL	4.11.2	71	Under sleep disturbance…instead of drugs use medicines	Thank you for your comment. The NICE style guide states that we should use the term 'drugs' in preference to medicine or medication, however in mental health guidelines we are advised to use the term 'medication' if stakeholders strongly prefer this, because of connotations relating to drug misuse. We therefore have amended the wording accordingly with the words 'medication', but we will not use

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								medicine or agent.
169	SH	College of Mental Pharmacists	24	FULL	4.12.2	72	This has implications for training in places such as ICU; HDU;PICU; postoperative and trauma wards as well as older care wards and long-stay care organisations. Training should be standardised and delivered by experienced professionals	Thank you for your comment. We agree. However, training issues are outside of the remit of a NICE guideline
170	SH	European Delirium Association	13	Full	4.12.2	72	Objective cognitive testing is reasonably sensitive to delirium; subjective clinical signs also have their place: why not recommend both? Make the point that tests can miss delirium. Also, it would be worth highlighting that evidence of mental status change from carers/staff with the patient around the clock should be sought alongside the bedside assessments.	Thank you for your comment. We have stressed the importance of 'clinical indicators' for delirium in recommendation 1.2.1, and advised the testing for cognitive impairment if this is suspected (recommendation 1.1.1.). We have prioritised the clinical indicators as these are more likely to engage a wider group of professionals, including care assistants in long-term care.
171	SH	College of Mental Pharmacists	25	FULL	4.13.2	73	Sentence 2 ends " that delirium might occur"; should also include 'has' e.g. " that delirium might or has occurred." Line 33	Thank you for your comment, the guideline document has been amended accordingly.
172	SH	European Delirium Association	14	Full	4.13.2	73	I am strongly supportive of the slogan, "Think Delirium".	Thank you for your comment.
173	SH	College of Mental Pharmacists	27	FULL	4.14.2	75	Line 16 please use 'pharmacological' not drug.	Thank you for your comment. The NICE style guide states that

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							Line 18 instead of "on drugs" please use "for medication." Line 26 please use 'agent' not 'drug' Line 27 please use "the possible harms of the medication…etc" Line 37 instead of "recommend drug treatment" please use 'recommend medication for…' Line 45 treatment spelt incorrectly	we should use the term 'drugs' in preference to medicine or medication, however in mental health guidelines we are advised to use the term 'medication' if stakeholders strongly prefer this, because of connotations relating to drug misuse. We therefore have amended where appropriate, the wording accordingly with the words 'medication', but we will not use medicine or agent.
174	SH	European Delirium Association	15	Full	4.14.2	75	Signage should include specific mention of toilets, eg. large, clear pictures of toilets on toilet doors.	Thank you for your comment. The developers feel that this is too much detail for inclusion in this broad national guideline.
175	SH	European Delirium Association	29	Full	4.14.2	75	NICE 25 on de-escalation. It's not bad advice, but NICE 25 emphasises the settings for which the advice was formulated (mental health wards and ED). I think this needs restating and probably reworking for this setting. Most acute medical and geriatric wards are very provocative environments – crowded, noisy, no orientation cues. This aspect of 'escalation prevention' must be addressed as well.	Thank you for your comment. The GDG were aware that NICE CG25 relates to mental health wards and ED. We agree that the care environment is important and have emphasised this in recommendation 1.3.1. The GDG acknowledged this issue and this has been detailed in the evidence to recommendations section on 'distressed people' at the end of chapter 12.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
176	SH	European Delirium Association	30	Full	4.14.2	75	The guidance appears to understate (or underappreciate) the evidence on the use of dopamine antagonist drugs to treat delirium, including hypoactive delirium. It may be worth spelling out 4 possible uses of these drugs: prevention of delirium, specific treatment of delirium (both low dose short course), antipsychotic effect, and sedation/behavioural control (both high dose, longer term – 3 or 4 weeks for the antipsychotic effect).	Thank you for your comment. We believe the guidance is consistent with the limited evidence available and that the routine use of antipsychotic drugs (including dopamine antagonists) to prevent and treat delirium remains an area for urgent research.
177	SH	Welsh Assembly Government	2	Full	4.14.2	75	The recommendation for a pharmacological intervention (when needed) is for the use of either haloperidol or olanzapine. The authors of the guidelines are to be congratulated for a thorough and accurate review of the literature. However this recommendation lacks face validity/practical usefulness when systematically assessing common clinical scenarios and thus gives practising clinician's unworkable guidelines for clinical practice. This can be illustrated by the two most common clinical presentations of delirium seen in the hospital	Thank you for your comment. We have now amended the recommendation on use of pharmacological treatment. We have also added an additional recommendation to cover Parkinson's disease and Lewy body dementia (1.6.5).

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							setting. 1. An older person usually older than 75 years, suffering from a dementia, who has a relatively mild trigger for their delirium of a urinary tract infection or chest infection. They develop neuropsychiatric and psychomotor symptoms associated with the delirium of such severity (as appropriately described in the guidelines) that pharmacological treatment is considered. 2. An older person again often older than 75 years who falls and suffers a fractured neck of femur. They are also known to have had some problems with increased "forgetfulness" with increased difficulty functioning and a number of falls for over a year prior to this. They develop a delirium in the post operative period with a similar presentation as that described in case 1. The clinician must now carefully	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							consider what would be the most appropriate medication to prescribe. In the Case one the clinician is compromised if they prescribe olanzapine as a first line choice because in 2004 the CSM directed all practitioners not to prescribe risperidone or olanzapine to patients with dementia or stroke disease (in older persons) because of evidence of an increased risk of stroke disease (see below). In practice it might be reasonable to consider this as a second line drug or to be used in very high risk patients. Also one would need to be cautious prescribing haloperidol particularly if there were concerns that the cause of the dementia might be Lewy Body Disease. The latter concern is particularly pertinent to Case 2 where it would be wiser to prescribe a low dose of quetiapine because the history is suggestive of Lewy Body Disease (the patient might react adversely to haloperidol and olanzapine is contraindicated)..	
178	SH	Welsh Assembly Government	3	Full	4.14.2	75	The Committee on Safety of Medicines (CSM) issued advice in	We agree with these comments. The balance of risks and

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							March 2004 that there is "clear evidence of an increased risk of stroke in elderly patients with dementia who are treated with risperidone or olanzapine". "Patients with dementia should therefore not be started on these drugs". It is thus difficult in a case of moderate to severe vascular dementia where the fluctuating clinical picture can be difficult diagnostically, when considering whether or not a patient has delirium, and where there is an increased risk of stroke disease, to justify using olanzapine as a first line choice where a patient has very challenging behavioural symptoms. However this scenario is extremely common in clinical practice- particularly in a residential home setting and again these guidelines are of limited practical use for clinicians.	benefits of drugs were discussed by the GDG and we have emphasised the short-term (less than one week) use of these agents.
179	SH	Welsh Assembly Government	4	Full	4.14.2	75	The recommendation of giving this medication for "one week or less" is also of limited practical usefulness from the viewpoint of the clinician. In practice one tries to give as little	We selected 'one week or less' as a pragmatic solution to the issues you raise.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							psycho-tropic drugs as is possible to patients with either delirium or dementia. The severe neuro psychiatric symptoms of delirium are often very short lived perhaps requiring only one or two doses of a psychotropic drug. Otherwise the medication should be reviewed daily while in hospital with a view to stopping them as soon as the symptoms become manageable but this might be one day or ten days or sometimes a few weeks.	
180	SH	College of Mental Pharmacists	28	FULL	4.14.2	76	Line 1: Use 'was' compromised	Thank you for your comment, the guideline document has been amended accordingly.
181	SH	College of Mental Pharmacists	29	FULL	4.15.2	76	Consider giving information to those entering high-risk secondary care sectors such as ITU;HDU; trauma wards and pre-operative/elective surgery	Thank you for your comment, this is the intention of recommendation 1.7.1.
183	SH	Royal College of Psychiatrists	6	full	4.16.2	77	It is not correct to say that "risperidone has been withdrawn for use in dementia because of increased risk of stroke". This should be rephrased to "risperidone has been associated with an increased risk of stroke in dementia".	Thank you for your comment. We have now deleted this sentence from the guideline document.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
184	SH	Alzheimers Society	3	Full	4.4 Interventions to prevent delirium	61	• **These interventions amount to what should be good quality care for people with dementia, yet is very often lacking. Staff will need support to implement these for people with dementia.** • **This section should therefore discuss how the interventions can be effectively implemented for people with dementia.** We fully support cognitive impairment being highlighted as a specific risk factor for delirium in section 4.2, page 60. However, the guideline does not explicitly discuss the management of dementia to reduce the risk of the person with dementia developing delirium. Yet this is vital as delirium superimposed on dementia can worsen the prognosis of dementia, increase rates of hospitalisation within 30 days and increase mortality rates. Recent studies have yet to find	Thank you for your comment. We have amended recommendations 1.1.1 and 1.5.1 to include dementia. We have also added a new recommendation 1.6.6 to assess again for dementia, as part of the recommendations we have cross-referred to the NICE dementia guideline. These changes have also been incorporated into the algorithm / care pathway.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							robust evidence for particular interventions effective in preventing delirium in people with dementia (Siddiqi et al, 2007). However, dementia is the most important risk factor for delirium (Lindesay, 2002). This must be acknowledged and it must be ensured that the list of clinical indicators that can contribute to delirium and the appropriate interventions (1.3.3.1 to 1.3.3.9) are effectively implemented for people with dementia. An Alzheimer's Society report *Counting the cost* (Alzheimer's Society, 2009) found that people with dementia on an acute hospital ward are receiving poor quality dementia care, which results in a deterioration in physical health (such as constipation, malnutrition, dehydration and lack of mobility) and a deterioration in the symptoms of dementia. Part of the problem is that staff do not have an understanding of dementia because of a lack of training and education. Many of the consequences of poor quality dementia care are risk factors for delirium.	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							If recommendations for indicators such as 1.3.3.2 (dehydration), 1.3.3.6 (poor nutrition) and 1.3.3.7 (mobility) are to be effectively implemented for people with dementia, a full discussion on how these can be achieved for this group must be included. This has been mentioned in 1.3.3.4, which acknowledges that it will be necessary to look for non-verbal signs of pain for people with dementia. Similar guidance must be provided for the other interventions. The section could also refer to further resources for more in-depth information. In addition, it is necessary to introduce other interventions that may support a person with dementia. In particular, there should be mention of the need for person-centred care. Counting the cost (Alzheimer's Society, 2009) found that care that wasn't meeting an individual's particular needs resulted in the symptoms of dementia (such as confusion and distress) becoming worse and physical health	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							consequences such as malnutrition – again, many of the consequences of a lack of person-centred care are risk factors for delirium.	
185	SH	European Delirium Association	12	Full	4.4	61	Add a section on hypoxia, with appropriate caveats (carbon dioxide retainers, etc.).	Thank you for your comments, we agree and have added a recommendation on hypoxia (recommendation 1.3.3.3)
187	SH	College of Mental Pharmacists	15	FULL	4.4	62	Under 'Disorientation' heading; should there be another heading around reducing environmental stressors such as: loud noises (banging and clanging of meal or tea rounds); television, radio; noisy visitors;	Thank you for your comment. In the environmental risk factors review, the evidence for environmental noisy/quiet environment or the presence of radio/television were not significant risk factors for the severity of delirium. However, we have emphasised the importance of other environmental factors in this recommendation.
188	SH	College of Mental Pharmacists	16	FULL	4.4	62	Under ' Polypharmacy effects' heading: 1.3.3.5 Carry out a medicines review	Thank you for your comment. The NICE style guide states that we should use the term 'drugs' in preference to medicine or medication, however in mental health guidelines we are advised to use the term 'medication' if stakeholders strongly prefer this,

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								because of connotations relating to drug misuse. We therefore have amended the wording of the recommendations accordingly with the words 'medication', but we will not use medicine or agent.
189	SH	College of Mental Pharmacists	17	FULL	4.4	63	Under sensory impairment please include (ensure visual aids are clean and correct prescription i.e. distance or reading as appropriate)	Thank you. These are important issues and have been assumed within the text "good working order" within the recommendation
193	SH	College of Mental Pharmacists	18	FULL	4.7.2	64	There should be a mandatory codicil with this advice which includes the evidence-based doses to be used; the monitoring indices and possible adverse events as mentioned previously	Thank you for your comment. NICE do not usually include doses in recommendations (the BNF dosages apply) unless there is specific evidence for a particular dose that is not typically used in clinical practice. In addition NICE guidelines are not mandatory (Technology Appraisals are mandatory). A codicil is outside of the remit of the scope.
194	SH	European Delirium Association	2	Full	4.7.2	64	Regarding statement 1.6.4. Several questions can be posed: 1. Should we wait	Thank you for your comment. 1. Non-pharmacological treatment (i.e. treating underlying causes) is effective but we agree that enhanced

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							with pharmacological treatment until non-pharmacological approaches have shown to be ineffective? As far as I know there is no evidence that non-pharmacological *treatment* of delirium is effective at all. In all studies addressing non-pharmacological treatment options this treatment is always part of a multicomponent intervention that also includes medication. I could not find any evidence to support this recommendation and would start pharmacological treatment at the same time as non-pharmacological treatment. 2. Why should treatment be 'short-term' and 'less then one week'? Sometimes deliria will take longer time to remit. Why not treat until remission? I could not find any evidence to support this recommendation. I agree that medication should be stopped shortly after symptoms have remitted. 3. Why only treat patients that are distressed or pose a risk? As far as I	care systems do not influence outcomes. The GDG were concerned about recommending what would amount to a substantial increase in anti-psychotic medication given the evidence base was one single study with a risk of bias. For this reason, the GDG prioritised a research recommendation to address this deficiency in the evidence base. 2. About 30% of delirium does not remit and there is a risk that a more open-ended approach might encourage long-term use of these potentially hazardous agents. The GDG recommended the short-term treatment, defined as 1 week or less, based on the evidence from the study by Hu (2006) and usual practice. 3. The GDG were reluctant to recommend a widespread increase in the use psychotropic medications on the basis of limited evidence base. We have modified the algorithm to reconsider the underlying

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							known there is no evidence that these patients have a worse outcome then delirious patients that are less distressed, and I also could find none in the guideline. So to summarise: the most important clinical recommendations are not based on evidence and will lead to undertreatment of patients.	causes for people with unresolved delirium, if they are not agitated and remain delirious after non-pharmacological interventions.
195	SH	College of Mental Pharmacists	19	FULL	4.9.1	65	Under quality of evidence 'vision impairment ' is stated should this be 'visual impairment?'	Thank you for your comment, the term vision is consistent with the terminology used by the studies and we have therefore kept this term.
196	SH	College of Mental Pharmacists	20	FULL	4.9.1	65	Other risk factors include: trauma; use of CNS-active medication and substance withdrawal (prescribed/non-prescribed)	Thank you for your comment. The risk factor review covers surgery, a common form of trauma. Use of CNS-active medication has been addressed in the pharmacological risk factors review. Delirium due to substance withdrawal was excluded from the scope.
197	SH	European Delirium Association	24	Full	4.9.1 4.9.2	65 67	'suspected cognitive impairment should be confirmed with a validated measure'. No, no, no!!! I think you mean dementia not cognitive	Thank you for your comment. We have amended recommendations 1.1.1 and 1.5.1 to include dementia. We

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							impairment. Cognitive impairment is part of delirium as well as dementia. You diagnose prior dementia by taking a collateral cognitive history (and examining the mental state, and excluding other explanations eg stroke causing aphasia), not by using a validated measure.	have also added a new recommendation 1.6.6 to assess again for dementia, as part of the recommendations we have cross-referred to the NICE dementia guideline. These changes have also been incorporated into the algorithm / care pathway.
199	SH	St Helens and Knowsley NHS Trust	20	Full	4.9.2	66	Visual impairment is unlikely to be a modifiable risk factor in a hospital population. The Inouye study defined visual impairment as 20/70 or less **after** correction with glasses. Visual aids such as magnifiers may assist patients in dealing with the effects of their visual impairment but they do not modify the impairment itself. The advice on using the multi-component intervention is based on the Inouye study which used visual impairment as part of its criteria to select patients for the intervention. Is use of the intervention valid without assessing patients by the same criteria used in the study?	Thank you for your comment. We agree that we are using the term 'visual impairment' in a non-technical sense. The idea is to reduce the impact 'visual impairment' by reducing visual disability and increasing participation. In this sense, it is therefore possible to modify the risk factor.
200	SH	West Hertfordshire Hospitals NHS Trust	13	Full	4.9.2	66	While historically physical restraint has not been used in ICU patients in the UK it has become more	Thank you for your comment. We believe the GDG discussion

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							accepted more particularly since much shorter-acting drugs are being used. There is specific evidence regarding physical restraint in ICU patients Micek Critical Care Medicine 2005 and Ely work and developing delirium. I am concerned that clinicians are "fast-tracking" patients off ventilators using physical restraints, aggravating delirium and potentially impacting on outcomes down the line. This needs to be carefully managed particularly in these guidelines. In addition I have been impressed by Dr Inouyes advice that physical restraint should never be used on the extremely elderly because of the risk of persistent delirium.	(summarised originally in section 4.9.2 in the consultation version of the full guideline, now in the evidence to recommendations section of chapter 7) are in accord with this comment i.e. the extent to which physical restraint is a risk factor for delirium is uncertain and that a pragmatic view is to generally avoid physical restraint.
204	SH	European Delirium Association	25	Full	4.9.2	67	4th bullet unclear (seems to end prematurely)	Thank you for your comment, the guideline document has been amended accordingly.
206	SH	European Delirium Association	33	Full	5.1	78	DSM-iv vs ICD10. DSMIV disallows 'delirium without a cause' (perhaps 20% of well described series), and a common scenario in my experience. ICD10 gives a better description of the cognitive impairment seem in delirium. I would see potential	There is a notable disparity in both numbers and characteristics between the people identified to have delirium when using the DSM criteria as compared to ICD-10. ICD-10 is more restrictive and appears to

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							occurrence rates of 25% as a problem for diagnostic criteria. This section als needs a better discussion of delirium mimics (in particular VaD and DLB)	mainly diagnose delirium in a group of people who have dementia, who are nursing home residents and who are dependent for care needs. ICD-10 requires the presence of additional factors for the diagnosis of delirium; emotional disturbance as an absolute requirement and either impairment in abstract thinking or comprehension as an optional requirement. The Laurila study (Dement Geriatr Cogn Disorder 2004; 18: 240-244) informs us three cohorts were identified, those identified by DSM alone, ICD10 alone and both, and suggests that people identified using the ICD-10 criteria are different to the people identified using DSM. We agree that people with dementia, who are resident in nursing homes & who are dependent for care needs will form a significant proportion of people with delirium, but to have this more restrictive diagnostic

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								criteria applied to all healthcare settings feels inappropriate. Regarding discussion of delirium mimics, in accordance with the remit of the guideline we have not discussed differential diagnosis in-depth but focused on actual delirium and not delirium like conditions. However, we recognise that some of the people identified by DSM IV may have had VaD or DLB, but the proportion of these groups is likely to be small. Even if the pure delirium rate in the studies is only 10% of that reported, there would still be a considerable disparity between the delirium rates in the studies compared with the HES data. We have added a paragraph to this effect to section 5.6.4.
207	SH	College of Mental Pharmacists	30	FULL	5.1	79	Table 5.1; point4; this diagnostic criteria is in contrast with the limitations of this guidance. That is; the criteria includes relationship to substance intoxication or substance withdrawal which this guideline has	Thank you for your comment. Table 5.1 has now been edited to make sure that it is consistent with the population covered by the guideline. Chapter 1 (section 1.5) outlines the excluded

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							excluded. Is there to be another guideline for this causal factor? Would it not be appropriate to include it within this guidance as it would form part of a medicines review in the first instance?	population (people with intoxication and/or withdrawing from drugs or alcohol, and people with delirium associated with these states). We have also referred to existing and forthcoming NICE guidance at the beginning of the guideline (section 1.7) and this includes guidance on alcohol use disorders.
208	PR	NETSCC, HTA Referee 2	40	Full	5.2		Table 5.2 should include median age.	Thank you for your comment, the guideline document has been amended accordingly.
209	PR	NETSCC, HTA Referee 2	37	Full	5.1.1	79	Suggest using Lasts Dictionary of Epidemiology as a reference instead	Thank you for your comment. We have amended the guideline document accordingly and referred to Last's dictionary of epidemiology (the latest edition of this is Porta 2008). We have also added a sentence into the results of this chapter (section 5.6) to clarify the use of the term occurrence rate.
210	PR	NETSCC, HTA Referee 2	7	Full	5.2	87	Why is 'occurrence rate' and 'total delirium' different in the general ICU setting? Shouldn't the figures be the same?	Thank you for your comment, we understand how this can look confusing. Most ICU studies observed patients from

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								admission until discharge or death and therefore prevalent and incident delirium are merged into occurrence rate which equates to total delirium. However, some studies did not include patients who developed delirium within the first 24 hours, and subsequently followed patients for a certain number of pre-specified days but not until discharge or death. The data would therefore be classed within occurrence rate as outlined in the *a priori* definitions but as follow-up was not ongoing until discharge or death the total delirium rates across the whole of the ICU stay were not measured.
211	PR	NETSCC, HTA Referee 2	5	Full	5.1.2	81	Clarify 'total delirium'	Thank you for your comment. We decided to include 'Total Delirium' to provide comparison between a pre-specified dataset and the HES data. Total delirium includes data from studies whereby delirium was measure from the day of admission to healthcare setting throughout admission until

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								discharge from the healthcare setting or death. This gives data that is more comparable to the HES data which is, by definition, generated over the whole course of the hospital admission. An alternative would be summating prevalent & incident rates (see *a priori* definitions) but the paucity of reliable data prevented this in most healthcare settings.
214	PR	NETSCC, HTA Referee 1	6	Full	5.5	85	Not clear why exclusion of dementia rules study out. Surely dementia diagnosis is usually an exclusion for delirium?	Thank you for your comment, you have raised an important point. A diagnosis of dementia is absolutely not an exclusion for delirium and the two are strongly linked (see main risk factors for delirium). A study measuring rates of delirium which excludes patients with dementia will exclude one of the highest risk groups for delirium and therefore the epidemiology data is unreliable. The results set will be skewed and the study will underestimate delirium rates. This is even more important in populations where the rates of dementia are high (i.e. long-term care) as the dataset will be

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								skewed still further. As the Alzheimer's Society point out in their comments, dementia is present in up to 2/3 of all long-term care residents. To exclude such a proportion of people who are at high risk of developing dementia will give both an unrepresentative population and a profoundly skewed dataset. Along with age over 65, which will realistically be present as a risk factor in all long-term care residents, dementia will be the only stable risk factor in long-term care, assuming severe illness and hip fracture leads to hospital admission. This further supports the exclusion of the Andrew CSHA study.
215	PR	NETSCC, HTA Referee 2	6	Full	5.5	85	Line 20. Why exclude Andrew 2006? This is effectively a delirium-prevalence study in CSHA in persons without dementia. It is important because it is the only community-based estimate in the literature.	Thank you for your comment. The CSHA (Andrew 2006) cohort was a point prevalence study of delirium rates in the community. The CSHA included 1672 long-term care (LTC) residents and 1658 older people living at home. People with dementia were excluded from

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								the study. People with dementia comprise up to 2/3 of long-term care residents. To exclude such a proportion of people who are at high risk of developing delirium will give both an unrepresentative LTC population and a skewed dataset. Along with age over 65, which will realistically be present as a risk factor in all LTC residents, dementia will be the only stable risk factor in LTC, assuming severe illness and hip fracture leads to hospital admission. Community-based populations (i.e. older people living at home) were outside the scope of the guideline & one study was excluded on the basis of this. The CSHA combined data from those living in LTC and those living at home. The CSHA, although providing important data in its own right, provides data that is arguably unrepresentative of a LTC population and combines this with epidemiology data from older people living at home, which is a population outside the

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								scope of the document. On the basis of this, it is reasonable to exclude the Andrew (2006) study.
216	PR	NETSCC, HTA Referee 1	7	Full	5.6	86	No formal summary is offered here and in many other places although the overall impression is that some sort of narrative summary is being offered. What would be wrong with doing it formally?	Thank you for your comment. Due to heterogeneity with particular regard to the frequency of measurement of delirium, heterogeneity in the duration of individual studies, small numbers of individual studies in a significant proportion of healthcare settings and variable quality of individual studies it was considered that a formal statistical analysis would not be likely to add substantial value to the discussion in this section. A formal statistical analysis including studies that met the a priori definitions of prevalent and incident delirium would be possible for an epidemiology analysis, but low numbers of studies meeting the a priori definitions in individual healthcare settings would potentially prohibit this
217	PR	NETSCC, HTA	23	Full	5.7	90	Line 28. Please give reference	Thank you for your comment,

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Referee 2						the guideline document has been amended accordingly.
218	PR	NETSCC, HTA Referee 2	41	Full	5.7	90	What does 'epidemiological' studies mean here? It is probably clearer to say a prospective cohort of patients admitted to x facility.	Thank you we agree with your comment. The guideline document has been amended accordingly and we have the added the words '*a prospective cohort of patients admitted to hospital or long-term care as compared to'* into section 5.6.
219	SH	Intensive Care Society	4	Full	5.6.3	88	The use of FCEs to estimate incidence of delirium in intensive care will underestimate it significantly as it is not recognised, measured or recorded in many ICUs.	Thank you for your comment. We agree that this may be the case. It also appears to be true in all healthcare settings, not just ICU (ie. delirium is considerably under reported). We have already tried to bring this point out in this section. When you look at the ratio of the rates for the epidemiology studies to HES data, critical care doesn't seem to be especially anomalous.
220	PR	NETSCC, HTA Referee 2	42	Full	6		Why was the frequent change of environment not in the a priori expectations of risk factors for delirium?	Thank you for your comment. Changes in environment was captured under the term settings, identified a priori as a risk factor for delirium by the GDG. Please refer to section titled *environmental* under *Types*

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								of risk factor in section 7.2.1 of the full guideline.
222	PR	NETSCC, HTA Referee 1	9	Full	Figure 6.1	113	Why summaries here and not elsewhere?	Thank you for your comment. Figure 6.1 outlines individual effect size for different types of hospital unit as a risk factor for the severity of delirium and is not illustrating a pooled effect.
223	PR	NETSCC, HTA Referee 1	8	Full	6.3	93	Exclusion of small studies is arbitrary, why give these studies just below the cutoff weight zero and those just above it weight unity? Surely this is what is done much better by meta-analysis using inverse variance weighting? I agree that random effects methods have problems with small studies but I would argue that meta-regression is the way forward in the face of heterogeneity and in fact most of the meta-analyses seem to have used fixed effects models anyway.	Thank you for your comment. It was decided a-priori to exclude small cohort studies. In cohort studies, for validity, there should be at least ten patients for each factor in the regression equation for continuous outcomes, or at least ten patients having the event (e.g. delirium) per factor for dichotomous outcomes. Taking these points into consideration we do no feel exclusion of small studies for this evidence review was arbitrary**.**
225	PR	NETSCC, HTA Referee 1	14	Full	Figure 6.30	148	This is totally unsatisfactory. Surely this should use a synthesised value, not the highest quality study, and what does midpoint mean? If you are going to summarise studies then use the appropriate techniques.	Thank you for your comment. In the prognostic factor reviews, studies were not combined in a meta-analysis because these were observational studies. We took into consideration the advice from the NICE Guidelines Manual when arriving at this

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								decision. The term 'midpoint' refers to a midrange point, an indicator of the central tendency of the data.
226	PR	NETSCC, HTA Referee 2	24	Full	6.3.1.	95	The heading suggests that the *retrospective* studies are in *italics* which is not true in the table.	Thank you for your comment. The table has been amended with retrospective studies indicated in italics.
228	PR	NETSCC, HTA Referee 1	11	Full	Figure 6.4	117	Why summaries here and not elsewhere?	Thank you for your comment. We are unable to respond to this comment, as Figure 6.4 refers to a forest plot including one study and is not presenting summaries of studies.
229	PR	NETSCC, HTA Referee 1	12	Full	Figure 6.6b	122	Summaries here are surely the correct approach	Thank you for your comment. The summary presented on this forest plot is an error and this has been amended accordingly.
230	PR	NETSCC, HTA Referee 1	10	Full	6.5.1.2	117	Heterogeneity referred to, but not calculated	Thank you for your comment. Observational studies were not combined in a meta-analysis and heterogeneity was not calculated. The heterogeneity referred to is based on a visual assessment of the forest plot. The sentence has been clarified to reflect this.
231	PR	NETSCC, HTA Referee 1	13	Full	Figure 6.8	124	Can these risks be converted onto a common scale? If some of them are	Thank you for your comment**.** Results were reported as risks

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							calculated from the data then this might be possible. There are more or less satisfactory ways of converting otherwise.	(odds, relative, or hazard) or beta-coefficients. We have presented the results for risks as reported in the studies.
235	SH	St Helens and Knowsley NHS Trust	23	Full	6.5.4	147	There is no comment on the evidence for the cumulative effect of more than one risk factor on the incidence of delirium. There is no definition given for intermediate and high risk of delirium. The Inouye study only included patients with more than one risk factor. The Inouye model of 4 risk factors in addition to age over 70 has been validated in an orthopaedic population.	Thank you for your comment. We have reported the independent effect of a risk factor on the incidence of delirium as reported in the studies. A cumulative effect of more than one risk factor can be obtained by multiplying the risks. The 'evidence to recommendation' section in this chapter has been amended to reflect the discussion on intermediate and high risk of delirium.
238	PR	NETSCC, HTA Referee 1	15	Full	Table 7.1	153	The range is a single number, the minimum and maximum or quartiles are reported	Thank you for your comment. It is our understanding that the term 'range' refers to a spread of a set of data reporting the lowest and highest values. We have therefore used the standard deviations reported in the papers as an indication of the 'range'.
240	SH	St Helens and Knowsley NHS Trust	22	Full	6.5.1.6	128	The blood urea nitrogen/creatinine ratio as used in the Inouye study can be converted into units used in the UK. The level of 18 used in the	We agree that dehydration is an important risk factor for delirium. However the methods used to measure risk factors does not

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							Inouye study equates to a urea/creatinine ratio of 73. In our trust this ratio is automatically calculated for all admissions via the emergency department or the medical assessment unit and appears with the u&e results on the pathology computer system.	form part of this guideline but is an important aspect for implementation by local provider organisation.
247	PR	NETSCC, HTA Referee 2	25	Full	7.3.2.	155	'Presence' should change to 'prevalence'	Thank you for your comment, the guideline document has been amended accordingly.
249	PR	NETSCC, HTA Referee 1	16	Full	7.4.1	163	Drawing lots is not an adequate method of randomization (see Fienberg, Science 1971 (171) 255-261 for an example of mechanical methods going wrong). Having said that allocation concealment is probably more important.	Thank you for your comment. We agree that allocation concealment is an important aspect to consider when assessing risk of bias. With respect to methods of sequence generation, we regard 'drawing lots' to be an adequate method as outlined in the NICE Guidelines Manual and the Cochrane Handbook for systematic reviewers.
250	PR	NETSCC, HTA Referee 2	26	Full	7.4.1	164	Lines 6-12. The studies referred to do not add up to 8	Thank you for your comment. The number of RCTs (5 trials) referred to in this section are only those considered at potential for bias and do not refer to the eight RCTs included

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								in the review.
253	PR	NETSCC, HTA Referee 2	27	Full	7.4.3.	168	It might be clearer if the Marcantonio paper is referred to as a nested case-control design.	Thank you for your comment. The guideline has been amended accordingly.
256	PR	NETSCC, HTA Referee 2	28	Full	7.5.1.1.	169	The OR needs to be described per unit of the continuous variable (per unit of midazolam)	Thank you for your comment. The guideline has been amended accordingly.
257	PR	NETSCC, HTA Referee 2	29	Full	7.5.1.1.	169	The section on lorazepam appears to treat the dose range as categorical data rather than continuous. If this is **not** the case, then more detail re: methodology should be given	Thank you for your comment. We have taken your comment into consideration, however, we feel it is already explicitly stated in this section that the dose range is continuous.
267	PR	NETSCC, HTA Referee 1	17	Full	7.5.5.1	174	All these tenth powers are incorrect, note that 0.95^10 must be less than unity but the others are both wrong as well.	Thank you for your comment. Thank you for highlighting the error and we have amended the guideline accordingly.
268	PR	NETSCC, HTA Referee 2	30	Full	7.5.5.1	174	It is not clear why so much is made of this result (lines 8-12)	Thank you for your comment. Although the results did not show a significant effect of morphine as a risk factor for delirium, the GDG wanted to highlight that even a 1mg increase in dose increased the odds of becoming delirious.
269	NICE	Technical Adviser	59	full	7.5.6	177	Is this risk for **incidence** of delirium?	Thank you for your comment. We have stated in the subsections that the studies

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								were examining the risk for incidence of delirium. We have clarified this in the introductory paragraph and the guideline has been amended accordingly.
270	SH	St Helens and Knowsley NHS Trust	21	Full	8.2	182	Data from some of the original studies in the critically ill that first raised the possible increased risk of mortality have been re-examined with statistical adjustment to account for immortal time bias (to adjust for events that don't occur at the same time) and show that the risk of mortality is actually higher, adjusted hazard ratio =3.2 (1.4-7.7) Ref: Crit Care Med 2009; 37: 2939-2945	Thank you for your comment. The article you have referred to has been published following the cut-off date date for searches (17th August 2009) and was therefore not included in the review. Having examined the evidence, we feel although the paper adds to the existing evidence base it does not alter the existing recommendations and will not be included and analysed in depth.
273	PR	NETSCC, HTA Referee 2	8	Full	8.2	183	Line 25: It is not clear why stroke should particularly confound this outcome rather than any of the other outcomes, i.e. is stroke separately analysed for other outcomes?	Thank you for your comment. The GDG felt that stroke would be confounded for an outcome which is assessing mobility.
274	SH	West Hertfordshire Hospitals NHS Trust	4	Full	7.3.3.7.	160	Regarding the Pandhiparipande study (2008) being confounded on the basis of patients maybe having received sedative medications as consequence of delirium between assessments – the same could be said of all the ICU studies. None of	Thank you for your comment. The GDG discussed the points raised in this comment and we have amended the guideline accordingly.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							them will have had delirium continually monitored, certainly those using the CAM-ICU, and if they were on sedative infusions grimacing due to hyperactive delirium may have been thought to be pain and the fentanyl increased. This is a concern because the 2008 study concludes that midazolam was the most consistent and significant predictor of transitioning into delirium in our cohort. The conclusion of the committee is that there is no evidence of this. I would ask that the committee review this decision regarding this study or review all the other ICU studies with the same question mark over sedative drugs given.	
278	SH	Royal College of Nursing	5	full	8.5	221	The study used is approaching 13 years old and the evidence from this appears to be of low quality, however when reviewing incidents of falls, this indicates that there is a link between falls and confusion. We hope that with the introduction of the guideline for assessment of delirium, this will allow further investigation of the relationship between falls and delirium.	Thank you for your comment. We agree this is an under-researched area and would benefit from a stronger evidence base.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
280	PR	NETSCC, HTA Referee 2	31	Full	8.4.1.1	204	I looked up the OR in the original paper as it seemed high as reported here. Adj OR in paper is 1.80 (1.11-2.92). This is a significant misreport	Thank you for your comment. The OR referred to in this comment relates to risk of mortality reported in the Rockwood (1999) study. The section 8.4.1.1 entitled 'risk factor: presence of prevalent or incident delirium' the dementia paragraph (now called section 9.4.1) is reporting results for the outcome dementia/cognitive impairment as a consequence of delirium. The results for this outcome [OR 5.97] can be found on p.553 in the Rockwood (1999) study and this is the value we have reported that reported in this section.
281	PR	NETSCC, HTA Referee 1	19	Full	8.4.1.2	206	Again I do not see why a formal summary cannot be made of the discharge studies. Indeed with a suitable covariate I would have included all of the studies in one analysis, the fall in risk with increased time is surely worthy of presentation.	Thank you for your comment. We have opted not to combine observational studies in a meta-analysis as per the guidance outlined in the NICE guidelines manual.
283	PR	NETSCC, HTA Referee 2	33	Full	8.4.1.3.	208	The mortality outcomes reported on this page is confusing; it is merges with institutionalisation outcomes	Thank you for your comment. We have amended the guideline accordingly.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
284	PR	NETSCC, HTA Referee 1	20	Full	8.4.1.3	210	Again this cries out for a formal synthesis.	Thank you for your comment. We have opted not to combine observational studies in a meta-analysis as per the guidance outlined in the NICE guidelines manual.
286	PR	NETSCC, HTA Referee 1	18	Full	8.3.4.4	197	Surprising that sex not considered as a confounder for mortality especially when it was considered for pressure sores.	Thank you for your comment. Sex was initially considered as a confounding factor for mortality. However, the GDG made a post-hoc decision to remove sex following the results for the risk factor review which showed this was not a significant risk factor for delirium. We have amended the guideline to reflect this discussion.
287	PR	NETSCC, HTA Referee 2	34	Full	8.4.1.6	214	Could OR be reported here rather than percentages?	Thank you for your comment. The adjusted odds ratio have been reported for the composite outcome, mortality *and* new admission to hospital, as reported in the individual studies. Calculating the odds ratio for the number of patients who *either* died *or* were newly admitted to hospital will not be accurate as this will not be reporting a result for the composite outcome adjusted for the confounding

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								factors.
296	PR	NETSCC, HTA Referee 1	22	Full	9.17.1	250	Why is the presentation method changed here, and which forest plots are in green boxes?	Thank you for your comment. As stated in section; 9.17.1 (now called section 10.21.1: multicomponent hospital care versus usual treatment), forest plots highlighted in green indicated that they include moderate or high quality studies.
300	PR	NETSCC, HTA Referee 1	21	Full	9.31.1.2	235	Both figures here have misleading widths for the central square which should not extend beyond the confidence intervals. This problem occurs repeatedly from this point onwards. If the software does not allow control of the box size then use different software.	Thank you for your comment. At present we are unable to address this formatting issue, but we will ensure that the forest plots are uniform and correct prior to publication of the guideline.
304	SH	Intensive Care Society	5	Full	9.15.3.6	243	Misprint: maintenance of fluid and electrolyte 'imbalance'	Thank you for your comment, The guideline has been amended accordingly.
307	PR	NETSCC, HTA Referee 1	23	Full	10.4.2.1	287	Why not combine the two RCT and then interpret the presumably large heterogeneity?	Thank you for your comment. It was agreed *a-priori* that the types of comparisons reported in this section would be treated separately. Please refer to the section entitled *Types of comparisons* within section 2.3.3 (*Selection criteria: reviews of interventions)* of the Methodology chapter (chapter

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								2).
308	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	14	Full	10.2.3.3	278	Line 19-27; Kalisvaart gave 500microg Haloperidol three times a day, not 1.5mg three times a day as stated.	Thank you for your comment. Thank you for highlighting this error and the guideline has been amended accordingly.
314	PR	NETSCC, HTA Referee 1	24	Full	11.4.2.1	303	What does it mean to say this is significant here? No formal analysis has been done of the studies presented in the figure. Incidentally the axis need relabelling for comparisons of two active agents the current one is suitable only for comparison against placebo.	Thank you for the comment. The included forest plot was incorrect. We have amended this. However, the following explanation still applies. As we are presenting results from cohort studies we have not produced an overall summary effect as per the advice in the NICE Guidelines Manual.
317	SH	Intensive Care Society	6	Full	12	306	There appears to be no reference in the chapter on accuracy of diagnosis to the Intensive Care Delirium Screening Checklist described by Bergeron et al, either in the chapter nor in the list of excluded references. It has sensitivity of 99%, specificity 64%, inter-rater reliability 0.94 (Bergeron, N, Dubois, MJ, Dumont, M, et al Intensive care delirium screening checklist: evaluation of a new screening tool. Intensive Care Med 2001;27,859-864).	Thank you for your comment. The GDG did not consider the Intensive Care Unit-Delirium Screening Checklist as an index test to be evaluated in the ICU setting. The Bergeron (2001) study has been added to the excluded study list.
318	PR	NETSCC, HTA	27	Full	Figure	336	Is it meaningful to draw ROC curve	Thank you for your comment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Referee 1			12.14		through so few points?	We agree ROC curve is not meaningful for the results presented in this section. We have removed this figure and the narrative has been amended accordingly.
321	PR	NETSCC, HTA Referee 2	9	Full	12.2.4.	316	The CAM cannot be treated as reference standard **and** an index test	Thank you for your comment. The study was comparing CAM test executed by a lay interviewer (index test) with CAM test executed by a geriatrician (reference standard). This is the reason CAM has been reported as an index and a reference test.
325	PR	NETSCC, HTA Referee 1	25	Full	12.1.3.5	307	Here ICD 10 is allowed but we have previously been told that DSM was the chosen definition for this report. This inconsistency needs dealing with expecially if it means that otherwise useful evidence has been excluded.	Thank you for your comment. The decision to exclude ICD-10 in the epidemiology review was based partly on the findings of the diagnostic test accuracy review. This is explained in the introduction and section 5.3 of the epidemiology review.
326	SH	West Hertfordshire Hospitals NHS Trust	6	Full	12.4.4.1	331	It is not clear on what basis the screening tests described were chosen (I may have missed it). For instance the NEECHAM or the Cognitive Test for Delirium. I know the CAM needs intense training and refreshing. Have such training needs of staff been incorporated	Thank you for your comment. The index tests considered in this review were based on GDG expertise. The cost of training a health care professional is not usually considered within the cost-effectiveness analysis but it may be included in the budget-

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							into the costings?	impact analysis of the guideline which is produced by NICE.
335	PR	NETSCC, HTA Referee 1	28	Full	Figure 13.7	359	Why can these not be combined?	Thank you for your comment. The GDG agreed that due to the differences in the multi-component interventions being considered in the two studies it was not suitable to combine such interventions.
336	SH	Intensive Care Society	7	Full	14		Although the paper on dexmedetomidine was excluded because it does not have a license for use in the UK, no mention is made of using clonidine another alpha-2 agonist which is used in many ICUs (see doi:10.1510/icvts.2009.217562); this could also be a useful source for future research.	Thank you for your comment. The article you have referred to was published after the cut-off date for the literature search for this guideline (17th August 2009) and has therefore not been included in the evidence review or in the future research recommendations.
340	SH	Intensive Care Society	8	Full	14.2.2	365	Despite the above, this (ICDSC) is the screening method used in one of the 3 papers referred to in this chapter.	Thank you for your comment. The Skrobik (2004) study reported that the method of delirium assessment at baseline was based on ICU-DSC but was confirmed with DSM-IV. We acknowledge we did not consider the ICU-DSC as an index test in the diagnostic test accuracy review assessment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								However, when we quality assessed the Skrobik (2004) study we based our decision that the study employed an adequate assessment of delirium was made based on the fact DSM-IV was used to confirm the diagnosis.
349	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	17	Full	Table 16.2	401-402	The costs cited in the table as input into the health economic model do not match the costs cited in the text. For example, the MTI (Hip fracture surgery) are cited as £511 in the table, but are cited as £516 in the text (page 399, line 37)	Thank you for your comment. The cost in the text should be £511 and not £516. Estimate on page 399, line 34 should be £235 and not £240. The guideline document has been updated accordingly with the correct estimates.
351	SH	European Delirium Association	1	Full	16.5.4	419	My greatest anxiety was over the use of a health economic argument to decide if haloperidol or olanzapine was best for treating delirium. I really do think that the cost of drugs pales into insignificance with an acute admission for delirium. Therefore using a health economic model is ill advised or even unethical here. What matters is the best outcome clinically in terms of recovery mortality and length of	Thank you for your comment. The NICE clinical guidelines manual requires that several factors are considered during the process of making recommendations. Health Economic evidence is one of the factors considered. The GDG first appraised the evidence on the clinical effectiveness and safety of olanzapine and haloperidol. They also considered the balance of total cost associated with using the

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							stay. So I would strongly question the conclusion to use haloperidol using a health economic model. Just give data on mortality and recovery for the two drugs.	drugs and the impact on the patient's quality-adjusted life years. It was after considering these factors that they recommended that health care professionals consider using the drugs (short-term use only) if people with delirium are distressed or a risk to themselves or others (see recommendation 1.6.4)
352	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	15	Full	16.2.7.1	399	The baseline costs for the multi-component targeted intervention model need to be more comprehensive. Small changes in cost appear to make large changes to the output as the QALY value is small for a modest cost saving (and is therefore magnified when multiplied up to full QALY). For example, there appears to be no cost attached to the placement of an NG tube or more intense physio /OT input. Highlighting the consequences of delirium and benefits of delirium prevention would naturally increase these interventions through the implementation of this guideline;	Thank you for your comment. The GDG considered the different modules in the multi-component intervention model for surgical and general medical patients. The Elder Life Program designers recommended a specified set of core staff involved in the application of the program in the hospital (Inouye 2000)*, and this was considered by the GDG. The Program designers acknowledged that other support staff could provide invaluable support but mentioned that their time is not covered by the program budget. The GDG advised on the core and equivalent NHS staff that

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							pragmatically speaking it is unlikely they will remain at the same level. Conversely, the prevention model could be improved (in terms of cost) by improving training to pharmacists, who review medication charts daily anyway (in secondary care), or through medication use review (MUR's in primary care), so can therefore highlight medication issues to the team and reduce the demand on the geriatricians time to less than the postulated 15mins.	will be needed to apply the multi-component interventions in surgical and general medical patients. They also advised on the equivalent staff pay band that will be required for applying the program (see chapter 16 section 16.2.7 entitled '*Cost of multicomponent targeted intervention*'). Trained volunteers were recognised by the program designers as important staff required for applying the program. We have not assumed that volunteers will be used to apply this program but have included cost of their time (equivalent to pay band 2) in our cost estimate. The GDG felt that it was enough to include only the cost of these members in the costing, and our estimate were based on these recommendations and advise. We increased the cost of applying the intervention in general medical patient (from £377 to £404). However, this was to account for possible additional work load for the

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								Geriatric nurse specialist and Elder Life Specialist. * Inouye SK, Bogardus ST Jr, Baker DI, Leo-Summers L, Cooney LM Jr. The Hospital Elder Life Program: a model of care to prevent cognitive and functional decline in older hospitalized patients. Hospital Elder Life Program. **J Am Geriatr Soc**. 2000 Dec;48(12):1697-706.
354	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	16	Full	16.2.7.2	400	The hospital elder life program makes use of a core team (included in the financial calculations) and a wider team (chaplain, pharmacist, dietitian, rehabilitation therapists, discharge planner, social worker, psychiatric liaison nurse) whose expertise is drawn on when required. No attempt is made at adding a cost for these team members.	Thank you for your comment. The GDG considered the different modules in the multi-component intervention model for surgical and general medical patients. The Elder Life Program designers recommended a specified set of core staff involved in the application of the program in the hospital (Inouye 2000)*, and this was considered by the GDG. The Program designers acknowledged that other support staff could provide invaluable support but mentioned that their time is not covered by the program budget.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								The GDG advised on the core and equivalent NHS staff that will be needed to apply the multi-component interventions in surgical and general medical patients. They also advised on the equivalent staff pay band that will be required for applying the program (see chapter 16 section 16.2.7 entitled '*Cost of multicomponent targeted intervention'*). Trained volunteers were recognised by the program designers as important staff required for applying the program. We have not assumed that volunteers will be used to apply this program but have included cost of their time (equivalent to pay band 2) in our cost estimate. The GDG felt that it was enough to include only the cost of these members in the costing, and our estimate were based on these recommendations and advise. * Inouye SK, Bogardus ST Jr, Baker DI, Leo-Summers L, Cooney LM Jr. The Hospital

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								Elder Life Program: a model of care to prevent cognitive and functional decline in older hospitalized patients. Hospital Elder Life Program. J Am Geriatr Soc. 2000 Dec;48(12):1697-706.
357	SH	Royal College of Speech and Language Therapists	3	Full	3.1.2		The section on indicators of prevalent delirium refers to assessment by a suitable healthcare professional- it would be helpful to have the expertise specified. SLT's would potentially have a very valuable role here particularly where patients are experiencing communication difficulties that may affect verbally mediated assessments.	Thank you for your comment. We agree that SLT have an important role. This is an issue that needs to be addressed locally by individual health care providers during guideline implementation.
358	SH	Royal College of Nursing	2	FULL/ NICE	14.7/ 1.6.4	375/ 15	We would query the specific recommendation of Olanzepine and Haloperidol as a short - term treatment option. Whilst we understand the need to offer something to people who are acutely distressed, the evidence is limited for using antipsychotics. These medications are not licensed for delirium and there is obviously the recent guideline on the use of antipsychotics for people with	Thank you for your comment. Delirium can be an extremely distressing condition in which harm to the individual and care staff is a real possibility. For this reason, the GDG consider a blanket ban on antipsychotic drugs would be inappropriate. We have therefore recommended a cautious approach with limited use of these agents for short periods. This recommendation has been

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							dementia, which should be taken into account, in which neither of these two drugs are recommended for use. As people with dementia are clearly an at risk group of experiencing delirium, we would be concerned about any guidelines specifically recommending the use of these drugs.	balanced against the evidence for harm literature to which you refer.
360	SH	Alzheimers Society	8	general	general	general	References Alzheimer's Society (2007) Dementia UK, a report to the Alzheimer's Society by King's College London and the London School of Economics. Alzheimer's Society: London. Alzheimer's Society (2009) Counting the cost: caring for people with dementia on hospital wards. Alzheimer's Society: London. Cole, M. G. (2004). Delirium in elderly patients. American Journal of Geriatric Psychiatry,12, 7-21. Department of Health (2001).	Thank you for your comment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							National Service Framework for Older People. Department of Health: London. Department of Health (2009) Living well with dementia: A National Dementia Strategy. Department of Health: London. Fick et al. (2002) Delirium superimposed on dementia: A systematic review. Journal of American Geriatric Society, 50, 1723-1732. Holmes, J. and House, A. (2000). Psychiatric illness predicts poor outcomes after surgery for hip fracture: a prospective cohort study. Psychological Medicine, 30, 921-929. King's Fund (2008). Paying the price: the cost of mental health care in England to 2026. King's Fund: London. Levkoff SE, Evans DA, Litpzin B, et al. (1992) Delirium: the occurrence and persistence of symptoms among elderly hospitalized patients.	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							Archives of Internal Medicine, 152, 334-40. Lindesay J, Rockwood K, Rolfson D. The epidemiology of delirium. In: Lindesay J, Rockwood K, Macdonald A editor(s). *Delirium in Old Age*. New York: Oxford University Press, 2002:27–50. National Audit Office (2007). Improving services and support for people with dementia. NAO: London. Pisani MA, McNicoll L, Inouye SK. (2003). Cognitive impairment in the intensive care unit. Clinical Chest Medicine, 24, 727-37. Siddiqi N, Holt R, Britton AM, Holmes J. Interventions for preventing delirium in hospitalized patients. *Cochrane Database of Systematic Reviews* 2007, Issue 2. Art. No.: CD005563. DOI: 10.1002/14651858.CD005563.pub2.	

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
361	SH	College of Mental Pharmacists	31	General	General	General	Do you think this guidance could be changed to better promote equality of opportunity relating to age, disability, gender, gender identity, ethnicity, religion and belief, sexual orientation or socio-economic status?. 1. As mentioned above; just highlighting increasing age as a risk factor may hinder recognition and prevention in other age groups 2. Perhaps a greater emphasis is needed throughout on the provision of person-centred care rather than on value-judgements made within the service provision and/or caring process?	Thank you for your comment. When writing the recommendations at every stage we have considered person-centred care, which is why for example the multicomponent preventative interventions recommendations have explicitly stated that these should be 'tailored' to the needs of the individual. Increasing age as a risk factor is based on evidence from the literature. By stating this, it is not to hinder recognition / prevention in other age-groups but rather the aim was to prevent unnecessary preventative measure being carried out for many younger people who are healthy and just coming into the hospital with a minor injury, and therefore not at risk of delirium.
362	SH	Department of Health	1	general	general	general	Thank you for the opportunity to comment on the draft for the above clinical guideline. I wish to confirm that the	Thank you.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							Department of Health has no substantive comments to make, regarding this consultation.	
363	SH	ICUsteps	1	General	General	General	After reviewing the draft guideline, ICUsteps has no comments to add to the consultation. We are happy with the content of the guideline and have confidence in the robust process undertaken to produce it. We would also like to thank the GDG for their hard work in producing this welcome piece of guidance	Thank you for your comment.
364	SH	Royal College of Nursing	1	General	General		The RCN promotes patient and nursing interests on a wide range of issues. The RCN welcomes this document.	Thank you.
365	SH	Royal College of Nursing	11	General	General	General	It is disappointing and worrying that issues of patient safety appear to have been superficially addressed. Healthcare has a fundamental duty of care to the patient and the maintenance of their safety particularly when the individual has issues of cognition which results in the patient being unable to make safe decisions.	Thank you for your comment. We agree that delirium is potentially a devastating illness with several associated possible harms, including death. This is why we have emphasised the prevention and early detection of delirium, and emphasised the importance of the care environment and the sensitive involvement of family and

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							Whilst addressing the underlying causative condition is important, it is equally important to ensure that the patient does not sustain any injury through a fall etc whilst suffering the effects of delirium. Drug interventions are of help but do not resolve all risks.	friends.
366	SH	Royal College of Nursing	12	General	General	General	Should this document also consider such interventions as 1:1 nursing / supervision?	Thank you for your comment The appropriate still mix and numbers of care staff is a matter for local health care providers.
369	SH	Royal College of Nursing	9	NICE	General	General	The emphasis on prevention and identifying casual factors for delirium is most welcome and helpful.	Thank you for your comment.
370	SH	Royal College of Nursing	10	NICE	General	General	The use of specialist assessor may be problematic if no one is available as often delirium needs to be managed immediately. However this may be useful to argue for the need for better mental health liaison services.	Thank you for your comment. How the guidance is implemented (there are many possible approaches) is a task for individual health care providers.
371	SH	Royal College of Psychiatrists	1	NICE	general	general	The issues which stand out as possible problems are those of drug and alcohol withdrawal. Although we accept that the scope of the guidance excludes alcohol, it seems	Thank you for your comment. The scope of the guideline was agreed by previous consultation and following a stakeholder meeting in May 2008.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							perverse to ignore this very common problem which will interact with so many clinical scenarios. The 65+ person with fractured hip may have sustained the injury due to a fall consequent upon alcohol misuse. Although the expert will know this, if the guidance doesn't remind the generalist in a care home or hospital they may not adequately check the history. So we should support the screening process for delirium but say that it is carried out in the context of a comprehensive assessment which should include enquiry about alcohol use and also previous medicine use. The latter picks up on the obvious problem of withdrawal states such as those caused by benzodiazepines. Therefore the review of medicines in relation to polypharmacy should also include a check of what medicines were taken previously.	
372	SH	Royal College of Psychiatrists	4	NICE	general	general	Overall the document is a thorough work of scholarship; however, we feel that the size is so daunting that it is questionable whether anyone will actually read anything more than the summary. We would therefore	Thank you for your comment We have amended the guideline document where appropriate. Narratives of study characteristics (description of studies, study design, sample

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							recommend that the document is shortened somewhat, if possible, or some of it put in a supplement.	size geographical location and funding) have been tabulated. All forest plots have been moved into the appendices and a summary table of the results has also been provided before the 'evidence to recommendations' section.
373	SH	Royal Pharmaceutical Society of Great Britain	1	NICE	General	General	The RPSGB welcomes these guidelines particularly the recommendations for pharmacological interventions in 1.6.4. and the need for further research on this area of prescribing.	Thank you.
374	SH	Royal Pharmaceutical Society of Great Britain	2	NICE	General	General	We would stress the importance of the role of pharmacists in reviewing such prescribing both in the hospital setting and in long term care e.g. nursing and residential homes.	Thank you. How the guidance is implemented (there are many possible approaches) is a task for individual health care providers. We believe we have set out the serious consequences of delirium in the introduction section of the guideline (chapter 1) and have stressed the importance and urgency of early delirium detection and provided detailed guidance on how to prevent delirium, as far as this is possible. Further, we have

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								emphasised the importance of severe illness (1.1.1).
375	SH	Royal Pharmaceutical Society of Great Britain	3	NICE	General	General	We would recommend that a summary of this guidance is included in the next edition of the BNF.	Thank you for your comment. The BNF is run by NHS evidence and the Joint Formulary Committee (JFC) is responsible for the content of the BNF. Further information is available on the BNF website. We can however, forward your comments to the Commissioning Manager at NHS evidence.
376	SH	St Helens and Knowsley NHS Trust	1	NICE	General	General	The approach of the guidance is very much from a care of the elderly aspect and perhaps misses the importance of delirium in the critical care setting. It does not emphasise adequately that the presence of delirium is a serious additional prognostic indicator and that the patient is more severely ill. For instance, a patient with pneumonia AND delirium is much sicker and more likely to die than one without delirium (they have lung and brain pathology) and needs more urgent or intensive care. Therefore the recognition of delirium takes on a	Thank you. We agree with your comment. The GDG membership included psychiatrists, specialist nurses, A&E and ICU. This was to ensure the guideline was as broad as required by the scope document. We identified that older people, people with cognitive impairment/dementia, people admitted to hospital with a facture and people with serious illness were at high risk of delirium – and the guideline reflects these high risk groups.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							new importance. It is not just about identifying delirium but about identifying the sicker patients.	
377	SH	St Helens and Knowsley NHS Trust	2	NICE	General	General	The guidance makes it clear that lifestyle problems such as alcohol abuse have been excluded, but the guideline should make some comment about taking a patient history at admission and asking about lifestyle.	Thank you for your comment. We agree that basic history taking in acutely ill patients should encompass lifestyle problems such as alcohol abuse and smoking. We did not feel that these aspects were sufficiently specific to delirium to warrant special emphasis.
378	SH	St Helens and Knowsley NHS Trust	3	NICE	General	General	It is good that pharmacotherapy is not emphasised. However, it needs to be discussed in more detail if this guideline is to have any use. Drugs are invariably only used for hyperactive delirium and the evidence is linked to the two anti-psychotics mentioned. While benzodiazepines are strongly associated with delirium they still play a role. In the critical care setting it is often necessary to give a short acting benzodiazepine to get patient control while the anti-psychotic drug takes effect so that the patient does not do themselves, or others, harm. Withdrawal of	We accept and respect that individual practitioners have considered views on the use of drugs in delirium. Our approach has been measured and cautious and reflects the evidence base. We are concerned about promoting the wider use of benzodiazepines because of the uncertainty about effectiveness and because of their potential for their precipitating or aggravating delirium.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							benzodiazepines is associated with delirium as well as acute anxiety and this needs to be considered. Examination of a patient's prescription is not only about what might be precipitating delirium but should also examine what they were receiving.	
379	SH	St Helens and Knowsley NHS Trust	4	NICE	General	General	There is very little evidence on delirium in long-term care settings. Whilst it is laudable that this population is being considered, is there really enough evidence on which to base any recommendations other than improving basic care and performing research in this population?	Thank you. We agree that an important finding arising from this guideline is the lack of good quality evidence for delirium care in long-term care settings. This is a very high risk population for delirium by virtue of age and highly prevalent dementia. We have made a research recommendation as a priority to address this.
380	SH	West Hertfordshire Hospitals NHS Trust	2	NICE	General	General	The guideline needs to clearly state in the summary that clinicians miss delirium because the majority of patients present with hypoactive and mixed delirium. It is assumed that the reader knows this – they won't. Getting clinicians to realise this is crucial.	Thank you for this contribution, we agree and have added a sentence about this into the evidence to recommendations section for this recommendation and also in the introduction of the guideline accordingly.
383	SH	Welsh Assembly Government	1	NICE	Introduction	3	The introduction is misleading in its description of the population who	Thank you for your comment. The guideline is consistent with

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							suffer from delirium. It describes the high prevalence of delirium on "medical wards" and after "surgery" not clarifying that the evidence shows that delirium only has such a high prevalence on medical wards and after surgery where the patients are elderly. In fact the prevalence is very low in adults of working age. There is a mention of the older people and people with dementia being "more at risk" of delirium but for those not knowledgeable in this area the magnitude of this difference is not clarified.	the points you raised. It is important to bear in mind that two thirds of people in hospital wards are 'elderly'. Thus, the terms 'medical wards' and 'surgical wards' implicitly imply an elderly population. We have fully emphasised the high risk population (including old age) in 1.1.1. We have also demonstrated the high occurrence rate of delirium in various hospital departmental settings in the Epidemiology chapter (chapter 5).
384	SH	West Hertfordshire Hospitals NHS Trust	11	NICE	Introduction	3	I think the fact that delirium can accelerate the cognitive decline (Fong, Neurology 2009) in Alzheimers Disease is important and could be added in with 2nd bullet point.	We have stated that one adverse consequence of delirium is dementia as the evidence is strongest in this area.
385	SH	College of Mental Pharmacists	1	NICE		4	Should refer to 'medicines' not 'drugs.' i.e. the sentence should read " The guidelines will assume that prescribers will use a medicine's Summary…etc" The url to the electronic medicines compendium which outlines all agents' Summary of Product Characteristics (SPCs) should be	Thank you for your comment. The NICE style guide states that we should use the term 'drugs' in preference to medicine or medication, however in mental health guidelines we are advised to use the term 'medication' if stakeholders strongly prefer this, because of connotations relating

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							included. (http://emc.medicines.org.uk/) This note does not appear in the FULL guidance and perhaps should for consistency of advice.	to drug misuse. However, in this case we have kept the words 'drugs' as we felt it was more appropriate here.
386	SH	College of Mental Pharmacists	2	NICE		6	The risk factor section is evidence-based according to the FULL guidance, however a note should be added that delirium is NOT confined to those over 65years and can be common in all age groups in the presence of infection; trauma; post operatively or severe illness	Thank you. We take on board the issue here. Our review of delirium risk factors suggests that delirium is less common in younger people. We have identified the key risk factors for delirium occurrence in recommendation 1.1.1.
387	SH	Royal College of Psychiatrists	2	NICE		6	Delirium can confound a new assessment of cognitive impairment; a good history is cornerstone.	We certainly agree that a good history is essential in the assessment of sick people. However, we also know that many people with delirium (perhaps as much as 50%) are missed in routine care. Hence our emphasis on clinical indicators for the delirium syndrome (recommendation 1.2.1).
391	SH	College of Mental Pharmacists	3	NICE		12	Sentence should read "carry out a medicines review" or "medication review for people taking multiple medicines in line with…etc" as this is in line with current terminology in this area.	Thank you for your comment. The NICE style guide states that we should use the term 'drugs' in preference to medicine or medication, however in mental health guidelines we are advised

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4896131) This amendment should apply to all areas in the NICE and FULL document where 'drug review' or 'multiple drugs' are used. It is also important to note that delirium can be caused by a medication (or other substance) being started or withdrawn. This guidance excludes this cause of delirium from the guidance however it is a very important and common cause and should be part of the medication review.	to use the term 'medication' if stakeholders strongly prefer this, because of connotations relating to drug misuse. We therefore have amended the wording of the recommendations accordingly with the words 'medication' where we felt this was appropriate, but we will not use medicine or agent.
392	SH	College of Mental Pharmacists	4	NICE		15	After haloperidol there should be a codicil to monitor carefully for worsening confusion caused by its anticholinergic effects and for both the risks of increased CVE and CVA mortality and morbidity.	Thank you. We have now included a clinical review/reassessment for patients whose delirium is not resolving
393	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	32	NICE	Appendix C	26	The Algorithm must reflect changes implied by the points made under Order Numbers 6 – 12	Thank you for your comment, we have amended the algorithm where appropriate.
394	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	33	NICE	Appendix C	26	When an appropriate algorithm is produced it could form an entry with some descriptive text in the British National Formulary, and thus be	Thank you for your comment. The BNF is run by NHS evidence and the Joint Formulary Committee (JFC) is

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							readily available to health care workers in the UK.	responsible for the content of the BNF. Further information is available on the BNF website. We can however, forward your comments to the Commissioning Manager at NHS evidence.
396	SH	St Helens and Knowsley NHS Trust	5	NICE	1.1.1	6	The risk factor assessment is useless for patients in critical care settings as all patients are at risk and therefore should be automatically screened using a tool such as the CAM-ICU at least once per shift. This needs to be forcefully stated in the text – "in the critical care setting all patients should be viewed as high risk for delirium and tested once per shift using a tool such as the CAM-ICU"	Thank you for your comment. We recognise that ICU patients are at high risk of delirium. Although the evidence was limited in this area, the GDG felt that this population has been captured in the severity of illness category. The GDG also recognised that ICU patients are likely to pass rapidly to assessment with CAM-ICU. We reviewed the evidence for the diagnostic accuracy of practical diagnostic tests but the evidence did not provide adequate information on frequency of testing. Therefore we have not provided guidance on frequency of testing.
400	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	25	NICE	1.2	10	Again, suggest separating out "fast" indicators from "slow" indicators to underscore that different manifestations of delirium occur.	Thank you for your comment, we agree and have denoted those associated with hypoactive delirium.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
401	SH	Sussex Partnership NHS Foundation Trust	1	NICE	1.1.1	9 (and also page 6 under "key priorities".	Under risk factor assessments there is no mention of alcohol / substance misuse, sensory impairment, dehydration, malnutrition or functional dependency. Any or all of these factors can increase risk of delirium and therefore should be added to the document	Thank you for your comment. Alcohol and/or substance misuse induced delirium is outside of the remit of the scope. With reference to the other risk factors, these have been reviewed in the risk factors: non pharmacological review (chapter 7) and the evidence has been used to underpin the recommendations on the tailored multicomponent intervention.
403	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	19	NICE	1.2.1	6	There appears to be a great reluctance to spell out the motoric subtypes of delirium. Utilising this approach is useful in highlighting that delirium can present as both a quiet motor form and/or the active motor form, more so than lumping all the features together in one bullet point. In general, healthcare workers are aware of "agitated delirium" but not hypoactive delirium and contrasting them is thus educationally useful.	Thank you for your comment, we agree and have denoted those associated with hypoactive delirium.
405	SH	St Helens and Knowsley NHS Trust	10	NICE	1.1.2	10	Of the risk factors listed, only "severe illness" is likely to change during hospital admission. Some people will become 65 or break a hip during hospital admission. If	Thank you for your comment. The GDG wanted to highlight that modifiable risk factors should be observed for following presentation to hospital in those

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							someone becomes cognitively impaired during their admission the cause of this needs to be found and they may well be delirious. The intervention trials did not reassess risk factors during the hospital admission. There is little evidence for the effectiveness of reassessment of risk factors. A simple one-off assessment of risk status on admission, followed by observation for symptoms of delirium is much more practical and evidence-based.	who were initially not found to be at risk for delirium. Changes in these risk factors coupled with changes to cognitive and behavioural would serve as a trigger to health care professionals to consider the patient to be at increased risk for delirium.
406	SH	St Helens and Knowsley NHS Trust	6	NICE	1.3.1	7	"avoids unnecessary room changes" should be stronger "avoids unnecessary bed space, room or ward changes"	Thank you for your comment. We do not feel it would be practical to say 'bed changes'. However, we have revised the wording of the recommendation to include ward and room changes.
408	SH	St Helens and Knowsley NHS Trust	8	NICE	1.4.1	14	See comment number 2 – these indicators are not useful in the critical care setting and regular screening with the CAM-ICU should be recommended.	Thank you for your comment. The GDG recognised that ICU patients are likely to pass rapidly to assessment with CAM-ICU. This has been added to the 'evidence to recommendations' section in chapter 6 (Diagnosis)
409	SH	St Helens and	7	NICE	1.3.3	7	The document defines all those over	Thank you for your comment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Knowsley NHS Trust					age 65 as at risk of delirium and recommends a multi-component intervention package for all of them. This approach would include a large number of patients who are actually at relatively low risk of developing delirium. The evidence for the clinical and cost-effectiveness of intervention is for people at intermediate and high risk of developing delirium.	The GDG debated this issue and agreed that even if age was removed from the list of risk factors, the other 3 risk factors mentioned mean that most of the hospital patients would be included anyway. They felt that it the intervention package should be implemented across the board as it is easier to implement and strengthens the message.
410	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	26	NICE	1.5.1	14	Both CAM-ICU and ICDSC should be "allowed". CAM-ICU is a "point in time" test; ICDSC assesses a patient over the course of a shift (useful for a fluctuating condition).	Thank you for your comment. We have only reviewed the evidence for CAM and CAM-ICU and not for ICU-DSC. Therefore the recommendation will not be altered.
411	SH	West Hertfordshire Hospitals NHS Trust	7	NICE	1.5.1	14	I do not think there is enough evidence currently to recommend the CAM-ICU over the Intensive Care Delirium Screening Checklist for routine screening of ICU patients. It is usually a matter of local preference. While the CAM-ICU is much more widely used I know the Sheffield hospitals are using the ICDSC.	Thank you for your comment. We have examined the evidence for CAM and CAM-ICU and have found it has moderate to high sensitivity compared with DSM-IV. We did not review the evidence for ICU-DSC.
414	SH	College of Occupational	1	NICE	1.3.3.1	11	I feel that there needs to be a bullet point highlighting the need to	Thank you for your comment. We feel that this is covered by

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Therapists					acknowledge the persons anxieties and not ignore them.	the second bullet point in recommendation 1.3.3.1, addressing reorientation. Providing reassurance to people with delirium is explicitly covered in recommendation 1.6.2.
415	SH	Royal College of Nursing	7	NICE	1.3.3.1	11	The use of soft lighting might not be helpful for those with visual impairments (see research by: http://www.pocklington-trust.org.uk/lightinganddesign/)	Thank you for your comment, we agree and have amended the wording of the recommendation to say 'appropriate' lighting.
416	SH	St Helens and Knowsley NHS Trust	11	NICE	1.3.3.1	11	This should include a statement about trying to create day/night differentiation in the critical care setting and family bringing in personal items from home such as photographs.	Thank you for your comment. We have amended the wording of the recommendation to say 'appropriate' lighting. However the developers feel that adding examples such as bringing in personal items is too much detail for inclusion in this broad national guideline.
419	SH	St Helens and Knowsley NHS Trust	15	NICE	1.6.1	14	This section needs to be specific about how to identify and manage the possible underlying cause(s) or it will not get done. This should include much more detail on checking and treating constipation, stop deliriogenic drugs, culture for infection, etc. The implication is that you should do everything that is in section 1.3 but users of the	Thank you for your comment. The GDG did not want to draw up an exhaustive list of all underlying causes that need to be addressed. This would detract from the key messages within this section and make for an unwieldy document.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							guideline may not make that link.	
420	SH	West Hertfordshire Hospitals NHS Trust	8	NICE	1.6.1	14	I believe the guideline would be more effective if this section stood alone. The identification and management of the precipitating cause(s) is the most important thing that can be done for delirious patients. This is indicated by the fact that incident delirium is thought to have better outcomes than prevalent. The identification of infection, correction of oxygen delivery and metabolic disturbances and the stopping of deliriogenic medication is key. This needs to be hammered home!	Thank you for your comment. We agree that identification and management of underlying causes is an important aspect and this has been identified as a key recommendation. We have also aimed to give this recommendation prominence in the treatment pathway by identifying as the first point to consider under 'initial management' of treatment of delirium. However, the GDG did not want to draw up an exhaustive list of all underlying causes that need to be addressed as this would detract from the key messages within this section and make for an unwieldy document.
423	SH	St Helens and Knowsley NHS Trust	12	NICE	1.3.3.2	11	Could we have more specific advice such as regular U&E's, keeping accurate fluid balance charts and an accumulative fluid balance for those receiving intravenous fluids to spot overload?	Thank you for your comment. The developers feel that this is too much detail for inclusion in this broad national guideline
425	SH	St Helens and	16	NICE	1.6.2	14	It should be recognised in this	Thank you for your comment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Knowsley NHS Trust					section that family may need reassurance themselves as it is distressing for them to see their loved one in this state.	The information for patients/carers review aims to address this.
430	SH	Medicines and Healthcare Products Regulatory Agency (MHRA)	1	NICE	1.7.2.1		Thank you for your email about the above NICE guidance and for the opportunity to comment. I can confirm that the proposed footnote related to the use of haloperidol and olanzapine is acceptable. We do not have any other comments on this draft guideline.	Thank you for agreeing to this.
431	SH	Royal College of Psychiatrists	3	NICE	1.6.4	8	"An alternative in patients with Dementia with Lewy Bodies and those with Parkinson's Disease is midepam 0.5 mg. to 1 mg. orally which can be given up to two hourly (maximum 3 mg. in 24 hours). If necessary, Lorazepam can be given 0.5 mg. – 1.0 mg. IV or IM (dilute up to 2 mls. with normal saline or water) up to a maximum of 3 mg. in 24 hours." from RCPsych guidelines (www.rcpsych.ac.uk/docs/Delirium-2006%201.doc).	Thank you for your comment. We have added a new recommendation (1.6.5) giving guidance for people with Lewy body dementia and Parkinsion's Disease (and have cross-referred to the relevant NICE guidelines)

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
432	SH	St Helens and Knowsley NHS Trust	9	NICE	1.6.4	8	The guidance suggests use of pharmacological interventions if people are distressed or a risk to themselves or others. There is no mention of the use of pharmacological management to assist treatment of the cause of delirium. For example, it may be difficult to give a course of antibiotics to a patient with hyperactive delirium. Prescription of antipsychotic treatment may be in their best interests in order to ensure treatment. There is a tendency in clinical practice to avoid drug therapy unless the situation is extreme and this guidance will perpetuate this. Patients with hyperactive delirium are therefore at risk of under treatment. There is no guidance given on dosages or frequency of administration.	We considered it self evident that "treat the underlying causes(s) of delirium" implied specific pharmacological treatments for many patients. The broad nature of the guideline precluded citing specific situations e.g. urinary or respiratory infections. We agree that antipsychotic treatment may be a "best interests" treatment – that is subsumed within our indication of patients "at risk to themselves." NICE is unable to recommend drug doses.
433	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	20	NICE	1.6.4	8	"If non-pharmacological approaches are ineffective, consider giving short term (for 1week or less) haloperidol or olanzapine if people with delirium are distressed or a risk to	We did not feel the evidence was sufficiently strong (one study) to recommend widespread sue of antipsychotic drugs. We have emphasised

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							themselves or others" It is not clear in the guideline how long healthcare workers should wait before deciding that non-pharmacological approaches are proving ineffective. In the Hu study (Chin J Clin Rehab 2006), patients were treated "somatically" in addition to pharmacological therapy, and patients had suffered delirium for between 30minutes and 17days. It should be clear in the guideline (and Algorithm) that pharmacological therapy can be given from the diagnosis of delirium (or 30 minutes) as in the Hu study.	"somatic" treatment in the initial management recommendation.
434	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	21	NICE	1.6.4	8	It is also not clear how healthcare workers can assess a patient and conclude whether the patient is or is not distressed. There is a significant risk that this will in practice mean that hyperactive patients are treated whilst hypoactive patients are not. There is evidence that hypoactive patients are distressed in that form of delirium. (The Delirium Experience: Delirium Recall and	We agree with your helpful description that delirium is indeed quite a distressing illness for patients (and often families). We have emphasised the need for effective communication and reorientation to help provide reassurance for people diagnosed with delirium (1.6.2). We consider that drugs should be reserved for patients who are so distressed that their behaviour was causing a threat

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							Delirium-Related Distress in Hospitalized Patients With Cancer, Their Spouses/Caregivers, and Their Nurses, W Breitbart., C Gibson, A Tremblay, Psychosomatics 2002; 43:183–194 Quote: "Patients with 'hypoactive' delirium were just as distressed as patients with 'hyperactive' delirium", "No longer can clinicians assume that a delirious patient 'doesn't seem to be uncomfortable' or 'isn't bothering anyone' and so does not require aggressive treatment" PMID: 12075033). These findings have been echoed (Impact of delirium and recall on the level of distress in patients with advanced cancer and their family caregivers. Bruera E, Bush SH, Willey J et al, Cancer. 2009 May 1;115(9):2004-12 PMID: 19241420). Whilst these studies are in cancer patients, the relevance of the findings are likely applicable to all patients with delirium. What is the definition for "distress"? (It will mean different things to different people)	to their personal safety or the safety of their carers. We felt that this practical definition of severe distress would be readily apparent to healthcare professional teams caring for the patient.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							Please include information on how to assess for distress in delirious patients (hypoactive, hyperactive and mixed forms) Please include information on how promptly pharmacotherapy should be initiated for "distress"	
435	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	22	NICE	1.6.4	8	Some guidance needs to be provided on what to do if delirium is still present after 7 days of pharmacotherapy. Delirium after 7 days of therapy is neither a) "persistent delirium", nor b) outside the scope of the guideline. Such guidance could take the form of pragmatic advice in the absence of evidence such as "Refer to a consultant led psychiatric liaison service for ongoing management".	We agree that including guidance on how to help patients with unresolved delirium/persisting symptoms is important and we have now amended the guidance by adding an additional recommendation (1.6.6) to prompt a re-evaluation and assessment for underlying delirium causes, and also to consider the possibility of a dementia.
436	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	23	NICE	1.6.4	8	Some guidance needs to be provided on when to review medication and discontinue if the patient is responding (Should medication be stopped suddenly, weaned over several days?)	We have now improved the guidance so that there is an explicit re-evaluation of patients whose delirium is not resolving or responding to initial treatments (new recommendation 1.6.6).
437	SH	United Kingdom Clinical Pharmacy	24	NICE	1.6.4	8	Guidance also needs to be provided on the management of severe	The guidance suggests that this is the situation in which the

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
		Association (UKCPA)					agitation secondary to delirium where such agitation / behaviour poses a danger to the patient or staff and the underlying delirium is not likely to be rapidly controlled with non-pharmacological or pharmacological therapy for delirium.	pharmacological approach should be adopted alongside the non-pharmacological interventions described in recommendations 1.6.1 and 1.6.2.
439	SH	College of Occupational Therapists	3	NICE	1.3.3.4	12	I feel this would benefit from some example actions such as considering alterative methods of assessing pain i.e. Abbey Pain Scale and use of Ametop gel to minimise pain when inserting canulas etc.	Thank you for your comment. We did not look at the evidence for pain scales and the developers feel that this is too much detail for inclusion in this broad national guideline.
440	SH	St Helens and Knowsley NHS Trust	13	NICE	1.3.3.4	12	The use of only non-verbal signs of pain in ventilated patients has been shown to under-estimate pain. A structured, well-validated pain tool should be used. Assessment of pain with pain scores should be recommended for all patients.	Thank you for your comment. We did not look at the evidence for pain scales and the developers feel that this is too much detail for inclusion in this broad national guideline.
442	SH	West Hertfordshire Hospitals NHS Trust	14	NICE	1.6.4	15	(On limited evidence) patients with traumatic brain injury should get olanzapine rather than haloperidol	We found no drug treatment evidence specific to traumatic brain injury.
443	SH	College of Mental Pharmacists	5	NICE	2	16	Under groups that are not covered; the following suggestions are made "people with intoxication and/or	Thank you for your comment. To make this clearer, we have added into the introduction of

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							those starting a new or withdrawing from a previously prescribed/other substance (including nicotine and alcohol), and etc…"	both the FULL and NICE versions of the guideline, which groups the guideline covers and which it excludes (as has been detailed in the guideline scope).
444	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	27	NICE	2	16	"Persistent delirium" as defined in the document is not excluded by the scope.	Thank you. We have now amended the guidance to include the importance of assessing for undetected precipitants and dementia in patients whose delirium is not resolving (recommendation 1.6.6).
445	SH	Sussex Partnership NHS Foundation Trust	2	NICE	1.6.4	15 (and also page 8 under "pharmacological interventions".	There is no mention of route or dose of medication. Even if no specifics are to be given, advice should be given to use the "lowest effective dose" and to administer by "oral route, where possible".	Thank you for your comment. NICE do not usually recommend doses or routes of administration as these should be used in accordance with the BNF. Additionally we have not looked at the evidence to state use orally where possible.
446	SH	Sussex Partnership NHS Foundation Trust	3	NICE	1.6.4	15 (and also page 8	The document advises use of haloperidol but makes no mention of the need for an ECG to be carried out before this preparation is used.	Use of any drug included in a Clinical Guideline should be in accord with usual practice as described in the BNF. To re-

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						under "pharmacological interventions".	This should be added.	state these aspects results in the guideline becoming unwieldy.
447	SH	Sussex Partnership NHS Foundation Trust	4	NICE	1.6.4	15 (and also page 8 under "pharmacological interventions".	There is no mention of second line pharmacological interventions, such as benzodiazepines. Whilst these are not commonly used in response to delirium they may be useful in those cases where the patient has underlying Parkinson's disease, dementia with Lewy Bodies, or a lowered seizure threshold.	Thank you for your comment. We have not looked at evidence for second-line pharmacological interventions. However, we have added a new recommendation (1.6.5) giving guidance for people with Lewy body dementia and Parkinson's Disease (and have cross-referred to the relevant NICE guidelines).
448	SH	St Helens and Knowsley NHS Trust	14	NICE	1.3.3.5	12	It is not just polypharmacy which is a problem in the critical care setting. There are a number of drugs which are clearly deliriogenic and should be avoided where possible. This should be linked with the section on treatment of delirium 1.6.1.	Although many drugs might be considered as deliriogenic, the Pharmacological risk factor review did not support this. Nonetheless, we accept that clinicians will wish to discontinue some drugs – that is why we emphasised the importance of a drug review (see polypharmacy recommendation 1.3.3.8) in the

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								prevention of delirium. However, we were unable to produce a reliable list of drugs more likely to be associated with delirium.
449	SH	Sussex Partnership NHS Foundation Trust	5	NICE	1.3.3.5	12	This section does not address which drugs or drug groups might be considered precipitatory – eg. sedatives / hypnotics, tricyclic antidepressants, anticholinergics, steroids, opioids etc. It might be useful to include guidance on this issue.	Although many drugs might be considered as deliriogenic, the Pharmacological risk factor review did not support this. Nonetheless, we accept that clinicians will wish to discontinue some drugs – that is why we emphasised the importance of a drug review (see polypharmacy recommendation 1.3.3.8) in the prevention of delirium. However, we were unable to produce a reliable list of drugs more likely to be associated with delirium.
451	SH	Royal College of Nursing	8	NICE	1.3.3.7	13	With reference to mobility, there needs to be some discussion around patient safety and mobility. A significant problem is that patients with any cognitive problem may not be able to recognise what is a risky action for them e.g. mobilising independently. There may be problems of understanding and following advice and instructions from carers etc.	We have assumed that usual good professional practice and commonsense clinical judgement will be applied when caring for patients who are at risk of falls.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							There needs to be indications as to actions and interventions to take in these circumstances in line with best evidence based practice. This is not just about the management of violence (NICE 25)	
452	SH	West Hertfordshire Hospitals NHS Trust	12	NICE	1.3.3.7	13	Mobilisation is a key part of the NICE guidelines into critical care rehabilitation. The paper in the Lancet by Schwieckhert 2009: 373: 1874 showed early mobilisation decreased length of stay and duration of delirium days 2 versus 4. The patients ranged from fully sedated to walking. The resources needed to action mobilising elderly cognitively impaired patients needs to be factored in or a study suggested comparing different levels of mobilising (see comment 9) This is especially important bearing in mind the tendency for some patients with dementia to wander which is generally discouraged in hospital.	Thank you for your comment. We did not look at the evidence for how or when to mobilise people and did not feel it was appropriate to give advice on this. The developers feel that this is too much detail for inclusion in this broad national guideline.
454	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	28	NICE	4	17	Research recommendations are a great feature of this guideline and help researchers when putting together bids for funding of delirium focussed studies.	Thank you for your comment.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
455	SH	College of Mental Pharmacists	6	NICE	4.1	17	Under 'why this is important' sentence 3; please replace the word 'drug' with the word 'agent'. Increasingly medicines; medication; agent; are being used to substitute for the word 'drug' which has connotations and links to 'drugs of misuse.' See also last sentence; could be changed to "..together with the adverse effects of any agent prescribed, notably extra-pyramidal symptoms, stroke, and increased confusion due to anticholinergic side effects	Thank you for your comment. The NICE style guide states that we should use the term 'drugs' in preference to medicine or medication, however in mental health guidelines we are advised to use the term 'medication' if stakeholders strongly prefer this, because of connotations relating to drug misuse. We therefore have amended the wording accordingly with the words 'medication' where we feel this is appropriate, but we will not use medicine or agent. Regarding adding the additional outcome measures to 4.1, our suggestions were not supposed to be exhaustive, we just mentioned the two that we felt were most important. We have therefore not added in your additional suggestion.
456	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	29	NICE	4.1	17	The phrasing of the question puts the emphasis on atypical antipsychotics and almost implies that they would be expected to be	Thank you for your comment. The document has been amended accordingly.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							more clinically or cost effective than other treatments. This can be avoided by rephrasing the question	
457	SH	West Hertfordshire Hospitals NHS Trust	3	NICE	4.1	17	Regarding the 5 arm study suggested, the evidence there is regarding all these drugs - and I accept that a lot of it is poor quality – would suggest that benzodiazepines make it worse. (Any clinician who is involved with treating high risk patients knows this) The antipsychotics, however, may in fact work and even it they don't there is no doubt they will be used in increasing amounts if clinicians start to take delirium seriously. This was recently demonstrated in a Dutch ICU (Van de Boogaard et al. Crit Care 2009; 13; R131). A 5 arm trial as suggested would take a considerably long time to complete and the question regarding antipsychotics in particular needs answering now.	Thank you for your comment. When developing the research recommendations the GDG had to take into consideration uncertainty or gaps in the evidence that were identified during the course of the guideline development process. With reference to future research recommendation 1, having identified these gaps, it would be counterintuitive to limit a research recommendation for just one class of pharmacological agents.
458	SH	West Hertfordshire Hospitals NHS Trust	5	NICE	4.2	17	Following on from comment 4 – a trial into the incidence and duration of delirium and benzodiazepines could be done in a critical care setting where the risk of delirium is	We agree this would be an important new research study. However, there are many areas of research that need to be conducted, but we felt the ones

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							very high and in many units benzodiazepines are given routinely.	we have highlighted in the guideline were the most important. In accordance with NICE practice, the GDG were able to prioritise only five recommendations for future research.
459	SH	College of Mental Pharmacists	7	NICE	4.2	18	Under 'why this is important' sentence 3; please replace the word 'drug' with the word 'agent' also typo. "…need to determine (no d) whether the agent should.." Also end of last sentence; increasing confusion, extrapyramidal effects and prolongation of delirium should be added as well as thought to the codicil 'reduction in doses for older patients; possible contra-indications for people with dementia with Lewy Bodies or care in those with Parkinson's disease	Thank you for your comment. The NICE style guide states that we should use the term 'drugs' in preference to medicine or medication, however in mental health guidelines we are advised to use the term 'medication' if stakeholders strongly prefer this, because of connotations relating to drug misuse. We therefore have amended the wording accordingly with the words 'medication' where we feel this is appropriate, but we will not use medicine or agent. Regarding adding the additional outcome measures to 4.2, our suggestions were not supposed to be exhaustive; we just mentioned the two that we felt were most important. We have

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								therefore not added in your additional suggestion.
460	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	30	NICE	4.2	18	As for point 29. The phrasing of the question puts the emphasis on atypical antipsychotics and almost implies that they would be expected to be more clinically or cost effective than other treatments. This can be avoided by rephrasing the question	Thank you for your comment. The document has been amended accordingly.
461	SH	College of Mental Pharmacists	8	NICE	4.3	18	When 'multicomponent non-pharmacological intervention' is used in the first sentence it should have the referral to 1.3.1 to 1.3.39 included.	Thank you for your comment. We do not feel it is appropriate to refer to the guideline recommendations within the research recommendation because these recommendations haven't actually been validated in the hospital setting. We feel that we have given enough information for a researcher to design a suitable research study and feel it is unnecessary to be too prescriptive.
462	SH	College of Mental Pharmacists	9	NICE	4.3	18	Under 'why this is important' sentence 3; please add a reference	Thank you for your comment. It is not usual for the research

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							for the need for the trial to be of adequate duration, i.e. minimum of 6 preferably 12months	recommendations to contain this level of detail. It would be for the researchers planning such a study to make a case to potential funders for a particular duration of follow up.
463	SH	United Kingdom Clinical Pharmacy Association (UKCPA)	31	NICE	4.3	18	The research recommendation to examine the effect of a multi-component intervention study in long term care is welcomed. There is no such data for critically ill patients and a further research recommendation to examine the effects of a multi-component intervention study in this population would also be welcomed.	Thank you for your comment. We agree that additional research into prevention methods in the context of critical care units is desirable. However, there are many areas of research that need to be conducted, but we felt the ones we have highlighted in the guideline were the most important. In accordance with NICE practice, the GDG were able to prioritise only five recommendations for future research.
464	SH	West Hertfordshire Hospitals NHS Trust	9	NICE / Full	4.3	18	This comment also refers to multicomponent interventions in the main document. The interventions that are suggested to prevent delirium in high risk patients are in essence the treatment that all our patients should have. Early mobilisations, orientation keys, fluids, attention to bowels, good	We envisage a trial of usual care verses an enhanced system of care based on individual patient assessment and targeted interventions. We have improved the wording of this research recommendation in the light of your comments.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							sleep hygiene have always been aims we need to have for every patient. What specifically extra would the study patients be getting? My comment is that is would be a difficult study - the resources are most definitely needed to reach these aims in our hospitals.	
465	SH	College of Mental Pharmacists	10	NICE	4.3	19	Please add as requested to the second full sentence starting "The intervention should include reorientation, medication or medicines' review, sensory assessment (working hearing or visual aids); nutritional assessment (including well-fitting teeth), hydration and etc…"	Thank you for your comment. The developers feel that this is too much detail to include in a research recommendation. Adding such detailed guidance in the research recommendations would risk producing an unwieldy document and detract from the key messages we wish to highlight.
466	SH	West Hertfordshire Hospitals NHS Trust	10	NICE	4.4	19	First a much simpler tool than the CAM would be need to be validated to screen patients in long-term care for delirium as the training and updating needed for the CAM may mean it is not "cost-effective".	We would envisage the CAM be used as part of a research procedure, not for routine care. We agree that alternative diagnostic instruments may need to be developed for the special circumstances of long-term care. We did consider a research recommendation in this area but it did not attract sufficient priority to be in the top 5 research

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								recommendations.
467	SH	Cambridge University Hospitals NHS Trust – Addenbrooke's Hospital		Full	General	General	The guidance is welcome if long. We presume that a briefer more accessible version will ultimately be produced. However, it is helpful to have access to the review process undertaken by the GDG. We appreciate that there is a general lack of good quality evidence, however it would be useful if, when produced, the guidelines weighted the recommendations given according to the strength of the evidence. The target population is clearly defined, although many will wish to extrapolate as the guidance given is surely likely to be as relevant to those receiving long-term care at home as in a care home.	Thank you for your comment. As per all NICE guidelines, 4 versions of the guideline will be produced. The **full guideline** (containing all the recommendations and the underlying evidence); the **NICE guideline** (presenting the recommendations in a format suited to implementation by health professionals and NHS bodies); the **quick reference guide** (presenting recommendations in a suitable format for health professionals); **understanding NICE guidance** (written using suitable language for people without specialist medical knowledge). NICE recommendations are phrased according to the standards set in the NICE Guidelines Manual, and no longer give a grading for strength of recommendations. However, the phrasing used is aimed at giving an indicator of the strength of recommendation.

Comment #	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								For example, a 'weaker' recommendation may use the words 'consider giving' rather than 'give' (which would indicate a 'strong' recommendation ie. based on strong evidence). The guideline also relates to people in long-term care and so extrapolation of the evidence is intended.
468	SH	Cambridge University Hospitals NHS Trust – Addenbrooke's Hospital		Full	1.6.4	8	We are surprised that haloperidol and olanzapine are recommended when they do not have a license for treating delirium and that risperidone, which does have a license, is not recommended.	There were poor quality studies or inadequate study designs the effectiveness of risperidone. Therefore, evidence for the effectiveness of haloperidol and olanzapine was taken into consideration when recommending pharmacological treatment of delirium.