National Institute for Health and Clinical Excellence

Delirium - Scope Consultation
16 April – 14 May 2008

Type

SH = Registered Stakeholders. These comments and responses will be posted on the NICE website after guideline development begins.
GRP = Guidelines Review Panel member. These are added to this table for convenience but will not be posted on the web.
NICE = Comments from NICE. These are added to this table for convenience but will not be posted on the web.
Non Reg = Comments from organisations and people who have not registered as stakeholder. These are added for convenience but will not be posted on the web.

Type	Stakeholder	No	Section number	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	5 Boroughs Partnership			This organisation was approached but did not respond.	
SH	Addenbrookes Hospital, Cambridge University Hospitals NHS Trust			This organisation was approached but did not respond.	
SH	Age Concern England			This organisation was approached but did not respond.	
SH	Alzheimer's Society	1	4.3 Clinical management	**The Society suggests that the clinical management section should include interventions and approaches to care that reflect the relationship between delirium and dementia**. Delirium in a person with dementia is very common.[i] Research suggests that two thirds of cases of delirium occur in people with dementia,[ii] and this is likely to increase in the future.[i] 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. Dementia is associated with an increased risk of developing delirium and conversely, delirium	

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				has been found to be associated with subsequent development of dementia. Studies examining outcomes in patients with delirium superimposed on dementia have demonstrated an increased risk of long term cognitive impairment and dementia[ii], increased rates of hospitalisation within 30 days[iii], and higher mortality rates.[iv] There are specific approaches that can be taken for preventing delirium in people with dementia. For example, Fick et al. (2002)[i] state that delirium may be preventable in people with dementia and the approach needed may be different to people without dementia. There are also approaches for preventing dementia in people with delirium (see comment two). It is therefore vital that clinicians are aware that there are specific approaches to care, in relation to delirium and dementia, which should be used.	
SH	Alzheimer's Society	2	4.1.2 Groups that will not be covered	**The Society strongly suggests that people in intensive care should be included in the scope.** As highlighted in the evidence above, delirium has been found to be associated with the subsequent development of dementia (and vice versa). There is a significant chance of this happening in an intensive care setting. Delirium in intensive care is associated with deterioration in cognitive function - termed ITU accelerated dementia. Delirium in intensive care is very common, affecting up to 80% of patients on ventilators. It is usually quiet (hypoactive) and has to be tested for.	

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				The Alzheimer's Society believes that this is a particularly important area for investment and is funding a project to promote the screening for, and management of, delirium in intensive care. 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 is 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 dementia resulting from delirium in intensive care and are able to implement protocols to mitigate this risk. The guideline must therefore incorporate this.	
SH	Association of the British Pharmaceuticals Industry (ABPI)			This organisation was approached but did not respond.	
SH	Barnsley Hospital NHS Foundation Trust			This organisation was approached but did not respond.	
SH	Barnsley PCT			This organisation was approached but did not respond.	
SH	Berkshire Healthcare NHS Foundation Trust			This organisation was approached but did not respond.	
SH	Bournemouth & Poole PCT			This organisation was approached but did not respond.	

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SH	British Association for Psychopharmacology			This organisation was approached but did not respond.	
SH	British Association of Critical Care Nurses			This organisation was approached but did not respond.	
SH	British Geriatrics Society			This organisation was approached but did not respond.	
SH	British National Formulary (BNF)			This organisation was approached but did not respond.	
SH	British Pain Society	1	3-f	Pain can be a factor contributing to delirium. More commonly, it is the drugs used to treat pain, both acute and chronic, that are a causative factor in precipitating delirium. Opioids, and atypical analgesics for neuropathic pain, are frequently implicated. Careful titration of analgesic medication is recommended, particularly in the elderly.	
SH	British Pain Society	2	3-i	Unrelieved pain is more commonly a precipitating factor for delirium in patients with underlying cognitive and sensory impairment. This is particularly true in the elderly and those in long-term residential care. Assessment of pain in the elderly can be difficult. We recommend the recently published document: The assessment of pain in older people: National Guidelines (2007). http://www.britishpainsociety.org/pub_professional.htm#painolderpeople This is joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the British Pain Society.	
SH	British Psychological Society			This organisation was approached but did not respond.	
SH	BUPA			This organisation was approached but did not respond.	
SH	Cancer Research UK			This organisation was approached but did not respond.	

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SH	Cardiff & Vale NHS Trust			This organisation was approached but did not respond.	
SH	CASPE Research			This organisation was approached but did not respond.	
SH	Cheshire PCT			This organisation was approached but did not respond.	
SH	College of Emergency Medicine			This organisation was approached but did not respond.	
SH	College of Occupational Therapists	1	General	It is important that rehab ensures that treatment is aimed at returning the person with delirium to their pre-morbid level. People with dementia are particularly prone to this and should be treated with the objective of a return to their previous functional level - even if it was impaired.	
SH	College of Occupational Therapists	2	General	Accurately identifying Delirium is crucial in the management of it. Therefore, should patients who are in the risk category have pre-op screening of their cognitive function so that the monitoring of delirium has a base line?	
SH	College of Occupational Therapists	3	General	Post operatively patients with hyperactive delirium can be difficult to manage if the appropriate training is not provided. Families are often asked to sit with patients to assist in managing aggressive behaviour. These patients are often marginalised and isolated. Have acute mental health wards also been considered as an area when this can also occur on?	
SH	College of Occupational Therapists	4	General	It is important to consider the impact that multidisciplinary approach can have on management Delirium.	
SH	College of Occupational Therapists	5	General	Consideration also needs to be given to those being admitted via emergency care, such as A&E, and providing an environment that is less intimidating.	

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SH	College of Occupational Therapists	6	General	It is important to ensure that previous work on this area is not excluded such as the RCP delirium guidance 2005.	
SH	Commission for Social Care Inspection			This organisation was approached but did not respond.	
SH	Connecting for Health			This organisation was approached but did not respond.	
SH	Department for Communities and Local Government			This organisation was approached but did not respond.	
SH	Department of Health	1	General	In our view, this scope is an important area for guidance and is generally acceptable. However, we are concerned that it excludes those with delirium, associated with intoxication with (or withdrawal from) drugs and/or alcohol. We would be rather surprised if this was easy to do, as many cases of acute hospital delirium are due to alcohol withdrawal. Therefore, we feel that it must always be given consideration. It may well be that there is separate guidance on delirium (associated with alcohol withdrawal) planned in the guidance on alcohol dependence but if not, we consider that it should be within the draft scope. We would also query the exclusion of those in intensive care units. There appears to be no specific reference to those in psychiatric hospitals, and we would welcome clarification as to whether they should be mentioned as being specifically included.	
SH	Department of Health, Social			This organisation was approached but did not respond.	

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	Security and Public Safety of Northern Ireland				
SH	Derbyshire Mental Health Services NHS Trust			This organisation was approached but did not respond.	
SH	European Delirium Association	1	3c	Some patients have neither hyperactive nor hypoactive delirium.	
SH	European Delirium Association	2	3e	There is some fluctuation in dementia ('sundowning', etc.)	
SH	European Delirium Association	3	3g	Some would use the term 'syndrome' rather than 'disease'.	
SH	European Delirium Association	4	4d	Some predisposing factors (eg. sensory impairment) can be ameliorated in delirium interventions – not just precipitating factors.	
SH	European Delirium Association	5	General	It might be worth slightly broadening the scope to include recommendations on follow-up of patients with delirium, given that delirium can be associated with 'earlier onset or progression of dementia' (section 3h). Many clinicians are interested in this issue.	
SH	European Delirium Association	6	General	Will there be any discussion of specialist units for delirium?	
SH	Health Commission Wales			This organisation was approached but did not respond.	
SH	Healthcare Commission			This organisation was approached but did not respond.	
SH	ICUsteps	1	4.1.2 d)	There is a wealth of evidence to show the majority of critically ill patients suffer from delirum with figures in excess of 80% of ICU patients being affected (Ely EW, Inouye SK, Bernard GR, et al. Delirium in mechanically ventilated patients: validity and reliability of the Confusion Assessment Method for the Intensive Care Unit (CAM-ICU). *JAMA*. 2001;286:2703–2710.) For this reason, intensive care patients should be one of the groups that will be covered in the scope. That this population should be	

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				listed as an excluded group is unreasonable and is not supported by the rest of the brief. It is our belief that intensive care patients must be one of the groups explicitly included in this guideline.	
SH	ICUsteps	2	4.1.2	Level 2 patients are treated both on wards and in critical care areas, therefore as the scope currently stands, exclusions would be based on location of care, not need.	
SH	ICUsteps	3	4.2 a)	Assuming the revision of 4.1.2 d), we would like to see critical care areas added as a healthcare setting covered by the guideline.	
SH	ICUsteps	4	4.3 b)	As above, we would like this amended to Diagnosis of delirium in acute, critical and long term care.	
SH	ICUsteps	5	General	The wording throughout the scope seems to lean towards covering delirium in geriatric patients and whilst this may be another major population that need to be covered by the guideline, it must be amended to include intensive care patients.	
SH	ICUsteps	6	General	Where elderly patients with delirium are often misdiagnosed as having dementia, younger patients with delirium are often misdiagnosed as being aggressive and abusive, both situations leading to compromised care and treatment, and with the latter group, in extreme cases, can lead to them being arrested.	
SH	ICUsteps	7	General	A lot of work has already been carried out on delirium in critical care patients. By excluding them from the guideline the Group will deny themselves information and research which is directly relevant.	
SH	ICUsteps	8	General	Intensive care patients should be included in this guideline. Most patients who have suffered from delirium and hallucinations whilst in intensive care still have problems when they leave there to go onto a general ward or	

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				discharge from hospital.	
SH	Institute for Ageing and Health	1	General	The scope addresses only acutre delirium. I feel that subacute and schronic delirium need also be addressed, since they apper to be quite prevalent in theelderly population with dementia.	
SH	Institute for Ageing and Health	2	3 c	refers to 2 types of delirium. This need to be changed to 3 (hypoactive, hyperactive and mixed) clinical subtypes.	
SH	Institute for Ageing and Health	3	3 e	statement regarding fluctuation of clinical symptoms in dementia does not refelect the fluctuation of clinical symptoms that occure in Vascular type fop dementia (sundowning syndrome), -it needs to be amnmended to include the fluctuation of clinical symptoms occuring in Vascular dementia (sundowning syndrome), as well as that present (and characteristic!) for the Lewy body spectrum diseases, e.g. Dementia with Lewy bodies, Parkinson's disease dementia etc. (a statement e.g. with the exception of VaD, DLB and PDD?).	
SH	Institute for Ageing and Health	4	4.1.1	would suggest that patients in primary care be also included	
SH	Institute for Ageing and Health	5	4.1.2	I am concerned that people in paliativbe care setting will not be included, esp since they sugger from delirium in 80-90% people in intensive care units wshould be treated equally to all other delirium patients.	
SH	Intensive Care Society	1	4.1.2.d.	Not covering people in intensive care would exclude a population with a high incidence of delirium and with an increasingly recognised need for appropriate management.	
SH	Intensive Care Society	2	4.1.2.d.	Delirium is important in the intensive care unit. 60 – 80% of mechanically ventilated patients (JAMA 2004;291:1753-62) and about 50% of non-ventilated intensive care patients (Crit Care 2005;9:R375-R381) develop delirium. Both	

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				their intensive care length of say and their hospital length of stay are significantly increased, thereby increasing costs to the NHS (Critical Care 2004;32:955-62). Mortality is also increased in critically ill patients who develop delirium (JAMA 2004;291:1753-62), as is cognitive impairment after hospital discharge.	
SH	Intensive Care Society	3	4.1.2.d.	A delirium guideline from NICE would have the most impact in the intensive care environment, where the incidence of delirium is higher than on general ward, the patients affected generally younger, and the costs to the NHS greatest.	
SH	Intensive Care Society	4	4.1.2.d.	Delirium in intensive care is currently not well diagnosed. Although there are three validated assessment methods for use in this environment (JAMA 2001;286:2701-10, Int Care Med 1993;60:356-60, Neurocritical Care 2005;2:150-58), they are not well used despite guidelines from the Society of Critical Care Medicine (US) recommending their implementation. Development of a NICE guideline including intensive care patients would highlight its importance in this group of patients in the UK.	
SH	Intensive Care Society	5	4.1.2.d.	Delirium is important for intensive care Outreach teams, who deal with level two patients who are cared for on hospital wards outside the intensive care environment. NICE aspires to cover the whole of the patient pathway, which includes patients who are acutely, critically ill and managed either in, or by staff from intensive care; inclusion of these patients would highlight the importance of delirium.	
SH	Intensive Care Society	6	4.1.2.d.	Intensive care is important for the delirious patient. Sometimes patient with hyperactive delirium can only be managed in the intensive care environment. Not including these patients excludes the most severe end of the spectrum	

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				and risks their management being non-standard.	
SH	Intensive Care Society	7	4.1.2.d.	A recent publication in the journal Chest describes a case of delirium in the critical care environment which was mistaken for hypoxic brain injury (Chest 2008;133:1217-20) almost leading to withdrawal of treatment. Diagnosing delirium appropriately in intensive care is vitally important	
SH	Intensive Care Society	8	4.1.2.d.	By specifically not including people in intensive care, NICE risks the conclusion from staff working in these areas that the guideline applies neither to them nor their environment, which would be a disservice to these patients.	
SH	Intensive Care Society	9	4.1.2.d.	Intensive care deals with an increasingly aged population (JAMA 2000; 284: 2762-70) who have many other reasons to develop delirium; any guideline on delirium for this population would be relevant to their management both inside and outside of intensive care.	
SH	Kirklees PCT			This organisation was approached but did not respond.	
SH	Lancashire Teaching Hospitals Acute Trust			This organisation was approached but did not respond.	
SH	Leeds Institute of Health Sciences			This organisation was approached but did not respond.	
SH	Leeds PCT			This organisation was approached but did not respond.	
SH	Marie Curie Cancer Care			This organisation was approached but did not respond.	
SH	Medicines and Healthcare Products Regulatory Agency (MHRA)			This organisation was approached but did not respond.	
SH	Mental Health Act Commission			This organisation was approached but did not respond.	
S	Mid Trent Critical	1	3c	There are 3 types of delirium, hyper, hypo and	

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H	Care Network			the third is referred to MIXED	
SH	Mid Trent Critical Care Network	2	3d	There is emerging evidence that delirium in the critically ill population is under diagnosed and under reported but reports do suggest anything from 15% to 85% 9these are reported as ventilated and non-ventilated patients). Also emerging evidence in other hospital settings.	
SH	Mid Trent Critical Care Network	3	3e and h	Sequelae of untreated delirium in critical care/acute settings are now being reported to last after discharge home and this can be many months in duration.	
SH	Mid Trent Critical Care Network	4	3f	There is a concise repost of causes in the critically il population in the publication by UKCPA 2006	
SH	Mid Trent Critical Care Network	5	3h	Emerging evidence of increased mortality in un-treated delirium in the critically ill population	
SH	Mid Trent Critical Care Network	6	4.1.2.d	Critically ill (ITU/HDU) patients MUST be included unless there is to be a separate document for this population. There is significant research underway investigating this and those who work in the field see the devastating effects every day. We know unrecognised and un-treated this can be fatal. This has previously been referred to as ICU syndrome, psychosis as if this was a natural consequence of being ill and treatment was passive acceptance that it occurred. Now we know better and this opportunity can not be missed. The UKCPA publication was ground breaking and has been endorsed by the ICS, collaborative work between Europe and USA is underway and this is a subject at every national and international critical care conferences	
SH	Mid Trent Critical Care Network 2	1	3 e	Sequelae of untreated delirium are reported to continue after discharge from hospital. These last for many months and may result in discharge to higher level care facilities such as	

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				nursing homes. Ely EW et al; Delirium in the Intensive Care Unit: An Under-Recognised Syndrome of Organ Dysfunction; Sem Resp Crit Care Med 22(2): 115-126, 2001	
SH	Mid Trent Critical Care Network 2	2	4.1.1 a	Are speciality patients in haematology and oncology who do not receive end-of-life care included?	
SH	Mid Trent Critical Care Network 2	3	4.1.2 d	Over 80% of critically ill patients experience delirium. This may present in 60-85% of ventilated patients and 48% of non-ventilated patients in intensive care. Due to developments in modern medicine we now find an increasingly aging population on medical and surgical intensive and high-dependency care units which may lead to a further increase in the incidence of delirium in the critically ill population. Critical ill patients are not exclusively looked after in intensive care units and thanks to the development of outreach services boundaries are blurring as to where services are provided. Ely EW et al; Delirium in the Intensive Care Unit: An Under-Recognised Syndrome of Organ Dysfunction; Sem Resp Crit Care Med 22(2): 115-126, 2001	
SH	Mid Trent Critical Care Network 2	3 cont.	4.1.2 d	Patients cared for in intensive care areas do not differ from other inpatients in terms of risk factors for delirium. Frequently the patient population on critical care units includes patients with a high vulnerability for delirium being exposed to many and/or strong but not different precipitating factors when compared to patients in ward areas. Medications are implicated in 20-40% of cases	

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				– many drugs with a high propensity to cause delirium are commonly used in intensive care areas and these patients often receive a large number of drugs. Meagher DJ; Delirium: optimising management; BMJ 322: 144-149, 2001 Patients are at particularly high risk of delirium during the immediate post-operative period, a time at which they may find themselves in higher level of care areas before being transferred to wards regardless of whether delirium has been recognised and effectively treated. Often patients need to return to high-dependency care areas because the symptoms of delirium cannot be managed in a normal ward environment. Indeed sequelae of untreated delirium in critical care/acute settings are now being reported to continue in ward areas and even after discharge home. As with non-intensive care patients more cases present with hypoactive delirium and remain unrecognised in as many as 66-84% of patients. This is no different in intensive care areas as delirium in these areas historically is thought to be transient and of little consequence. The absence of routine systematic screening may also be a contributor. Established instruments like the Confusion Assessment Method (CAM) can be used in many non-ventilated patients; modified validated tools like the CAM-ICU exist for ventilated patients. APA Practice Guidelines – Guideline Watch: Practice Guideline for the Treatment of Patients with Delirium; American Psychiatric Association, 2004. Available online at http://www.psych.org/psych_pract/treatg/pg/prac	

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				_guide.cfm Ely EW et al; Delirium in mechanically ventilated patients: validity and reliability of the confusion assessment method for the intensive care unit (CAM-ICU). JAMA 286: 2701-2710, 2001 There is sufficient evidence that delirium in intensive care leads to increased length of stay in intensive therapy areas as well as total length of hospital stay. Resulting mortality and morbidity are thought to be significant as well the increase in cost. Education and guidance regarding the recognition, prevention and management of delirium is as needed in intensive care areas as in the other hospital areas. Delirium in critical care has previously been passively accepted as ICU syndrome, an unavoidable consequence of being severely ill. Recent research and published guidance has challenged this view and awareness has been increased but there is still need for improvement. Detection, Prevention and Treatment of Delirium in Critically Ill Patients, UKCPA, 2006 available online at http://www.ics.ac.uk/icmprof/standards.asp In order for patients to be able to benefit from these developments the opportunity to include this patient group in such an influential document as a NICE Guidance must not be missed. Indeed the exclusion of this patient group would seriously reduce the effectiveness of such guidance. To single out patients in intensive care areas would also mean to exclude them due to their geographical location within the hospital rather than their aetiology of delirium.	

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SH	Mid Trent Critical Care Network 2	3	4.3 d	We are not aware that any licensed pharmacological treatments of delirium exist. Guidance by NICE on the most appropriate choice will be appreciated	
SH	Mid Trent Critical Care Network 2	4	General	We do not feel that anything should be removed from this scope. All efforts should be made to produce a comprehensive guidance including all hospital inpatients except those stated in points 4.1.2 a-c	
SH	Milton Keynes PCT			This organisation was approached but did not respond.	
SH	National Institute for Mental Health in England			This organisation was approached but did not respond.	
SH	National Patient Safety Agency			This organisation was approached but did not respond.	
SH	National Public Health Service - Wales			This organisation was approached but did not respond.	
SH	National Treatment Agency for Substance Misuse			This organisation was approached but did not respond.	
SH	NHS Direct	1	General	Content considered by NHS Direct and noted. No comments.	
SH	NHS Lothian			This organisation was approached but did not respond.	
SH	NHS Plus			This organisation was approached but did not respond.	
SH	NHS Purchasing and Supply Agency			This organisation was approached but did not respond.	
SH	NHS Quality Improvement Scotland			This organisation was approached but did not respond.	
SH	North Staffordshire Combined	1	General	The introduction is well written and comprehensive	

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	Healthcare NHS Trust				
SH	North Staffordshire Combined Healthcare NHS Trust	2	General	The scoping outline would seem to cover all the appropriate areas	
SH	North Staffordshire Combined Healthcare NHS Trust	3	General	I would hope that there would be, within the final draft, a comment about differential causes of delirium and recommended screening processes	
SH	North Staffordshire Combined Healthcare NHS Trust	4	General	I would also hope that they would consider first line treatment of delirium to be nursing care rather than medication based	
SH	North Staffordshire Combined Healthcare NHS Trust	5	General	If drugs are used and they recommend the use of Haloperidol I would hope that they would comment upon the risks, side effects and dosage.	
SH	North Yorkshire and York PCT			This organisation was approached but did not respond.	
SH	Oxford Radcliffe Hospitals NHS Trust	1	3.i	Misdiagnosis of hypo-active delirium as depression is also described "Delirium presenting with symptoms of depression" Psychosomatics 1995 36: 471-479	
SH	Oxford Radcliffe Hospitals NHS Trust	2	3.i	Improved delirium management could also save lives and reduce long term morbidity (accelerated dementia) "A multifactorial intervention program reduces the duration of delirium, length of hospitalisation and mortality in delirious patients" J Am Geriatr Soc 2005; 53: 622-628 "Delirium as a predictor of mortality in mechanically ventilated patients in the intensive care unit", JAMA. 2004; 291:1753-62 "Long-term neurocognitive function after critical illness" Chest. 2006, 130:869-78	
S	Oxford Radcliffe	3	4.1.1.a	Are cancer patients covered..?	

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H	Hospitals NHS Trust				
SH	Oxford Radcliffe Hospitals NHS Trust	4	4.1.2.d	Not covering "intensive care" would seriously dilute the effectiveness of this treatment guideline. There are approximately 3500 patients receiving care in a designated critical care unit in English trusts every day. Critical Care Bed Census Jan 2008, DoH, Form KH03a Audits have also indicated that level 2 critically ill patients are distributed throughout Trusts in large numbers. The wider hospital population contains critically ill patients. Levels of Care Census Report, Mersey Cheshire Critical Care Network, V Cleary Unmet Needs Project, Central Southern Critical Care Network, M Nielsen To apply the proposed guideline to some of these patients and not others simply because of an accident of geographical location within an organisation flies in the face of the founding principals of NICE. "A new National Institute for Clinical Excellence to give a strong lead on clinical and cost-effectiveness, drawing up new guidelines and ensuring they reach **all** parts of the health service" The New NHS: Modern, Dependable : 1997; 3.5	
SH	Oxford Radcliffe Hospitals NHS Trust	5	4.1.2.d	Epidemiological data shows that delirium occurs in up to 80% of critically ill patients and that these patients experience delirium for approximately 60% of their stay (i.e. not a simple sedation transition effect). This represents large numbers of patients that would benefit if the treatment guidelines do not	

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				exclude them. "The impact of delirium in the intensive care unit on hospital length of stay", Intensive Care Med. 2001, 27:1892-900 To do otherwise provides an easy and obvious "opt-out" clause for organisations that would prefer to not tackle the issue.	
SH	Oxford Radcliffe Hospitals NHS Trust	6	4.1.2.d	At the NICE meeting with stakeholder organisations it was suggested by the NICE project team that critically ill patients had additional complicating interventions (particularly ventilation) that affected the course of delirium and that these factors merited the exclusion of critically ill patients from the scope. The high incidence of delirium in critically ill patients is thought to be as a consequence of the large number of precipitating factors found in critical care that interact with predisposing factors to produce delirium. "Pathophysiology of delirium in the Intensive Care Unit", Crit. Care. Clin. 2008, 24: 45-65 The precipitants of delirium within critical care are in almost all cases identical to those in the wider hospital population, but the magnitude and number of insults are greater. This fact should not be used to treat critically ill patients differently from the wider hospital population. A high incidence of delirium has been shown to occur even in critically ill patients who are not ventilated. 48% of non-ventilated patients were found to be delirious, and experienced a longer ICU and hospital length of stay in one study "Intensive care unit delirium is an independent	

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				predictor of longer hospital stay: a prospective analysis of 261 non-ventilated patients" Critical Care 2005, 9:R375-R381	
SH	Oxford Radcliffe Hospitals NHS Trust	7	4.1.2.d	The underlying pathological processes are also believed to be the same in the critically ill patient as in the wider hospital population. The terminology "ICU psychosis" utilised by the NICE project team during the scoping meeting is generally being challenged in order to draw attention to the fact that patients are suffering from delirium, not a specific ICU illness or syndrome. "Detection, Prevention and Treatment of Delirium in Critically Ill Patients", UKCPA, 2006 By introducing an artificial boundary that delineates and separates the condition in critical care from the rest of the hospital population by an organisation with the importance of NICE would seriously undermine years of work in this respect.	
SH	Oxford Radcliffe Hospitals NHS Trust	8	4.1.2.d	The demographic of patients within an intensive care unit is not dissimilar to that of the wider hospital population. Arguments that critically ill patients are somehow younger and therefore should be treated differently are somewhat suspect. "Absence of ageism in access to critical care: a cross-sectional study" Age and Ageing 2003; 32: 382-387	
SH	Oxford Radcliffe Hospitals NHS Trust	9	4.1.2.d	The assessment tools used in non-critically ill patients have been adapted and validated for use in patients unable to verbalise due to the presence of an endotracheal tube. These tools	

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				should be utilised on critical care units for ventilated patients, but they do not differ substantially from the "non-adapted" tool they have been derived from. It should of course be noted, that many level 2 critically ill patients are quite capable of giving verbal responses and thus the assessment of this group for delirium is the same as for the wider hospital population. "Delirium in mechanically ventilated patients: validity and reliability of the confusion assessment method for the intensive care unit (CAM-ICU)" JAMA 2001; 286: 2701-2710	
SH	Oxford Radcliffe Hospitals NHS Trust	10	4.1.2.d	Outreach services have been developed to support critically ill patients in general ward areas. The active inclusion of critical care in the delirium guideline could provide a route whereby expertise in delirium management can be reinforced throughout organisations via outreach services, as has occurred for other skills. "Implementing the severe sepsis care bundles outside the ICU by outreach", Nurs Crit Care. 2007	
SH	Oxford Radcliffe Hospitals NHS Trust	11	4.3.e	Are there any drugs actually licensed to treat delirium…? Certainly none licensed for hypo-active delirium, this sentence then feels a little incongruous.	
SH	Oxleas NHS Trust	1		There are a couple of points you may wish to think through carefully	
SH	Oxleas NHS Trust	2	Diagnosis	The diagnosis of delirium as et out in DSM and ICd classifications often suggests that delirium is an active illness with hallucinations and delusions etc. I fact the majority of delirium is a quiet presentation of people sitting in bed and	

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				doing little. So awareness and diagnosis will have to identify the majority of patients who are not disturbed and are quiet. See **1.** Macdonald AJD*, Treloar A*. Delirium and dementia: Are they distinct? *Journal of the American Geriatric Society*. (1996) ; **44:** 1001 -1002 2. *Treloar A.* Delirium;- prevalence, prognosis and management. *Reviews in Clinical Gerontology* 1998; **8:** 241-249. 3. *Treloar A*, Macdonald AJD. Clinical features of reversible cognitive dysfunction;- are they the same as accepted definitions of delirium? *International Journal of Geriatric Psychiatry*(1997); **12:** 614-618	
SH	Oxleas NHS Trust	3	Prognosis	The prognosis is poor and often, in elderly people associated with irreversible cognitive decline . This needs careful thinkg though and understanding 4. *Treloar A*, Macdonald AJD. Outcome of delirium diagnosed by DSM-III-R, ICD-10 and Camdex and derivation of the reversible cognitive dysfunction scale among acute geriatric inpatients. *International Journal of Geriatric Psychiatry* (1997); **12:** 609-613 More importantly, recovery is slow, and it is often the case that placement wil occur before recovery can take place,. A real shame and bad practice. Need a system to allow longer rehab and recovery.	
SH	Oxleas NHS Trust	4	Treatment	Work by Sharon Innouye of the management of delirium;- exercising and rehab shows real	

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				potential to limit the long term disability of this condition.	
SH	Oxleas NHS Trust	5	Research	A real need to look at ways of reducing long term brain damage as a result of delirium.	
SH	Oxleas NHS Trust	1	Prognosis of deliurium	Delirium is generally thought to resolve with the resolution of the medical illness. In fat plenty of evidence suggests that this is not so, and recovery is slow. NICE may wish to consider the health economic costs of placing people on the basis of persistent confusion after recovery form the medical illness but before they have recovered from the delirium. When this occurs, then delirium is the cause of permanent admission to a home, and loss of ones own home, something which I do see at least occasionally.	
SH	Oxleas NHS Trust	2	Irreversible decline as a result of delirium	On the other hand delirium is often associated with an irreversible deterioration in function and permanent worsening of dementia. The mechanism of this still lie within the realm of scientific conjecture, but suggestions for research to try and modify that damage would be very welcome and worth exploring.	
SH	Oxleas NHS Trust	3	Recognition of delirium	Delirium is most often recognised by staff when it is hyperactice but the majority of delirium is hypoactive and thus missed by staff. 1. *Treloar A*, Macdonald AJD. Clinical features of reversible cognitive dysfunction;- are they the same as accepted definitions of delirium? *International Journal of Geriatric Psychiatry*(1997); **12:** 614-618 2. *Treloar A*, Macdonald AJD. Recognition of cognitive impairment by day and night nursing staff among acute geriatric patients. *Journal of the Royal Society of Medicine* (1995) ; **88:** 196-198.	

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				Better screening for picking up delirium is important	
SH	Oxleas NHS Trust	4	Intervention in delirium	NICE is strongly recommended to look at evidence from Innouye that rehab and activity improves the outcome of delirium.	
SH	Oxleas NHS Trust	5	Markers for delirium	NICE may also wish to look at emerging evidence for biological markers of delirium 3. AJD Macdonald, D Adamis, A Treloar, FC Martin. (2006) C-Reactive Protein levels predict incidence of and recovery from delirium. Age & Ageing (in press) *C-reactive protein levels predict the incidence of delirium and recovery from it* Alastair Macdonald; Dimitrios Adamis; Adrian Treloar; Finbarr Martin Age and Ageing 2006; doi: 10.1093/ageing/afl121 D Adamis, A Treloar, FC Martin, N Gregson, G Hamilton, AJD Macdonald. APOE and cytokines as biological markers for recovery of prevalent delirium in elderly medical inpatients. Int J Geriatr Psychiatry	
SH	PERIGON Healthcare Ltd			This organisation was approached but did not respond.	
SH	Research Institute for the Care of the Elderly			This organisation was approached but did not respond.	
S	Royal College of			This organisation was approached but did not	

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H	General Practitioners			respond.	
SH	Royal College of Nursing	1	1	Suggest that the Title should read Delirium: Prevention, diagnosis and management of delirium. It is essential to emphasise the prevention aspect of the guideline rather than dealing with the consequences of the onset of delirium.	
SH	Royal College of Nursing	2	3 i	Delirium can be prevented in up to a third of cases. In the remaining 2/3 the aim is to reduce the length of the delirium and to minimise the impact on the patient and carers.	
SH	Royal College of Nursing	3	4.1.2 d	Exclusions: people in intensive care. Current literature points to the fact that delirium is associated with not only elderly people but also ill people who have undergone a significant stressor, such as surgery, trauma acute illness. In modern critical care we have level one beds on wards or closer monitoring, level 2 beds or HDU and Level 3 beds or ITU beds. By excluding people in intensive care what does this exactly mean? Which patients are excluded? Where will this line be drawn? Or will this be left to a local decision? Exclude level 3 but not level 2 & 1, or exclude level 2&3 or exclude level 1, 2, &3. These patients are the illest of patients in acute care and therefore are susceptible to the onset of delirium which will affect the outcome of there stay and impact on costs. As with all documents from NICE, this guideline will carry significant weight and will become accepted practice standard. Perhaps the language of the document should be considered i.e. remove the notion of exclusion of a part of the patient groups to emphasis the principle that	

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				as a guideline, its principles can be utilised in all patient areas.	
SH	Royal College of Nursing	4	General	This scope covers the expected themes for this condition. It would be beneficial for the guideline to make recommendations concerning healthcare professional education. It is one thing to introduce a guideline but another to get it into practice. The Scope clearly states that this is a complex condition that needs to be prevented but where it occurs, it needs to be diagnosed and appropriate treatment commenced dependent upon the causative factors. No matter where we stand upon this unless the health care professionals in primary and secondary care have the necessary training and education then this guideline will not have the impact that is necessary.	
SH	Royal College of Nursing	5	General	How will we measure the impact of this guideline? Some estimates suggest that all patients with a hip fracture will develop a delirium at some point in their hospital stay. There are however conflicting statements concerning the incidence of delirium in literature.	
SH	Royal College of Nursing	6	General	Key to identifying delirium is the communication and interaction between healthcare professionals and family and carers and other healthcare professionals, the people who know the patients, they will know what is normal and what is different. The guideline needs to highlight the importance of this information source and the importance in the recording this information in the case notes.	
SH	Royal College of Nursing	7	4.2	When referring to patients in hospital does this refer to inpatients or to patients who attend the	

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				hospital.	
SH	Royal College of Nursing	8	4.2	The guideline should include those patients who attend A&E particularly when considering the older person with dementia who has developed a hypoalert- hypoactive delirium whose symptoms may be put down to the dementia and depression or just being unwell, and is sent home. Again Delirium is a complex syndrome and when subtle in its presentation can be misdiagnosed or undiagnosed.	
SH	Royal College of Pathologists			This organisation was approached but did not respond.	
SH	Royal College of Physicians of London			This organisation was approached but did not respond.	
SH	Royal College of Psychiatrists			This organisation was approached but did not respond.	
SH	Royal College of Speech and Language Therapy	1	3 (a)	**Title -** The RCSLT welcomes that reference is made to **"**Acute Confusional State", however we would wish for this to be added to section one in the title of the guideline as this term is more commonly used.	
SH	Royal College of Speech and Language Therapy	2	3 (b) and (g)	**Diagnosis –** The guideline discusses standard criteria for delirium to help make the diagnosis and instruments that may be used. However referencing only one method suggests that the guideline is recommending it. It would useful at this point to describe the strengths and limitations of each test – for example people might perform poorly if they have low English literacy or an underlying communication disorder.	
SH	Royal College of Speech and	3	4.2 (a)	**Healthcare setting** – The RCSLT welcomes that healthcare professionals are referenced in	

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	Language Therapy			this section.	
SH	Royal College of Speech and Language Therapy	4	4.3(c)	Malnutrition and dehydration may be due to an impaired swallowing function. **Add** – it is necessary to check the ability to swallow or for mechanical problems preventing fluid intake.	
SH	Royal Society of Medicine			This organisation was approached but did not respond.	
SH	SACAR			This organisation was approached but did not respond.	
SH	Scottish Intercollegiate Guidelines Network (SIGN)			This organisation was approached but did not respond.	
SH	Sedgefield PCT			This organisation was approached but did not respond.	
SH	Sheffield PCT			This organisation was approached but did not respond.	
SH	Sheffield Teaching Hospitals and NHS Foundation Trust			This organisation was approached but did not respond.	
SH	Sherwood Forest Hospitals Foundation Trust			This organisation was approached but did not respond.	
SH	Social Care Institute for Excellence (SCIE)			This organisation was approached but did not respond.	
SH	South of Tyne & Wear PCT			This organisation was approached but did not respond.	
SH	UK Clinical Pharmacy Association			This organisation was approached but did not respond.	
SH	University Hospital Birmingham NHS Foundation Trust			This organisation was approached but did not respond.	
SH	Welsh Assembly Government			This organisation was approached but did not respond.	

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SH	Welsh Scientific Advisory Committee (WSAC)			This organisation was approached but did not respond.	

[i] Fick et al. (2002) Delirium superimposed on dementia: A systematic review. Journal of American Geriatric Society, 50, 1723-1732.
[ii] Cole MG. Delirium in elderly patients. Am J Geriatr Psychiatry 2004;12:7-21;
[iii] Levkoff SE, Evans DA, Litpzin B, et al. Delirium: the occurrence and persistence of symptoms among elderly hospitalized patients. Arch Intern Med 1992; 152:334-40.
[iv] Pisani MA, McNicoll L, Inouye SK. Cognitive impairment in the intensive care unit. Clin Chest Med 2003; 24:727-37.