Delirium: prevention, diagnosis and management

Consultation on draft guideline - Stakeholder comments table
20/10/22 to 09/11/22

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British Geriatrics Society Dementia and Related Disorders Special Interest Group	Guideline	005	002 - 007	This refers back to section 1.4.1. around indicators of delirium. Though on p6 it is noted no specific simple assessment tool is to be recommended, it may well be helpful to make mention that a simple single stage tool may be helpful with examples. However we would urge caution as the NEWS2, which recommends the SQiD tool has been shown to have low sensitivity for delirium in older people (Vardy et al, in press RCP clinical medicine), as is the case for many of the simple delirium assessment tools. As a minimum a comment to the effect that simple one step screening tests have an associated false positive/negative rate might helpfully be made. Equally it might be considered that at transitions of care eg hospital admission, that there is a role for use of the 4AT as opposed to a simpler test, given the high incidence of delirium and high sensitivity and specificity of the 4AT.	Thank you. The rationale and impact section of the guideline discusses the possible utility of simple tools like SQiD and its alternatives. Please note that recommendation 1.4.1 from the consultation document has been renumbered and is 1.5.1 of the full guideline. Transitions of care such as hospital admission are covered in section 1.3 of the guideline which recommends assessment of risk factors at presentation. The committee agree that single question tools such as SQiD may have low sensitivity and specificity, but since they do not recommend any single stage tools they did not include this detail in the guideline.
British Geriatrics Society Dementia and Related Disorders	Guideline	005	008 - 010	Direct response to question 1 "Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or	Thank you. The committee have reworded this recommendation since stakeholders have interpreted the term specialist in a different way than was intended

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Special Interest Group				national initiatives." In section 1.5.2 there is an implication that all patients with delirium should be reviewed by a geriatrician or psychiatrist experienced in the care of older patients. Given that approximately 25% of hospitalised medical patients develop delirium, this will imply that 25% of patients will require referral for confirmation of the diagnosis of delirium, which seems a significant challenge with current staffing levels of these specialties. Delirium is currently under-diagnosed, this additional guidance seems likely to reduce diagnosis rates further. Furthermore this potentially fails to acknowledge the contributions of other health professionals who often carry out a large proportion of clinical assessments (e.g. psychiatry liaison nurses) and disempowers professionals from assessing and treating delirium. Additionally there are also implications for primary care. We would suggest rewording to the effect that following an indicative 4AT score that diagnosis of delirium should be confirmed by a	

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				healthcare professional able to do so. If there is difficulty establishing the diagnosis, the opinion of a specialist with the relevant expertise, such as a specialist in geriatric medicine or old age psychiatry, may be required.	
British Geriatrics Society Dementia and Related Disorders Special Interest Group	Guideline	005	008 - 010	Direct response to question 2 "Would implementation of any of the draft recommendations have significant cost implications?" As described above, the resource required to facilitate this recommendation are likely to require a significant increase in staffing with associated cost implication.	Thank you. The committee have reworded this recommendation since stakeholders have interpreted the term specialist in a different way than was intended. The recommendation will not require organisations to employ more staff'
Dementia UK	Guideline	005	008	Recommendation 1.5.2 Agree that diagnosis should be made by specialist healthcare professional but may be challenging in community setting particularly for people living with dementia and availability of community resources	Thank you. The committee have reworded this recommendation since stakeholders have interpreted the term specialist in a different way than was intended. The recommendation will not require organisations to employ more staff'
Dementia UK	Guideline	005	011 - 012	Recommendation 1.4.2 Agree that documentation reflects changes that indicate delirium in practice this may be challenging but would like to add that additional training should also include Social Care staff to enable to	Thank you. Social care staff who are working in long-term residential or nursing care would be included in recommendation 1.5.1.

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				improve awareness and prevention of delirium to reduced inappropriate hospital admissions	
Dementia UK	Guideline	005	013	Recommendation 1.5.1 Assessment and diagnosis Training should also be recommended to social care practitioners working in domiciliary care settings i.e., intermediate care staff and others supporting transitions in care	Thank you. The committee have reworded this to include social care practitioners.
GP Reference Panel	Guideline	001	007	We are surprised that this guidance does not include assessment of people in their own homes? Perhaps the guideline title should be changed to reflect this fact.	Thank you. The title of the guideline has been updated to 'Delirium: prevention, diagnosis and management in hospital and long-term care' as you suggest.
GP Reference Panel	Guideline	001	007	There appears to be some inconsistency in the current scope and previous recommendations e.g. 1.3.2 does not relate to people in Care Homes but this isn't explicitly stated. We suggest that all recommendations are updated to reflect the current scope.	Thank you. The scope of the original guideline covered hospital, long-term residential and nursing homes. This update covers the same areas, so there is no inconsistency. We can only update recommendations in the areas of the guideline selected for update, and 1.3 was not selected for update.
GP Reference Panel	Guideline	004	003 - 010	"Observe daily": this is fair, but previous guidance advised clinical assessment whereas it now suggests the application of the 4AT tool. One respondent cited evidence of variable, sometimes very low, thresholds for triggering 4AT assessment in Care Homes resulting in multiple same day referrals.	Thank you. The committee agreed that clinical assessment was ambiguous, and this was part of the reason that delirium was often missed. The tool recommended takes very little time to administer and should reduce the number of inappropriate referrals if used by staff who are competent to administer it.
GP Reference Panel	Guideline	005	002 - 007	We agree with the altered assessment process (including removal of the phrase 'specialist	Thank you for your support.

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				clinical assessment') that means that allied healthcare professionals (AHPs), albeit after adequate training, will be able to make these judgements. AHPs often have prime responsibility for the care of Nursing and Residential Home residents.	
GP Reference Panel	Guideline	005	002 - 007	There are challenges to using the score on patients in primary care with pre-existing dementia	Thank you. The committee agreed that delirium was commonly attributed to peoples pre-existing conditions. They were unable to unpick this in the evidence but made a research recommendation to investigate this further. They retained the existing recommendation that if dementia and delirium are present, the delirium should be managed first (now recommendation 1.6.3).
GP Reference Panel	Guideline	005	002 - 007	The guideline makes no mention of conditions other than dementia and delirium that can cause cognitive changes	Thank you. The scope of this guideline update was specifically to address the assessment and diagnosis of delirium. The rationale and impact section discusses some of the other changes, such as cognitive impairment and learning disabilities in the context of making a research recommendation. Further detail is contained in the committee discussion section of the evidence review, and in appendix K of the same review.
GP Reference Panel	Guideline	005	002 - 007	There is a contradiction in terminology 1.2.1 and new guidance 1.5.1.	Thank you. The recommendation has been refreshed to make the language consistent. We have also added glossary terms to define

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				1.2.1: a healthcare professional 'who is trained and competent in diagnosing delirium' whereas 1.5.1 requires this to be someone 'trained and competent in the 4AT assessment'	what is meant by healthcare professional and practitioner.
GP Reference Panel	Guideline	005	002 - 007	Please, however, further alter the phrase "A healthcare practitioner who is trained and competent to do so should carry out an assessment using the 4AT". 'Trained' suggests specific training, perhaps mandatory training – 'competent' would suffice and better reflects management and training in generalist/ community contexts.	Thank you. The committee agreed that no formal training is required for 4AT and so removed this wording. However, for CAM-ICU and ICDSC, there does need to be some training and understanding of the relevant manual, so this detail was added to the rationale and impact section of the guideline.
GP Reference Panel	Guideline	005	008 - 010	If a geriatrician has to confirm the diagnosis then admission is necessary? Is this what NICE intended?	Thank you. The committee have reworded this recommendation since stakeholders have interpreted the term specialist in a different way than was intended
Prolira BV	Guideline	006	022 - 024	Observations can surely be inconsistent and often have considerable interrator variability; caretaker/healthcare professionals often do not know the patient's cognitive, attention, awareness and language baseline. Therefor an objective brain state measurement with an easy to use device can be of great added value. That is why DeltaScan is developed.	Thank you. The use of technologies such as DeltaScan is beyond the remit of this update which looked specifically at checklists, as you note. We have passed your comment on to our medical technology evaluation programme team.
Prolira BV	Guideline	007	014 - 021	We noticed that only checklists (like CAM, CAM-ICU, ICDSC, 4AT, DOS etc) were reviewed as possible tools for screening /	Thank you. The use of technologies such as DeltaScan is beyond the remit of this update

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				helping to spot delirium. By merely considering checklist as tools, important innovations and improvements that have surfaced over the past years are left out. Since 2019 there is an objective device to measure patient's brain state, to help detect and monitor acute encephalopathy and delirium; the device is CE marked since 2019 (CE marked means: safe and effective for the intended use). The device, DeltaScan, is a single channel bedside EEG device to help detect and monitor acute encephalopathy and delirium in adult, awake hospital patients. DeltaScan is based on research of the University Medical Center Utrecht and developed together with nursing teams, so that it fits in their workflow. DeltaScan is currently used in more than 30 hospital departments in the Netherlands, Germany, Austria and in the UK. DeltaScan has high sensitivity and specificity (and is validated against the highest level of accuracy for the clinical diagnosis of delirium and EEG assessment for acute encephalopathy). Please find attached 2 publications with validation and sens-spec data.	which looked specifically at checklists, as you note. We have passed your comment on to our medical technology evaluation programme team.

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				DeltaScan is a newer screening tool, and as such, the evidence base surrounding it is smaller than a tool such as CAM-ICU, ICDSC or 4AT. However, it is objective. And biomarker based. There is enough evidence in the extended literature to support the diagnostic accuracy and implementability of DeltaScan (see e.g. https://pubmed.ncbi.nlm.nih.gov/36098948/, https://pubmed.ncbi.nlm.nih.gov/33993579/, https://pubmed.ncbi.nlm.nih.gov/30579407/). An objective EEG based device like DeltaScan has high potential to advance clinical care, because contrary to checklists that rely on good communication/language skills, an objective brain state measurement device may better serve those "people who might struggle to understand or respond because they are not fluent English speakers (chapter 1.1.11.5 of the draft)" as well as all patients with hypoactive or subsyndromal delirium, who are currently often overlooked. More info can be found on: https://prolira.com/onderzoek/?lang=en	

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Prolira BV	Guideline	008	004 – 010	If an assessment using an appropriate tool only takes place *upon reported* changes or fluctuations indicating delirium, the majority of cases will remain undetected. Especially hypoactive delirium, subsyndromal delirium, and delirium in patients with language barriers will then be overlooked. In many other countries, e.g. the Netherlands and Germany, therefor delirium guidelines prescribe daily screening of all patients who are at risk* with a validated tool. *: definition of 'at risk' varies per department, e.g. in the ICU every patient is at risk, in the cardiac surgery postoperative ward the frail elderly.	Thank you. The committee agreed that people at risk of delirium should be observed at least daily (recommendations 1.5 in the guideline). This can (but does not need to) incorporate a brief tool such as SQiD, for example. Please see the rationale and impact section of the guideline and the committee discussion section of the evidence review for further details.
Royal College of Emergency Medicine	General	General	General	1. Would suggest consideration of highlighting the need for prompt action if a delirium is suspected and consideration of treating it as a medical emergency, due to high associated morbidity and mortality rates. 2. Would encourage consideration of recommending screening for delirium occurs in the Emergency Department. 3. Would encourage consideration of supporting families/carers when this diagnosis is made, and that recovery can be very long	Thank you for your comments: 1. Treatment for delirium is outside the scope of this update, which focuses specifically on identifying delirium. Please see the scope document for more details. 2. Recommendations in sections 1.2 and 1.3 of the guideline recommend that people are assessed for risk factors, and for delirium (if indicated) at presentation. This would include Emergency Departments.

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					3. Supporting families and carers is outside the scope of this update which deals specifically with assessment. Section 1.8 of the guideline covers information and support for families and carers.
Royal College of Emergency Medicine	Guideline	005	004	Agree with the use of the 4AT. This tool is well recognised, quick and simple to use. It is becoming widely used within Emergency Departments within the UK	Thank you for confirming this.
Royal College of Emergency Medicine	Guideline	005	010	I understand the recommendation for a suspected diagnosis of delirium to be confirmed by a Psychiatrist or Geriatrician, but question if this might lead to a delay in time to diagnosis? Could this be extended to other roles such as Specialist Nurses? Frailty Teams?	Thank you. The committee have reworded this recommendation since stakeholders have interpreted the term specialist in a different way than was intended
St Helens and Knowsley Teaching Hospitals NHS Trust	Appendix G	139	General	The economic evaluation does not include the cost implications of the recommendation that the diagnosis of delirium should be made by a specialist. Some organisations will need to employ a significant amount of new staff to meet this criteria.	Thank you. The committee have reworded this recommendation since stakeholders have interpreted the term specialist in a different way than was intended. The recommendation will not require organisations to employ more staff'
St Helens and Knowsley Teaching Hospitals NHS Trust	Guideline	005	008	We were unable to identify any evidence within the document which supported the statement that a specialist is required to make the final diagnosis.	Thank you. The committee have reworded this recommendation since stakeholders have interpreted the term specialist in a different way than was intended

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				Identification and diagnosis of delirium is a core part of medical training. Many non-medical healthcare practitioners who work with older people are also trained to identify and diagnose delirium. Please consider amending this to "consider a specialist assessment if the diagnosis is unclear".	
Tees Esk and Wear Valley NHS Foundation Trust	Guideline	005	001 - 010	Could recommendations 1.5.1 and 1.5.2 emphasise the importance of early identification and prompt treatment of delirium?	Thank you. The first recommendation in this guideline emphasises the importance of "thinking delirium".
UK Clinical Pharmacy Association	Guideline	005	001	For screening in ICU (section 1.5), CAM-ICU-7 should be included alongside ICDSC as a useful screening tool that allows a degree of quantification rather than a simple binary answer of yes or no.	Thank you. The committee discussed this and agreed that CAM-ICU-7 is a specific subsection of CAM-ICU, which is included as a useful screening tool in recommendation 1.6.1.

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*