NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Delirium

Date of Quality Standards Advisory Committee post-consultation meeting:
23 April 2014

2 Introduction

The draft quality standard for delirium was made available on the NICE website for a 4-week public consultation period between 27 February and 27 March 2014. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 13 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include overarching outcomes, thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Stakeholders were also invited to respond to the following statement specific questions:

3. For draft quality statement 6: Can you suggest a measureable definition of “delirium that does not resolve”?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- The quality standard was generally well received and considered to cover an important area for quality improvement.
- Draft quality standard does not sufficiently address rehabilitation and discharge planning for people with delirium.

- Concern that highlighting people aged 65+ years will mean that younger people are missed e.g. those with early onset dementia, and also could be seen as age discrimination.
- It needs to be clear that long-term residential care includes nursing care.
- Staff require training in the detection and management of delirium which could be included as part of dementia awareness training.

Consultation comments on data collection

- Data collection will require a tailored audit. Suggested either a 'National Delirium Audit' or incorporate delirium within the national dementia audit.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

People newly admitted to hospital or long-term residential care who are at risk of delirium are assessed for recent changes in behaviour.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Statement:
  - Concern that 'assessment of recent change in behaviour' is vague and request for NICE to recommend a tool to use e.g. Confusion Assessment Method (CAM).
  - Query whether an earlier statement is needed on the initial assessment of risk of delirium.
  - Suggestion that more emphasis is needed on the importance of involving families and carers in the assessment of changes in behaviour which would support the Adult Social Care Outcomes Framework (ASCOF) measures for carers.
- Measures:
  - Queried whether an outcome measure is needed.

  - Data collection could include measuring use of CAM or specific sections relating to cognition in nursing or medical records. This may be less feasible in long term residential care.
- Definitions:
  - Suggestion that definition for people at risk of delirium should specify that previous cognitive impairment includes previous delirium.
  - Suggested re-wording of definition for recent behaviour changes from 'lack of cooperation with reasonable requests' to 'difficulty with or inability to co-operate with reasonable requests' to be more person-centred.

5.2 Draft statement 2

People newly admitted to hospital or long-term residential care who are at risk of delirium have a multicomponent intervention package to prevent delirium that is tailored to their needs.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Statement:
  - Confirmation needed that the multicomponent intervention package is aspirational rather than basic care.
  - Could a separate statement be written specifically on medication review?
  - Suggestion that the tailored multicomponent intervention should be delivered by a multidisciplinary team, which includes pharmacists, who are trained and competent in delirium prevention.
- Measures:
  - It may be difficult to collect data for the structure measure. It may be easier for organisations to demonstrate that they have a delirium prevention pathway and risk assessment in place.
  - A recommended clinical pathway /checklist with options for interventions for delirium based on the guideline would support the data collection process.
  - The national dementia audit already collects data on ward moves for those with dementia which may be relevant.

5.3 Draft statement 3

People with delirium in hospital or long-term residential care who are distressed or are a risk to themselves or others are not prescribed antipsychotic medication unless verbal and non-verbal de-escalation techniques are ineffective or inappropriate.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Statement:
  - Clarify that the statement refers to the prescribing of antipsychotic medication for delirium and not for other indications.
  - More emphasis needed that any chemical restraint should be a final resort.
  - Suggestion to simplify wording of statement to, for example, “People with delirium in hospital or long-term residential care who are distressed or are a risk to themselves or others are not prescribed antipsychotic medication routinely”
- Measures:
  - Data collection will be difficult in areas that do not use electronic prescribing.
  - It may be difficult to disentangle anti-psychotic prescribing rates for people with delirium and dementia separately.
- Definitions:
  - Concern that it is no longer appropriate to recommend haloperidol and olanzapine as they present significant increased risk of mortality or increased confusion. Suggest definition should be in line with guidance on the use of antipsychotics for people with dementia.
- Audience descriptors:
  - Suggested addition for service providers to ensure they employ staff who are skilled in using de-escalation techniques.
  - Description for commissioners is too prescriptive in that it suggests commissioner should change provider if this requirement is not met. Suggested re-wording to “Commissioners support providers in developing, monitoring and improving protocols and procedures for these services.”

5.4 Draft statement 4

People with delirium who are discharged from hospital have their diagnosis of delirium communicated to their GP.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Statement:
  - Although communication of diagnosis is important the GP should also provide good support to someone with delirium following hospital discharge.
  - Queried whether statement also needs to include communication between both the hospital/GP and long term residential care. This overlaps with guidance currently being developed on transition between health and social care which will include communication.
- Measures:
  - Queried whether an outcome measure is needed.

5.5 Draft statement 5

People with delirium in hospital or long-term residential care, and their family members and carers, are given information that explains the condition and describes other people's experiences of delirium.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Statement:
  - Is it possible to clarify the specific quality improvement area? Is it just about staff talking to families of elderly patients with delirium or providing more specific information to, for example, patients in ICU that have experienced hallucinations or flashbacks?
- Measures:
  - Useful information could be gathered through patient experience surveys.
- Equality and diversity

- Queried whether there are any evidence based information materials that are accessible to people with delirium.

5.6 Draft statement 6

People with delirium in hospital or long-term residential care that has not resolved are reassessed for underlying causes and assessed for possible dementia.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Statement:
  - Consider re-wording to ensure it is clear that follow-up in primary care after hospital discharge is important.
- Measures:
  - The link to the Commissioning for Quality and Innovation (CQUIN) dementia indicator should be clarified. Currently, any person aged over 75 admitted to an acute hospital setting as an emergency for more than three days with a diagnosis of delirium is assessed for dementia. Suggestion made that CQUIN may need to be re-worded to recognise persistent delirium and avoid pushing clinicians into a diagnosis of dementia too early. Another stakeholder was concerned that a decision to assess for dementia should not be delayed more than necessary.
  - It would be possible to collect data on follow-up of delirium through audit of hospital discharge letters. This may be more difficult to measure in the long-term care setting.

Consultation question 3

Stakeholders made the following comments in relation to consultation question 3:

- There was no agreement on how to measure ‘delirium that does not resolve’ with suggestions as follows:
  - 2 to 4 weeks because of known mortality increase.
  - 3 months after resolution of precipitants. However it is important to recognise that, in some instances, delirium can persist for a number of months.

  - Need to differentiate between delirium which has not responded to treatment within an anticipated timeframe and repeated and frequent recurrence of delirium for example due to repeated infections.
- Suggested that all patients with delirium should be assessed for dementia.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Initial assessment of risk of delirium
- Medication review to prevent delirium
- Care of people with hyperactive delirium in a safe environment e.g. a specialist locked Delirium Ward
- Not prescribing benzodiazepines for delirium unless antipsychotics are contraindicated
- Rehabilitation and discharge planning for people with delirium
- Follow up after hospital discharge in a primary care setting

Appendix 1: Quality standard consultation comments table

ID	Stakeholder	Statement No	Comments[1]
1	Orion Pharma (UK) Ltd	General	We would like to draw the review groups attention to an article published by Barr et al, Crit Care Med. 2013 Jan;41(1):263-306. These guidelines were designed to provide a roadmap for developing integrated, evidence-based, and patient-centred protocols for preventing and treating pain, agitation, and delirium in critically ill patients.
2	Alzheimer's Society	General	Alzheimer's Society welcomes this NICE Quality Standard on delirium. As stated in the introduction, people with dementia are at risk of delirium. Currently, diagnosis rates for dementia are below 50% in the UK, but if people are assessed for delirium when they are admitted to hospital or a care home, this could help to ensure people receive appropriate care and lead to better identification of dementia.
3	Alzheimer's Society	General	The Quality Standard would also improve outcomes for people already diagnosed with dementia, providing that the diagnosis has been shared with the relevant health and care staff.
4	Alzheimer's Society	General	Alzheimer's Society believes that once delirium has been diagnosed, the right treatment can be delivered, avoiding the need for antipsychotic medication. This would improve outcomes for people with dementia in acute hospital care and care homes. However, this is also dependent on a skilled workforce which is able to assess patients and care for them. Alzheimer's Society has concerns that the workforce is not equipped to assess and care for people with dementia who may also have delirium and recommends that all staff working in health and social care have an awareness and understanding of dementia.
5	College of Occupational Therapists	General	The College of Occupational Therapists is pleased to see the development of the Quality Standards for delirium. We would welcome the opportunity to participate in any further discussion on how to support meeting the standards as this will have implications for occupational therapists. Occupational therapy assessments are focused on identifying a person's functional abilities. Clinicians need to be mindful that an assessment completed when a person is in a delirious state will give information about the delirium but not about the person's abilities once the delirium is over. With this in mind the College believe that the draft standards do not sufficiently address rehabilitation and discharge planning for people with delirium.
6	NHS England	General	Thank you for the opportunity to comment the draft consultation for the above quality standard I wish to confirm that NHS England has no substantive comments to make regarding this consultation.
7	British Association of Critical Care Nurses	General	BACCN welcomes this quality standard as many critically ill / acutely ill patients are affected by delirium while in our care

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

ID	Stakeholder	Statement No	Comments[1]
8	Department of Health	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
9	Rotherham Doncaster and South Humber NHS Foundation Trust	General	Comment received from a Consultant Psychiatrist - People with hyperactive delirium are usually incapacitous and are not safe nursed on MAUs or General Medical wards. This would seem an opportunity to set a standard that each DGH should have a strategy for managing these patients in a safe environment, usually a specialist locked Delirium Ward, as developed in many centres round the country e.g. Cambridge.
10	British Geriatrics Society	General	Overall much of this data to demonstrate that QS have been met would need tailored audit data collection by named members of staff. Perhaps this would warrant a specific 'National Delirium Audit', or perhaps it may be possible to incorporate into the national dementia audit. Data that would be difficult to collect would involve those cases where delirium had not in fact been clinically detected.
11	Royal College of Nursing	General	We do have a general concern about the consistent use of the age of 65. Whilst it is accepted that it is more common for people over the age of 65 to experience delirium, we also need to reflect early onset dementia and also to avoid falling into any form of age discrimination.
12	British Association of Critical Care Nurses	Introduction	Why this quality standard is needed Page 1 - It can be difficult to distinguish between delirium and dementia – this really needs to stand out
13	British Association of Critical Care Nurses	Introduction	Page 6 Question 1 - How will this be addressed in critically ill or acutely ill patients
14	British Association of Critical Care Nurses	Introduction	Page 6 Question 2 - It should be possible to collect the data in critically ill patients
15	College of Emergency Medicine	Introduction	Question 1, pg 6 of 29 - Yes it reflects the areas for quality improvement
16	College of Emergency Medicine	Introduction	Question 2, pg 6 of 29 - Yes it would be possible to collect this data
17	College of Mental Health Pharmacists (CMHP)	Quality Statement 1	Assessment of recent change in behaviour is vague- please could you recommend a tool to use eg CAM
18	College of Mental Health Pharmacists (CMHP)	Quality Statement 1	Outcomes have not been stated for this standard.
19	Alzheimer's Society	Quality Statement 1	Process - Alzheimer's Society welcomes the process for identifying cases of delirium. For people with dementia, a change of setting can lead to a change in behaviour. However, the Society has concerns that, staff in the new setting would not be able to determine what is usual or changed behaviour. Alzheimer's Society strongly recommends that the Quality Statement acknowledge the importance of carers and family members in managing care. Carers must be involved in this process and their views listened to as they will recognise a change in behaviour.
20	College of Emergency Medicine	Quality Statement 1	"Commissioners…" para 3, pg 8 of 29 - Consider rewording this: "Commissioners ensure…that service providers are commissioned form the perspective of capacity and capability for these assessments to be carried out"
21	British Geriatrics Society	Quality Statement 1	This QS does reflect the key areas for quality improvement. In terms of collecting data for the proposed quality measures, this would be possible either by measuring use of the Confusion Assessment Method (CAM) or by

ID	Stakeholder	Statement No	Comments[1]
			measuring completion rates of a specific section relating to cognition in nursing or medical records. This may be less feasible for long-term residential care.
22	British Geriatrics Society	Quality Statement 1	Page 9 first bullet point - We would suggest that you specify that previous cognitive impairment includes previous delirium
23	Royal College of Nursing	Quality Statement 1	In order to assess changes in function and behaviour as result of delirium it is essential that history /collateral information is gathered from family carers/ supporters wherever possible, as the person may be unable to share this information themselves. This needs to be reflected in the Quality statement and should also support the Adult Social Care Outcomes Framework for carers to be seen as equal partners in care. The Royal College of Nursing and Carers Trust have developed the Triangle of Care for dementia whose principles can be applied to the care of people with delirium. See: http://www.rcn.org.uk/development/practice/dementia/triangle_of_care
24	Royal College of Nursing	Quality Statement 1	(measures) - In order to achieve accurate and meaningful gathering of data for this quality statement staff need to have access to training and education in the detection and management of delirium. This should be included as part of dementia awareness training.
25	Royal College of Nursing	Quality Statement 1	(definitions) - Recent behavior change: The use of the wording 'lack of cooperation with reasonable requests' (see page 9) is not person –centred and suggests intentional behaviour, which does not reflect the experience of delirium. Would suggest instead: difficulty with or inability to cooperate with reasonable requests.
26	Royal Pharmaceutical Society	Quality statement 2	We support the use of tailored multi component intervention packages to prevent delirium in people newly admitted to hospital or in long-term residential care who are at risk of delirium. As experts in medicines, pharmacists provide advice on how to take medicines, adverse effects, possible interactions and cautions, to raise patients' and carers' awareness and increase their understanding of their condition and therapy and would therefore be ideally placed to inform on these intervention packages. The tailored multi component intervention should be delivered by a multidisciplinary team, that includes pharmacists, who are trained and competent in delirium prevention and this should be reflected in the quality standard.
27	Orion Pharma (UK) Ltd	Quality Statement 2	Comment about scope of statement 2. There is no mention of drug treatment specifically in this section. In some instances, delirium could be minimised by appropriate treatment choices, so should be a factor considered. For example in the ICU setting, choice of sedative may have a direct impact on frequency of delirium and therefore patient outcomes. (Jakob et al, JAMA 2012; 307:1151-60. Maldonado et al, Psychosomatics 2009; 50:206 –217. Mo et at. Ann Pharmacother 2013; 47: 869-76)
28	Orion Pharma (UK) Ltd	Quality Statement 2	Comment about scope of statement 2. Length of time on mechanical ventilation can impact on the rates of delirium in ICU patients (Riker et al, JAMA 2009; 301: 489-499). We would suggest adding those on mechanical ventilation to the list of People at risk of delirium.
29	Orion Pharma (UK) Ltd	Quality Statement 2	Comment about the scope of statement 2. Use of the PRE-DELIRIC model for intensive care patients may be recommended. The model allows for early prediction of delirium and initiation of preventive measures. (BMJ 2012;344:e420)

ID	Stakeholder	Statement No	Comments[1]
30	College of Mental Health Pharmacists (CMHP)	Quality Statement 2	Could there be a statement for review of medication or rationalisation in this section. Review of medication that can cause delirium eg anticholinergics, opioids etc. Would be worth including this in this standard and also when treating delirium medication should be reviewed and rationalised.
31	Alzheimer's Society	Quality Statement 2	Process - Alzheimer's Society welcomes the process for identifying cases of delirium. For people with dementia, a change of setting can lead to confusion, particularly in the first few days. Therefore as assessment within the first 24 hours of admission would recognise the person's needs and encourage early intervention.
32	British Geriatrics Society	Quality Statement 2	Evidence is necessary that delirium prevention strategies are in place. Methods of measuring this may be difficult. It would be possible for organisations to demonstrate that they have a delirium prevention pathway and risk assessment. It would also be possible to measure whether such strategies were effective by measuring outcomes such as incidence of delirium. However as data is dependent on detection of delirium this may not be robust. The national dementia audit collects data on ward moves for those with dementia, which should be low for an organisation with an effective delirium prevention strategy.
33	Royal College of Nursing	Quality statement 2	See comment above on training and education of staff - this needs to be offered to all staff who have regular and frequent contact with people who may be at risk of delirium and to be effective it may need to be separate training
34	Royal College of Nursing	Quality statement 2	(measure) - Local data collection is suggested here on intervention for managing delirium but would question how easy it will be to gather this data as it would require significant examination of notes. A recommended clinical pathway /checklist with options for interventions for delirium based on the guidelines would support this process.
35	Royal College of Psychiatrists- Old Age Faculty	Quality statement 3	Haloperidol and olanzapine are probably not the best drugs to use. Haloperidol is twice as likely to cause death compared with other antipsychotics (Huybrechts et al BMJ 2012) and olanzapine is anticholinergic so may increase confusion. At least you didn't suggest quetiapine. Maybe risperidone or amisulpride are more logical choices pending definitive studies.
36	College of Mental Health Pharmacists (CMHP)	Quality Statement 3	All parts of this statement need to clarify that it refers to the prescribing of antipsychotic medication for delirium and not for other indications. Without clarification of this point, readers may assume that long-term prescriptions of antipsychotics should be withheld whilst the patient has co-morbid delirium. May be useful to have a statement about not prescribing benzodiazepines for delirium unless antipsychotics are contraindicated.
37	College of Mental Health Pharmacists (CMHP)	Quality Statement 3	Data collection for this statement will be difficult in areas that do not use electronic prescribing. Many psychiatric hospitals still use drug charts and antipsychotics are kept as "stock" on the wards. Therefore information on antipsychotic use would not be electronically traceable. It would only be traceable if all drug charts were examined manually.
38	Alzheimer's Society	Quality Statement 3	Alzheimer's Society welcomes this Quality Statement as antipsychotic medication should only be prescribed as a last resort. I would delete this unless you want to tie back into why it is so important to people with dementia?
39	Alzheimer's Society	Quality Statement 3	What the quality standard means for service providers and professionals - This Quality Statement is dependent on a skilled and effective workforce. In terms of what this means for service providers, professionals and commissioners, Alzheimer's Society believes that training has been omitted. Service providers must employ staff who are skilled in using de-escalation techniques. Alzheimer's Society would like to see the addition of training to this Quality

ID	Stakeholder	Statement No	Comments[1]
			Statement.
40	British Association of Critical Care Nurses	Quality Statement 3	Page 5 - How will this be addressed in critically ill or acutely ill patients
41	College of Emergency Medicine	Quality Statement 3	What about not prescribing antipsychotics to those with dementia? Does not seem very clear up front although Lewy body dementia is referred to later
42	College of Emergency Medicine	Quality Statement 3	line 18, page 14 of 29 - "Commissioners ensure…only commission services from providers….." - this is not in the spirit of QI but QA!! The service provider may be perfectly fine for other services and it would be a waste to change provider for the virtue of 1 service. Why not say: "commissioners support providers in developing, monitoring and improving protocols and procedures for these services."
43	British Geriatrics Society	Quality Statement 3	Use of antipsychotic medication in delirium is an important QS. It would be possible to ask organisations to demonstrate whether they have delirium management pathways that give guidance on anti-psychotics in keeping with NICE guidelines. What would be difficult in assessing anti-psychotic prescribing rates would be disentangling delirium from dementia. What is important overall is to ensure audit of anti-psychotic prescribing rates and asking organisations to demonstrate what processes have been taken to reduce prescription rates.
44	Royal College of Nursing	Quality statement 3	With regard to the statement about the use of antipsychotic medication, we would also like to see some clarity that any chemical restraint should be a final resort.
45	Royal College of Nursing	Quality statement 3	(definitions) - The standard recommends the use of Haloperidol and Olanzapine in small doses. However recent studies seem to suggest these may not be the best drug options as they may present significant risk of mortality or increased confusion, as indicated in guidance on the use of antipsychotics for people with dementia. Risperidone is the only antipsychotic drug that has been approved for use for people with dementia with aggression and we would suggest that the standard and statement should reflect this.
46	College of Mental Health Pharmacists (CMHP)	Quality Statement 4	No outcomes have been stated
47	Alzheimer's Society	Quality Statement 4	Alzheimer's Society welcomes this Quality Statement as any diagnosis should be communicated to the GP without any delays. However, GPs will also need training in delirium in order to know relevant treatments or make referrals for the right support when necessary. The Quality Standard must include a sentence recognising the importance of good support from a GP following a hospital discharge.
48	British Association of Critical Care Nurses	Quality Statement 4	Page 14 –Agree that GPs should be informed of all delirious episodes
49	British Geriatrics Society	Quality Statement 4	It is entirely appropriate that a diagnosis of delirium should be conveyed to GP. It should be possible to collect data through coding regarding where delirium mentioned during inpatient admission, whether this is documented on the discharge summary
50	Alzheimer's Society	Quality Statement 5	Information provision is an important part of a support package after any diagnosis. However, Alzheimer's Society believes this information needs to be of a high-quality. In addition, the information must be produced in a variety of formats to ensure accessibility.

ID	Stakeholder	Statement No	Comments[1]
51	British Geriatrics Society	Quality Statement 5	Information and support relating to delirium is important. Equality and diversity considerations states that information should be accessible to people with delirium, however we wonder whether there are any such materials with an evidence base.
52	British Geriatrics Society	Quality Statement 5	It would be possible to assess organisational use of information resources. In order to gather this information at an individual level specific audit would be necessary. Useful information may be gathered through patient experience surveys.
53	Alzheimer's Society	Quality Statement 6	Alzheimer's Society welcomes this Quality Statement as it will support the appropriate identification of dementia cases. Again, the Society reiterates the importance of an assessment for dementia being carried out by a person who also (?) has knowledge and understanding of dementia and the impact on delirium.
54	Alzheimer's Society	Quality Statement 6	Process - In terms of process, the dementia Commissioning for Quality and Innovation (CQUIN) already includes an indicator for hospitals which states that any person aged over 75 admitted to an acute hospital setting as an emergency for more than three days is asked a dementia case finding question. This process would support professionals working in an acute setting to make a decision on whether they should further investigate a person with delirium who falls into the CQUIN category. Other than the CQUIN, professionals, supported with appropriate training, must use their judgement and consider the risk factors of dementia before assessing a person for the condition; however, Alzheimer's Society believes that a decision to assess for dementia should not be delayed more than necessary.
55	College of Emergency Medicine	Quality Statement 6	Question 3, pg 6 of 29 - Delirium that does not resolve - from the perspective of influencing outcomes, we know that mortality starts to increase between 2 to 4 weeks after unresolved delirium and more so after 4 weeks. It would seem reasonable to me that 2 weeks should be taken as the criteria as it is reasonable to assume that if we do not get to the bottom of this by then, latest within 4 weeks, the mortality would be significantly higher.
56	British Geriatrics Society	Quality Statement 6	Following up people where delirium has not resolved has huge resource implications, but is a vitally important area. This is difficult as it may take several weeks to resolve. Follow-up may be initiated by GPs which may be difficult to measure. Many people with a delirium will have a background of cognitive impairment; hence these people should be followed up in relation to the dementia CQUIN. It may be preferable to issue NICE guidance to ensure all delirium is followed up, with clear advice as to when this would be appropriate in a primary care setting as opposed to secondary care.
57	British Geriatrics Society	Quality Statement 6	It would be possible to collect data on follow-up of delirium through audit of hospital discharge letters. This may be more difficult to measure in long-term care setting.
58	British Geriatrics Society	Quality Statement 6	The wording of the CQUIN should recognise the existence of persistent delirium and consideration should be given to careful wording to avoid pushing clinicians into a diagnosis of dementia too early, when patients may still experience some resolution of cognitive impairment.
59	British Geriatrics Society	Quality Statement 6	Persistent delirium could be defined as "when all identified precipitants of delirium have been corrected and an appropriate length of time allowed for the body's physiological responses to return to normal homeostasis". Additionally one should take in to account evidence that the person has not reached their usual baseline of cognitive

ID	Stakeholder	Statement No	Comments[1]
			function (family/care witness statement, by repeated cognitive assessment). Initial assessment for dementia as a possible cause of apparent persistent delirium might be best done at 3 months after resolution of precipitants. However it is important to recognise that, in some instances, delirium can persist for a number of months.
60	Royal College of Nursing	Quality Statement 6	For delirium that has not resolved there needs to be some differentiation between those with a known detected delirium which has not responded to treatment within an anticipated timeframe and those with repeated and frequent recurrence of delirium for example due to repeated infections.

Stakeholders who submitted comments at consultation

- Alzheimer's Society
- British Association of Critical Care Nurses
- British Geriatrics Society
- College of Emergency Medicine
- College of Occupational Therapists
- College of Mental Health Pharmacists (CMHP)
- Department of Health
- NHS England
- Orion Pharma (UK) Ltd
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Royal College of Nursing
- Royal College of Psychiatrists- Old Age Faculty
- Royal Pharmaceutical Society