NICE National Institute for Health and Care Excellence

NICE quality standard

Delirium in adults

Quality standard
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Contents

This standard is based on CG103.

This standard should be read in conjunction with QS15, QS16, QS24, QS50, QS61, QS86, QS85, QS66, QS110, QS158 and QS184.

Quality statements

Statement 1 Adults newly admitted to hospital or long-term care who are at risk of delirium are assessed for recent changes that affect cognition, perception, physical function or social behaviour.

Statement 2 Adults newly admitted to hospital or long-term care who are at risk of delirium receive a range of tailored interventions to prevent delirium.

Statement 3 Adults with delirium in hospital or long-term care who are distressed or are a risk to themselves or others are not prescribed antipsychotic medication unless de-escalation techniques are ineffective or inappropriate.

Statement 4 Adults with delirium in hospital or long-term care, and their family members and carers, are given information that explains the condition and describes other people's experiences of delirium.

Statement 5 Adults with current or resolved delirium who are discharged from hospital have their diagnosis of delirium communicated to their GP.

Quality statement 1: Assessing recent changes that may indicate delirium

Quality statement

Adults newly admitted to hospital or long-term care who are at risk of delirium are assessed for recent changes that affect cognition, perception, physical function or social behaviour.

Rationale

The early detection of delirium is important, because it allows supportive care and treatment for reversible causes to be put in place as quickly as possible. People may already have delirium when they are admitted to hospital or to long-term care, so it is important to assess for any recent changes affecting cognition, perception, physical function or social behaviour that may indicate delirium. If possible, family members and carers of people at risk of delirium should be involved in identifying any changes.

Quality measures

Structure

Evidence of local arrangements to ensure that adults newly admitted to hospital or long-term care who are at risk of delirium are assessed for recent changes that affect cognition, perception, physical function or social behaviour.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example from clinical protocols.

Process

Proportion of adults newly admitted to hospital or long-term care who are at risk of

delirium who are assessed for recent changes that affect cognition, perception, physical function or social behaviour.

Numerator – the number in the denominator who are assessed for recent changes that affect cognition, perception, physical function or social behaviour.

Denominator – the number of adults newly admitted to hospital or long-term care who are at risk of delirium.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Detection of delirium.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers (such as hospitals, residential care homes and nursing homes) ensure that guidance is available on changes that may indicate delirium, and that systems are in place to assess recent changes that affect cognition, perception, physical function or social behaviour in adults newly admitted to hospital or long-term care who are at risk of delirium.

Health and social care practitioners ensure that they assess adults newly admitted to hospital or long-term care who are at risk of delirium for recent changes that affect cognition, perception, physical function or social behaviour.

Commissioners (such as integrated care systems and local authorities) ensure that the hospitals and long-term care they commission can demonstrate (for example, by auditing current practice) that newly admitted adults who are at risk of delirium are assessed for

recent changes that affect cognition, perception, physical function or social behaviour.

Adults admitted to hospital or to a residential care home or nursing home who are thought to be at risk of delirium are assessed to spot any recent changes that may show that they have delirium, such as to their ability to understand or make decisions, or to their physical and social behaviour. A person is at risk of delirium if any of the following apply: they are 65 or older, already have difficulties with memory or understanding (known as cognitive impairment), have dementia, have a broken hip or are seriously ill.

Source guidance

Delirium: prevention, diagnosis and management. NICE guideline CG103 (2010, updated 2023), recommendation 1.3.1

Definitions of terms used in this quality statement

Long-term care

Residential care provided in a home that may include skilled nursing care and help with everyday activities. This includes nursing homes and residential homes. [NICE's guideline on delirium, terms used in this guideline]

Adults at risk of delirium

If any of these risk factors is present, the person is at risk of delirium:

- Age 65 years or older.
- Cognitive impairment (past or present) and/or dementia. If cognitive impairment is suspected, confirm it using a standardised and validated cognitive impairment measure.
- Current hip fracture.
- Severe illness (a clinical condition that is deteriorating or is at risk of deterioration).

[NICE's guideline on delirium, recommendation 1.2.1]

Recent changes that affect cognition, perception, physical function or social behaviour

Recent (within hours or days) changes or fluctuations that may indicate delirium may be reported by the person at risk, or a carer or family member. The changes may affect:

- Cognitive function: for example, worsened concentration, slow responses, confusion
- Perception: for example, visual or auditory hallucinations.
- Physical function: for example, reduced mobility, reduced movement, restlessness, agitation, changes in appetite, sleep disturbance.
- Social behaviour: for example, difficulty engaging with or following requests, withdrawal, or alterations in communication, mood and/or attitude.

[Adapted from NICE's guideline on delirium, recommendation 1.3.1]

Equality and diversity considerations

A learning disability specialist nurse should be involved in assessing changes indicating delirium in adults with a learning disability who are at risk of delirium, to ensure that the person's specific needs are taken into account.

Quality statement 2: Interventions to prevent delirium

Quality statement

Adults newly admitted to hospital or long-term care who are at risk of delirium receive a range of tailored interventions to prevent delirium.

Rationale

Delirium is potentially preventable, and interventions can be effective in preventing delirium in adults who are at risk. These preventative measures should be tailored to each person's needs, based on the results of an assessment for clinical factors that may contribute to the development of delirium. Such clinical factors include cognitive impairment, disorientation, dehydration, constipation, hypoxia, infection or other acute illness, immobility or limited mobility, pain, effects of medication, poor nutrition, sensory impairment and sleep disturbance.

Quality measures

Structure

Evidence of local arrangements to ensure that adults newly admitted to hospital or long-term care who are at risk of delirium receive a range of tailored interventions to prevent delirium.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example from clinical protocols.

Process

a) Proportion of adults newly admitted to hospital or long-term care who are at risk of

delirium who are assessed for clinical factors that may contribute to the development of delirium within 24 hours of their admission.

Numerator – the number in the denominator who are assessed for clinical factors that may contribute to the development of delirium within 24 hours of their admission.

Denominator – the number of adults newly admitted to hospital or long-term care who are at risk of delirium.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of adults newly admitted to hospital or long-term care who are at risk of delirium who receive a range of tailored interventions to prevent delirium.

Numerator – the number in the denominator who receive a range of tailored interventions to prevent delirium.

Denominator – the number of adults newly admitted to hospital or long-term care who are at risk of delirium who have an assessment for clinical factors that may contribute to the development of delirium.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Incidence of delirium.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers (such as hospitals, residential care homes, nursing homes) ensure that guidance is available on using a range of tailored interventions to prevent delirium.

Health and social care practitioners ensure that adults newly admitted to hospital or long-term care who are at risk of delirium receive a range of tailored interventions to prevent delirium.

Commissioners (such as integrated care systems and local authorities) ensure that the hospitals and long-term care they commission services from can demonstrate (for example, by auditing current practice) the use of a range of tailored interventions to prevent delirium.

Adults admitted to hospital or to a residential care home or nursing home who are thought to be at risk of delirium are assessed and offered care to reduce their chances of getting delirium that takes into account their particular needs and circumstances.

Source guidance

Delirium: prevention, diagnosis and management. NICE guideline CG103 (2010, updated 2023), recommendations 1.4.2 and 1.4.4 to 1.4.13

Definitions of terms used in this quality statement

Long-term care

Residential care provided in a home that may include skilled nursing care and help with everyday activities. This includes nursing homes and residential homes. [NICE's guideline on delirium, terms used in this guideline]

Adults at risk of delirium

If any of these risk factors is present, the person is at risk of delirium:

- Age 65 years or older.
- Cognitive impairment (past or present) and/or dementia. If cognitive impairment is suspected, confirm it using a standardised and validated cognitive impairment measure.
- Current hip fracture.
- Severe illness (a clinical condition that is deteriorating or is at risk of deterioration).

[NICE's guideline on delirium, recommendation 1.2.1]

Tailored interventions to prevent delirium

Interventions to prevent delirium are provided by a multidisciplinary team and are tailored to the care setting and to the person's individual needs. They are based on the results of an assessment for clinical factors that may contribute to the development of delirium, including cognitive impairment, disorientation, dehydration, constipation, hypoxia, infection or other acute illness, immobility or limited mobility, pain, effects of medication, poor nutrition, sensory impairment and sleep disturbance. Interventions could include:

- avoiding moving people within and between wards or rooms unless absolutely necessary
- ensuring that the person is cared for by a team of healthcare professionals who are familiar to them
- providing appropriate lighting and clear signage; for example, a 24-hour clock, a calendar
- talking to the person to reorientate them
- introducing cognitively stimulating activities
- if possible, encouraging regular visits from family and friends
- ensuring that the person has adequate fluid intake
- looking for and treating infections
- avoiding unnecessary catheterisation

- encouraging the person to walk or, if this is not possible, to carry out active range-of-motion exercises
- reviewing pain management
- carrying out a medication review
- ensuring that the person's dentures fit properly
- ensuring that any hearing and visual aids are working and are used
- reducing noise during sleep periods
- avoiding medical or nursing interventions during sleep periods.

[Adapted from NICE's guideline on delirium, recommendations 1.4.1 to 1.4.13]

Equality and diversity considerations

A learning disability specialist nurse should be involved in providing tailored interventions aimed at preventing delirium for adults with a learning disability who are at risk, to ensure that the person's specific needs are taken into account.

Quality statement 3: Use of antipsychotic medication for people who are distressed

Quality statement

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

Rationale

Antipsychotic medication is associated with a number of adverse effects. Therefore it should only be considered as a short-term treatment option for delirium if a person is distressed or is a risk to themselves or others and de-escalation techniques have failed or are inappropriate. Antipsychotic medication may be inappropriate in a variety of circumstances; for example, if reversible causes such as pain or urinary retention have not been treated or excluded, if barriers to communication have not been overcome, or for people with specific conditions such as Parkinson's disease or dementia with Lewy bodies.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with delirium in hospital or long-term care who are distressed or are a risk to themselves or others are not prescribed antipsychotic medication unless de-escalation techniques are ineffective or inappropriate.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example from clinical protocols.

Process

Proportion of adults with delirium in hospital or long-term care who have been prescribed antipsychotic medication who were distressed or a risk to themselves or others and for whom de-escalation techniques were ineffective or inappropriate.

Numerator – the number in the denominator who were distressed or a risk to themselves or others and for whom de-escalation techniques were ineffective or inappropriate.

Denominator – the number of adults with delirium in hospital or long-term care who have been prescribed antipsychotic medication.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from local antipsychotic prescribing audits.

Outcome

Antipsychotic medication prescribing rates.

Data source: The NHS Business Services Authority Medicines Used in Mental Health – England contains data on drugs used in psychoses and related disorders.

What the quality statement means for different audiences

Service providers (such as hospitals, residential care homes, nursing homes and GPs) ensure that there are procedures and protocols in place to monitor the use of antipsychotic medication in adults with delirium, to ensure that this is only considered as a treatment option for delirium when the person is distressed or a risk to themselves or others and de-escalation techniques are ineffective or inappropriate.

Healthcare professionals ensure that they do not prescribe antipsychotic medication for adults with delirium who are distressed or a risk to themselves or others unless de-escalation techniques are ineffective or inappropriate.

Commissioners (such as integrated care systems, local authorities and NHS England area

teams) ensure that staff in hospitals and long-term care homes are trained in de-escalation techniques if appropriate, monitor antipsychotic medication prescribing rates for adults with delirium, and support providers to develop, monitor and improve procedures and protocols to monitor this prescribing.

Adultsin hospital or in a residential care home or nursing home who have delirium are not given antipsychotic medication (which can be used to treat people who experience hallucinations or delusions) unless they are very distressed or are thought to be a risk to themselves or others, and if other ways of calming them down have not worked or are not suitable.

Source guidance

Delirium: prevention, diagnosis and management. NICE guideline CG103 (2010, updated 2023), recommendation 1.7.4

Definitions of terms used in this quality statement

Long-term care

Residential care provided in a home that may include skilled nursing care and help with everyday activities. This includes nursing homes and residential homes. [NICE's guideline on delirium, terms used in this guideline]

Antipsychotic medication for adults with delirium

Short-term (usually for 1 week or less) use of appropriate antipsychotic medication, starting at the lowest clinically appropriate dose and titrating cautiously according to symptoms, should be considered for adults with delirium who are distressed or considered a risk to themselves or others when de-escalation techniques have been ineffective or are inappropriate.

Antipsychotic drugs should be avoided, or used with caution if they are needed, in people with conditions such as Parkinson's disease or dementia with Lewy bodies. [Adapted from NICE's guideline on delirium, recommendation 1.7.4]

De-escalation techniques

Communication approaches that can help solve problems and reduce the likelihood or impact of confrontation. This includes verbal and non-verbal communication such as signs, symbols, pictures, writing, objects of reference, human and technical aids, eye contact, body language and touch. [Adapted from Skills for Care's National minimum training standards for healthcare support workers and adult social care workers in England, standard 3.5: Deal with confrontation and difficult situations]

Equality and diversity considerations

A learning disability specialist nurse should be involved in treating the symptoms of delirium in adults with a learning disability, to ensure that the person's specific needs are taken into account.

Quality statement 4: Information and support

Quality statement

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

Rationale

Experiencing delirium can be upsetting and distressing, particularly if the person has hallucinations or delusions, and they may go on to have flashbacks. It is important to provide information that describes how others have experienced delirium in order to help adults with delirium, and their family members and carers, to understand the experience and to support recovery.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with delirium in hospital or long-term care, and their family members and carers, are given information that explains the condition and describes other people's experiences of delirium.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example from clinical protocols.

Process

a) Proportion of adults with delirium in hospital or long-term care who are given information that explains the condition and describes other people's experiences of

delirium.

Numerator – the number in the denominator who are given information that explains the condition and describes other people's experiences of delirium.

Denominator – the number of adults with delirium in hospital or long-term care.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of family members or carers of adults with delirium in hospital or long-term care who are given information that explains the condition and describes other people's experiences of delirium.

Numerator – the number in the denominator whose family members or carers are given information that explains the condition and describes other people's experiences of delirium.

Denominator – the number of adults with delirium in hospital or long-term care.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Patient and carer experience.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations. The Care Quality Commission's Adult inpatient survey asks about information provision (not specific to adults with delirium).

What the quality statement means for different audiences

Service providers (such as hospitals, residential care homes, nursing homes) ensure that they have protocols and procedures in place so that adults with delirium, and their family members and carers, are given information that explains the condition and describes other people's experiences of delirium.

Health and social care practitioners ensure that they give adults with delirium, and their family members and carers, information that explains the condition and describes other people's experiences of delirium.

Commissioners (such as integrated care systems and local authorities) seek evidence from providers that they have protocols and procedures in place to ensure that adults with delirium, and their family members and carers, are given information that explains the condition and describes other people's experiences of delirium.

Adults with delirium, and their family members and carers, are given information that explains what delirium is and includes descriptions of other people's experiences of delirium.

Source guidance

Delirium: prevention, diagnosis and management. NICE guideline CG103 (2010, updated 2023), recommendation 1.8.1

Definitions of terms used in this quality statement

Long-term care

Residential care provided in a home that may include skilled nursing care and help with everyday activities. This includes nursing homes and residential homes. [NICE's guideline on delirium, terms used in this guideline]

Information for adults with delirium, and their family members and carers

Appropriate verbal and written information, which:

- informs them that delirium is common and usually temporary
- describes people's experiences of delirium
- encourages adults at risk of delirium, and their family members and carers, to tell their healthcare team about any sudden changes or fluctuations in behaviour
- encourages the person who has had delirium to share their experience with the healthcare professional during recovery
- advises the person of any support groups.

[Adapted from NICE's guideline on delirium, recommendation 1.8.1]

The Royal College of Psychiatrists' information on delirium is an example of written information for adults with delirium and their family members and carers.

Equality and diversity considerations

All written information should be accessible to adults with delirium, and their family members and carers, who have additional needs such as physical, sensory or learning disabilities. Adults with delirium, and their family members and carers, should have access to an interpreter or advocate if needed, and should be provided with information that meets their cultural, cognitive and language needs.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 5: Communication of diagnosis to GPs

Quality statement

Adults with current or resolved delirium who are discharged from hospital have their diagnosis of delirium communicated to their GP.

Rationale

Improving communication between hospitals and GPs, and within hospital departments, may help people who are recovering from or who still have delirium to receive adequate follow-up care once they are back in the community or a long-term care home. Follow-up care may include treatment for reversible causes, investigation for possible dementia and a greater emphasis on preventing delirium recurring. A person's diagnosis of delirium may not be communicated to their GP because it is usually secondary to their main reason for admission, and it also may not be communicated between hospital wards when the person is transferred. A person's diagnosis of delirium during a hospital stay should be formally included in the discharge summary sent to their GP, and the term 'delirium' should be used.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with current or resolved delirium who are discharged from hospital have their diagnosis of delirium communicated to their GP.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example from data sharing agreements and hospital discharge protocols.

Process

Proportion of adults with current or resolved delirium who are discharged from hospital who have their diagnosis of delirium communicated to their GP.

Numerator – the number in the denominator who have their diagnosis of delirium communicated to their GP.

Denominator – the number of adults with current or resolved delirium who are discharged from hospital.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations. The NHS Admitted patient care datasets contain data on the coding of delirium. Data for admissions to NHS hospitals in England are available at NHS Digital's Hospital Episode Statistics.

Outcome

Continuity of care from hospital to home.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers (such as hospitals, GPs) ensure that systems are in place so that a diagnosis of delirium during a hospital stay is communicated to the person's GP after discharge.

Healthcare professionals in all hospital care settings ensure that a diagnosis of delirium during a hospital stay is communicated to the person's GP when they are discharged.

Commissioners (such as integrated care systems and NHS England area teams) ensure that they commission services that have systems in place to record people's diagnoses of

delirium during hospital stays in discharge summaries sent to GPs. Integrated care systems may wish to seek evidence that protocols are in place to record episodes of delirium during hospital stays.

Adults who have had delirium in hospital have their diagnosis of delirium shared with their GP by hospital staff when they are discharged.

Source guidance

Delirium: prevention, diagnosis and management. NICE guideline CG103 (2010, updated 2023), recommendation 1.6.4

Update information

Minor changes since publication

January 2023: Changes have been made to align this quality standard with the updated NICE guideline on delirium: prevention, diagnosis and management. Statement 1 was amended to reflect that some indicators of delirium may not be related to behaviour. References and source guidance sections have been updated. Data sources have been updated throughout.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the

quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- British Geriatrics Society
- Royal College of Emergency Medicine
- ICUsteps
- Royal College of Physicians (RCP)
- Royal College of Psychiatrists (RCPsych)