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.

Introduction

This quality standard covers the prevention, diagnosis and management of delirium in adults (18 years and over) in hospital or long-term care settings. For more information see the topic overview.

Why this quality standard is needed

Delirium (sometimes called 'acute confusional state') is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course. It usually develops over 1 to 2 days. It is a serious condition that may be associated with poor outcomes. However, it can be prevented and symptoms treated if dealt with urgently.

Delirium can be hyperactive or hypoactive, but some people show signs of both (known as mixed delirium). People with hyperactive delirium have heightened arousal and can be restless, agitated and aggressive. People with hypoactive delirium become withdrawn, quiet and sleepy. Hypoactive and mixed delirium can be more difficult to recognise.

It can be difficult to distinguish between delirium and dementia because symptoms overlap, and some people may have both conditions. Dementia tends to develop slowly, whereas delirium is characterised by sudden changes. Dementia is generally a chronic, progressive disease for which there is no cure. Delirium is a potentially reversible condition if the causes are identified and they are treatable. If clinical uncertainty exists over the diagnosis, initial management should be for delirium.

Older people, and people with cognitive impairment, dementia, severe illness or a hip fracture, are more at risk of delirium. About 20–30% of people on medical wards in hospital have delirium, and between 10% and 50% of people who have surgery develop delirium, with considerable variation across different types of surgery and settings. In long-term care settings, the prevalence of delirium is under 20%. The prevalence of delirium tends to

rise with increasing age, but reporting of delirium is poor in the UK, indicating that awareness and reporting procedures need to be improved.

The quality standard is expected to contribute to improvements in the following outcomes:

- length of hospital stay
- detection of delirium
- incidence of delirium
- falls in hospital
- mortality
- adults' experience of hospital care
- carer involvement in healthcare.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following outcomes frameworks published by the Department of Health:

- The Adult Social Care Outcomes Framework 2014 to 15
- NHS Outcomes Framework 2014 to 15
- Improving outcomes and supporting transparency: a public health outcomes framework for England 2013 to 2016, Part 1 and Part 1A.

Coordinated services

The quality standard for delirium specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway. A person-

centred, integrated approach to providing services is fundamental to delivering high-quality care to adults with delirium.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality delirium service are listed in related NICE quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health and social care practitioners involved in assessing, caring for and treating adults with delirium should have sufficient and appropriate training and competencies to detect and manage delirium in order to deliver the actions and interventions described in the quality standard.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting adults with delirium. If appropriate, health and social care practitioners should ensure that family members and carers are involved in the assessment of delirium and the decision-making process about investigations, treatment and care.

List of quality statements

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

Quality statement

Adults newly admitted to hospital or long-term care who are at risk of delirium are assessed for recent changes in behaviour, including cognition, perception, physical function and 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 or fluctuations in behaviour that may indicate that the person has delirium. If possible, family members and carers of people at risk of delirium should be involved in identifying any changes in behaviour.

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 in behaviour, including cognition, perception, physical function and social behaviour.

Data source: Local data collection.

Process

Proportion of adults newly admitted to hospital or long-term care who are at risk of delirium who are assessed for recent changes in behaviour, including cognition, perception, physical function and social behaviour.

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

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

Data source: Local data collection.

Outcome

Detection of delirium.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as hospitals, residential care homes, nursing homes) ensure that guidance is available on changes in behaviour that may indicate that a person has delirium, and that systems are in place to assess recent changes in behaviour, including cognition, perception, physical function and 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 in behaviour, including cognition, perception, physical function and social behaviour.

Commissioners (such as clinical commissioning groups [CCGs], local authorities) ensure that the hospitals and long-term care they commission services from can demonstrate (for example, by auditing current practice) that newly admitted adults who are at risk of delirium are assessed for recent changes in behaviour, including cognition, perception, physical function and social behaviour. CCGs may include this in local Commissioning for Quality and Innovation (CQUIN) targets for improving dementia and delirium care.

What the quality statement means for patients,

service users and carers

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 in their behaviour that may show that they have delirium. 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), recommendation 1.2.1 (key priority for implementation)

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 full guideline on delirium, glossary of terms]

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 1.1.1]

Recent changes in behaviour

Recent (within hours or days) changes or fluctuations in behaviour may be reported by the person at risk, or a carer or family member, and 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 with or unable to cooperate with reasonable requests, withdrawal, or alterations in communication, mood and/or attitude.

[Adapted from NICE's guideline on delirium, recommendation 1.2.1]

Equality and diversity considerations

A learning disability specialist nurse should be involved in assessing changes in behaviour 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: Local data collection.

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: Local data collection.

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: Local data collection.

Outcome

Incidence of delirium.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

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 clinical commissioning groups [CCGs], 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. CCGs may include this in local Commissioning for Quality and Innovation (CQUIN) targets for improving dementia and delirium care.

What the quality statement means for patients, service users and carers

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), recommendations 1.3.2 (key priority for implementation) and 1.3.3.1 to 1.3.3.10

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 full guideline on delirium, glossary of terms]

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 1.1.1]

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 1.3.1 and 1.3.3.1 to 1.3.3.10]

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: Local data collection.

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: Local antipsychotic prescribing audits.

Outcome

Antipsychotic medication prescribing rates.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as hospitals, residential care homes, nursing homes, 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 clinical commissioning groups [CCGs], local authorities, 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.

What the quality statement means for patients, service users and carers

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), recommendation 1.6.4 (key priority for implementation)

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 full guideline on delirium, glossary of terms]

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. [Adapted from NICE's guideline on delirium, recommendation 1.6.4]

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 1.6.5]

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 5.5: Dealing 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: Local data collection.

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: Local data collection.

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: Local data collection.

Outcome

Patient and carer experience.

Data source: Local data collection. The Care Quality Commission's Adult inpatient survey asks about information provision (not specific to adults with delirium).

What the quality statement means for service providers, health and social care practitioners, and commissioners

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 clinical commissioning groups [CCGs], 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.

What the quality statement means for patients, service users and carers

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), recommendation 1.7.1 (key priority for implementation)

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 full guideline on delirium, glossary of terms]

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 1.7.1]

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.

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: Local data collection.

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: Local data collection. 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: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

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 clinical commissioning groups [CCGs], 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. CCGs may wish to seek evidence that protocols are in place to record episodes of delirium during hospital stays.

What the quality statement means for patients,

service users and carers

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), recommendation 1.5.2 (key priority for implementation)

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

See NICE's how to use quality standards for further information, including advice on using quality measures.

Levels of achievement

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, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is particularly important to ensure that decisions about the care of adults with delirium are made in line with the code of practice that accompanies the Mental Capacity Act. It is also important that the quality standard is considered alongside the documents listed in development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments for this quality standard are available.

Good communication between health and social care practitioners and adults with delirium, and their families and carers, is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults with delirium, and their family members and carers, should have access to an interpreter or advocate if needed.

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.

Development sources

Further explanation of the methodology used can be found in the quality standards process guide on the NICE website.

Evidence sources

The document below contains recommendations from NICE guidance that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

Delirium: prevention, diagnosis and management. NICE guideline CG103 (2010)

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- The King's Fund. Continuity of care for older hospital patients: a call for action (2012)
- The King's Fund. The care of frail older people with complex needs: time for a revolution (2012)
- National Confidential Enquiry into Patient Outcome and Death. Elective and emergency surgery in the elderly: an age old problem (2010)
- Ministry of Justice. Mental Capacity Act Code of Practice (2005)

Definitions and data sources for the quality measures

NHS Digital. Hospital Episode Statistics

Related NICE quality standards

Other quality standards that should be considered when commissioning or providing delirium services include:

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE quality standard 136 (2016)
- Falls in older people. NICE quality standard 86 (2015, updated 2017)
- Medicines management in care homes. NICE quality standard 85 (2015)
- Infection prevention and control. NICE quality standard 61(2014)
- Mental wellbeing of older people in care homes. NICE quality standard 50 (2013)
- Supporting people to live well with dementia. NICE quality standard 30 (2013)
- Nutrition support in adults. NICE quality standard 24 (2012)
- Hip fracture in adults. NICE quality standard 16 (2012)
- Patient experience in adult NHS services. NICE quality standard 15 (2012)
- Dementia. NICE quality standard 1 (2010)

A full list of NICE quality standards is available from the quality standards topic library.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 3. Membership of this committee is as follows:

Dr Alastair Bradley
General Medical Practitioner, Tramways Medical Centre/Academic Unit of Primary Medical Care, University of Sheffield

Ms Jan Dawson
Public Health Nutrition Lead and Registered Dietician, Manchester City Council

Dr Matthew Fay
GP, Westcliffe Medical Practice, Shipley, West Yorkshire

Dr Malcolm Fisk
Co-Director, Ageing Society Grand Challenge Initiative, Coventry University

Ms Margaret Goose
Lay member

Mrs Geeta Kumar
Clinical Director, Women's Services (East), Betsi Cadwaladr University Health Board

Mrs Rhian Last
Clinical Lead, Education for Health

Dr Hugh McIntyre (Chair)
Consultant Physician, East Sussex Healthcare Trust

Mrs Mandy Nagra
Cancer Drug Fund and Individual Funding Request Manager, Specialised Commissioning,

NHS England

Ms Ann Nevinson
Lay member

Dr Jane O'Grady
Director of Public Health, Buckinghamshire County Council

Mrs Jane Orr-Campbell
Director, Orr-Campbell Consultancy, Bedfordshire

Professor Gillian Parker
Professor of Social Policy Research, Social Policy Research Unit, University of York

Mr David Pugh
Independent Consultant, Gloucestershire County Council

Dr Eve Scott
Head of Safety and Risk, The Christie NHS Foundation Trust, Manchester

Dr Jim Stephenson
Consultant Medical Microbiologist, Epsom and St Helier NHS Trust

Mr Darryl Thompson
Psychosocial Interventions Development Lead, South West Yorkshire Partnership NHS Foundation Trust

Mrs Julia Thompson
Strategic Commissioning Manager, Sheffield City Council

The following specialist members joined the committee to develop this quality standard:

Ms Kate Ahrens
Staff Nurse, Department of Critical Care Medicine, Leicester General Hospital

Dr Dave Anderson
Associate Medical Director, Mersey Care NHS Trust

Ms Victoria Elliot
Principal Care Consultant, The Orders of St John Care Trust

Dr Duncan Forsyth
Consultant Geriatrician, Addenbrooke's Hospital, Cambridge University Hospitals

Dr John Holmes
Senior Lecturer in Liaison Psychiatry of Old Age, University of Leeds

Professor Alasdair MJ MacLullich
Professor of Geriatric Medicine, Edinburgh Delirium Research Group, Geriatric Medicine Unit, University of Edinburgh

Mr Matt Wiltshire
Lay member

NICE project team

Dylan Jones
Associate Director

Shirley Crawshaw
Consultant Clinical Adviser

Craig Grime
Technical Adviser

Melanie Carr
Lead Technical Analyst

Rachel Neary-Jones
Programme Manager

Esther Clifford
Project Manager

Lee Berry
Coordinator

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 standard advisory committees for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

This quality standard has been incorporated into the NICE Pathway for delirium, which brings together everything we have said on a topic in an interactive flowchart.

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 produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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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)