National Institute for Health and Clinical Excellence

Clinical guideline: Delirium

PRE-PUBLICATION CHECK ERROR TABLE

Organisation	Order number	Section number in FULL guideline	Page number	**ERROR REPORT**	**RESPONSE**
Department of Health	1	general	general	These are excellent guidelines which we completely endorse, having read through the initial iteration and the responses. Regarding factual errors, we have no comments to offer	Thank you for your comment.
Institute for Ageing and Health, Newcastle University	1	General comment		The guidelines are very comprehensive and detailed, with main studies in the field included and critiqued. There is very little on implementation which we all know is challenging (e.g. probs with BGS uptake). The NICE dementia guidelines has implementation guidelines with, for example guidance on education – will this follow? There is mention of implementation priorities but little advice how to go about the implementing.	Thank you for your comment. We are not able to answer because we are only answering comments about factual errors at this stage. However, we would like to inform you that the implementation strategy is separated from the full guideline.
Institute for Ageing and Health, Newcastle University	2	General comment		The Liaison Old Age Psychiatry (LOAP) services and their roles are not really mentioned (e.g. education, follow-up etc.).	Thank you for your comment. We are not able to answer because we are only answering comments about factual errors at this stage.
Institute for Ageing and Health, Newcastle University	3	General comment		There are a number of spelling and punctuation errors, and we have attempted to highlight some of them further down in the text. Hope this is helpful.	Those have been corrected, thank you.
Institute for Ageing and Health, Newcastle	4	2	47-48	The GRADE classification includes 4-level quality of evidence classification: high, moderate, low or very low, and 2 levels of recommendations (strong and	Thank you for your comment. The classification has been amended throughout the chapter to reflect

University				weak). However, in the text, further classifications e.g. poor (p 104; 285; 305-307; 362-364), very poor (p 364) and good (e.g. pages 305-307; 308; 309; 316; 362-364) are introduced later in the text, without previous explanation. Please note that they are not included in the GRADE classification 2004.	GRADE classification.
Institute for Ageing and Health, Newcastle University	5	5	70-71	Delirium in primary care is only partially addressed, with GPs seeing patients with delirium in Nursing Homes and other continuing care facilities. However, although the prevalence rates of delirium in community are estimated to be 4-5%, the latter appears to be largely an under-estimation, since a number of patients as noted in the guidelines are also discharged with delirium, and will continue having (long-term) care not only in 24h care, but also in their own homes. In our LOAP outpatient clinics we are increasingly seeing and following/monitoring people with intermittent delirium(s), who reside in their family homes, and do not necessarily end up in hospitals. This is a largely under-investigated situation, and needs further Maybe this can be included as a further research recommendation (?).	Thank you for your comment. We are not able to answer because we are only answering comments about factual errors at this stage.
Institute for Ageing and Health, Newcastle University	6	5	75/82	Interesting that geriatric medicine is no represented/no data	Thank you for your comment. We are not able to answer because we are only answering comments about factual errors at this stage.
Institute for Ageing and Health, Newcastle University	7	5	80 (line 27)	Spelling: ‘vascualr’ – change to ‘vascular’	This has been corrected.
Institute for Ageing and Health, Newcastle University	8	6	92	Yates et al (2009) study also included assessments of delirium with DSI and DSM-IV criteria, besides CAM	Thank you for your comment. DSI is not one of the index tests GDG wished to investigate (see section 6.1.3). DSM IV was the reference standard against which CAM was compared.

Institute for Ageing and Health, Newcastle University	9	6	104 (line 10)	Please note, Yates study is published in 2009, not 2008 as stated.	This has been corrected.
Institute for Ageing and Health, Newcastle University	10	7	164	Table 7.9 contains 2 entries for polypharmacy (>7 and >3 drugs) -you may consider rearranging these entries to follow one another.	This has been changed.
Institute for Ageing and Health, Newcastle University	11	8	191 (line 41)	Change 'lowquality' to 'low quality'	This has been corrected.
Institute for Ageing and Health, Newcastle University	12	9	237 (line 26)	Change 'ofdelirium' to 'of delirium'	This has been corrected.
Institute for Ageing and Health, Newcastle University	13	10		This whole chapter appears to be written somewhat differently [authors are referred to as being a study, e.g. Lundstrom (2005) was considered to be at…..)]. The text will benefit of editing, to match the writing style of the most of the chapters.	The chapter has been amended throughout to read, for example, "the Lundstrom (2005) study was considered to be at….."
Institute for Ageing and Health, Newcastle University	14	10	272-279	Similarly in this chapter the results are presented in a different way, with studies being allocated a star/asterix labelling to denote the GRADE classification. This is different to previous results sections. Furthermore, in the later text (chapter 14), it appears that this star/asterix numbering is replaced by another….	The asterix to denote studies with GRADE classification have been removed and details about indirect population have been added to the text.
Institute for Ageing and Health, Newcastle University	15	10	279	Line 10: put '.' After dehydration immediately. Line 12: omit ';' Line 17: replace '/' with ';'	This has been corrected.
Institute for Ageing and Health, Newcastle University	16	11	294	Line 6: delete '.' between '2001) and interventions'	This has been corrected.
Institute for Ageing and Health,	17	11	301	Line 30: change 'stay(endepoint)' to 'stay (endpoint)'	This has been corrected.

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Institute for Ageing and Health, Newcastle University	18	12	328	Line 56: omit '.' between '5.10)].(figure..'	This has been corrected.
Institute for Ageing and Health, Newcastle University	19	12	332	';' appears isolated from the text within the Cognitive impairment column referring to Mislen 2001 and Pitkala refernces	Thank you for your comment. This might be due to a different version of the program you open the file with.
Institute for Ageing and Health, Newcastle University	20	13	339	Line 15: omit ')' after 'records'	This has been corrected.
Institute for Ageing and Health, Newcastle University	21	13	347	Table and table legend on one page?	Thank you for your comment. This might be due to a different version of the program you open the file with.
Institute for Ageing and Health, Newcastle University	22	14	359	Labelling of studies with stars/asterix appear agin – is this the same labelling as in chapter 10? The labelling of the GRADE classification (if with *) needs to be consistent throughout the guideline, and not restricted only to 2 chapters.	The asterix to denote studies with GRADE classification have been removed and details about indirect population have been added to the text.
John Radcliffe Hospital Oxford	1	general	general	The annual cost of dementia in Table 16.3 (input parameters for model) is stated as £16,302. The text says that actually after deductions, the cost is £ 5,859 page 396, line 9 and page 403 line 30) This is a huge difference and will undoubtedly impact significantly on the final cost effectiveness output of the model depending on what the true value put into the model actually was.	The figure of £16,302 was used in the base case analysis (i.e. the primary analysis). The figure of £5,859 was used in a sensitivity analysis. The base case analysis should be considered as our best estimate. But the presence of a sensitivity analysis reflects our uncertainty regarding this parameter. The model results showed that regardless of the estimate used, MTI was still cost-effective (Table

					16.5).
John Radcliffe Hospital Oxford	2	general	general	I do not understand how £16,302 can be "best estimate", if it is highlighted in the text that the figure of £5,859 is the best cost to be used for the reasons cited in the text. I accept that the results show "cost-effectiveness". The most powerful argument to adopt this guideline for commissioners is that the intervention is cost releasing and of course I am going to use the point estimate to argue this (from the primary analysis). However, I would like to know if using the figure £5,859 instead of £16,302 still means that the interventions are cost releasing, rather than cost effective (which I understand can cost up to £30,000 per QALY, something commissioners are somewhat less likely to invest in).	Using the figure of £5,859, there were still cost savings of £327 per patient (compared with £458 in the base case analysis).
John Radcliffe Hospital Oxford	3	general	general	Is there some resource to be available so that I can plug in my local figs to work out what the local needs / impact will be? I have spent the last few days putting all the figs etc from the draft guidance into an Excel spreadsheet and then running local admission numbers, etc through. I have managed to work out that the NICE model overestimates new admissions to long term care institutes for example by comparing the output from the NICE model with what actually happens here in Oxford. NICE model overestimates about 4 fold, either its my programming, a local anomaly or the trial data used for the NICE model is not valid for the UK. It would be better to use the NICE model rather than my Heath Robinson Excel spreadsheet so that I can rule out operator error…	A cost impact analysis tool will be downloadable from the date the guideline is published. Almost all of the variables within the costing model can be amended by PCTs to reflect their local practice. We assume you are referring to the prevention model. We agree that any of those explanations could explain this discrepancy. The study we used to estimate effects delirium on long-term care was set in France and was of moderate quality but it was the only study that evaluated the effects of incident delirium. We could have used other studies for the baseline incidence of long-term care but the other studies in our review showed similar results

					– certainly they did not show a four-fold difference.
Royal College of Nursing	1	general	General	There are no factual errors to report	Thank you for your comment.
United Kingdom Clinical Pharmacy Association	1	7	165	Figure 7.30: incorrectly formatted	It displays correctly in the word file.
United Kingdom Clinical Pharmacy Association	2	7	166	Figure 7.31: incorrectly formatted	It displays correctly in the word file.
United Kingdom Clinical Pharmacy Association	3	8	193	Figure 8.3: incorrectly formatted	It displays correctly in the word file.
United Kingdom Clinical Pharmacy Association	4	16	399	Figure 16.3 incorrectly formatted (absent in fact)	It displays correctly in the word file.
Welsh Assembly Government	1	general	general	We have no comment to make at this stage	Thank you for your comment.
Worcestershire PCT	1	1.3.3.4		Ensure people receive prescribed pain relief - the use of opioid analgesics often leads to constipations, which itself is listed as a clinical indicator that can contribute to constipation. Use of high dose opioids should always be accompanied by the co-prescribing of laxatives.	Thank you for your comment. We are not able to answer because we are only answering comments about factual errors at this stage.