NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Delirium: prevention, diagnosis and management

Draft for consultation, October 2022

This is an update to NICE guideline CG103 (published July 2010 and previously updated March 2019). We have:

- reviewed the evidence on assessing people for delirium
- amended the recommendations.

Who is it for?

- NHS staff caring for patients in hospital (including critical care) and long-term residential care settings (including primary care healthcare professionals)
- Adults in hospital, long-term residential care or a nursing home who have, or are at high risk of developing, delirium; their family and carers

What does it include?

- the amended recommendations
- related recommendations that have not been updated (shaded in grey and marked **[2010]**), included here for context
- recommendation for research
- rationale and impact sections that explain why the committee made the 2023 recommendations and how they might affect practice.

Information about how the guideline was developed is on the guideline's webpage. This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

New and updated recommendations

We have reviewed the evidence on assessing and diagnosing delirium. You are invited to comment on the new recommendations (1.4.2, 1.5.1 and 1.5.2).

We have not reviewed the evidence for the recommendations marked **[2010]** (shaded in grey) and cannot accept comments on them. In some cases, we have made minor wording changes for clarification, which are highlighted in yellow where the changes could affect the intent).

Sections of the guideline that have had no changes at all have been temporarily removed for this consultation and will be re-instated when the final guideline is published. See the current version of the guideline.

See update information for a full explanation of what is being updated.

Full details of the evidence and the committee's discussion on the 2023 recommendations are in the evidence review.

Contents

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.4 Indicators of delirium: daily observations

1.4.1 Observe, at least daily, all people in hospital or long-term care for recent (within hours or days) changes or fluctuations indicating delirium (for example, see recommendation 1.2.1). These may be reported by the person at risk, or a carer or relative. If any of these changes are present the person should have an assessment using an appropriate tool (see recommendation 1.5.1). **[2010, amended 2023]**

1.4.2 Ensure that any changes that may indicate delirium are documented in the person's record or notes. **[2023]**

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on indicators of delirium: daily observations.

Full details of the evidence and the committee's discussion are in evidence review A: diagnostic accuracy of tests to identify delirium.

1.5 Assessment and diagnosis

1.5.1 If indicators of delirium are identified, a healthcare practitioner who is trained and competent to do so should carry out an assessment using the 4AT. In critical care or in the recovery room after surgery use the Brief Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) or Intensive Care Delirium Screening Checklist (ICDSC) instead of the 4AT. **[2023]**

1.5.2 If the assessment described in recommendation 1.5.1 indicates delirium, a specialist with the relevant expertise should make the final diagnosis, for example a geriatrician or psychiatrist. **[2023]**

1.5.3 If there is difficulty distinguishing between the diagnoses of delirium, dementia or delirium superimposed on dementia, manage the delirium first. **[2010]**

1.5.4 Ensure that the diagnosis of delirium is documented both in the person's record or notes, and in their primary care health record. **[2010]**

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on assessment and diagnosis.

Full details of the evidence and the committee's discussion are in evidence review A: diagnostic accuracy of tests to identify delirium.

Recommendation for research

Delirium assessment tools

What is the diagnostic accuracy, and ease of implementation, of different delirium assessment tools:

- for people with pre-existing cognitive impairment, for example dementia, learning disability or severe depression
- for people who do not speak English as a first language
- in different settings, for example emergency departments, residential care homes or virtual consultations
- when delivered by different types of healthcare practitioners, for example healthcare assistants or allied health professionals such as paramedics?

For a short explanation of why the committee made this recommendation for research, see the rationale and impact section on assessment and diagnosis.

Full details of the evidence and the committee's discussion are in evidence review A: diagnostic accuracy of tests to identify delirium.

Rationale and impact

This section briefly explains why the committee made the updated recommendations and how they might affect practice.

Indicators of delirium: daily observations

Recommendations 1.4.1 to 1.4.2

Why the committee made the recommendations

The committee agreed with the recommendation in the previous version of the guideline that all staff should be observing the people in their care and should be alert for changes indicating delirium. They noted that some simple tools like the Single Question to Identify Delirium (SQiD) might be useful to help practitioners notice any changes. They did not add SQiD specifically to the recommendation because they agreed that it is just one of many ways to encourage observation and that many places already had systems set up for this. They noted that in some settings the recording of these observations could be inconsistent, and that routine recording of changes that might indicate delirium was important.

How the recommendations might affect practice

Better recording of the indicators of delirium will improve the chances of these changes being noticed and acted upon.

Assessment and diagnosis

Recommendations 1.5.1 to 1.5.2

Why the committee made the recommendations

The committee agreed that once a change that might indicate delirium has been noted and recorded, a member of staff trained to do so should carry out a formal assessment.

Several assessment tools had high enough sensitivity and specificity to be useful in clinical practice. However, the committee agreed that implementation issues need to be considered as well. For example, who can do the test, how long does it take and how much training is needed?

Balancing the evidence for accuracy and cost-effectiveness with the practicality of implementing the tests, the committee agreed that the 4AT was the best option for most settings. It is among the most accurate of the tools reviewed, quick and simple to use, and has a broader range of evidence to support it. For critical care and post-surgical settings, the Brief Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) and Intensive Care Delirium Screening Checklist (ICDSC) worked best because they were specifically designed for those settings.

If the assessment shows delirium is likely, the committee agreed that the final diagnosis should be carried out by a specialist healthcare professional with the necessary experience and expertise, for example a geriatrician or psychiatrist.

The committee agreed that although the evidence allowed them to make recommendations overall, further, more specific, research on the accuracy and ease of use of different assessment tools in different settings, for different patient groups (including those with dementia, cognitive impairments, learning

disabilities or affective disorders) and by different healthcare practitioners, would help to make future guidance more specific. They therefore made a research recommendation on delirium assessment tools.

How the recommendations might affect practice

The committee noted that the assessment tools they recommended are already the most commonly used in practice. The change from healthcare professional in the previous version of this guideline to healthcare practitioner in this version will potentially reduce the workload on healthcare professionals who previously had to carry out assessments for delirium.

Return to recommendations

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on delirium.

For details of the guideline committee see the committee member list.

Update information

This guideline is an update of NICE guideline CG103 (published July 2010). We have reviewed the evidence on assessing and diagnosing delirium.

Recommendations are marked **[2023]** if the evidence has been reviewed.

For recommendations shaded in grey and ending **[2010, amended 2023]**, we have made changes that could affect the intent without reviewing the evidence. Yellow shading is used to highlight these changes. We changed ‘changes or fluctuations in usual behaviour’ to ‘changes or fluctuations indicating delirium’ to reflect that some indicators may not be related to behaviour. We also updated the recommendation to reflect the new recommendation on the use of an assessment tool.

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