

Delirium

NICE quality standard

Draft for consultation

February 2014

Introduction

This quality standard covers the diagnosis, prevention and management of delirium in adults (18 years and over) in hospital or long-term residential 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 1–2 days. It is a serious condition that may be associated with poor outcomes. However, it can be prevented and 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 People with hypoactive delirium become withdrawn, quiet and sleepy.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, and some people may have both conditions. 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. The prevalence of delirium in people on medical wards in hospital is about 20–30%, and 10–50% of people who have surgery develop delirium. In long-term care settings the prevalence of delirium is under 20%. The prevalence of delirium tends to rise with 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 dementia
- incidence of delirium
- mortality
- people's experience of hospital care.

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 framework published by the Department of Health:

- [The Adult Social Care Outcomes Framework 2014–15](#) (Department of Health, November 2012)
- [NHS Outcomes Framework 2014/15](#)

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [The Adult Social Care Outcomes Framework 2014–15](#)

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	<p>Overarching measure</p> <p>1A. Social care-related quality of life (NHSOF2*)</p> <p>Outcome measures</p> <p>Carers can balance their caring roles and maintain their desired quality of life.</p> <p>1D. Carer-reported quality of life (NHSOF2.4*)</p>
2 Delaying and reducing the need for care and support	<p>Overarching measure</p> <p>2A. Permanent admissions to residential and nursing care homes, per 1,000 population</p> <p>Outcome measures</p> <p>Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services</p> <p>2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (NHSOF3.6i**)</p>
3 Ensuring that people have a positive experience of care and support	<p>Overarching measure</p> <p>People who use social care and their carers are satisfied with their experience of care and support services</p> <p>3A. Overall satisfaction of people who use services with their care and support</p> <p>3B. Overall satisfaction of carers with social services</p> <p>Outcome measures</p> <p>Carers feel that they are respected as equal partners throughout the care processes.</p> <p>3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for</p>
<p>Aligning across the health and care system</p> <p>* Indicator shared with NHS Outcomes Framework (NHSOF)</p> <p>** Indicator complementary with NHS Outcomes Framework (NHSOF)</p>	

Table 2 [NHS Outcomes Framework 2014–15](#)

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	Overarching indicator 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults
2 Enhancing quality of life for people with long-term conditions	Improvement areas Enhancing quality of life for carer 2.4. Health-related quality of life for carers (ASCOF 1D ^{**})
3 Helping people to recover from episodes of ill health or following injury	Improvement areas Helping older people to recover their independence after illness or injury 3.6i. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service (ASCOF 2B [*])
4 Ensuring that people have a positive experience of care	Overarching indicator 4b Patient experience of hospital care Improvement areas Improving hospital's responsiveness to personal needs 4.2. Responsiveness to in-patients personal needs
Aligning across the health and care system	
* Indicator shared with Adult Social Care Outcomes Framework (ASCOF)	
* Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)	

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 people 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 service are listed in [Related 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 people with delirium should have sufficient and appropriate training and competencies 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 people with delirium. If appropriate, health and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

[Statement 1.](#) People newly admitted to hospital or long-term residential care who are at risk of delirium are assessed for recent changes in behaviour.

[Statement 2.](#) People newly admitted to hospital or long-term residential care who are at risk of delirium have a multicomponent intervention package to prevent delirium that is tailored to their needs.

[Statement 3.](#) People with delirium in hospital or long-term residential care who are distressed or are a risk to themselves or others are not prescribed antipsychotic medication unless verbal and non-verbal de-escalation techniques are ineffective or inappropriate.

[Statement 4.](#) People with delirium who are discharged from hospital have their diagnosis of delirium communicated to their GP.

[Statement 5.](#) People with delirium in hospital or long-term residential care, and their family members and carers, are given information that explains the condition and describes other people's experiences of delirium.

[Statement 6.](#) People with delirium in hospital or long-term residential care that has not resolved are reassessed for underlying causes and assessed for possible dementia.

Questions for consultation

Questions about the quality standard

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

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

Questions about the individual quality statements

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

Quality statement 1: Assessment of recent changes in behaviour

Quality statement

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

Rationale

The early detection of delirium is important to ensure that supportive measures are put in place as quickly as possible. People may already have delirium when they are admitted to hospital or to long-term residential care, so it is important to assess for any recent changes or fluctuations in behaviour that may indicate that the person has delirium.

Quality measures

Structure

Evidence of local arrangements to ensure that people newly admitted to hospital or long-term residential care who are at risk of delirium are assessed for recent changes in behaviour.

Data source: Local data collection.

Process

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

Numerator – the number of people in the denominator who are assessed for recent changes in behaviour.

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

Data source: Local data collection. [NICE clinical guideline 103 audit support](#), criterion 2.

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

Service providers 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 in people newly admitted to hospital or long-term residential care who are at risk of delirium.

Health and social care practitioners ensure that they assess people newly admitted to hospital or long-term residential care who are at risk of delirium for recent changes in behaviour.

Commissioners ensure that the hospitals and long-term residential care they commission services from can demonstrate that people newly admitted who are at risk of delirium are assessed for recent changes in behaviour.

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

People admitted to hospital or to long-term residential care who are thought to be at risk of delirium are assessed to identify any recent changes in their behaviour that may indicate that they have delirium. A person is at risk of delirium if they are 65 or older, already have difficulties with memory or understanding (known as cognitive impairment) or have dementia, have a broken hip, or are seriously ill.

Source guidance

- Delirium (NICE clinical guideline 103), recommendation [1.2.1](#) (key priority for implementation)

Definitions of terms used in this quality statement

People 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 clinical guideline 103](#), recommendation 1.1.1]

Recent behaviour changes

Recent (within hours or days) changes or fluctuations in behaviour may be reported by the person at risk, or a carer or relative, 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, lack of cooperation with reasonable requests, withdrawal, or alterations in communication, mood and/or attitude. [Adapted from [NICE clinical guideline 103](#) recommendation 1.2.1]

Quality statement 2: Interventions to prevent delirium

Quality statement

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

Rationale

Delirium is potentially preventable and interventions exist which can be effective in preventing delirium in people who are at risk. Preventative measures should be tailored to each person needs, based on the results of an assessment for clinical factors contributing to delirium, such as dehydration.

Quality measures

Structure

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

Data source: Local data collection.

Process

a) Proportion of people newly admitted to hospital or long-term residential care who are at risk of delirium who are assessed for clinical factors that may contribute to delirium within 24 hours of their admission.

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

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

Data source: Local data collection.

b) Proportion of people newly admitted to hospital or long-term residential care who are at risk of delirium who receive a multicomponent intervention package based on an assessment of clinical factors that may contribute to delirium.

Numerator – the number of people in the denominator who receive a multicomponent intervention package based on the assessment of clinical factors that may contribute to delirium.

Denominator – the number of people newly admitted to hospital or long-term residential care who are at risk of delirium who have an assessment for clinical factors that may contribute to 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 ensure that guidance is available on the use of tailored multicomponent intervention packages to prevent delirium, based on the results of an assessment for clinical factors contributing to delirium, and systems are in place to record the use of these packages.

Health and social care practitioners ensure that people newly admitted to hospital or long-term residential care who are at risk of delirium receive a tailored multicomponent intervention package that is tailored to the person's needs, based on the results of an assessment for clinical factors contributing to delirium,

Commissioners ensure that the hospitals and long-term residential care they commission services from can demonstrate the use of tailored multicomponent intervention packages to prevent delirium, based on the results of an assessment for clinical factors contributing to delirium.

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

People admitted to hospital or to long-term residential care who are thought to be at risk of delirium are assessed and offered care that is tailored to their particular needs and circumstances, in order to reduce the risk and so prevent delirium from developing.

Source guidance

- Delirium (NICE clinical guideline 103) recommendation [1.3.2](#) (key priority for implementation) and recommendations [1.3.3.1 to 1.3.3.10](#).

Definitions of terms used in this quality statement

People 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 clinical guideline 103](#) recommendation 1.1.1]

Tailored multicomponent intervention package

Interventions are provided as part of a multicomponent package that is tailored to the care setting and the person's individual needs, based on the results of an assessment of clinical factors contributing to delirium, as described in [NICE clinical guideline 103](#), recommendations 1.3.3.1 to 1.3.3.10.

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

Quality statement

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

Rationale

Antipsychotic medication is associated with a number of adverse effects, and so should be considered as a short-term treatment option if a person is distressed or is considered a risk to themselves or others only if other de-escalation techniques have failed.

Quality measures

Structure

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

Data source: Local data collection.

Process

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

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

Denominator – the number of people with delirium in hospital or long-term residential 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 ensure that there are procedures and protocols in place to monitor the use of antipsychotic medication in people with delirium to ensure that this is considered as a treatment option when people are distressed or a risk to themselves or others only if verbal and non-verbal de-escalation techniques are ineffective or inappropriate.

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

Commissioners ensure that they monitor antipsychotic medication prescribing rates for people with delirium, and only commission services from providers who can demonstrate that they have procedures and protocols in place to monitor this prescribing.

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

People in hospital or long-term residential care who have delirium are offered antipsychotic medication (which can be used for treating people who experience hallucinations or delusions) only if they are very distressed or are thought to be a risk to themselves or others, and other ways of calming them down have not worked or are not suitable.

Source guidance

- Delirium (NICE clinical guideline 103) recommendation [1.6.4](#) (key priority for implementation)

Definitions of terms used in this quality statement

Antipsychotic medication for people with delirium

Short-term (usually for 1 week or less) haloperidol or olanzapine, starting at the lowest clinically appropriate dose, should be considered for people with delirium who are distressed or considered a risk to themselves or others when verbal and non-verbal de-escalation techniques have been ineffective or are inappropriate. [Adapted from [NICE clinical guideline 103](#) recommendation 1.6.4]

Use of antipsychotic drugs for all people with conditions such as Parkinson's disease or dementia with Lewy bodies should be avoided or if necessary used with caution. [Adapted from [NICE clinical guideline 103](#) recommendation 1.6.5]

Quality statement 4: Communication of diagnosis

Quality statement

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

Rationale

Poor communication between hospitals and GPs may be a factor in people who are recovering from delirium receiving inadequate follow-up care once they are back in the community or a residential care home. People's diagnosis of delirium should be included in discharge summaries sent to GPs.

Quality measures

Structure

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

Data source: Local data collection.

Process

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

Numerator – the number of people in the denominator with their diagnosis of delirium communicated to their GP.

Denominator – the number of people with delirium who are discharged from hospital.

Data source: Local data collection. The [admitted patient care](#) datasets contain data on coding of delirium. Data for admissions to NHS hospitals in England available are at [HES Online](#).

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

Service providers ensure that systems are in place so that a diagnosis of delirium is communicated to a person's GP after discharge from hospital.

Healthcare professionals in hospital care settings ensure that a diagnosis of delirium is shared with the person's GP when the person is discharged.

Commissioners ensure that the services they commission from providers have systems in place to communicate diagnoses of delirium to GPs after discharge from hospital.

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

People with delirium have their diagnosis of delirium communicated to their GP by hospital staff when they are discharged from hospital.

Source guidance

- Delirium (NICE clinical guideline 103) recommendation [1.5.2](#) (key priority for implementation)

Quality statement 5: Information and support

Quality statement

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

Rationale

Experiencing delirium can be upsetting and distressing, particularly if the person has hallucinations, 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 people 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 people with delirium in hospital or long-term residential care, and their family members and carers, are given information that explains the condition and describes other people's experiences of delirium

Data source: Local data collection.

Process

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

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

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

Data source: Local data collection.

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

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

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

Data source: Local data collection.

Outcome

Patient experience.

Data source: Local data collection.

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

Service providers ensure that they have protocols and procedures in place so that people 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 people with delirium, and their family members and carers, information that explains the condition and describes other people's experiences of delirium.

Commissioners ensure that they commission services that have protocols and procedures in place so that people 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

People 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 (NICE clinical guideline 103) recommendation [1.7.1](#) (key priority for implementation)

Definitions of terms used in this quality statement

Information for people with delirium and their family members and carers

Information which:

- informs them that delirium is common and usually temporary
- describes people's experience of delirium
- encourages people at risk 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 clinical guideline 103](#) recommendation 1.7.1]

Equality and diversity considerations

All written information should be accessible to people with delirium, and their family members and carers, who have additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with delirium and their family members and carers should have access to an interpreter or advocate if needed. People with delirium and their family members and carers should be provided with information that reflects any religious, ethnic, cultural or transgender needs.

Quality statement 6: Follow-up if delirium has not resolved

Quality statement

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

Rationale

Delirium is usually temporary, but if it does not resolve there should be a reassessment to identify possible underlying causes. Delirium can be a common complication of dementia, so it is important that the opportunity to detect underlying dementia is taken if delirium does not resolve.

Quality measures

Structure

Evidence of local arrangements to ensure that people with delirium in hospital or long-term residential care that has not resolved are reassessed for underlying causes and assessed for possible dementia.

Data source: Local data collection.

Process

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

Numerator – the number of people in the denominator who are reassessed for underlying causes and assessed for possible dementia.

Denominator – the number of people with delirium in hospital or long-term residential care that has not resolved.

Data source: Local data collection.

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

Service providers ensure that systems are in place so that people who have delirium that has not resolved are reassessed for underlying causes and assessed for possible dementia.

Health and social care practitioners ensure that they reassessed for underlying causes and assess for possible dementia if a person has delirium that has not resolved.

Commissioners ensure that the services they commission reassess for underlying causes and assess for possible dementia if people have delirium that has not resolved.

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

People with delirium that does not get better are assessed again to check if any underlying causes of the delirium have been missed, and also assessed to see if they have dementia.

Source guidance

- Delirium (NICE clinical guideline 103) recommendation [1.6.6](#) (key priority for implementation)

Status of this quality standard

This is the draft quality standard released for consultation from 27 February to 27 March 2014. It is not NICE's final quality standard on delirium. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 27 March 2014. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the [NICE website](#) from July 2014.

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.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its [Indicators for Quality Improvement Programme](#). If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's [What makes up a NICE quality standard?](#) 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 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](#) are available.

Good communication between health and social care practitioners and people with delirium 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. People with delirium 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](#). NICE clinical guideline 103 (2010).

Policy context

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

- [Continuity of care for older hospital patients: A call for action](#). King's Fund (2012).
- [The care of frail older people with complex needs: time for a revolution](#). King's Fund (2012).
- [Elective and Emergency Surgery in the Elderly: An Age Old Problem](#). National Confidential Enquiry into Patient Outcome and Death (2010).

Definitions and data sources for the quality measures

- [Hospital episode statistics](#). Health and Social Care Information Centre.

Related NICE quality standards

Published

- [Supporting people to live well with dementia](#). NICE quality standard 30 (2013).
- [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).

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:

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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.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

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