Letters to the Editor

would request that this is brought to the attention of your readers. Thank you.

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Non-pharmacological prevention of delirium

SIR—Tabet and Howard [1] are to be congratulated for their recent review on non-pharmacological interventions in the prevention of delirium. They report that there is still no evidence that pharmacological interventions can prevent delirium, while several non-pharmacological intervention studies have been shown to be efficacious. Although methodological issues need to be recognised, data from studies directly targeting risk factors and/or testing the efficacy of educational intervention programmes have been promising.

Delirium is a common, potentially preventable source of morbidity and mortality among hospitalised older patients. Patients showing delirium during hospitalisation usually show increased length of stay and mortality.

The hospital surrounding may play a role in causing delirium in elderly patients. To avoid delirium, older patients should be cared for in a good sensory environment, less intrusive onto patients’ daily routine, with a reality orientation approach and involving a multidisciplinary team [2].

The results of a prospective, non-randomised study on elderly patients at intermediate or high risk of developing delirium have been recently published by the Geriatric Hospital at Home Service (GHHS) team [3] and add further information about non-pharmacological prevention of delirium. GHHS is a hospital service dedicated to acutely ill patients requiring hospital care. It is not an early discharge service, but a substitutive hospital-at-home care in a ‘clinical unit’ model for patients admitted directly by the Emergency Department. GHHS is delivered by a multidisciplinary team of three geriatricians, 13 nurses, two physiotherapists, one social worker and one counsellor.

Two groups of acutely ill patients have been studied: those treated in the geriatric hospital ward (GHW) and those treated in the GHHS. The risk of developing delirium during the observational period was detected according to the Confusion Assessment Method (CAM) [4].

Although non-pharmacological treatment strategies to prevent and treat delirium were adopted in both setting of care, the incidence of delirium was significantly lower in GHHS patients than in GHW ones (P < 0.05) and GHW patients had a risk of developing delirium more than three times higher. Moreover, the onset of delirium occurred earlier after hospital admission in GHW as compared to GHHS (P < 0.001) and the mean duration of the episode was longer in GHW than in GHHS (P < 0.001).

Treatment of old patients in their homes helps them to maintain a reassuring environment with usual time and space references and protection of their privacy. The old person still belongs to his family, keeps tight relations with relatives, maintains his habits and lifestyles [5].

In conclusion, we can assume that, despite the limits of this study, substitutive hospital-at-home care for acutely ill elderly patients should offer some health outcome advantages. For old patients at risk of developing delirium, GHHS could represent a protective environment against the onset of acute confusion.

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