Postoperative delirium is an acute brain failure syndrome. It is a manifestation of complex interactions between the patient's intrinsic neural reserve/compensation, disease processes (systemic versus localised), medical/surgical therapies, and the health care environment. Older age, co-morbid neurodegenerative disease and the use of anticholinergic drugs predispose to more severe and prolonged delirium, with neurodegeneration as a consequence. There is an associated 30-40% one-year mortality following an episode of delirium in the older person.

One in three cases of postoperative delirium can be prevented by simple attention to the following measures:

- Ensure appropriate use of sensory adaptive devices, namely hearing aids, spectacles and dentures.
- Promote a calm, comfortable, reassuring environment with regular patient reorientation, including the use of orientation devices such as clocks, watches and calendars.
- Promote non-pharmacological sleep hygiene, and prevent sleep deprivation.
- Minimise medications with a high risk of delirium, particularly drugs with anticholinergic effects.
- Optimise hydration and nutrition, paying attention to vitamin B₁₂ and thiamine status.
- Diagnose and manage infections early.
- Recognise and manage pain.
- Mobilise patients early.
- Minimise all restraints, including medical restraints (e.g. catheters, lines)
- Promote bladder and bowel function.
- Optimise cerebral perfusion, oxygenation and glycaemia.
- Pharmacological management is adjunctive. Low-dose haloperidol is the safest agent, provided the total daily dose does not exceed 3 mg. Perioperative prophylaxis with haloperidol (1.5 mg/day) in hip surgery has been shown to reduce delirium severity and duration and hospital stay. Benzodiazepines remain the treatment of choice for alcohol-related or benzodiazepine withdrawal delirium.