



Delirium Screen: 4AT Assessment

For all patients age above 65 or with new onset confusion (any age) or with hip fracture.

Name:	Hosp Number:	
DOB:	Date/time assessed:	
Assessor:		
4AT assessment		
[1] ALERTNESS		
Observe the patient. If asleep, attempt to wake with spec	ech or gentle touch on shoul	der.
Normal (fully alert, but not agitated, throughout assessment) Mild sleepiness for <10 seconds after waking, then normal Clearly abnormal		0 0 4
[2] AMT4		
Age, date of birth, place (name of the hospital or building	g), current year.	
No mistakes 1 mistake 2 or more mistakes/untestable		0 1 2
[3] ATTENTION		
Ask the patient: "Please tell me the months of the year in	n backwards order, starting a	at December."
Achieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start because unwell, drow	vsy, inattentive)	0 1 2
[4] ACUTE CHANGE OR FLUCTUATING CO	URSE	
Evidence of significant change or fluctuation in: alertness	s, cognition, other mental fur	nction.
No Yes		0 4
	Total :	

4 or above: possible delirium +/- cognitive impairment

1-3: possible cognitive impairment

0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)



Delirium Management Pathway

History of acute change in mental status

Age ≥ 65

Hip fracture

Pre-existing cognitive impairment

Acute medical illness



Perform 4AT assessment

DELIRIUM is a Medical Emergency!

Initiate TIME bundle within 2 hours.

Think about Possible Triggers

History (Polypharmacy/Alcohol)
Think sepsis

Pain

Urinary retention/constipation Nutrition/hydration Investigate underlying cause

Blood test

ECG CXR/CT brain

MSU

TIME

Manage

Intitiate treatment for ALL underlying causes found

Review medication

Explain

Document Diagnosis of Delirium Explain diagnosis to patient and family/carers