Name:…… Ward:…… Unit Number: ……

University Hospitals of North Midlands NHS Trust

Delirium Screening Tool and Management Plan

To be completed for all patients over the age of 65 years on admission and if any changes in cognition or behaviour.

The 4AT Test: Screening Tool for Cognitive Impairment and Delirium	Score	Score	Score
1: **ALERTNESS** This includes patients who maybe markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Normal (fully alert, but not agitated throughout assessment) 0 Mild sleepiness for < 10 seconds after waking, then normal 0 Clearly abnormal 4			
2: **AMT4 (Abbreviated Mental Test 4)** Age, date of birth, place (name of hospital or building currently in) and current year No mistakes 0 1 mistake 1 2 mistakes 2			
3: **ATTENTION** Ask the patient: "please tell me the month of the year in backwards order starting with December" To assist initial understanding a prompt of "What is the month before December?" is permitted Achieve 7 months or more correctly 0 Starts but scores <7 months/refuses to start 1 Untestable (cannot start because unwell/drowsy/inattentive) 2			
4: **ACUTE CHANGE OR FLUCTUATING STATE** Evidence of significant change or fluctuation in: alertness, cognition, or mental function (e.g. paranoia, hallucinations) over the last two weeks and still evident in the last 24 hours. (May require patient relative assistance to answer) No 0 Yes 4			
TOTAL SCORE			
Date			
Signature			

RESULTS	
4 or above: possible delirium +/- cognitive impairment	Complete delirium prevention and management plan (see reverse) Refer to Doctor/ANP Repeat 4AT after 24 hours
1-3: possible cognitive impairment	Inform Doctor/ANP Complete 6-CIT Refer MHLT if patient does not already have dementia diagnosis
0: delirium or cognitive impairment unlikely	Complete 6 CIT

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Delirium Prevention and Management Checklist

To be completed within 12 hours of a 4AT score of 4 or more.

Intervention	Comments
Screen for infection. Complete Sepsis Screening tool if required.	Observations [ ] NEWS…….. Routine Bloods [ ]
Thyroid function test	
Serum B12 and folate levels	
Check blood glucose level	
Correct hypoxia	
Consider 1-1 supervision if patient is agitated and at risk of harming themselves or others	
Medication review	
Fluid Balance Correct dehydration Consider IVI	
Monitor for urinary retention Bladder scan	
Monitor for and treat constipation	BNO day……
Monitor nutritional intake. Food chart Refer to dietician	
Assess pain regularly Ensure regular and adequate analgesia	
Promote sleep Avoid sedation where possible	
Re-orientate to time and place Orientation boards/clocks Refer to OT	
Check hearing aids/glasses functioning correctly Ref to Dr/ANP if new visual/hearing impairment	
Encourage mobility (adhere to falls prevention guidance) Refer to physiotherapy	
Involve family/carers and ask them to complete 'THIS IS ABOUT ME' booklet	Delirium leaflet given to NOK/carers [ ]
Complete DoLS request if required	

Name……Designation……..
Signature……..

Version 1. Developed: February 2020. Review date: February 2021.

Name:…… Ward:…… Unit Number: ……

Date……..Time……..