CLINICAL TEAMS

A positive 4AT is the start of the assessment

Turn a 4AT result suggesting possible delirium into timely clinical assessment, action, documentation and communication.

Interpret the result correctly

- A 4AT score of 4 or more suggests possible delirium, with or without cognitive impairment.
- The result is not a diagnosis; a healthcare professional with relevant expertise should make the final diagnosis in the full clinical context.
- A lower score does not override a convincing acute change, incomplete information or ongoing clinical concern.

Check urgency first

- Assess the person's immediate clinical state and act on physiological instability or another time-critical presentation.
- Note marked drowsiness as well as agitation; inability to engage is not a reason to abandon the 4AT.
- Use the organisation's emergency response for any severe deterioration.

Build the clinical picture

- Seek collateral information about the person's baseline and the timing or fluctuation of the change.
- Review current illness, examination findings, observations, medicines and recent changes or withdrawals.
- Consider more than one underlying cause and select investigations according to the clinical context rather than a fixed panel.

Make the result lead somewhere

- Record the score, item responses, time, baseline information and any communication or sensory barriers.
- Document the clinical conclusion and revise it if the course or new information changes the picture.
- Start cause-directed treatment and supportive care while the assessment continues, and tell the person and their family or carers what is happening.

Safety box - never stop at the score: A positive 4AT requires clinical assessment and action. A score of 0 does not definitively exclude delirium, and a score of 1-3 may indicate cognitive impairment while clinical concern still requires evaluation. Use the recommended critical-care tool in ICU or postoperative recovery settings.

Verified official sources

- Official 4AT user guide
- Official 4AT frequently asked questions
- NICE CG103: assessment and diagnosis recommendations
- SIGN 157 on Right Decisions: detecting delirium
- NHS: sudden confusion

Use and review: UK-focused general education. This resource supports but does not replace clinical assessment, individual advice or current local guidance. Prepared from source materials curated by Professor Alasdair MacLullich, University of Edinburgh; AI-assisted production. Professor MacLullich led development of the 4AT and reports no financial interest in its uptake. Final named human clinical approval is required before use in patient care. Independent resource; not an official University of Edinburgh or NHS publication.