ACE-T

Initial nursing response after a positive delirium screen

Acute Triggers · Patient Experience · Treatment. Start after a positive screen or when delirium is suspected.

Patient label, or name, date of birth and hospital number

Date _____ **Time of screen** _____ **Screening tool** 4AT ☐ Other ☐ _____ **Score** _____

Aim to complete, start or escalate the actions that apply within 4 hours of the positive screen. **Act on urgent concerns immediately.** Work on the three domains in parallel, using clinical judgement, your scope of practice and local policy.

AC Acute Triggers

What might be causing or worsening the delirium?

DONE	ACTION	NOTES, FINDINGS, ESCALATED TO
☐	Observations: pulse, blood pressure, oxygen saturation, respiratory rate, temperature, conscious level	
☐	Capillary blood glucose	
☐	Check that routine blood tests have been sent	
☐	Assess for urinary retention and constipation	
☐	Assess hydration status	
☐	Assess nutrition status	
☐	Initiate or review infection work-up as appropriate (for example, urinalysis or wound check)	
☐	Assess pain: none / mild / moderate / severe	
☐	Check whether medication review has been completed	

E Patient Experience

How is the person feeling, and what would help?

DONE	ACTION	NOTES, FINDINGS, ESCALATED TO
☐	Check for distress using the Quick Distress Assessment Tool (QDAT), where appropriate. Score: ____	
☐	Note any agitation	
☐	Provide reassurance and reorientation	
☐	Consider patient environment (for example, whether a single room is needed)	
☐	Ensure glasses, hearing aids and other communication aids are available	
☐	Consider involving relatives, friends or carers	

T Treatment · Nursing treatment and communication

What does the person need now, and who needs to know?

DONE	ACTION	NOTES, FINDINGS, ESCALATED TO
☐	Consider falls risk	
☐	Consider whether fluids, oxygen or other immediate supportive measures are required	
☐	Document “delirium” or “? delirium” and the 4AT (or local screening) score in the clinical record	
☐	Communicate the screening score and relevant findings to the clinical team	
☐	Inform the family where appropriate	
☐	Provide the delirium information leaflet to the patient and family where appropriate	
☐	Discuss the treatment plan with the multidisciplinary team	

Quick Distress Assessment Tool (QDAT)

Observe the person and ask: *“How are you feeling? Is anything bothering you?”*

- **0** Appears settled, lying or sitting comfortably, with no signs of pain or distress.
- **1** Verbalises mild distress and/or appears mildly concerned or worried (for example, furrowed brow).
- **2** Verbalises moderate distress and/or displays physical signs of distress (for example, restlessness).
- **3** Verbalises severe distress and/or is visibly in distress throughout the assessment, needing ongoing reassurance.

Completed by _____

Role _____

Signature _____

Date and time completed _____

Adapted from Table 1 of Cours A, Trabert J, Higgins M, Saleem U, Sampson E, Storr-Street N, MacLullich A. Development and pilot evaluation of ACE-T, a nurse-focused delirium initial-response tool, across three health systems. Submitted for publication, 2026. Screening tool wording follows the 4AT; record your local tool if different.