Cognitive Assessment
Screening for delirium: the process involved

Baseline Cognitive Function Assessment
- Assess cognitive function
  – may involve use of tool such as MMSE or AMT on admission to health care setting

If normal, or no change from previous assessment

Repeat Cognitive Function
In all settings when:
- Sudden change in behaviour or cognition
- Abrupt decline in ADL performance
- Sudden deterioration in the person’s condition

In community and residential care when:
- Resident or client at higher risk of developing delirium, such as on return from hospital admission; or when acutely unwell
- In high risk hospital settings:
  - As part of screening process repeat frequently (eg. daily)

Decline in score by 2 or more points (if using MMSE, AMT)

Or if high level of suspicion

Suspect Delirium
- Formal diagnosis using a tool and/or
- Notify expert in delirium diagnosis — nurse or medical staff, general practitioner

If abnormal cognitive function OR change from previous assessment OR high level of suspicion that the person has delirium

Adapted from: Clinical Epidemiology and Health Services Evaluation Unit 2006, Clinical Practice Guidelines for the Management of Delirium in Older People, Victorian Government Department of Human Services, Melbourne, Victoria.