

2. When is it not appropriate to do a cognitive screen such as a MMSE? What do I do if I do not agree with the request for a specific test e.g. the MMSE?

The Mini-Mental State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975) has low sensitivity and it often does not detect mild cognitive impairment (Tombaugh & McIntyre, 1992). It can also miss cases of delirium that can be identified with more sensitive measures (National Guidelines for Seniors Mental Health, 2006). If cognitive impairment is suspected, but a previous MMSE did not detect any significant impairment, then a more sensitive screen such as the Montreal Cognitive Assessment (MoCA) (Nasreddine et al., 2005) could be considered. If delirium is suspected, other tests such as the Cognitive Abilities Screening Instrument (CASI) (Teng et al., 1994) or the MoCA could be used as an alternative or supplement to the MMSE, to inform the Confusion Assessment Method (CAM) ratings (National Guidelines for Seniors Mental Health, 2006). Document your rationale for your choice of screen. If in-depth information is needed, a more in-depth assessment tool, rather than a screen, should be chosen.

Bear in mind, however, that if a previous MMSE was done, the request for another MMSE may be in order to detect changes over time. In this case it would be appropriate to do the MMSE to compare it to previous results, and then do the test which you feel is more appropriate, as well. Document your rationale.

Fluency in English and education level are factors that are known to affect the results of the MMSE (Tombaugh & McIntyre, 1992). Diminished vision, hearing, and other physical deficits may impact on any cognitive screen. Depending on the level of function you could choose to administer the test but clearly describe the factors that might have negatively affected the result (e.g. "client scored 19/30, but it is felt that his poor English language skills contributed to losing 3 points on the following items . . ."). If the client is totally unable to participate (e.g. no understanding of English, total deafness) then the test cannot be administered and the reasons for that should be documented. Use other assessment methods such as alternate cognitive tests, observation of client doing functional tasks, and collateral information from family.

There are times when an MMSE or other cognitive testing should be postponed (e.g. if a client is temporarily emotionally distraught related to an identifiable event, or has just woken up, client does not have his/her glasses or hearing aides, or the environment for testing is not appropriate because of too many distractions). If you feel that the test should be postponed, document your rationale and plans for further assessment at a later time. However, if the client's state of mind and behavior (diminished level of consciousness; agitation) are suspected to be related to an undiagnosed delirium, then it would be appropriate to do the test along with documentation of the CAM. Sometimes it is clear from observation alone that a client is delirious but you feel that a formal assessment of delirium is not indicated (e.g. too soon post operatively, client is in severe pain). In this case document your observations of client's behavior, your rationale for postponing the cognitive testing portion of the delirium assessment and your plans for assessment at a later time. However, timely diagnosis of delirium is important (National Guidelines for Seniors Mental Health, 2006) and therefore should not be postponed for too long.

The MMSE, as with any test, should not be repeated too frequently, as there is a learning effect. Folstein and colleagues have recently developed the MMSE-2 which has several versions, to address this issue of the practice effect (as cited in PAR, 2010).

References:

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