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General Assessment Series

Best Practices in Nursing Care to Older Adults

Recognizing Dementia Among Hospitalized Older Adults

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WHY: An estimated 57 million people worldwide are living with dementia (World Health Organization, 2026). In the United States, about 40% of emergency department visits among older adults with dementia resulted in hospitalization (Santo et al., 2024), making acute care an important setting for recognizing cognitive impairment. Early identification and accurate screening can improve outcomes (Hua et al., 2022). Conversely, unrecognized dementia is associated with increased hospital-associated disability, delirium, and threefold greater odds of mortality (Alberti et al., 2025).

Cognitive screening in acute care is not always straightforward. Lengthy standardized assessments may be impractical because of patient factors such as acute illness, pain, confusion, sensory impairment, fatigue, and medical equipment that affects the capacity to draw. Provider factors including time constraints and limited training to use the assessment tool, and system barriers such as licensing costs and limited health record integration also impact evidence-based screening practices.

TARGET POPULATION: All hospitalized adults aged 65 years and older, as well as younger adults with known risk factors for Alzheimer Disease and related dementia, such as genetic predisposition and obesity, should be screened. In the United States, the estimated lifetime risk of dementia after age 55 is 42%, with higher rates among women, Black adults, and carriers of the apolipoprotein ε4 (APOEε4) allele, a genetic risk factor for Alzheimer disease (Fang et al., 2025).

BEST PRACTICES: Recognizing dementia among hospitalized older adults combines direct patient cognitive testing with an informant-based assessment. For direct patient testing, the 10-Point Cognitive Screener (10-CS) is recommended (Apolinario et al., 2016). The 10-CS assesses temporal orientation (current year, month, and date; three points), three-word recall (three points), and verbal fluency (naming animals in one minute; four points). The test is easy to administer and takes only 2-3 minutes, with no writing, drawing, or visual materials needed. Total scores range from 0 to 10, with a score of 0-5 indicating probable cognitive impairment, 6-7 indicating possible cognitive impairment, and ≥ 8 indicating normal. To adjust for effects of educational attainment of those screened, add 2 points (to a max of 10) for those with no formal education, and for those with 1-2 years of education, add 1 point (to a max of 10).

For informant-based testing, the AD8 (Ascertain Dementia 8) is recommended when a reliable contact person is available or when patient cooperation is challenging. The AD8 is an 8-item questionnaire consisting of yes-or-no questions. A spouse, relative, or friend familiar with the patient can complete it in 2 to 3 minutes. It measures perceived intra-individual behavioral and functional changes in judgment, hobbies, repetition, learning, orientation, finances, appointments, and consistency over recent years. A score of 2 or higher indicates cognitive impairment.

Recognizing dementia is more than interpreting a single screening score; attention should focus on establishing baseline cognition and function. It is also important to rule out delirium, which can lead to inaccurate results on direct cognitive testing. Best practice should include: first, screening for active delirium using validated tools such as the 4AT (Penfold et al., 2025); second, after delirium is ruled out, a brief dementia screening tool can be administered; lastly, screening results must be confirmed with patient informant, physical examination, medication review, and laboratory or diagnostic evaluation.

VALIDITY AND RELIABILITY: The 10-CS has been shown to be valid and reliable for recognizing dementia among older adults in acute care settings (Aliberti et al., 2026). The diagnostic accuracy shows an Area Under the ROC Curve (AUC) of 0.87 (95% CI: 0.85–0.89) and a strong correlation with the Clinical Dementia Rating Sum of Boxes (Spearman's rho = -0.59). The 10-CS yields 88.4% sensitivity, 70.5% specificity, and a 95.4% negative predictive value (NPV) at a cutoff of ≤5, indicating severe cognitive impairment (Apolinario et al., 2016). Similarly, the AD8 shows strong diagnostic performance across healthcare settings, with AUCs ranging from 0.88 to 0.95 discriminating mild cognitive impairment from normal aging, sensitivity between 92% and 99.2%, and specificity between 64% and 76% at the ≥2 threshold (Razavi et al., 2014).

STRENGTHS AND LIMITATIONS: Multiple cognitive screening tools are available. Although the 10-CS and AD8 are recommended here as best practice, selection should consider the patient's language, education level, any sensory impairment (hearing and vision), cultural appropriateness, and the need for provider training. Results should be interpreted in the context of the patient's cognitive and functional status. The 10-CS and AD8 are brief, available for free, and easy to administer, requiring almost no training. Both tools overcome individual, provider, and system barriers and maintain strong predictive value for dementia recognition. Finally, the 10-CS may become unreliable during active delirium episodes, and the AD8 depends on informant availability and relationship type, which may cause reporting bias.

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