

# Delirium, Depression and Dementia

*Martha Watson, MS, APRN, GCNS*

# Program Objectives

- 🌐 Describe the difference between dementia, delirium and depression.
- 🌐 Review simple screening tools for each that the RN can perform.
- 🌐 Identify first interventions for each.



# Prevalence in Older Adults

	Depression	Delirium*	Dementia
General population	Minor depressive symptoms 3-26%		5% of 65+ adults 50% of 85+ adults
Hospitalized patients	Minor depressive symptoms 23%	10-15% on admission 10-40% in-hospital (new onset) 43-61% of hip surgery patients 31% of older adults admitted to medical intensive care units 83% of mechanically ventilated patients (all ages)	25%
	Depression + dementia 22-54%	Delirium + dementia 22-89%	

\*Based on 1994 U.S. vital health statistics, complications associated with delirium occur in more than 2.3 million hospitalized older adults every year with associated Medicare costs equaling \$8 billion annually.

# Delirium, Depression and Dementia



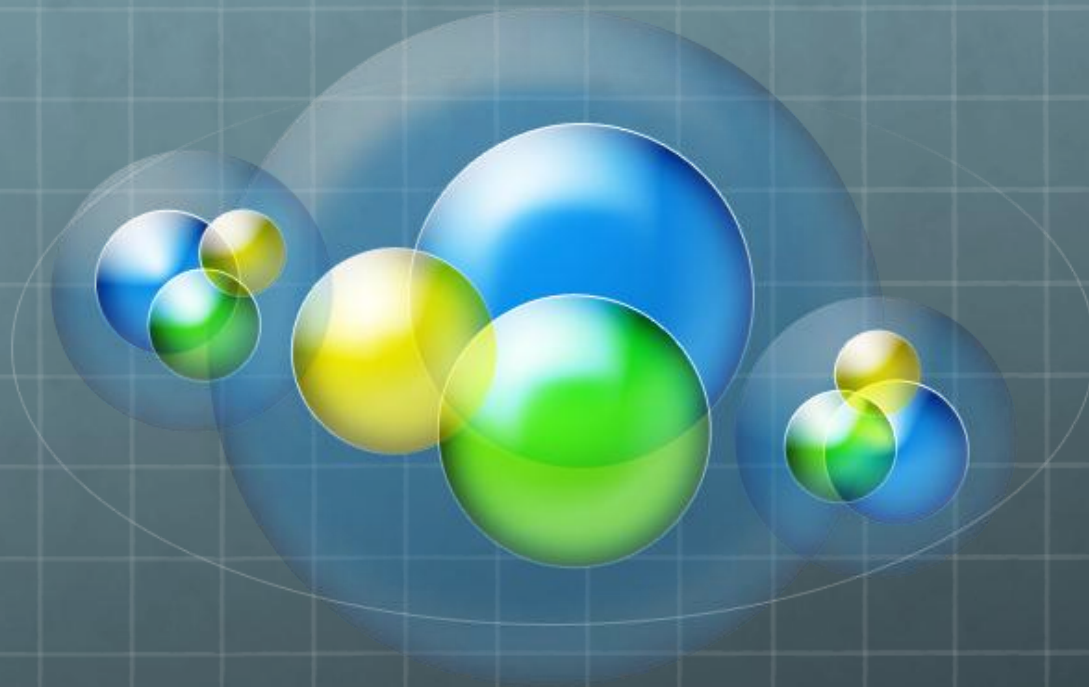
**What are the  
differences  
between the 3 D's?**

**...the ultra short version....**



### Clinical features of Delirium, Dementia, and Depression

<b>Feature</b>	<b>Delirium</b>	<b>Dementia</b>	<b>Depression</b>
<b>Onset</b>	Acute or sub acute, often at twilight	Chronic, generally insidious	Coincides with life changes; often abrupt
<b>Course</b>	Short, diurnal fluctuations in symptoms; often worse at night, in the dark, and on awakening	Long, no diurnal effects, symptoms progressive yet relatively stable over time	Diurnal effects, typically worse in the morning; situational fluctuations but less than in delirium
<b>Progression</b>	Abrupt	Slow but even	Variable, uneven
<b>Duration</b>	Hours to less than one month, seldom longer	Months to years	At least two weeks, but can be several months to years
<b>Awareness</b>	Reduced	Clear	Clear
<b>Alertness</b>	Lethargic or hyper vigilant; fluctuates	Generally normal	Normal
<b>Attention</b>	Impaired, fluctuates	Generally normal	Minimal impairment but is distractible
<b>Orientation</b>	Generally impaired; fluctuates in severity	May be impaired	Selective disorientation
<b>Memory</b>	Recent and immediate impaired	Recent and remote impaired	Selective or patchy impairment; "islands" of intact memory
<b>Thinking</b>	Disorganized, distorted, fragmented, slowed or accelerated; speech is incoherent	Difficulty with abstraction; thoughts impoverished; judgment impaired; words difficult to find	Intact but with themes of hopelessness, helplessness, or self-deprecation
<b>Perception</b>	Distorted; illusions, delusions, and hallucinations; difficulty distinguishing between reality and misperceptions	Misperceptions often absent	Intact; delusions and hallucinations absent except in severe cases
<b>Psychomotor Behavior</b>	Variable, hypo kinetic, hyper kinetic, or mixed	Normal, may have apraxia	Variable, psychomotor retardation or agitation
<b>Sleep-Wake Cycle</b>	Disturbed; cycle may be reversed	Fragmented	Disturbed, often early morning awakening
<b>Associated Features</b>	Variable affective changes; symptoms of autonomic hyper arousal; exaggeration of personality type; associated with physical illness	Affect superficial, inappropriate, and labile; Attempts to conceal deficits in intellect; personality changes; aphasia; agnosia; lack of insight	Affect depressed; exaggerated and detailed complaints; preoccupation with personal thoughts; insight present; verbal elaboration
<b>Mental Status Testing</b>	Distracted from task	Failings highlighted by family; frequent near miss answers; struggles with test; great effort to find an appropriate reply	Failings highlighted by the patient; don't know answers; little effort; frequently gives up; indifferent, does not care or attempt to find answer

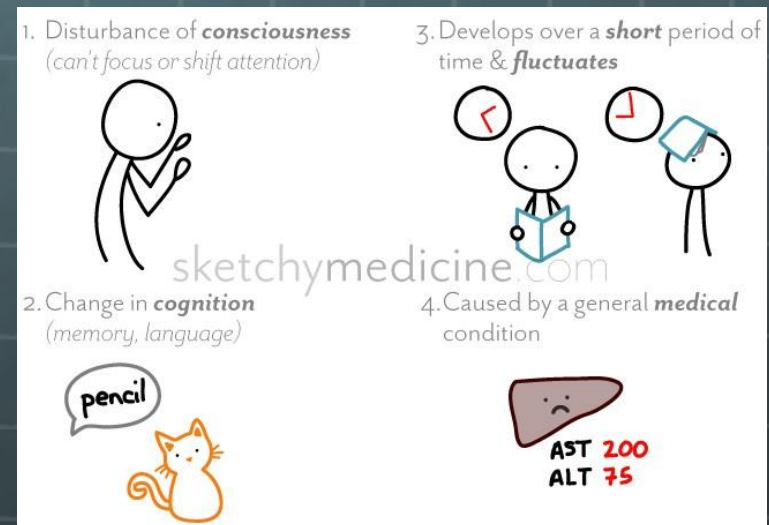


# DELIRIUM

# Delirium

DSM-5 (May 2013):

1. Disturbance in attention
2. Acute fluctuation in mental status
3. Altered mental status
4. Not a result of severely reduced LOC (ie. Coma)



# Significance of Delirium

- ◆ Increased healthcare
- ◆ Increased death rate
- ◆ Increased complications post op
- ◆ Longer hospital stays
- ◆ Functional decline
- ◆ New nursing home placement
- ◆ Long term cognitive decline



# Prevalence?

Prevalence varies by population being studied

🌐 Delirium in the Community overall prevalence 0.4-2%.

🌐 Higher rates in the Hospital setting.

20-30 % of hospitalized patients above age 65

Post operative Delirium 15-62%

Intensive care units 70-87%

🌐 50% of our Hospital beds occupancy are in ages > 65.  
Delirium complication put in dollars. 6.9 billion Medicare  
Hosp. Exp. (2004)

# Description of Delirium

- “Acute confusional state”, “ICU psychosis”  
“Change in Mental Status”
  - Common syndrome with *rapid* onset (hours or days)
  - Impaired attention
  - Disorganized thinking
  - Tends to change with a variable course
  - Evidence of underlying medical condition

# Do we do a good job of detecting delirium?

- 🌐 Only 50% recognized by nurses
- 🌐 Only 20% recognized by physicians



# Persons at Risk for Delirium

The risk of delirium increases with age, but it is *not not* a normal age related change

## Most common

- Dementia
- Male gender
- Advanced age
- Medical illness

## Predisposing

- Poor functional status
- Alcohol abuse
- Depression
- Dehydration
- Sensory impairment



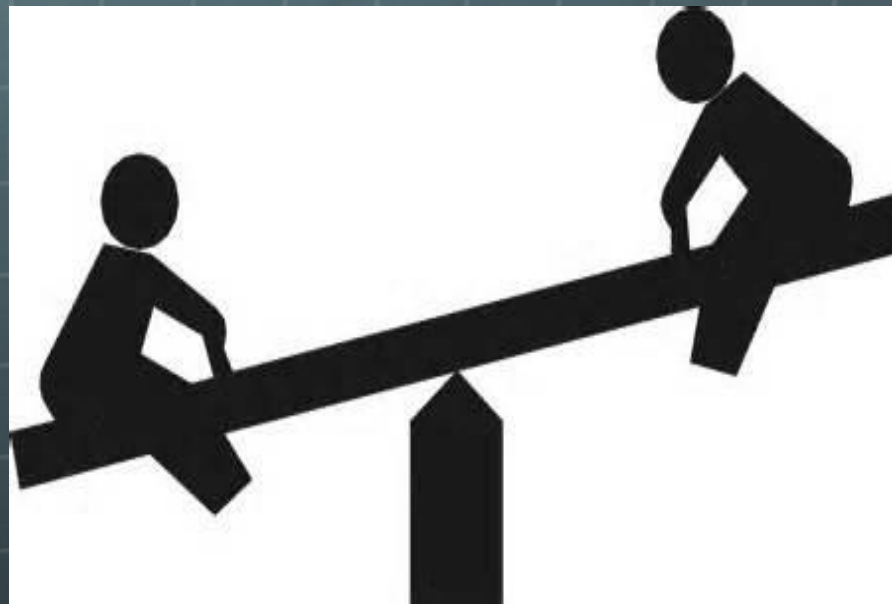
# High Risk Medications

- Anticholinergics (benadryl)
- Opioids (meperidine)
- Sedative hypnotics (benzodiazepines)
- Histamine (H<sub>2</sub>) receptor antagonists
- Corticosteroids (prednisone)
- Centrally acting antihypertensives
- Antiparkinsonian drugs



# Delirium Risk Factors

Predisposing  
+  
Precipitating  
Factors



Delirium

# Types of Delirium

**Hyperactive**

**Hypoactive**

**Mixed**

# Hypoactive Delirium



- Most likely to be missed/not recognized
- 60% of all delirium cases
- Higher risk for DEATH

## Signs and symptoms

- Sleepy, sluggish, uninterested, withdrawn
- Slow speech, mumbling
- Laying in bed with little interaction
- Visual hallucinations (sensory perception not related to external event) often seen as “picking in the air”



# Hypoactive Delirium

## *Patients are...*

- 🌐 Sicker on admission
- 🌐 Have longer lengths of stay
- 🌐 Are more likely to develop pressure ulcers as a result of immobility
- 🌐 Are more likely to die
  
- 🌐 May be diagnosed as having depression
- 🌐 The hypoactive form is often overlooked in elderly!!!  
(increased lethargy, decreased activity)

# Hyperactive Delirium

- Most easily recognized
- 30% of all delirium cases
- Higher fall risk



## Signs and symptoms

- Restless, irritable, combative, angry, uncooperative, easily distracted
- Fast or loud speech
- Wandering, climbing out of bed
- Visual hallucinations

# Mixed Delirium

- Shift between hyperactive & hypoactive states
- May account for about 10% of all delirium cases



*Daily care is challenging because course of the disease is unpredictable and changing*



# Implications of Delirium

## Patient

- Acute anxiety
- Barrier to communication
- Decreased self care
- Time lost
- Increased blood tests, x-rays, etc.
- Increased treatment and medications

## Family

- Barrier to communication
- Time lost
- Stressful
- Increased risk of conflict with staff
- Possible bereavement

## Staff

- Barrier to communication
- Difficulty in assessing patient symptoms and course of illness
- Stressful
- Increased risk of conflict with family
- **TIME!!!**



# Risk Factors During Hospitalization


- Medications added
- Malnutrition
- Physical restraints used
- Bladder catheter and other tubes
- Untreated pain
- Infection
- Relocation especially to ICU

It is reasonable to anticipate delirium in a hospitalized older adult

# Recognition of Delirium

*EARLY RECOGNITION IS  
KEY TO TREATING  
UNDERLYING CAUSES AND  
REDUCING NEGATIVE  
CONSEQUENCES....*

# Simple Screening

 **try this:**<sup>®</sup>

Best Practices in Nursing  
Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 13, Revised 2012

Editor-in-Chief: Sherry A. Greenberg, PhD(c) MSN, GNP-BC  
New York University College of Nursing

## **The Confusion Assessment Method (CAM)**

*By: Christine M. Waszynski, MSN, APRN, BC, Hartford Hospital*

**WHY:** Delirium is present in 10%-31% of older medical inpatients upon hospital admission and 11%-42% of older adults develop delirium during hospitalization (Siddiqi, House, & Holmes, 2006; Tullmann, Fletcher, & Foreman, 2012). Delirium is associated with negative consequences including prolonged hospitalization, functional decline, increased use of chemical and physical restraints, prolonged delirium post hospitalization, and increased mortality. Delirium may also have lasting negative effects including the development of dementia within two years (Ehlenbach et al., 2010) and the need for long term nursing home care (Inouye, 2006). Predisposing risk factors for delirium include older age, dementia, severe illness, multiple co-morbidities, alcoholism, vision impairment, hearing impairment, and a history of delirium. Precipitating risk factors include acute illness, surgery, pain, dehydration, sepsis, electrolyte disturbance, urinary retention, fecal impaction, and exposure to high risk medications. Delirium is often unrecognized and undocumented by clinicians. Early recognition and treatment can improve outcomes. Therefore, patients should be assessed frequently using a standardized tool to facilitate prompt identification and management of delirium and underlying etiology.

**BEST TOOL:** The Confusion Assessment Method (CAM) is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings. The CAM

# Simple Screening

## The Confusion Assessment Method (CAM) Diagnostic Algorithm

### **Feature 1: *Acute Onset or Fluctuating Course***

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

### **Feature 2: *Inattention***

This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

### **Feature 3: *Disorganized thinking***

This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

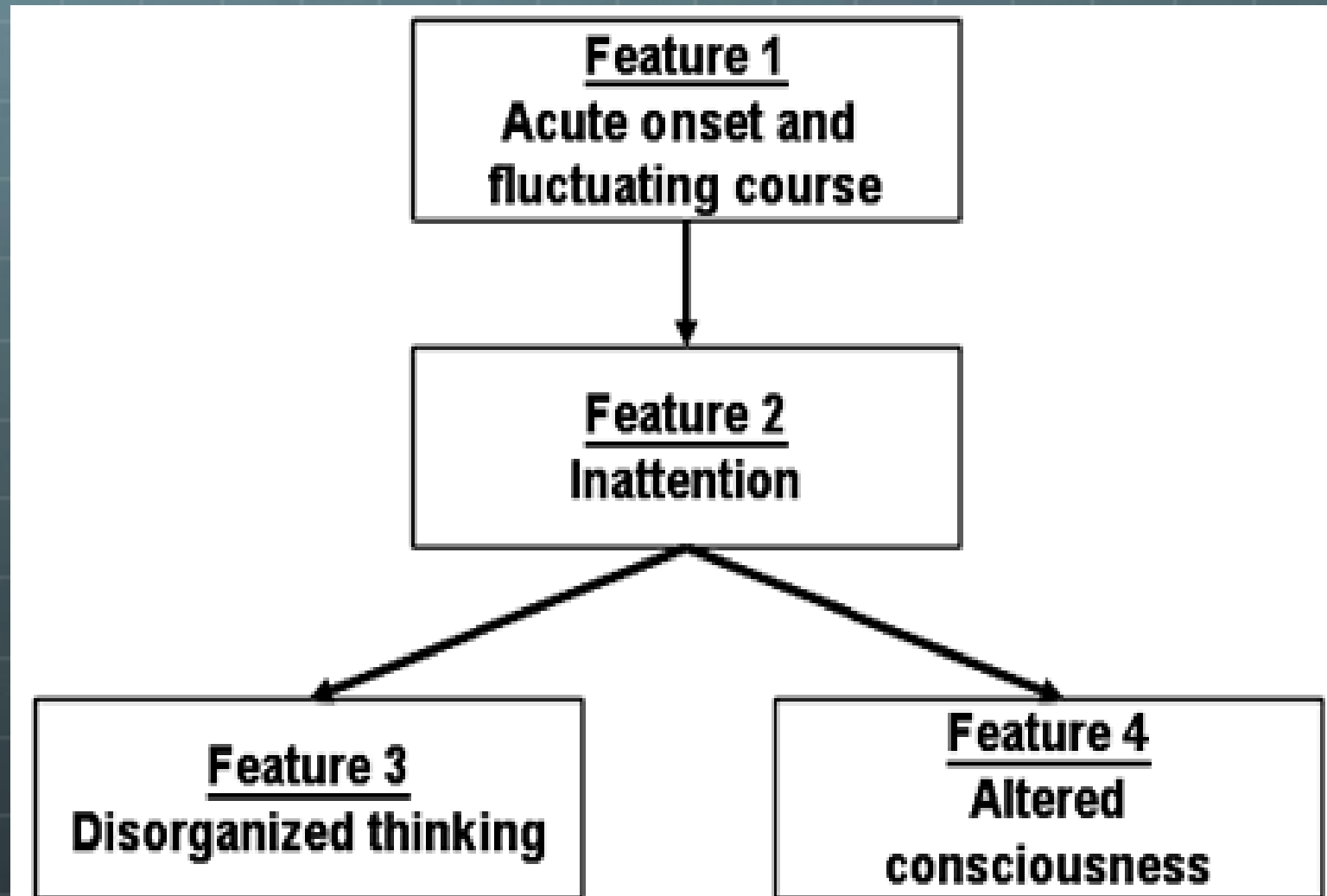
### **Feature 4: *Altered Level of consciousness***

This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal]), vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

**The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.**



# The Confusion Assessment Method (1990)





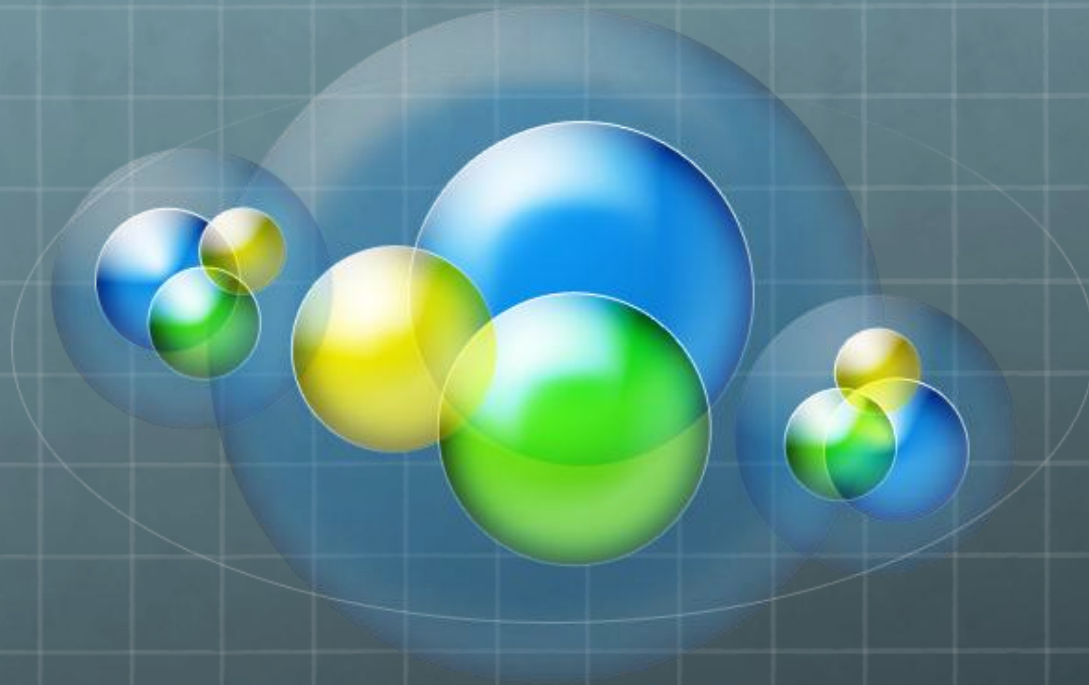
# Early Interventions for Delirium.....

- 🌐 **Know your patient's history**
  - 🌐 **Be alert for risk factors**
  - 🌐 **Look – Listen – See**
  - 🌐 ***Believe* the family**
  - 🌐 ***Believe* the family**
- 🌐 **Non-pharmacologic Management**
    - 🌐 **Control environment by reducing over stimulation, avoiding sleep deprivation, establishing routines following day and night**
    - 🌐 **Minimize relocation and maintain consistency of caregivers**

# Simple Interventions for Delirium...

- **Maximize Orientation**
  - **Clocks and calendars**
  - **Dry erase boards for staff names and scheduled activities**
  - **Keep family informed**
  - **Involve family members in care and routine**

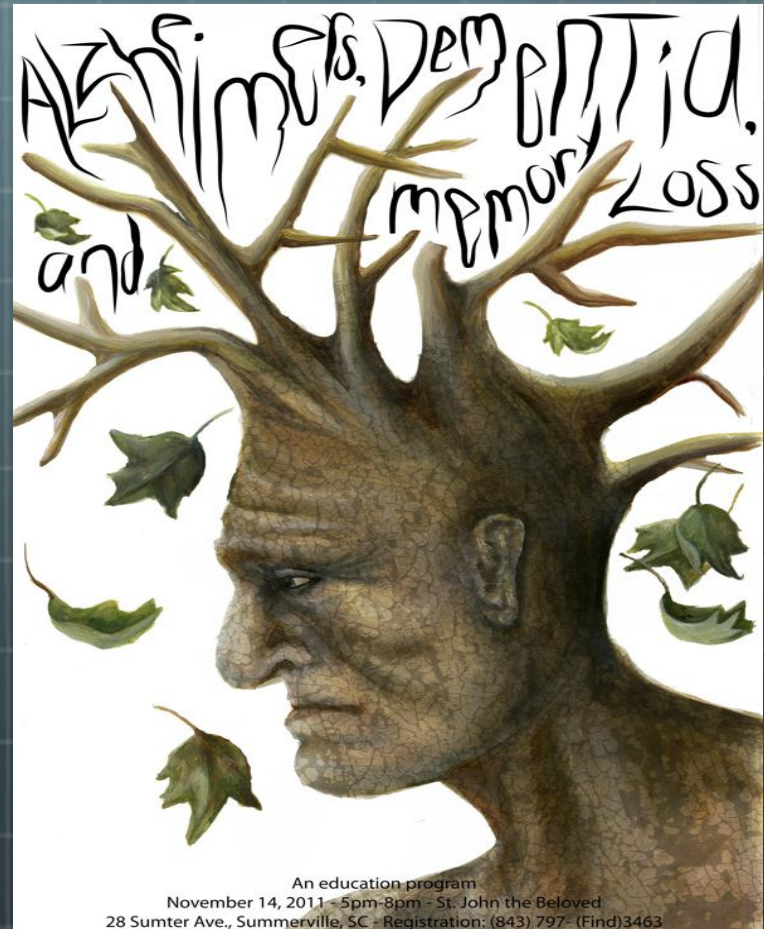




# DEMENTIA

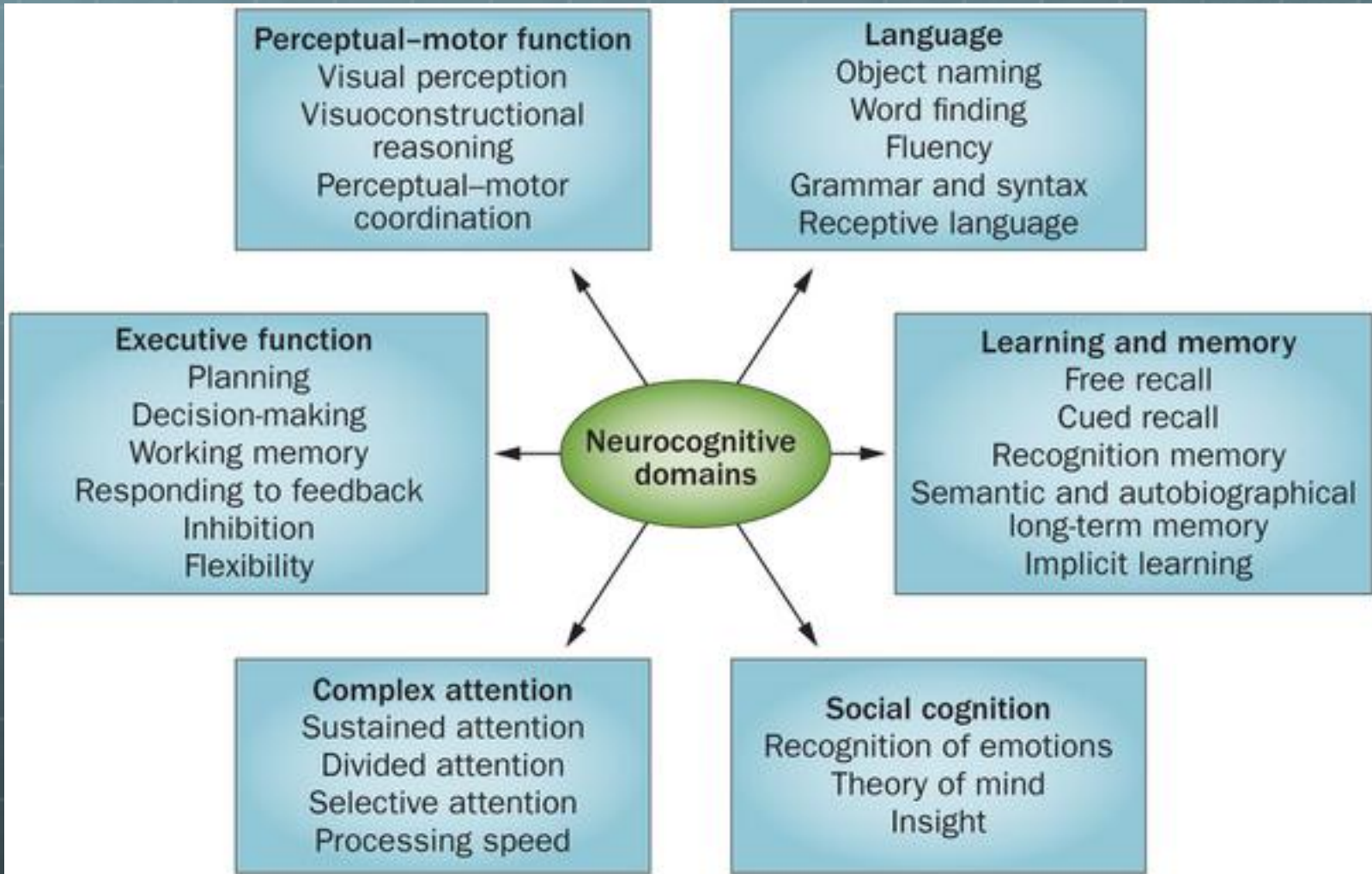
# Dementia

- Clinical syndrome of cognitive defects
- Memory impairments and disturbance in at least one other area of cognition
- Gradual decline in function
- Gradual changes in mood and behavior



An education program  
November 14, 2011 - 5pm-8pm - St. John the Beloved  
28 Sumter Ave., Summerville, SC - Registration: (843) 797- (Find)3463







# Dementia

- Not senility and *not, not, not* normal aging
- Syndrome of cognitive defects; many types of dementia
- Characterized by impaired memory, change in intellect, and personality
- Gradual decline in function
- Gradual changes in mood and behavior
- Most common form of dementia is Alzheimer's disease (60% of all dementias)

*About 25% of hospitalized older patients have dementia*

*Dementia is a risk factor for delirium and delirium is a risk factor for dementia*

# Forms of Progressive Dementia

Dementia Types	% of all dementias	Lesions
Alzheimer's disease (AD)	60%	Neurofibrillary plaques and tangles
Vascular dementia (VaD, multi-infarct)	20%	Multiple infarctions Single infarctions Diffuse subcortical white matter disease Hemorrhagic lesions
Dementia with Lewy Bodies (DLB)	Less common	Lewy bodies are aggregations of alpha-synuclein in cytoplasm of neurons

# Clinical Presentation of Dementias

AD	VaD	DLB
Progressive loss of memory Deterioration in language & other cognitive functions Decline in ADLs Changes in personality & behavior	Evidence of focal deficits Gait disturbance Impairments in executive function Memory not as affected as in AD	Cognitive & behavioral changes in combination with features of Parkinson's disease

# Alzheimer's Disease

<b>Early</b>	Noticeable deficits in demanding job situations	Mild cognitive decline
<b>Mild</b>	Deficit associated with complicated tasks	Moderate cognitive decline Denial and withdrawal from challenging situations
<b>Moderate</b>	Deficit associated with choosing proper attire	Moderate to severe cognitive decline
<b>Moderately severe</b>	Deficits during ADLs	Severe cognitive decline with total dependence
<b>Severe</b>	Declined speech ability, loss of ability to walk, sit up, smile, hold head up	Severe cognitive decline with no verbal or self care abilities

# Common Co-Morbidities

- ◆ **Psychosis (30-50% frequency)**
  - ◆ **Delusions and paranoia**
  - ◆ **Hallucinations, most commonly visual**
- ◆ **Agitation (80% frequency)**
  - ◆ **Aggression, combativeness, hyperactivity, wandering, hypervocalization, and disinhibition**
- ◆ **Depressive symptom (> 70% frequency)**



# Simple Screening



*try this:*<sup>®</sup>

*general assessment series*

Best Practices in Nursing  
Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 3, Revised 2013

Editor-in-Chief: Sherry A. Greenberg, PhD(c) MSN, GNP-BC  
New York University College of Nursing

## **Mental Status Assessment of Older Adults: The Mini-Cog<sup>™</sup>**

*By: Deirdre M. Carolan Doerflinger, CRNP, PhD, Inova Fairfax Hospital, Falls Church, Virginia*

**WHY:** Five and a third (5.3) million Americans of all ages have Alzheimer's disease or other dementias. Age is by far the greatest risk factor. One in ten individuals over 65 and nearly half of those over 85 are affected. A new case of dementia in some form is diagnosed every 70 seconds according to the *2010 Alzheimer's Disease Facts and Figures; Older Americans 2010 Key Indicators of Well-Being*. The increased availability of successful treatments for dementia and dementia-related illnesses means there is a substantial need for increased early identification of cognitive impairment, particularly in the geriatric population. Using a reliable and valid tool that clinicians can quickly implement facilitates early identification and allows the person to receive prompt treatment. Early identification and intervention in the form of medication and behavioral therapy may slow disease progression, delay functional decline, allow for pre-planning, and postpone nursing home placement.

**BEST TOOL:** The Mini-Cog<sup>™</sup> is a simple screening tool that is well accepted and takes up to only 3 minutes to administer. This tool can be used to detect cognitive impairment quickly during both routine visits and hospitalizations. The Mini-Cog<sup>™</sup> serves as an effective triage tool to identify patients in need of more thorough evaluation. The Clock Drawing Test (CDT) component of the Mini-Cog<sup>™</sup> allows clinicians to quickly assess numerous cognitive domains including cognitive function, memory, language comprehension, visual-motor skills, and executive function and provides a visible record of both normal and impaired performance that can be tracked over time.

**TARGET POPULATION:** The Mini-Cog<sup>™</sup> is appropriate for use in all health care settings. It is appropriate to be used with older adults at various heterogeneous language, culture, and literacy levels.

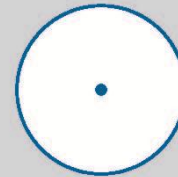
**VALIDITY AND RELIABILITY:** The Mini-Cog<sup>™</sup> was developed as a brief screening tool to differentiate patients with dementia from those without dementia. Depending on the prevalence of dementia in the target population, the Mini-Cog<sup>™</sup> has sensitivity ranging from 76-99%, and specificity ranging from 89-93% with 95% confidence interval. A chi square test reported 234.4 for Alzheimer's dementia and 118.3 for other dementias ( $p < 0.001$ ). This tool has strong predictive value in multiple clinical settings (Borson et al., 2003). Newer research suggests that a 5-point numerical scoring system based on the original algorithm may be easier to apply: repeating three items (0 points), a clock drawing distractor (CDT) (0-2 points), and recall of the earlier three items after the CDT (0-3 points). A score of 3-5 out of 5 is a negative

# Mini-Cog

Ask patient to repeat and remember 3 items (e.g., ball, car, man).

## Clock drawing test (CDT)

“This is a clock face. Please put in the numbers and hands to show 10 minutes after 10 o'clock.”



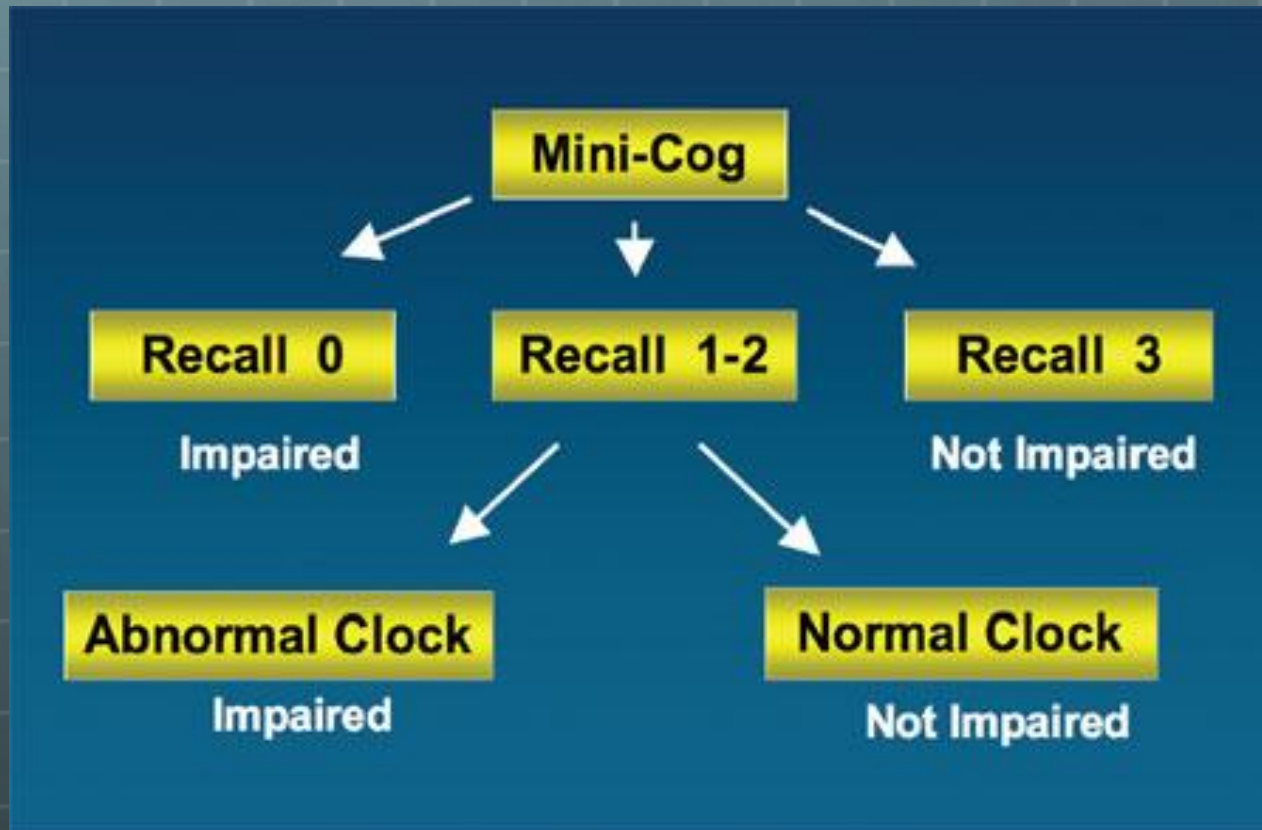
Ask patient to recall the 3 items above.

**Impairment in the clock drawing test or item recall test warrants more detailed assessment with the Mini-Mental States Exam (MMSE) or another instrument.**

### SCORING

3 recalled words	Negative for cognitive impairment
1-2 recalled words + normal CDT	Negative for cognitive impairment
1-2 recalled words + abnormal CDT	Positive for cognitive impairment
0 recalled words	Positive for cognitive impairment

# Mini-Cog



# Reality of Dementia

- It changes everything, with time
- It is **NOT** something the individual can control
- It is different for every person
- It is **NOT** a mental illness
- It is very hard for families
- **Information to obtain from caregiver:**
  - Best way to communicate
  - How to deal with episodes of agitation
  - Best way to perform ADL functions
  - Tips on getting patient to eat
  - Usual signs of pain
  - Sleep habits
  - Previous occupations and interests
  - Situations that upset the patient and best responses to them



# Pearls of Wisdom



*Patients with dementia are more likely  
to develop delirium*

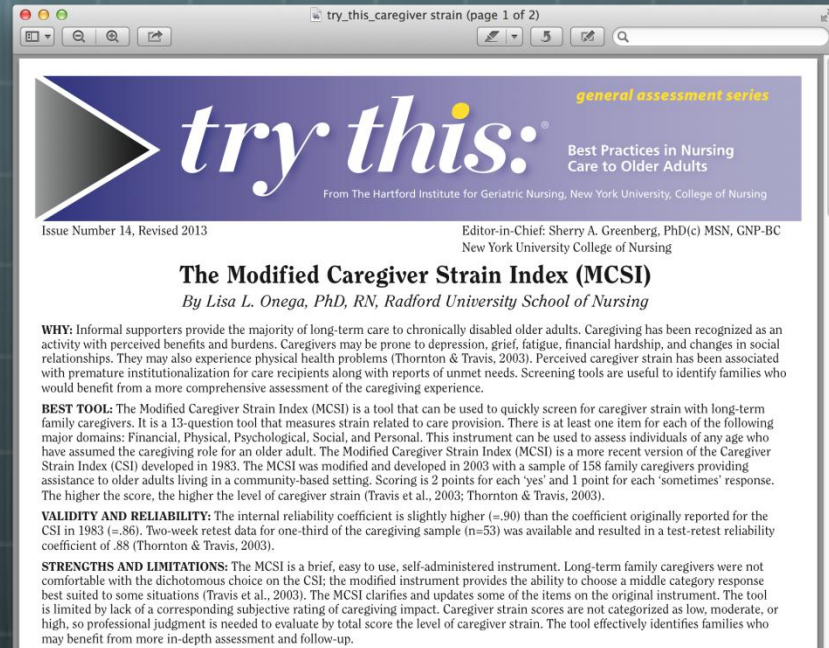
- **Be aware of what is normal behavior**
- **Be alert for pain, nausea, fatigue**
- **Be aware of any medication changes**
- **Be alert to protein/energy malnutrition and dehydration**



# Caregiver Assessment

## Caregiver Burden:

- Fatigue
- Grief
- Changes in social relationships
- Depression
- Physical illness
- Death



try this: general assessment series  
Best Practices in Nursing  
Care to Older Adults  
From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 14, Revised 2013 Editor-in-Chief: Sherry A. Greenberg, PhD(c) MSN, GNP-BC  
New York University College of Nursing

### The Modified Caregiver Strain Index (MCSI)

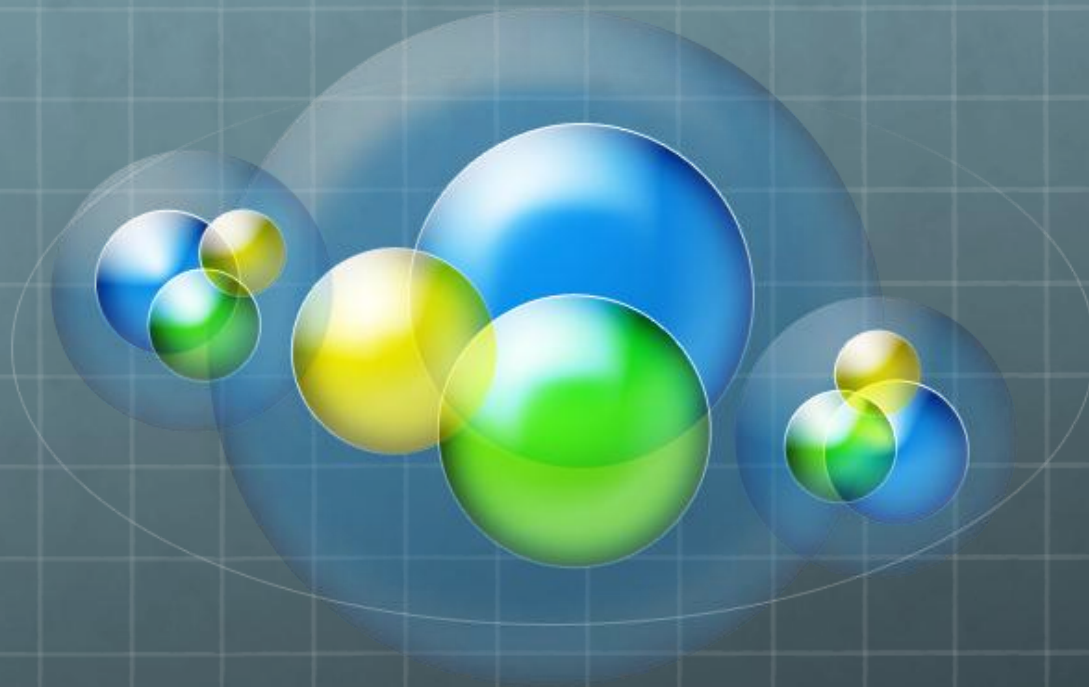
By Lisa L. Omega, PhD, RN, Radford University School of Nursing

**WHY:** Informal supporters provide the majority of long-term care to chronically disabled older adults. Caregiving has been recognized as an activity with perceived benefits and burdens. Caregivers may be prone to depression, grief, fatigue, financial hardship, and changes in social relationships. They may also experience physical health problems (Thornton & Travis, 2003). Perceived caregiver strain has been associated with premature institutionalization for care recipients along with reports of unmet needs. Screening tools are useful to identify families who would benefit from a more comprehensive assessment of the caregiving experience.

**BEST TOOL:** The Modified Caregiver Strain Index (MCSI) is a tool that can be used to quickly screen for caregiver strain with long-term family caregivers. It is a 13-question tool that measures strain related to care provision. There is at least one item for each of the following major domains: Financial, Physical, Psychological, Social, and Personal. This instrument can be used to assess individuals of any age who have assumed the caregiving role for an older adult. The Modified Caregiver Strain Index (MCSI) is a more recent version of the Caregiver Strain Index (CSI) developed in 1983. The MCSI was modified and developed in 2003 with a sample of 158 family caregivers providing assistance to older adults living in a community-based setting. Scoring is 2 points for each 'yes' and 1 point for each 'sometimes' response. The higher the score, the higher the level of caregiver strain (Travis et al., 2003; Thornton & Travis, 2003).

**VALIDITY AND RELIABILITY:** The internal reliability coefficient is slightly higher ( $r=.90$ ) than the coefficient originally reported for the CSI in 1983 ( $r=.86$ ). Two-week retest data for one-third of the caregiving sample ( $n=53$ ) was available and resulted in a test-retest reliability coefficient of .88 (Thornton & Travis, 2003).

**STRENGTHS AND LIMITATIONS:** The MCSI is a brief, easy to use, self-administered instrument. Long-term family caregivers were not comfortable with the dichotomous choice on the CSI; the modified instrument provides the ability to choose a middle category response best suited to some situations (Travis et al., 2003). The MCSI clarifies and updates some of the items on the original instrument. The tool is limited by lack of a corresponding subjective rating of caregiving impact. Caregiver strain scores are not categorized as low, moderate, or high, so professional judgment is needed to evaluate by total score the level of caregiver strain. The tool effectively identifies families who may benefit from more in-depth assessment and follow-up.



# DEPRESSION

# Depression

1. Depressed, sad, or irritable mood
2. Diminished pleasure in pleasurable people and activities
3. Feelings of worthlessness, self reproach, and excessive guilt
4. Difficulty thinking or diminished concentration
5. Suicidal thinking or attempts
6. Fatigue and loss of energy
7. Changes in appetite and weight
8. Disturbed sleep
9. Psychomotor agitation or retardation





# Depression in Rhode Island

<http://www.health.ri.gov/publications/healthriskreports/adults/2006Depression.pdf>



# Depression

- **Most common emotional disorder in older adults; *not, not, not* a normal part of aging**
- **May range from mild to severe**
- **Under diagnosed and under treated**
- **High rate of suicide among white men > 85 years**
- **Depressed mood may be not be obvious**
- **Atypical presentation: somatic complaints, anxious, irritable, pacing, constant worrying, feeling “tired”**
- **Symptoms may be associated with a medical illness  
( CHF or lung disease)**



# Clinical Presentation

- Major depression (most severe)

- 5 out of 9 criteria present for 2 week period

- Change from previous functioning

- Minor depression (most common)

- Fewer than 5 criteria for 2 week period

- Change from previous functioning



*The somatic or physical symptoms of depression are often difficult to distinguish from symptoms associated with acute or chronic physical illness*

# Risk Factors/High Risk Groups

Social and demographic  
risk factors:

- Female sex,
- Unmarried status
- Stressful life events,
- Absence of social support
- Current alcohol/substance abuse
- Functional disability



**Medical co-  
morbidities**



*Disability, older age, new medical diagnosis, and poor health status are among the most consistent of all correlates of depression among older medical patients*

# Consequences of Depression

- **“Turns up the Volume”**
  - **Pain and disability**
  - **Delayed recovery**
  - **Worsening of medical symptoms**
  - **Risk of physical illness**
  - **Increased healthcare use**
  - **Cognitive impairment**
  - **Poor nutrition**
  - **Depression is present in 22-54% of the cases of dementia**

# Suicide in Older Adults

- Higher mortality rate
- Highest rate of any age group
- White men >85 years at greatest risk
- Depressive symptoms, perceived health status, sleep quality, and no confidant
- Physical illness, functional impairment, and depression
- Disruption of social support, family conflict, and loneliness





# Simple Screening



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Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 4, Revised 2012

Editor-in-Chief: Sherry A. Greenberg, PhD(c) MSN, GNP-BC  
New York University College of Nursing

## The Geriatric Depression Scale (GDS)

*By: Sherry A. Greenberg, PhD(c), MSN, GNP-BC,  
Hartford Institute for Geriatric Nursing, NYU College of Nursing*

**WHY:** Depression is common in late life, affecting nearly 5 million of the 31 million Americans aged 65 and older with clinically significant depressive symptoms reaching 13% in older adults aged 80 and older (Blazer, 2009). Major depression is reported in 8-16% of community dwelling older adults, 5-10% of older medical outpatients seeing a primary care provider, 10-12% of medical-surgical hospitalized older adults with 23% more experiencing significant depressive symptoms (Blazer, 2009). Recognition in long-term care facilities is poor and not consistent amongst studies (Blazer, 2009).

Depression is not a natural part of aging. Depression is often reversible with prompt recognition and appropriate treatment. However, if left untreated, depression may result in the onset of physical, cognitive, functional, and social impairment, as well as decreased quality of life, delayed recovery from medical illness and surgery, increased health care utilization, and suicide.


**BEST TOOL:** While there are many instruments available to measure depression, the Geriatric Depression Scale (GDS), first created by Yesavage, et al., has been tested and used extensively with the older population. The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. A Short Form GDS consisting of 15 questions was developed in 1986. Questions from the Long Form GDS which had the highest correlation with depressive symptoms in validation studies were selected for the short version. Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (question numbers 1, 5, 7, 11, 13) indicated depression when answered negatively. Scores of 0-4 are considered normal, depending on

# Simple Screening






Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? **YES / NO**
2. Have you dropped many of your activities and interests? **YES / NO**
3. Do you feel that your life is empty? **YES / NO**
4. Do you often get bored? **YES / NO**
5. Are you in good spirits most of the time? **YES / NO**
6. Are you afraid that something bad is going to happen to you? **YES / NO**
7. Do you feel happy most of the time? **YES / NO**
8. Do you often feel helpless? **YES / NO**
9. Do you prefer to stay at home, rather than going out and doing new things? **YES / NO**
10. Do you feel you have more problems with memory than most? **YES / NO**
11. Do you think it is wonderful to be alive now? **YES / NO**
12. Do you feel pretty worthless the way you are now? **YES / NO**
13. Do you feel full of energy? **YES / NO**

# Scoring

-  Answers in bold indicate depression. Score 1 point for each bolded answer.
  - A score  $> 5$  points is suggestive of depression.
  - A score  $\geq 10$  points is almost always indicative of depression.
  - A score  $> 5$  points should warrant a follow-up comprehensive assessment

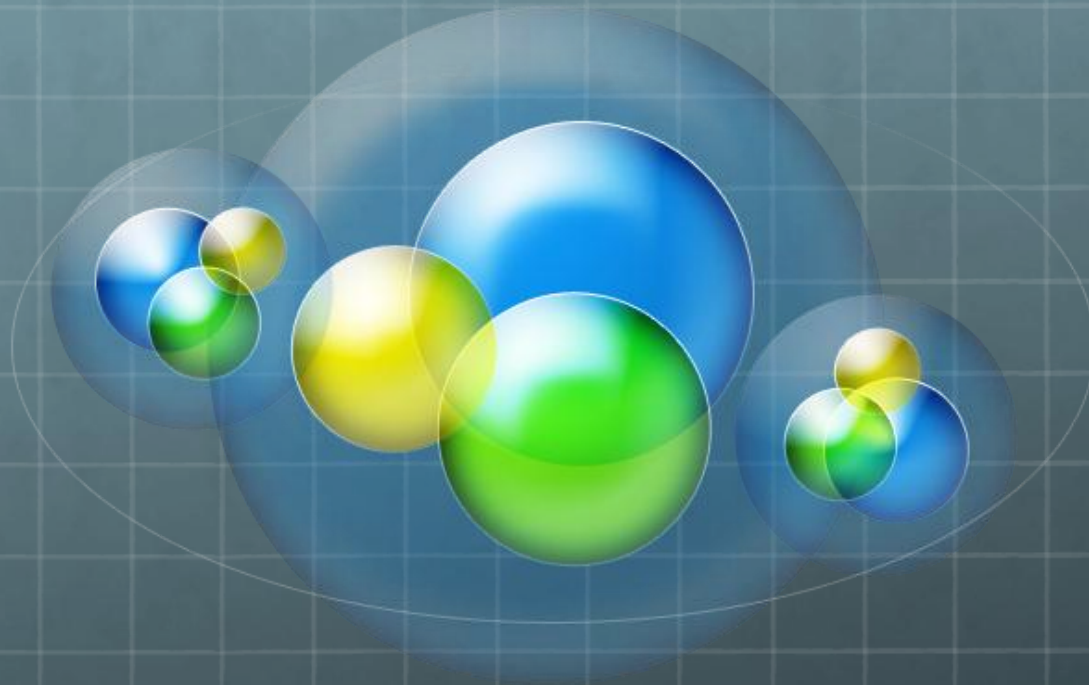
# Treatment Strategies

-  Pharmacologic
  -  TCAs, SSRIs, SNRIs
-  Group and Individual psychotherapy
-  Electroconvulsive Therapy
-  Interdisciplinary team approach



# Nursing Strategies

1. Promote nutrition, elimination, sleep/rest patterns, physical comfort, and pain control
2. Structure and encourage daily participation in relaxation therapies and pleasant activities
3. Enhance function
4. Enhance social support
5. Maximize autonomy, personal control, self efficacy, and decision making
6. Encourage pleasant reminiscing
7. Provide emotional support and supportive listening, encourage expression of feelings, and instill hope
8. Identify and reinforce strengths and capabilities
10. Monitor and document responses to medication and other therapies
11. Promote communication
12. Educate patients and families about depression and effective management



**REVIEW**

### Clinical features of Delirium, Dementia, and Depression

<b>Feature</b>	<b>Delirium</b>	<b>Dementia</b>	<b>Depression</b>
<b>Onset</b>	Acute or sub acute, often at twilight	Chronic, generally insidious	Coincides with life changes; often abrupt
<b>Course</b>	Short, diurnal fluctuations in symptoms; often worse at night, in the dark, and on awakening	Long, no diurnal effects, symptoms progressive yet relatively stable over time	Diurnal effects, typically worse in the morning; situational fluctuations but less than in delirium
<b>Progression</b>	Abrupt	Slow but even	Variable, uneven
<b>Duration</b>	Hours to less than one month, seldom longer	Months to years	At least two weeks, but can be several months to years
<b>Awareness</b>	Reduced	Clear	Clear
<b>Alertness</b>	Lethargic or hyper vigilant; fluctuates	Generally normal	Normal
<b>Attention</b>	Impaired, fluctuates	Generally normal	Minimal impairment but is distractible
<b>Orientation</b>	Generally impaired; fluctuates in severity	May be impaired	Selective disorientation
<b>Memory</b>	Recent and immediate impaired	Recent and remote impaired	Selective or patchy impairment; "islands" of intact memory
<b>Thinking</b>	Disorganized, distorted, fragmented, slowed or accelerated; speech is incoherent	Difficulty with abstraction; thoughts impoverished; judgment impaired; words difficult to find	Intact but with themes of hopelessness, helplessness, or self-deprecation
<b>Perception</b>	Distorted; illusions, delusions, and hallucinations; difficulty distinguishing between reality and misperceptions	Misperceptions often absent	Intact; delusions and hallucinations absent except in severe cases
<b>Psychomotor Behavior</b>	Variable, hypo kinetic, hyper kinetic, or mixed	Normal, may have apraxia	Variable, psychomotor retardation or agitation
<b>Sleep-Wake Cycle</b>	Disturbed; cycle may be reversed	Fragmented	Disturbed, often early morning awakening
<b>Associated Features</b>	Variable affective changes; symptoms of autonomic hyper arousal; exaggeration of personality type; associated with physical illness	Affect superficial, inappropriate, and labile; Attempts to conceal deficits in intellect; personality changes; aphasia; agnosia; lack of insight	Affect depressed; exaggerated and detailed complaints; preoccupation with personal thoughts; insight present; verbal elaboration
<b>Mental Status Testing</b>	Distracted from task	Failings highlighted by family; frequent near miss answers; struggles with test; great effort to find an appropriate reply	Failings highlighted by the patient; don't know answers; little effort; frequently gives up; indifferent, does not care or attempt to find answer

# Tools For Assessment

- 🌐 **Mini-Cog**
- 🌐 **Confusion Assessment Method**
- 🌐 **Geriatric Depression Scale**



**QUESTIONS?**

**Thank you.**