RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
Speaking out for nursing. Speaking out for health.

RNAO Delirium, Dementia, and Depression in Older Adults: Assessment and Care

Recommendation Comparison Chart

RECOMMENDATIONS FROM SCREENING FOR DELIRIUM, DEMENTIA AND DEPRESSION IN THE OLDER ADULT (2010)	SECTION OF DELIRIUM, DEMENTIA, AND DEPRESSION IN OLDER ADULTS: ASSESSMENT AND CARE (2016) WHICH CAPTURES THIS CONTENT OR SIMILAR CONCEPT
1. Nurses should maintain a high index of suspicion for delirium, dementia and depression in the older adult.	Background Context, Recommendations 1.2, 2.1, 4.2, 6.1a, 10.1
2. Nurses should screen clients for changes in cognition, function, behaviour and/or mood, based on their ongoing observations of the client and/or concerns expressed by the client, family and/or interdisciplinary team, including other specialty physicians.	Recommendations 1.2, 4.2, 6.1a
3. Nurses must recognize that delirium, dementia and depression present with overlapping clinical features and may co-exist in the older adult.	Background Context, Recommendation 1.2, Appendix D: Comparison of the Clinical Features of Delirium, Dementia, and Depression
4. Nurses should be aware of the differences in the clinical features of delirium, dementia and depression and use a structured assessment method to facilitate this process.	Background Context, Recommendation 1.2, Appendix D: Comparison of the Clinical Features of Delirium, Dementia, and Depression
5. Nurses should objectively assess for cognitive changes by using one or more standardized tools in order to substantiate clinical observations.	Recommendations 4.2, 6.1a, 10.1
6. Factors such as sensory impairment and physical disability should be assessed and considered in the selection of mental status tests.	Recommendations 6.4, 14.2, 15.2
7. When the nurse determines the client is exhibiting features of delirium, dementia and/or depression, a referral for a medical diagnosis should be made to specialized geriatric services, specialized geriatric psychiatry services, neurologists, and/or members of the multidisciplinary team, as indicated by screening findings.	Recommendations 1.3, 6.1b, 10.3
8. Nurses should screen for suicidal ideation and intent when a high index of suspicion for depression is present, and seek an urgent medical referral. Further, should the nurse have a high index of suspicion for delirium, an urgent medical referral is recommended.	Recommendations 10.2, 10.3
9. All entry-level nursing programs should include specialized content about the older adult, such as normal aging, screening assessment and caregiving strategies for delirium, dementia and	Recommendation 14.1

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depression. Nursing students should be provided with opportunities to care for older adults.	
10. Organizations should consider screening assessments of the older C adult's mental health status as integral to nursing practice. Integration of a variety of professional development opportunities to support nurses in effectively developing skills in assessing the individual for delirium, dementia and depression is recommended. These opportunities will vary depending on model of care and practice setting.	Recommendations 14.2, 15.3
11. Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes: • An assessment of organizational readiness and barriers to education. Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process. • Dedication of a qualified individual to provide the support needed for the education and implementation process. • Ongoing opportunities for discussion and education to reinforce the importance of best practices. • Opportunities for reflection on personal and organizational experience in implementing guidelines. In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the "Toolkit: Implementation of clinical practice guidelines", based on available evidence, theoretical perspectives and consensus. The RNAO strongly recommends the use of this Toolkit for guiding the implementation of the best practice guideline on "Screening for Delirium, Dementia and Depression in Older Adults".	Recommendations 15.3, Evaluating and Monitoring this Guideline, Appendix L: Description of the Toolkit

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Practice Recommendations for Delirium	1.1 Nurses should maintain a high index of suspicion for the prevention, early recognition and urgent treatment of delirium to support positive outcomes.	Recommendations 2.1, 4.2
	1.2 Nurses should use the diagnostic criteria from the Diagnostic and Statistical Manual (DSM) IV-R to assess for delirium, and document mental status observations of hypoactive and hyperactive delirium.	Recommendation 4.2, Table 1 *Note: DSM criteria is not specifically referred to in the recommendation. The latest version, DSM-5 is listed in Appendix H: Screening and Assessment Tools*
	1.3 Nurses should initiate standardized screening methods to identify risk factors for delirium on initial and ongoing assessments.	Recommendation 2.1 Appendix G: Delirium Risk Factors and Interventions
	1.4 Nurses have a role in prevention of delirium and should target prevention efforts to the client‘s individual risk factors.	Recommendation 3.1, Appendix G: Delirium Risk Factors and Interventions
	1.5 In order to target the individual root causes of delirium, nurses working with other disciplines must select and record multicomponent care strategies and implement them simultaneously to prevent delirium.	Recommendations 3.1, 4.5 Appendix G: Delirium Risk Factors and Interventions
	1.5.1 Consultation/Referral Nurses should initiate prompt consultation to specialized services.	Recommendations 1.3, 4.4
	1.5.2 Physiological Stability/Reversible Causes Nurses are responsible for assessing, interpreting, managing, documenting and communicating the physiological status of their client on an ongoing basis.	Guiding Principles and Assumptions Recommendations 4.5, 5.1
	1.5.3 Pharmacological Nurses need to maintain awareness of the effect of pharmacological interventions, carefully review the older adults’ medication profiles, and report medications that may contribute to potential delirium.	Recommendations 1.5, 4.5
	1.5.4 Environmental Nurses need to identify, reduce, or eliminate environmental factors that may contribute to delirium.	Recommendations 3.1, 4.5, Appendix G: Delirium Risk Factors and Interventions

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	1.5.5 Education Nurses should maintain current knowledge of delirium and provide delirium education to the older adult and family.	Recommendations 4.6, 14.2
	1.5.6 Communication/Emotional Support Nurses need to establish and maintain a therapeutic supportive relationship with older adults based on the individual's social and psychological aspects.	Guiding Principles and Assumptions Recommendation 1.1
	1.5.7 Behavioural Strategies: Nurses have a role in the prevention, identification and implementation of delirium care approaches to minimize responsive behaviours of the person and provide a safe environment. Further, it is recommended that restraints should only be used as a last resort to prevent harm to self and others.	Recommendations 1.6, 4.5, Appendix G: Delirium Risk Factors and Interventions
	1.6 Nurses must monitor, evaluate, and modify the multi-component intervention strategies on an ongoing basis to address the fluctuating course associated with delirium.	Recommendations 4.5, 5.1
Practice Recommendations for Dementia	2.1 Nurses should maintain a high index of suspicion for the early symptoms of dementia to initiate appropriate assessments and facilitate individualized care.	Recommendations 1.2, 6.1a
	2.2 Nurses should have knowledge of the most common presenting symptoms of: Alzheimer Disease, Vascular Dementia, Frontotemporal Lobe Dementia, Lewy Body Dementia, and be aware that there are mixed dementias.	Recommendations 14.2, Appendix D: Comparison of the Clinical Features of Delirium, Dementia, and Depression
	2.3 Nurses should contribute to comprehensive standardized assessments to rule out or support the identification and monitoring of dementia based on their ongoing observations and expressed concerns from the client, family, and interdisciplinary team.	Recommendation 6.1a, 6.2
	2.4 Nurses should create partnerships with family members or significant others in the care of clients. This is true for clients who live in either the community or in healthcare facilities.	Guiding Principles and Assumptions Recommendation 1.1
	2.5 Nurses should know their clients, recognize their retained abilities,	Recommendations 6.2, 6.3, 7.1, 8.3

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	understand the impact of the environment, and relate effectively when tailoring and implementing their caregiving strategies.	Guiding Principles and Assumptions Appendix K: Attitudes, Skills, and Knowledge That Are Beneficial for Communication in Dementia Care
	2.6 Nurses caring for clients with dementia should be knowledgeable about pain assessment and management in this population to promote physical and emotional well-being.	Recommendations 6.4, 8.2
	2.7 Nurses caring for clients with dementia should be knowledgeable about non-pharmacological interventions for managing behaviour to promote physical and psychological well-being.	Recommendation 6.3, 7.1
	2.8 Nurses caring for clients with dementia should be knowledgeable about pharmacological interventions, and contribute to the decisions and education regarding the risks and benefits of medication for targeted symptoms, monitor for efficacy and side effects, document response, and advocate for re-evaluation and withdrawal of psychotropics after a time period of behavioural stability.	Recommendations 1.5, 8.5a, Appendix F: Resources for Optimal Medication use in Older Adults
	2.9 Nurses caring for older adults should promote healthy aging and protective strategies to minimize the risk of future cognitive changes.	Recommendation 8.4
Practice Recommendations for Depression	3.1 Nurses should maintain a high index of suspicion for early recognition/early treatment of depression in order to facilitate support and individualized care.	Recommendation 1.2, 10.1
	3.2 Nurses should use the diagnostic criteria from the Diagnostic and Statistical Manual (DSM) IV-R to assess for depression.	Recommendation 10.1 and Table 4 *Note: DSM criteria is not specifically referred to in the recommendation. The latest version, DSM-5 is listed in Appendix H: Screening and Assessment Tools*
	3.3 Nurses should use standardized assessment tools to identify the predisposing and precipitating risk factors associated with depression	Recommendation 10.1 and Table 4, Appendix H: Screening and Assessment Tools

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	3.4 Nurses must initiate prompt attention for clients exhibiting suicidal ideation or intent to harm others.	Recommendations 10.2, 10.3
	3.5 Nurses must be aware of multi-component care strategies for depression. 3.5.1 Non-pharmacological interventions 3.5.2 Pharmacological caregiving strategies	Recommendations 11.1, 12.1 and Table 5
	3.6 Nurses need to facilitate creative client/family/community partnerships to ensure quality care that is individualized for the older client with depression.	Recommendations 1.1, 11.1
	3.7 Nurses should monitor the older adult for re-occurrence of depression for 6 months to 2 years in the early stages of recovery and ongoing for those with chronic depression.	Recommendation 13.1 *Note: Recommendation does not specify a time frame for monitoring depression*
Practice Recommendations for Delirium, Dementia and Depression	4.1 In consultation/collaboration with the interdisciplinary team: • Nurses should determine if a client is capable of personal care, treatment and property decisions. • If a client is incapable, nurses should approach the substitute decision makers regarding care decisions. • Nurses should determine who the client has appointed as Powers of Attorney (POA) for personal care and property and whenever possible include the Powers of Attorney along with the client in decision making, consent and care planning. • If there is no Power of Attorney for personal care, nurses should encourage and facilitate the process for older adults to appoint Powers of Attorney for personal care and to have discussions about end of life treatment and wishes while mentally capable.	Recommendations 1.4a, 1.4b
	4.2 In care settings where Resident Assessment Instrument (RAI) and Minimum Data Set (MDS) instruments are mandated assessment tools, nurses should utilize the MDS data to assist with assessment for delirium, dementia and	*Note: The RAI and MDS are listed, among other tools in Appendix H: Screening and Assessment Tools*

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	depression.	
	4.3 Nurses should avoid physical and chemical restraints as first line care strategies for older adults with delirium, dementia and depression.	Recommendation 1.6
Education	5.1 All entry-level nursing programs should include specialized content about the older adult such as normal aging, involvement of client and family throughout the process of nursing care, diseases of old age, assessment and management of delirium, dementia and depression, communication techniques and appropriate nursing interventions.	Recommendation 14.1
Organization & Policy	6.1 Organizations should consider integration of a variety of professional development opportunities to support nurses in effectively developing knowledge and skills to provide care for older adults with delirium, dementia and depression.	Recommendation 14.2
	6.2 Healthcare agencies should implement a model of care that promotes consistency of the nurse/client relationship.	Recommendations 15.1 discusses Healthy Work Environment concepts and guidelines; 15.4 addresses communication and coordination of care and care transitions
	6.3 Agencies should ensure that nurses' workloads are maintained at levels conducive to care of persons with delirium, dementia and depression.	Recommendation 15.1
	6.4 Staffing decisions must consider client acuity, complexity level, and the availability of expert resources.	Recommendation 15.1
	6.5 Organizations must consider the nurses' well-being as vital to provide care to persons with delirium, dementia and depression.	Recommendation 14.2, 15.1
	6.6 Healthcare agencies should ensure the coordination of care through the appropriate processes to transfer information (e.g., appropriate referrals, communication, documentation, policies that support formal methods of information transfer, and networking between healthcare providers).	Recommendation 15.4
	6.7 (Delirium) Brief screening questions for delirium should be incorporated into	Recommendation 15.3

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	nursing histories and/or client contact documents with opportunity to implement care strategies.	
	6.8 (Delirium) Organizations should consider delirium programs that contain screening for early recognition and multi-component interventions for treatment of clients with, but not limited to, hip fractures, post-operation surgery, and those with complex medical conditions.	Recommendation 15.2, 15.3
	6.9 (Depression) Caregiving activities for the older adult presenting with depression and/or suicidal ideation should encompass primary, secondary and tertiary prevention practices.	*Note: Primary prevention is out of the scope of the guideline. See Depression Recommendations 10.1-13.1 that capture secondary and tertiary prevention*