Interprofessional Assessment and Management Strategies for Older Adults with
Delirium, Dementia, or Depression

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Case Scenario:

Helen was living in a long-term care facility due to impaired self-care ability related to Parkinson disease. She told several nurses and family members that there was a red rabbit running across the floor repeatedly in her room. She was calling her family members the wrong names and thought she was in the nursing home visiting her sister (who had died 20 years earlier). Her husband had passed away recently. What conditions might be represented in this case (list any and all)?

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Survey Question:

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How many times in this past year have you seen a similar case scenario in which it was challenging to determine if the case was related to delirium, depression, or neurocognitive disorder (dementia)?

o   0
o   1-5
o   6-10
o   More than 10

Statement of Need: UND

There is a need for skill development of healthcare providers in interprofessional teams to differentiate delirium, depression, dementia, and other conditions in order to refer and manage conditions effectively

Statement of Need: Delirium

Delirium is often unrecognized and undocumented in 60% of all cases (Oh, Fong, Hshieh, & Inouye, 2017)
- Delirium is frequently misdiagnosed (Hercus & Rahman Hudaib, 2020)
- 41.8% to 73% of studies in a literature review
- Complicating factors: age, pain, sex, psychiatric comorbidity, hypoactive delirium subtype, and lack of healthcare provider time contribute to misdiagnosis
- Diagnostic overshadowing: Healthcare providers attribute delirium symptoms to past psychiatric diagnoses

Statement of Need: Depression UND

o Older adults have approximately *double the rate of suicide* as compared to general population (Casey, 2017)
  ▪ Many of these people saw their provided within days prior to the suicide
o *Depression/anxiety has been misused as a wild card/default label* when the cause of the physical symptoms is unknown
o It is *extremely hurtful* to patients to be *misdiagnosed with depression/anxiety without an assessment for it* when there truly is a medical issue
o Conversely, *depression is undertreated among older adults* because it can manifest as physical symptoms and older adults often do not seek help for depression

Statement of Need: Neurocognitive disorder (dementia)

Case Report: Kaya, Dokuzlar, Kaya, Soysal, & Turan Isik (2020)

- Misdiagnosed with Lewy body dementia due to visual hallucinations
- No indicators of cognitive impairment
- Antipsychotic medication cause postural instability and Parkinson-like symptoms
- Rediagnosed with Charles Bonnet Syndrome, a visual impairment that causes pseudo visual hallucinations
- Gradually eliminated the antipsychotic medication
- Recovered physically

Statement of Need

There is a need for skill development of healthcare providers in interprofessional teams to differentiate delirium, depression, dementia, and other conditions in order to refer and manage conditions effectively

Objectives

- Participants will utilize a bank of screening assessments to differentiate delirium, depression, dementia, and other conditions among older adults

- Participants will utilize effective interprofessional management strategies for older adults with delirium, depression, or dementia

Definitions: Delirium

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o Disturbance in *attention & cognition*; fairly *abrupt onset*; it is *NOT another neurocognitive condition*; evidence that *disturbance IS a consequence of another medical condition*
  ▪ Hypoactive: Less likely to be recognized, diagnosed, and treated
  ▪ Hyperactive: More likely to be recognized, diagnosed, and treated
o Hercus & Rahman Hudaib (2020)

Definitions: Depression

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• "Presence of 5 or more core depressive symptoms during a 2-week period

• Symptoms: depressed mood or loss of interest or pleasure, significant weight loss or gain (without dieting) or appetite change, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, diminished ability to think or concentrate or indecisiveness, and recurrent thoughts of death or suicide. (American Psychiatric Association, 2013, pp. 160-168).

Definition: Neurocognitive Disorder

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o Syndrome with *underlying pathology* causing cognitive impairment
o Subtypes indicate syndrome is due to: Alzheimer, Vascular, Lewy bodies, Parkinson's, Frontotemporal, TBI, HIV infection, substance-medication induced, Huntington's, prior disease, another medical condition
o (American Psychiatric Association, 2013b, pp. 591-643).

Differentiation UN🔥

Dementia/AD	Depression	Delirium
Typically gradual onset	Definitive or gradual onset	Sudden onset; consequence of a medical condition
Cognitive impairment with Limited awareness	5 or more core depressive symptoms	Attention & cognitive impairment
Progressive global impairments: memory and executive functioning. Can have episodes of delirium	Limited scope of impairment: executive functioning	Intermittent global impairments: some remember the symptoms after resolution
Progressive limited orientation to person, place, time	Can resolve with or without treatment	Symptoms improve with treatment to the underlying medical condition

Assessments: UN🔥

- Use of **validated screening tools** and **spending time with a patient** increased accuracy of diagnosis (delirium), regardless of discipline (Hercus & Rahman Hudaib, 2020)

Assessment: Delirium UN🔥

- o *Confusion Assessment Method* (*CAM*)-ICU (Iouye, van Dyck, Alessi, Balkin, Siegal, & Horwitz, 1990): validated screening process rather than a tool
  - ▪ Algorithm: Diagnosis of delirium requires presence of features 1 and 2 and either 3 or 4
    - 1) Acute or fluctuating course
    - 2) Inattention
    - 3) Disorganized thinking
    - 4) Altered level of consciousness
- o *4AT:* validated screening tool

Assessment: Depression UND

- *Patient Health Questionnaire-9* (Kroenke, Spitzer, & Williams, 2001)
- *Geriatric Depression Scale* (Sheikh & Hesavage, 1986)
- *Beck Depression Inventory* (Beck, Epstein, Brown, & Steer, 1988)
- *Cornell Scale of Depression in Dementia* (Alexopoulos, Abrams, Young, & Shamoian, 1998): Simple assessment of depressive symptoms; 15 min
- *Rule of all other conditions*: physical, laboratory, neuroimaging, medication side effects and interactions), cognition, ADL function, mobility, nutrition (Casey, 2017)

Assessment: Neurocognitive Disorder UND

- *Mini Mental State Exam* (Folstein, Folstein, & McHugh, 1975): Multidisciplinary screening tool, 5-10 min
- *Mattis Dementia Rating Scale* (Mattis, 1988)
- *Montreal Cognitive Assessment [MoCA]* (Nasreddine, Phillips, Bedirian, Charbonneau, Whitehead, Collin…Chertkow, 2005): Screening for mild cognitive dysfunction; 10 min
- *MiniCog* (Borson, Scanlan, Chen, & Ganguli, 2003)
- *Alzheimer's Disease 8 (AD8):* Self-report screening interview (Galvin, et al, 2005)

Assessment: Neurocognitive Disorder UND

- *Short Blessed Test* (Katzman, Brown, Fuld, Peck, Schechter, & Herbert Schimmel, 1983): Screening for mild cognitive dysfunction; 10-20 min
- *Global Deterioration Scale* (Reisberg, Ferris, de Leon, & Crook, 1982): Screening that offers overview of cognitive function to caregivers; Time Varies
- *St. Louis University Mental Status (SLUMS)* exam (Tariq, Tumosa, Chibnall, Perry, Morley, 2006): Screening for detecting mild cognitive impairment and dementia. More sensitive than Mini-Mental Exam; 15 min

Referrals and Management: UND

- *Delirium diagnosis*: Identify delirium as a medical emergency and urgently initiate a diagnostic work-up for precipitating factors

- *Depression risk or diagnosis:* Immediate psychological consultation and intervention as indicated, especially due to the higher rates of suicide among older adults

- *Neurocognitive disorder:* referrals and planning for long-term supportive services, OT & PT for caregiver training, home care and respite services

Communication Strategies   UND

- Delirium Delusions: Typically, avoid reality orientation; it can be offensive or hurtful because the delusion is their reality.
- Depression: Validate feelings and experiences; draw out prior successes in coping to support self-efficacy
- Therapeutic Communication: Helps them feel heard and understood.
  - *Paraphrase*: "So you're saying it's important to…?"
  - *Reflect on feelings* "It sounds like you are really worried?"
  - *Open-ended questions*: "I want to understand more. What else can you tell me about…?"

Redirect with Activity   UND

- Have farming/gardening magazines on hand and start paging through it with resident, discussing farming-related images on the pages
- Bring in another resident to look at the magazine together and talk about it
- Offer a cup of coffee (normal routine before feeding cows for many)
- Bring a newspaper, card game, or another meaningful activity
- Try to keep resident engaged in any activity until the delusion or extreme sadness starts to subside or other treatment can be implemented if needed for the condition causing the delusion

Return to Case Scenario: UND

• Helen was living in LTC due to impaired self-care ability related to Parkinson disease. She saw a red rabbit running across the floor. Disoriented person, place, time. Mild CHF. Recent loss of husband. SW did Geriatric Depression Scale a week ago: no indicators of depression. NA reported strong, foul odor urine. Helen's sister had developed dementia from Parkinson's.
• (Break out room for 5 minutes to role play Geriatric Depression Scale & identify other assessment to do).

- How efficient was it to complete this scale?
- What other assessments should the IP team do?

Case Assessment Results   UND

• CAM showed presence of features 1, 2, and 3 (acute, inattention, disorganized thinking)
• Urine analysis showed presence of leukocyte esterase (presence of white blood cells) and red blood cells. No typical signs of stroke (e.g. hemiparesis, dysarthria, dysphagia). Temperature is 103.2; heart rate is 110 (normal resting heart rate for Helen is 75); respirations are 22/min; BP is 155/90. Family said that Helen does not like to drink water lately because she does not want to bother the SNF staff to help her to the bathroom and it's getting harder to speak to request help. Helen's muscles have gotten more rigid lately and she has been needing more help in the bathroom to transfer to the toilet, pull her pants down/up, and manipulate the toilet paper.

Case Management: Break out rooms   UND

- What condition is most likely indicated by the test results and additional information?
- What initial communication strategies should IP team members use with Helen to redirect her?
- What referrals are indicated?
- What management strategies are indicated?

Final Case Results

- Helen was admitted to the hospital for a UTI with related delirium. She was treated with an antibiotic; IV fluids; diuretics, and redirection activities. PT did manual therapy to reduce muscle rigidity and promote mobility for toileting. OT taught compensatory strategies to support independence with toileting. SLP developed communication strategies and board. Helen was able to get herself to the bathroom with modified independence and felt more confident asking for help when needed with the communication strategies/board. Helen's cognition cleared almost immediately but she later remembered the delusions and her experience and joked with her family about seeing the little red rabbit.

Summary

Differentiating delirium, depression, and neurocognitive disorder is essential for effective intervention planning.

Multiple IP team members can conduct parts of the overall comprehensive evaluation.

Appropriate communication, referrals, services, and interventions support effective treatment that enhances overall quality of life for older adults.

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