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

Second Edition

RNAO

Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

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

Second Edition

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario

The Registered Nurses' Association of Ontario (RNAO) is delighted to present the second edition of the clinical best practice guideline *Delirium, Dementia and Depression in Older Adults: Assessment and Care*. Evidence-based practice supports the excellence in service that health professionals are committed to delivering every day. RNAO is delighted to provide this key resource.

We offer our heartfelt thanks to the many stakeholders who are making our vision for best practice guidelines a reality, starting with the Government of Ontario, for recognizing RNAO's ability to lead the program and for providing multi-year funding. For their invaluable expertise and leadership, I wish to thank Dr. Irmajean Bajnok, Director of the RNAO International Affairs and Best Practice Guidelines Centre, and Michelle Rey, the Associate Director. I also want to thank the co-chairs of the expert panel, Michelle Acorn (Nurse Practitioner, Lakeridge Health and PHC NP Coordinator, University of Toronto) and Lori Schindel Martin (Associate Professor and Associate Director—Scholarly, Research and Creative Activities, Ryerson University, Daphne Cockwell School of Nursing) for their exquisite expertise and stewardship of this guideline. Thanks also to RNAO staff Susan McNeill, Verity White, Diana An, Laura Legere, and the rest of the RNAO Best Practice Guidelines Program Team for their intense work in the production of this new Guideline. Special thanks to the members of the expert panel for generously providing time and expertise to deliver a rigorous and robust clinical resource. We couldn't have done it without you!

Successful uptake of best practice guidelines requires a concerted effort from educators, clinicians, employers, policy-makers, and researchers. The nursing and health-care community, with their unwavering commitment and passion for excellence in patient care, have provided the expertise and countless hours of volunteer work essential to the development and revision of each best practice guideline. Employers have responded enthusiastically by nominating best practice champions, implementing guidelines, and evaluating their impact on patients and organizations. Governments at home and abroad have joined in this journey. Together, we are building a culture of evidence-based practice.

We invite you to share this Guideline with your colleagues from other professions and with the patient advisors who are partnering within organizations, because we have so much to learn from one another. Together, we must ensure that the public receives the best possible care every time they come in contact with us—making them the real winners in this important effort!

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How to Use this Document

This nursing Best Practice Guideline (BPG)G* is a comprehensive document that provides resources for evidenceG-based nursing practice. It is not intended to be a manual or "how to" guide, but rather a tool to guide best practices and enhance decision-making for nursesG and other health-care providersG working with older adultsG who have delirium, dementia, and/or depression. The Guideline should be reviewed and applied in accordance with both the needs of individual organizations or practice settings and the needs and preferences of persons and their familiesG accessing the health system for care and services. In addition, the Guideline offers an overview of appropriate structures and supports for providing the best possible evidence-based care.

Nurses, other health-care providers, and administrators who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols, educational programs and assessments, interventions, and documentation tools. Nurses and other health-care providers in direct care will benefit from reviewing the recommendations and the evidence that supports them. We particularly recommend that practice settings adapt these guidelines in formats that are user-friendly for daily use.

If your organization is adopting this Guideline, we recommend you follow these steps:

1. Assess your nursing and health-care practices using the recommendations in this Guideline,
2. Identify which recommendations will address needs or gaps in services, and
3. Develop a plan for implementing the recommendations.

Implementation resources, including the RNAO *Toolkit: Implementation of Best Practice Guidelines* (2012b), are available at www.RNAO.ca. We are interested in hearing how you have implemented this Guideline. Please contact us to share your story.

* Throughout this document, terms marked with a superscript G (G) can be found in the lossary of Terms (**Appendix A**).

Purpose and Scope

Best practice guidelines are systematically developed statements designed to assist nurses working in partnership with persons and their families to make decisions about health care and services (Field & Lohr, 1990). This nursing Best Practice Guideline (BPG) is intended to replace the RNAO BPGs *Screening for Delirium, Dementia and Depression in Older Adults* (2010b) and Caregiving Strategies for Older Adults with Delirium, Dementia and Depression (2010a). It is to be used by nurses and other members of the interprofessional health-care team^{G} to enhance the quality^{G} of their practice pertaining to delirium, dementia, and depression in older adults^{G}, ultimately optimizing clinical outcomes through the use of evidence-based practices.

In March 2015, RNAO convened an expert panel consisting of a group of individuals with expertise in delirium, dementia, and/or depression across a variety of health-care settings. The RNAO expert panel was interprofessional in composition, comprising individuals holding clinical, administrative, and academic positions in a range of health-care organizations, practice areas, and sectors. These experts work with older adults receiving care and services in different types of health-care settings (acute care, long-term care^{G}, home health care, mental health, and in the community in primary care and family health teams), as well as in other types of organizations such as associations and teaching institutions.

To determine the scope and organization of the Guideline, the RNAO development team took the following steps:

- reviewed the RNAO BPGs *Screening for Delirium, Dementia and Depression in Older Adults* (2010b) and *Caregiving Strategies For Older Adults with Delirium, Dementia and Depression* (2010a);
- conducted a scoping review^{G} of the literature to assess whether or not a strong enough connection exists between delirium, dementia, and depression to warrant combining them in a single Guideline; and
- conducted three focus groups with experts in the field, including those who actively implement the Guidelines.

Upon analysis of the results of these activities, the RNAO development team decided to publish a single Guideline encompassing screening and caregiving for all three conditions; this new Guideline therefore outlines recommendations for the assessment and care of delirium and/or dementia and/or depression in older adults. The focus is on the provision of effective, compassionate, and dignified care, and on the management of presenting signs, symptoms, and behaviours. The recommendations apply to the foundational clinical care provided by nurses and other health-care providers in a range of community and health-care settings.

Recommendations are provided at the following three levels:

- Practice recommendations^{G} are directed primarily toward nurses who provide direct clinical care to older adults across the spectrum of care, including (but not limited to): primary care, acute care, home-care settings, alternative level of care/complex continuing care, and long-term care. The secondary audience of the practice recommendations includes other members of the interprofessional team who collaborate with nurses to provide comprehensive care. All of the recommendations are applicable to the scope of practice of registered nurses and nurse practitioners (general and extended class); however, many are also applicable to other members of the interprofessional team.
- Education recommendations^{G} are directed at those who are responsible for the education of health-care providers, such as educators, quality improvement teams, managers, administrators, and academic and professional institutions. These recommendations outline core content and training strategies required for entry-level health-care programs, ongoing education, and professional development. The primary focus is nurses, and the secondary focus is interprofessional team members.

- Organization and policy recommendations[G] apply to managers, administrators, and policy-makers who are responsible for developing policy or securing the supports required within health-care organizations that enable the implementation of best practices.

For optimal effectiveness, recommendations in these three areas should be implemented together.

The following conditions and topics are *not* covered within the scope of this Guideline: delirium caused by alcohol withdrawal, delirium in the last days of life, early onset dementia (dementia occurring in middle age), and prevention of dementia or depression. As well, the Guideline does not specifically address mild cognitive impairment[G]. For guidance on topics outside the scope of this Guideline or for detailed clinical information on delirium, dementia, or depression that is not captured in this Guideline (e.g., diagnostic processes or specific pharmacological treatment options), please refer to the clinical guidelines listed in **Appendix C**, Process for Systematic Review and Search Strategy.

It should be noted that the evidence to support the recommendations in this Guideline is uneven across health-care settings; for example, for delirium, considerable evidence exists for acute-care settings but very little exists for home care. The discussions of evidence clarify, whenever possible, whether or not the evidence is specific to a particular setting; in some cases, the expert panel provides guidance to health-care settings for which evidence is lacking. In adopting and implementing this BPG, organizations are encouraged to determine whether or not individual recommendations are applicable to their particular setting. Refer to Research Gaps and Future Implications for additional information.

For more information about this Guideline, including the Guideline development process and the systematic review[G] and search strategy, refer to **Appendices B** and **C**.

Use of the Term "BPSD" in This Guideline

Terminology in the field of dementia care continues to evolve. The expert panel has chosen to use the term *behavioural and psychological symptoms of dementia* (BPSD) to describe the way a person with dementia expresses his/her needs and exhibits symptoms of dementia—for example, through changes in mood, delusions, apathy, agitation, wandering, calling out, repetitive questioning, and sexual disinhibition (Moniz Cook et al., 2012). Other terms used to describe these symptoms include "neuropsychiatric symptoms," "behavioural and emotional symptoms," and "needs-driven behaviour." However, the expert panel has chosen the term BPSD because of its widespread use, and the general acceptance of its comprehensive definition within the clinical field, the literature, and clinical guidelines.

The expert panel acknowledges that the term BPSD has been criticized as being too medicalized or focused too heavily on how behaviours challenge care providers. However, the intent of the term was to provide an alternative to the negative labels associated with some of the other terms used to describe symptoms (e.g., "aggression"). Newer definitions or descriptions of symptoms, including "BPSD," highlight the fact that these symptoms stem from a person's unmet needs, or describe them as an expression of the person's experiences, feelings, or emotions, or as a method of communicating needs.

Use of the Term "Older Adult" in This Guideline

For the purpose of the systematic review database searches for this Guideline, RNAO applied the limiting term "adults age 65 years and older." When the term *older adult* is used within the Guideline, however, it may refer to people younger than 65 who have aged prematurely or who have a shortened life expectancy due to factors such as the social determinants of health or chronic disease. Therefore, this Guideline may also apply to some individuals younger than 65 years of age.

Use of the Term "Burden/Caregiver Burden" in This Guideline

The term *burden/caregiver burden* is used in this Guideline to align with terminology used in particular studies and guidelines. It is important to note that, although caregiving can be stressful and challenging, some family caregivers/care partners dislike the use of the word "burden" to describe their experiences. Alternative words may include "caregiver stress," "distress," or "challenges."

Interpretation of Evidence

Levels of evidence are assigned to study designs to rank how well particular designs are able to eliminate alternate explanations of the phenomena under study. The higher the level of evidence, the greater the likelihood that the relationships presented between the variables are true. Levels of evidence do not reflect the merit or quality of individual studies.

For the recommendations in this Guideline, the highest level of evidence that aligns most closely with the recommendation statement is assigned. In cases where there are multiple studies of various design with similar findings, the studies with the highest level of evidence are assigned (and cited) in support of the recommendation.

In some cases, recommendations are assigned more than one level of evidence. This reflects the varied study designs that support the multiple components of a recommendation. For transparency, the level of evidence for each component of the recommendation statement is identified in the discussion of evidence.

LEVEL	SOURCE OF EVIDENCE
Ia	
Ib	
IIa	
IIb	
III	
IV	
V	

Adapted from the Scottish Intercollegiate Guidelines Network (Scottish Intercollegiate Guidelines Network [SIGN], 2011) and Pati (2011).

For information on the systematic review process and how studies are appraised for quality, see **Appendix C**.

Summary of Recommendations

This Guideline replaces the RNAO BPGs *Screening for Delirium, Dementia and Depression in Older Adults* (2010b) and *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression* (2010a).

A summary of how the recommendations in this Guideline compare to the recommendations in the previous Guidelines is available at www.RNAO.ca/bpg/Delirium-Dementia-Depression

PRACTICE RECOMMENDATIONS		LEVEL OF EVIDENCE
	RECOMMENDATIONS RELATED TO DELIRIUM, DEMENTIA, AND DEPRESSION	
1.0 General Recommendations	Recommendation 1.1: Establish therapeutic relationships and provide culturally sensitive person- and family-centred care when caring for and providing education to people with delirium, dementia, and depression and their families and care partners.	Ia & V
	Recommendation 1.2: Identify and differentiate among signs and symptoms of delirium, dementia, and/or depression during assessments, observations, and interactions with older persons, paying close attention to concerns about changes expressed by the person, his/her family/care partners, and the interprofessional team.	V
	Recommendation 1.3: Refer older adults suspected of delirium, dementia, and/or depression to the appropriate clinicians, teams, or services for further assessment, diagnosis, and/or follow-up care.	Ia
	Recommendation 1.4a: Assess the person's ability to understand and appreciate information relevant to making decisions and, if concerns arise regarding the person's mental capacity, collaborate with other members of the health-care team as necessary.	V
	Recommendation 1.4b: Support the older person's ability to make decisions in full or in part. If the older person is incapable of making certain decisions, engage the appropriate substitute decision-maker in decision-making, consent, and care planning.	V

PRACTICE RECOMMENDATIONS		LEVEL OF EVIDENCE
	Recommendation 1.5: Exercise caution in prescribing and administering medication to older adults (within the health-care provider's scope of practice), and diligently monitor and document medication use and effects, paying particular attention to medications with increased risk for older adults and polypharmacy.	Ia
	Recommendation 1.6: Use principles of least restraint/restraint as a last resort when caring for older adults.	V
RECOMMENDATIONS RELATED TO **DELIRIUM**		
2.0 Assessment	Recommendation 2.1: Assess older adults for delirium risk factors on initial contact and if there is a change in the person's condition.	Ia & V
3.0 Planning	Recommendation 3.1: Develop a tailored, non-pharmacological, multi-component delirium prevention plan for persons at risk for delirium in collaboration with the person, his/her family/care partners, and the interprofessional team.	Ia
4.0 Implementation	Recommendation 4.1: Implement the delirium prevention plan in collaboration with the person, his/her family/care partners, and the interprofessional team.	Ia
	Recommendation 4.2: Use clinical assessments and validated tools to assess older adults at risk for delirium at least daily (where appropriate) and whenever changes in the person's cognitive function, perception, physical function, or social behaviour are observed or reported.	Ia & V
	Recommendation 4.3: Continue to employ prevention strategies when caring for older adults at risk for delirium who have not been identified as having delirium.	Ia & V

PRACTICE RECOMMENDATIONS		LEVEL OF EVIDENCE
4.0 Implementation	Recommendation 4.4: For older adults whose assessments indicate delirium, identify the underlying causes and contributing factors using clinical assessments and collaboration with the interprofessional team.	Ia
	Recommendation 4.5: Implement tailored, multi-component interventions to actively manage the person's delirium in collaboration with the person, the person's family/care partners, and the interprofessional team (level of evidence = Ia). These interventions should include: ■ treatment of the underlying causes (level of evidence = Ia), ■ non-pharmacological interventions (level of evidence = V), and ■ appropriate use of medications to alleviate the symptoms of delirium and/or manage pain (level of evidence = Ia).	Ia & V
	Recommendation 4.6: Educate persons who are at risk for or are experiencing delirium and their families/care partners about delirium prevention and care.	V
5.0 Evaluation	Recommendation 5.1: Monitor older adults who are experiencing delirium for changes in symptoms at least daily using clinical assessments/observations and validated tools, and document the effectiveness of interventions.	V

PRACTICE RECOMMENDATIONS RECOMMENDATIONS RELATED TO **DEMENTIA**		LEVEL OF EVIDENCE
6.0 Assessment	Recommendation 6.1a: Assess older adults for possible dementia when changes in cognition, behaviour, mood, or function are observed or reported. Use validated, context-specific screening or assessment tools, and collaborate with the person, his/her family/care partners, and the interprofessional team for a comprehensive assessment. Recommendation 6.1b: Refer the person for further assessment/diagnosis if dementia is suspected.	Ia & V Ia
	Recommendation 6.2: Assess the physical, functional, and psychological status of older adults with dementia or suspected dementia, and determine its impact on the person and his/her family/care partners using comprehensive assessments and/or standardized tools.	V
	Recommendation 6.3: Systematically explore the underlying causes of any behavioural and psychological symptoms of dementia that are present, including identifying the person's unmet needs and potential "triggers." Use an appropriate tool and collaborate with the person, his/her family/care partners, and the interprofessional team.	Ia
	Recommendation: 6.4: Assess older adults with dementia for pain using a population-specific pain assessment tool.	Ia
7.0 Planning	Recommendation 7.1: Develop an individualized plan of care that addresses the behavioural and psychological symptoms of dementia (BPSD) and/or the person's personal care needs. Incorporate a range of non-pharmacological approaches, selected according to: ■ the person's preferences, ■ the assessment of the BPSD, ■ the stage of dementia, ■ the person's needs during personal care and bathing, ■ consultations with the person's family/care partners and the interprofessional team, and ■ ongoing observations of the person.	Ia

PRACTICE RECOMMENDATIONS		LEVEL OF EVIDENCE
8.0 Implementation	Recommendation 8.1: Implement the plan of care in collaboration with the person, his/her family/care partners, and the interprofessional team.	V
	Recommendation 8.2: Monitor older adults with dementia for pain, and implement pain-reduction measures to help manage behavioural and psychological symptoms of dementia.	Ia & V
	Recommendation 8.3: Employ communication strategies and techniques that demonstrate compassion, validate emotions, support dignity, and promote comprehension when caring for people with dementia.	Ia
	Recommendation 8.4: Promote strategies for people living with dementia that will preserve their abilities and optimize their quality of life, including but not limited to: ■ exercise (level of evidence = Ia), ■ interventions that support cognitive function (level of evidence = Ia), ■ advanced care planning (level of evidence = Ia), and ■ other strategies to support living well with dementia (level of evidence = V).	Ia & V
	Recommendation 8.5a: Provide education and psychosocial support to family members and care partners of people with dementia that align with the person's unique needs and the stage of dementia.	Ia
	Recommendation 8.5b: Refer family members and care partners who are experiencing distress or depression to an appropriate health-care provider.	V
9.0 Evaluation	Recommendation 9.1: Evaluate the plan of care in collaboration with the person with dementia (as appropriate), his/her family/care partners, and the interprofessional team, and revise accordingly.	V

PRACTICE RECOMMENDATIONS RECOMMENDATIONS RELATED TO **DEPRESSION**		LEVEL OF EVIDENCE
10.0 Assessment	Recommendation 10.1: Assess for depression during assessments and ongoing observations when risk factors or signs and symptoms of depression are present. Use validated, context-specific screening or assessment tools, and collaborate with the older adult, his/her family/care partners, and the interprofessional team.	Ia & V
	Recommendation 10.2: Assess for risk of suicide when depression is suspected or present.	V
	Recommendation 10.3: Refer older adults suspected of depression for an in-depth assessment by a qualified health-care professional. Seek urgent medical attention for those at risk for suicide and ensure their immediate safety.	V
11.0 Planning	Recommendation 11.1: Develop an individualized plan of care for older adults with depression using a collaborative approach. Where applicable, consider the impact of co-morbid dementia.	Ia & V
12.0 Implementation	Recommendation 12.1: Administer evidence-based pharmacological and/or non-pharmacological therapeutic interventions for depression that are tailored to the person's clinical profile and preferences.	Ia & V
	Recommendation 12.2: Educate older adults with depression (and their families/care partners, if appropriate) about depression, self-management, therapeutic interventions, safety, and follow-up care.	V
13.0 Evaluation	Recommendation 13.1: Monitor older adults who are experiencing depression for changes in symptoms and response to treatment using a collaborative approach. Document the effectiveness of interventions and changes in suicidal risk.	V

EDUCATION RECOMMENDATIONS		LEVEL OF EVIDENCE
14.0 Education	Recommendation 14.1: All entry-level health-care programs include content and practice education opportunities that are specific to caring for older adults who have or are suspected of having delirium, dementia, and/or depression, and that are tailored to the discipline's scope of practice.	V
	Recommendation 14.2: Organizations provide opportunities for nurses and other health-care providers to enhance their competency in caring for older adults with delirium, dementia, and depression. Pertinent educational content should be provided during the orientation of new staff and students, and continuously through refresher courses and professional development opportunities.	Ia & V
	Recommendation 14.3: Design dynamic, evidence-based educational programs on delirium, dementia, and depression that support the transfer of knowledge and skills to the practice setting. Such programs should be: ■ interactive and multimodal (level of evidence = Ia), ■ interprofessional (level of evidence = Ia), ■ tailored to address learners' needs (level of evidence = V), ■ reinforced at the point of care by strategies and tools (level of evidence = Ia), and ■ supported by trained champions or clinical experts (level of evidence = Ia).	Ia & V
	Recommendation 14.4: Evaluate educational programs on delirium, dementia, and depression to determine whether they meet desired outcomes, such as practice changes and improved health outcomes. Refine programs as required.	V

ORGANIZATION AND POLICY		LEVEL OF EVIDENCE
15.0 Organization and Policy	**Recommendation 15.1:** Organizations demonstrate leadership and maintain a commitment to foundational principles that support care for older adults with delirium, dementia, and depression, including: ■ person- and family-centred care (level of evidence = Ia), ■ collaborative, interprofessional care (level of evidence = Ia), and ■ healthy work environments (level of evidence = V).	Ia & V
	Recommendation 15.2: Organizations select validated screening and assessment tools for delirium, dementia, and depression that are appropriate to the population and health-care setting, and provide training and infrastructure to support their application.	V
	Recommendation 15.3: Organizations implement comprehensive, multi-component programs, delivered by collaborative teams within organizations, to address delirium, dementia, and depression (level of evidence = Ia). These should be supported by: ■ comprehensive educational programs (level of evidence = V), ■ clinical experts and champions (level of evidence = Ia), and ■ organizational processes that align with best practices (level of evidence = V).	Ia & V
	Recommendation 15.4: Establish processes within organizations to ensure that relevant information and care planning for older adults with delirium, dementia, and depression is communicated and coordinated over the course of treatment and during care transitions.	Ia & V

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Declarations of interest that might be construed as constituting an actual, potential, or apparent conflict were made by all members of the Registered Nurses' Association of Ontario expert panel, and members were asked to update their disclosures throughout the guideline development process. Information was requested about financial, intellectual, personal, and other interests and documented for future reference. No limiting conflicts were identified.

Further details are available from the Registered Nurses' Association of Ontario.

Stakeholder Acknowledgment

As a component of the guideline development process, RNAO is committed to obtaining feedback from nurses from a wide range of practice settings and roles, knowledgeable administrators and funders of health-care services, and stakeholder^{G} associations. Stakeholders representing diverse perspectives were solicited* for their feedback, and RNAO wishes to acknowledge the following individuals for their contribution in reviewing this Guideline.

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*Stakeholder reviewers are individuals who have expertise in the subject matter of the Guideline or are representatives of organizations involved in implementing the Guideline or are affected by its implementation. Reviewers may be nurses and other point-of-care health-care providers, nurse executives, administrators, research experts, members of the interdisciplinary team, educators, nursing students, or patients/family. RNAO aims to solicit stakeholder expertise and perspectives representing diverse health-care sectors, roles within nursing and other professions (e.g., clinical practice, research, education, and policy), and geographic locations.

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Reviewers are asked to read a full draft of the Guideline and participate in the review prior to its publication. Stakeholder feedback is submitted online by completing a survey questionnaire. The stakeholders are asked the following questions about each recommendation:

- Is this recommendation clear?
- Do you agree with this recommendation?
- Is the discussion of evidence thorough and does the evidence support the recommendation?

The survey also provides an opportunity to include comments and feedback for each section of the Guideline.

Survey submissions are compiled and feedback is summarized by the RNAO Guideline development team. The RNAO development team and expert panel review and consider all feedback and, if necessary, modify the Guideline content and recommendations prior to publication to address the feedback received.

Stakeholder reviewers have given consent to the publication of their names and relevant information in this Guideline.

Background Context

Relationship Between Delirium, Dementia, and Depression

Delirium, dementia, and depression in the context of older adults are often discussed and researched independently of one another. However, these three conditions are related in several important ways, and it is essential for health-care providers to be aware of these relationships, particularly when providing care to older adults.

Coexistence and Overlapping Symptoms

Delirium, dementia, and/or depression can coexist (Regan & Varanelli, 2013); for example, a person who has delirium may also have underlying dementia and depression, or a person with dementia may also be depressed with an underlying delirium. Depression is a common neuropsychiatric symptom^{G} of dementia (Brodaty & Arasaratnam, 2012; Enmarker, Olsen, & Hellzen, 2011; Ueda, Suzukamo, Sato, & Izumi, 2013). In addition to the potential for coexistence, delirium, dementia, and depression share common features with overlapping symptoms, which makes it a challenge to determine the correct diagnosis (Development Group of the Clinical Practice Guideline on the Comprehensive Care of People with Alzheimer's Disease and Other Dementias [Development Group], 2010; RNAO, 2010b). For example, due to their similarity, the following can occur:

- hypoactive delirium can be mistaken for depression,
- hyperactive delirium can be mistaken for behavioural disturbance in dementia,
- dementia can be mistaken for depression, and
- depression can be mistaken for dementia.

For a comparison of the clinical features of delirium, dementia, and depression, see **Appendix D**.

Risk Factors and Exacerbation of Existing Conditions

Having delirium, dementia, or depression can increase a person's risk of developing one of the other conditions, can exacerbate an existing condition, or can be a consequence of one of the other conditions. For example, studies have found the following:

- People with cognitive impairment and depression have a higher risk of developing delirium (Flaherty, Gonzales, & Dong, 2011; Inouye, Westendorp, & Saczynski, 2014; Khan et al., 2012).
- Delirium may increase a person's risk of developing dementia (Hshieh et al., 2015; Khan et al., 2012; National Institute for Health and Care Excellence [NICE], 2010) or may worsen the progression of dementia (Clegg, Siddiqi, Heaven, Young, & Holt, 2014).
- People with a diagnosis of dementia have a high prevalence of depressive symptoms (American Medical Directors Association [AMDA], 2011; Orgeta, Qazi, Spector, & Orrell, 2014; Potter, Ellard, Rees, & Thorogood, 2011).
- Experiencing a major episode of depression in later life may increase a person's risk of Alzheimer's dementia (Trangle et al., 2016).
- Depression interacts with and may exacerbate cognitive impairment (Kiosses, Leon, & Arean, 2011).
- Depression may contribute to behavioural symptoms (e.g., aggression) in persons with dementia (Enmarker et al., 2011).

Delirium

Delirium is a complex neuropsychiatric syndrome marked by an acute onset, fluctuating course, altered level of consciousness, inattention, and disorganized thinking (Inouye, 2006, as cited in Marcantonio, 2011; Martinez, Tobar, & Hill, 2015). It is described as an acute condition, usually lasting for one to seven days (Flaherty et al., 2011), although it can persist for days or weeks (AMDA, 2008). Delirium can be thought of as acute brain failure, and may in fact indicate that the person's brain is vulnerable and has diminishing capacity (Inouye et al., 2014). Delirium can signal a medical emergency, and its consequences may include permanent neurological effects (Inouye et al., 2014), the development or worsening of dementia (Clegg et al., 2014; Khan et al., 2012; NICE, 2010), transfer to a long-term care facility (Brooks, 2012; Khan et al., 2012; NICE, 2010), falls, functional decline (Hshieh et al., 2015), and increased risk of death (Brooks, 2012; Khan et al., 2012; NICE, 2010).

Delirium is not uncommon in older adults. It is reported to affect up to 50 percent of hospitalized older adults (Inouye et al., 2014), with higher incidences seen in intensive care units; among people with hip fractures; and among those undergoing surgical procedures, such as cardiac surgery (Holroyd-Leduc, Khandwala, & Sink, 2010; Martinez et al., 2015). Delirium is common in long-term-care settings (AMDA, 2008) and often leads to hospital admission (Clegg et al., 2014). In home-care settings, the incidence of delirium is unclear; however, it is seen frequently among people receiving palliative care. For detailed information regarding delirium at the end of life, see the Canadian Coalition for Seniors Mental Health's (CCSMH) (2010) *Guideline on the Assessment and Treatment of Delirium in Older Adults at the End of Life*.

Causation of delirium is multifactorial. Delirium develops as a result of a combination of predisposing factors (e.g., older age, frailty, cognitive impairment) that create vulnerability, and a variety of precipitating factors (e.g., illness, surgery, immobility, noisy environment) (Clegg et al., 2014; Holroyd-Leduc et al., 2010; Inouye et al., 2014). An older person with multiple morbidities and dementia is at high risk for developing delirium. In this case, even small changes in the person's environment or medical condition may trigger the onset of delirium, whereas a healthy older adult may only develop delirium after being exposed to several precipitating risk factors (Marcantonio, 2011).

There are three main types of delirium:

1. **Hyperactive delirium** is characterized by heightened arousal, restlessness, agitation, delusions, and/or aggressive behaviour.
2. **Hypoactive delirium** is characterized by sleepiness, quieting of symptoms, and/or disinterested behaviour.
3. **Mixed delirium** is characterized by alternating hyperactive and hypoactive states (NICE, 2010).

According to Khurana, Gambhir, & Kishore (2011), hypoactive delirium is the most common type of delirium in older adults, accounting for approximately 65 percent of delirium cases. However, despite its prevalence, it is often overlooked and can be mistaken for dementia or depression (AMDA, 2008; NICE, 2010).

In addition to the three main types of delirium listed above, the literature describes subsyndromal delirium, in which the person presents with some but not all features of delirium (Marcantonio, 2011), and persistent delirium, which describes delirium that lasts to discharge and beyond (Cole, Ciampi, Belzile, & Zhong, 2009). Persistent delirium has been associated with poor outcomes, such as significant increases in cognitive impairment, functional disability, prolonged hospital stay, institutionalization, and fatality (Cole et al., 2009).

In many cases, delirium can be prevented. Multi-component interventions to prevent delirium can reduce incidence rates by approximately 30 percent (Martinez et al., 2015), and organized prevention programs have been found to improve the identification and treatment of delirium (Hshieh et al., 2015; Inouye et al., 2014; Marcantonio, 2011) (see **Recommendation 15.3**).

Dementia

The Alzheimer Society of Ontario (2012, p. 3) defines dementia as "a brain disorder characterized by impaired cognitive functioning that can affect learning and memory, mood and behaviour, as well as the ability to conduct daily activities and high level functions such as management of other chronic conditions." Dementia develops gradually and is progressive, but its manifestation and course can vary considerably, depending on the disease (Development Group, 2010).

"Dementia" can be thought of as an umbrella term for a variety of diseases that create irreversible changes in the brain, including the following: Alzheimer's disease (associated with protein plaques and tangles); vascular dementia (associated with strokes); mixed dementias (any combination of dementias, most commonly Alzheimer's and vascular); dementia with Lewy body disease; frontotemporal dementia; and dementias associated with Creutzfeldt-Jakob disease, Parkinson's disease, and Huntington's disease (Alzheimer Society of Canada, 2015b). In the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association [APA], 2013), these various diseases are classified as major neurocognitive disorders and have specific diagnostic criteria. For a summary of the main types of dementia, see **Appendix E**.

Risk factors depend on the type of dementia, and may include progressive aging (over age 65), vascular risk factors (e.g., hypertension, hypercholesterolemia, and diabetes), family history in first-degree relatives, and depression (Development Group, 2010).

In 2011, the Alzheimer Society of Canada reported that 747,000 older Canadians (almost 15 percent) were living with dementia; by 2031, this number is projected to reach 1.4 million (Alzheimer Society of Canada, 2015a). The World Health Organization (WHO) reports that the prevalence of dementia increases with age, and appears to double every five years after age 65 (WHO, 2012). This is of great concern, given that the number of Ontarians aged 65 years and older is expected to double within the next 20 years, and the majority of these older adults will have at least one chronic disease or condition (Ontario Ministry of Health and Long-Term Care, 2012), some of which are associated with dementia (Development Group, 2010).

While dementia can have a devastating impact on the lives of those who are affected and their families, people with dementia can be active members of society, especially during the earlier stages[G] of the disease. As dementia progresses, health-care providers can collaborate with families to support the person's quality of life and dignity.

Behavioural and psychological symptoms of dementia[G] (BPSD) are estimated to occur in about 80 percent of people with dementia, particularly among people with moderate and advanced stages of the disease (Development Group, 2010; Spector, Orrell, & Goyder, 2013). BPSD is a term used to describe the way a person expresses his/her needs and exhibits symptoms of dementia, including through changes in mood, delusions, apathy, agitation, wandering, calling out, repetitive questioning, and sexual disinhibition[G] (Moniz Cook et al., 2012). It is important to note that these symptoms have been described and defined in numerous ways (see **Appendix A**). Furthermore, the discourse and the philosophical underpinnings around terminology and approaches to care are evolving. Regardless of the terms used, effective management and response to these symptoms is an essential skill for health-care providers (see **Recommendations 6.3** and **7.1**, and **Appendix A** for more information).

When supporting people with dementia, it is also important to provide support and education to the person's family and caregivers[G]. Family members are often central partners in care, and while family caregiving can be rewarding, it can also affect the physical and emotional health of caregivers; in some cases, this may be associated with abuse or neglect of the older adult (for more information, see RNAO's [2014a] BPG *Addressing and Preventing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches*). The WHO (2012) reports that between half and threequarters of all caregivers of people with dementia experience symptoms of depression or anxiety. Providing support and education for caregivers can not only affect the quality of care and quality of life for persons with dementia, but these strategies can also alleviate psychosocial outcomes in caregivers themselves (e.g., caregiver distress, stress, depression, etc.) (Corbett et al., 2012). (See **Recommendations 1.1** and **8.5**).

Depression

The American Medical Directors Association (2011, p. i) has defined depression as "a spectrum of mood disorders characterized by a sustained disturbance in emotional, cognitive, behavioural, and/or somatic regulation that is associated with both significant functional impairment in daily living and often loss of one's capacity for pleasure and enjoyment (anhedonia)." Depression can be chronic, persistent, or recurrent (Krishna et al., 2011), or it can be a reaction to events that are common in the lives of older adults, such as developing an illness, experiencing cognitive decline, losing a loved one, or being admitted to hospital or long-term care (O'Connor, Whitlock, Gaynes, & Beil, 2009). The *DSM–5* outlines diagnostic criteria for the various types of depressive disorders (APA, 2013).

Although depression is common in older adults, it should not be considered a normal part of aging (Trangle et al., 2016). Depression is estimated to affect approximately 35 percent of people in long-term care facilities (AMDA, 2011), and 15 percent of older adults living in the community (Canadian Psychological Association, 2015; Dreizler, Koppitz, Probst, & Mahrer-Imhof, 2014).

Depression can be disabling, and has a tremendous impact on individuals' quality of life and family relationships (Kiosses et al., 2011; Krishna et al., 2011). It can complicate co-morbidities and the management of chronic diseases (Chang-Quan et al., 2009; Samad, Brealey, & Gilbody, 2011). In extreme cases, depression can result in death by suicide (O'Connor et al., 2009; Samad et al., 2011), especially among men over the age of 85 (Butler-Jones, 2010).

Effective treatments for depression are available, and recovery is more likely when depression is identified, is managed effectively, and when the person receives adequate support. Unfortunately, depression is associated with stigma and discrimination (NICE, 2009), and often goes unrecognized by health-care providers (O'Connor et al., 2009). For these reasons, it is important that health-care providers possess the skills, knowledge, attitudes, and abilities to effectively assess for and provide care to older adults with depression.

Guiding Principles and Assumptions

The following general principles inform the recommendations in this Guideline:

- Each older adult is a distinctly unique human being with his/her own life experiences, strengths, preferences, cultural practices, values, and beliefs.
- All older adults deserve equal access to high-quality care that is based on the best available evidence and is provided by knowledgeable, skilled, and compassionate health-care providers.
- Older adults with delirium, dementia, and/or depression deserve to be treated with dignity by health-care providers and to take part in caring human interactions.
- The health-care provider's attitudes, behaviours, and communication style during interactions with older adults, and the language used to describe symptoms or behaviours related to delirium, dementia, and/or depression, are powerful; as such, ongoing education and reflective practice[G] in relation to these topics is important.
- Person- and family-centred care[G] is essential to the care of older adults with delirium, dementia, and/or depression.
- A recovery perspective[G]—and an approach to care that promotes well-being, the reduction of symptoms, and/or the accommodation of behaviours—is beneficial to older adults, especially those with long-term conditions.

- Quality of life for older adults with delirium, dementia, and/or depression is best optimized according to what the individual person values. Quality of life is subjective, as expressed by the person: the person determines what quality of life means for him/her.

The following assumptions underlie the recommendations in this Guideline and their application in practice:

- "Family" is whomever the person considers to be family. Family members are often central to the lives of older adults and may be active partners in care.
- Health-care providers value and engage family, recognizing that some people do not have family, that others may not want or need their family to be involved, and that family members are not always willing or able to help.
- Health-care providers communicate assessments, care plans, interventions, and evaluations of care to other members of the health-care team, to families/care partners, and across care settings (as appropriate) through verbal communication and formal documentation processes.
- Health-care providers practice within their scope of knowledge and abilities, and adhere to legal and ethical principles.

Flow Charts

The following flow charts summarize the steps, context, and considerations involved in the assessment and care of persons with delirium, dementia, and/or depression. References to recommendations in this Guideline are included in parentheses.

Flow Chart For Delirium, Dementia, and Depression

Therapeutic relationship, cultural sensitivity, person- and family-centred care (R 1.1); engage appropriate substitute decision-maker, as needed (R 1.4b)

- Identify signs, symptoms, and risk factors of delirium, dementia, and depression (R 1.2)
- Differentiate between indications of delirium, dementia, and depression (R 1.2, 2.1, 6.1)

At Risk of Delirium

- Develop a tailored, non-pharmacological delirium prevention plan (R 3.1)
- Implement prevention plan (R 4.1)
- Assess at-risk older adults for delirium at least daily (R 4.2)

Possible Dementia

- Assess for dementia using validated tools & collaborative assessments (R 6.1a)
- Assess impact of dementia on the person and his/her family (R 6.2);
- Explore underlying causes of BPSD (R 6.3)
- Assess for pain (R 6.4)

Possible Depression

- Assess for depression when risk factors or signs and symptoms are present (R 10.1)
- Assess for suicide risk (R 10.2)

- Refer to appropriate clinician(s), team, or service for further assessment and diagnosis (R 1.3, 6.1b)
- Possible delirium and suicidal ideation require urgent attention (R 1.3, 10.3)

Positive for delirium:

- Identify causes (R 4.4)
- Implement multicomponent interventions to manage delirium (R 4.5)
- Educate the person and his/her family (R 4.6)

Negative for delirium:

- Continue preventative measures (R 4.3)

- Develop an individualized plan of care to address BPSD and personal care needs (R 7.1)
- Implement the plan of care (R 8.1)
- Monitor for and manage pain (R 8.2)
- Communicate effectively (R 8.3)
- Promote strategies to preserve abilities and optimize quality of life (R 8.4)

- Develop an individualized plan of care (R 11.1)
- Administer tailored pharmacological and/or non-pharmacological interventions (R 12.1)

- Education and support for the person and his/her family (R 4.6, 8.5a, 12.2)

- Ongoing assessment, evaluation, and follow-up care
- Collaborate to revise care plan according to evolving needs and preferences (R 1.3, 5.1, 9.1, 13.1)

Documentation & communication (R 1.3); appropriate medication use (R 1.5); restraint as a last resort (R 1.6)

Flow Chart For Delirium

ASSESSMENT

- Assess for delirium risk factors (R 2.1)

PLANNING

- Develop a tailored, non-pharmacological delirium prevention plan (R 3.1)

IMPLEMENTATION

- Implement prevention plan (R 4.1)

- Assess at-risk older adults for delirium at least daily (R 4.2)

- Refer for assessment and diagnosis (R 1.3)
- Identify causes of delirium (R 4.4)

- Continue to provide preventative measures (R 4.3)

- Implement multicomponent interventions to manage delirium (R 4.5)

- Educate the person and his/her family (R 4.6)

EVALUATION

- Monitor symptoms and document effectiveness of interventions (R 5.1)

Documentation & communication (R 1.3); appropriate medication use (R 1.5); restraint as a last resort (R 1.6)

Therapeutic relationship, cultural sensitivity, person- and family-centred care (R 1.1); engage appropriate substitute decision-maker, as needed (R 1.4b)

Flow Chart For Dementia

Documentation & communication (R 1.3); appropriate medication use (R 1.5); restraint as a last resort (R 1.6)

ASSESSMENT

- Identify signs and symptoms of dementia (R 1.2)
- Assess for dementia using validated tools & collaborative assessments (R 6.1a)
- Refer for further assessment/diagnosis (R 1.3, 6.1b)
- Assess physical, functional, and psychological status, and impact of changes on the person and his/her family (R 6.2)
- Explore underlying causes of BPSD (R 6.3)
- Assess for pain (R 6.4)

PLANNING

- Develop an individualized plan of care to address BPSD and personal care needs (R 7.1)

INTERVENTION

- Implement the plan of care (R 8.1)
- Monitor for and manage pain (R 8.2)
- Communicate effectively (R 8.3)
- Promote strategies to preserve abilities and optimize quality of life (R 8.4)
- Educate and support family (R 8.5a)
- Refer distressed caregivers to health-care providers (R 8.5b)

EVALUATION

- Evaluate the plan of care and revise accordingly (R 9.1)

Therapeutic relationship, cultural sensitivity, person- and family-centred care R 1.1); engage appropriate substitute decision-maker, as needed (R 1.4b)

Flow Chart For Depression

Documentation & communication (R 1.3); appropriate medication use (R 1.5); restraints as a last resort (R 1.6)

ASSESSMENT

- Risk factors or signs and symptoms of possible depression are identified (R 1.2, 10.1)
- Assess for depression when risk factors or signs and symptoms are present (R 10.1)
- Assess for suicide risk (R 10.2)

Depression suspected; Risk of suicide

- Refer for further assessment and diagnosis (R 1.3)
- Urgent attention for those at risk for suicide (R 10.3)

PLANNING

- Develop an individualized plan of care for depression (R 11.1)

INTERVENTION

- Administer tailored pharmacological and/or non-pharmacological interventions (R 12.1)
- Educate the older adult and his/her family (R 12.2)

EVALUATION

- Monitor depression and response to treatment, and changes in suicide risk (R 13.1)

Therapeutic relationship, cultural sensitivity, person- and family-centred care (R 1.1); engage appropriate substitute decision-maker, as needed (R 1.4b)

Practice Recommendations

OVERARCHING RECOMMENDATIONS RELATED TO **DELIRIUM, DEMENTIA,** AND **DEPRESSION**

1.0 GENERAL RECOMMENDATIONS

RECOMMENDATION 1.1:

Establish therapeutic relationships and provide culturally sensitive person- and family-centred care when caring for and providing education to people with delirium, dementia, and depression and their families and care partners.

Level of Evidence = Ia & V

Discussion of Evidence:

The expert panel emphasizes that health-care providers must demonstrate behaviours and skills that support care for people with delirium, dementia, and depression and their families. This includes establishing and maintaining therapeutic relationships^G, and demonstrating cultural sensitivity^G and person- and family-centred-care attitudes and behaviours^G. The expert panel points out that these skills are essential, not only in order to provide quality care, but because of the sensitive nature of these conditions and the possibility of stigma associated with a diagnosis (especially dementia and depression). Note: some health-care providers may refer to a similar and complementary concept, relational practice^G (e.g., listening, empathy, reflection), to describe some of these behaviours and skills.

The College of Nurses of Ontario (CNO) (2013) and RNAO (2006a) highlight the importance of therapeutic relationships as a foundational nursing skill. Therapeutic relationships involve establishing trust and rapport, and using effective communication skills (CNO, 2013). They require self-awareness, self-knowledge, and empathy on the part of nurses and other health-care providers (RNAO, 2006a).

Evidence from systematic reviews and clinical guidelines on this topic suggests that person- and family-centred care must be a central element of care for people with delirium, dementia, and depression (Cabrera et al., 2015; Enmarker et al., 2011; Konno, Stern, & Gibb, 2013; Lawrence, Fossey, Ballard, Moniz-Cook, & Murray, 2012; Livingston et al., 2014; NICE, 2009, 2010; Spenceley, Sedgwick, & Keenan, 2015). Person- and family-centred behaviours and skills involve knowing the person holistically, honouring autonomy and decision-making, sharing power, and communicating verbally and non-verbally in ways that show respect and caring (RNAO, 2015b).

It is also important to take a person- and family-centred approach when providing education to people and their families/care partners. Education should be provided in a way that is understandable and culturally appropriate, that promotes dialogue, and that is tailored to the needs and abilities of older adults and their families (American Geriatrics Society [AGS], 2014; CCSMH, 2010; Elvish, Lever, Johnstone, Cawley, & Keady, 2013; NICE, 2010; Topo, 2009). In some cases, interpreters or cultural mediators may be necessary to facilitate learning. As well, supplementary resources, such as handouts, videos, and Internet links, can be offered to support learning (Development Group, 2010).

For additional information to support this recommendation, refer to the following resources:

- **CNO**:
    - **Culturally Sensitive Care**
      http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf
    - **Therapeutic Nurse–Client Relationship**
      http://www.cno.org/Global/docs/prac/41033_Therapeutic.pdf
- **RNAO:**
    - **Embracing Cultural Diversity in Health Care: Developing Cultural Competence**
      http://RNAO.ca/bpg/guidelines/embracing-cultural-diversity-health-care-developing-cultural-competence
    - **Establishing Therapeutic Relationships**
      http://RNAO.ca/bpg/guidelines/establishing-therapeutic-relationships
    - **Person- and Family-Centred Care**
      http://RNAO.ca/bpg/guidelines/person-and-family-centred-care

RECOMMENDATION 1.2:

Identify and differentiate among signs and symptoms of delirium, dementia, and/or depression during assessments, observations, and interactions with older persons, paying close attention to concerns about changes expressed by the person, his/her family/care partners, and the interprofessional team.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends that health-care providers be alert for signs and symptoms of delirium, dementia, and depression so that these conditions are identified and treated as soon as possible. This is important, given the prevalence of these conditions among older adults (see the discussion under Background Context) and the fact that symptoms are often overlooked or misinterpreted (NICE, 2009). Furthermore, early recognition can lead to timely structured assessments, diagnosis, treatment, and care (AMDA, 2012; U.S. Preventative Services Task Force, 2014).

Health-care providers may identify or observe signs and symptoms of delirium, dementia, and/or depression during assessments, ongoing observations, conversations, and encounters with older adults. Family members are often familiar with a person's baseline cognition, function, mood, and behaviour, and will raise concerns about changes (Inouye et al., 2014). These changes, noted by the family or by the person himself/herself, require careful consideration and follow-up assessment. Family members may also be in a position to corroborate assessments (NICE, 2009), especially if there are concerns about capacity or lack of insight.

Health-care providers must be able to differentiate among signs and symptoms of delirium, dementia, and depression, because these conditions may co-exist and have overlapping clinical features (Regan & Varanelli, 2013). **Appendix D**, which highlights the clinical features of each, can be used to help distinguish unique indicators. It should be noted that the presence of other co-morbid conditions may also make assessment and diagnosis a challenge (Development Group, 2010). For example, depression in older adults complicates or is masked by certain co-morbid conditions, such as hypothyroidism, as demonstrated in a systematic review rated moderate for methodological quality (Chang-Quan et al., 2009). (For more information on methodological quality ratings, see **Appendix C.**)

RECOMMENDATION 1.3:

Refer older adults suspected of delirium, dementia, and/or depression to the appropriate clinicians, teams, or services for further assessment, diagnosis, and/or follow-up care.

Level of Evidence = Ia

Discussion of Evidence:

Whenever delirium, dementia, or depression is suspected, health-care providers should make referrals to the most appropriate clinician(s), team, or service in their area for a comprehensive assessment and diagnosis, as supported by a moderately rated literature review and a clinical guideline (Inouye et al., 2014; NICE, 2010).

The diagnostic process may require additional cognitive assessments to rule out differential diagnosis (i.e., alternative diagnoses) (Inouye et al., 2014). In some cases, co-morbid conditions may need to be managed or treated before an accurate diagnosis can be made. Clinical assessments and diagnostic tests may be required to support a diagnosis (see the study by Inouye et al., 2014 for examples of common tests to evaluate the causes of delirium). Depending on the situation, referrals can be made to primary care providers[G], specialized geriatric services, specialized geriatric psychiatry services, neurologists, and/or members of the interprofessional team (RNAO, 2010b).

Health-care providers should keep in mind the following recommendations, which are supported by clinical guidelines and expert panel opinion, when referring or communicating their findings to other members of the health-care team (the list is not exhaustive):

- If delirium or risk of suicide is suspected, health-care providers should **take immediate action** to refer individuals to the appropriate services (see **Recommendation 10.3**).
- When it is difficult to differentiate between a diagnosis of delirium, dementia, or delirium superimposed on dementia, delirium should be treated first.
- Hypoactive delirium can be misinterpreted as depression and requires careful assessment.
- Often, depression must be treated before a diagnosis of dementia can occur (AMDA, 2008; Development Group, 2010; NICE, 2010).

RECOMMENDATION 1.4a:

Assess the person's ability to understand and appreciate information relevant to making decisions and, if concerns arise regarding the person's mental capacity, collaborate with other members of the health-care team as necessary.

Level of Evidence = V

Discussion of Evidence:

A person's mental capacity[G], or his or her ability to understand information relevant to making a decision and appreciate the consequences of a decision or lack of a decision (*Health Care Consent Act, 1996*), may be compromised if he or she has delirium, dementia, or depression. In their day-to-day interactions and conversations, health-care providers can use their clinical judgment to assess whether or not a person can understand and appreciate information, and make decisions. However, making such determinations can be complicated. The expert panel points out the following:

- A person's ability to understand and appreciate information may vary—for example, it can fluctuate throughout the day or over the course of an illness (e.g., acute delirium and sundowning[G]). Therefore, assessments in this area may need to be ongoing.
- A person may be able to make decisions in some areas but not others.
- A diagnosis of dementia does not automatically mean that a person lacks mental capacity.

If concerns about a person's mental capacity arise, health-care providers should collaborate with other members of the health-care team to determine the best course of action. In some instances, a formal capacity assessment will be conducted to determine a person's legal mental capacity, and a substitute decision-maker[G] will be appointed. For example, in Ontario, a power of attorney (for personal care or property) may be predetermined. See **Recommendation 1.4b** and **Appendix J**, Resources, for additional information and resources.

RECOMMENDATION 1.4b:

Support the older person's ability to make decisions in full or in part. If the older person is incapable of making certain decisions, engage the appropriate substitute decision-maker in decision-making, consent, and care planning.

Level of Evidence = V

Discussion of Evidence:

In keeping with principles of person-centred care, the expert panel recommends that nurses and other health-care providers support individuals to direct and participate in their care to the best of their abilities, promote informed consent[G], and respect individuals' choices.

The expert panel points out that many people may wish to have assistance to make decisions in full or in part, depending on their abilities. Nurses and other health-care providers can engage in dialogue with the older adult to determine the level of support desired in decision-making.

When a person is unable to make certain decisions for themselves, an appropriate substitute decision-maker should be involved. As stated in RNAO's (2010a) BPG *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression*, the health-care provider must identify the appropriate substitute decision-maker and engage them in decision-making, consent, and care planning.

For more detailed information about consent, capacity, and substitute decision-making (e.g., powers of attorney) in Ontario, see **Appendix J.** For information on advanced care planning, see **Recommendation 8.4**.

RECOMMENDATION 1.5:

Exercise caution in prescribing and administering medication to older adults (within the health-care provider's scope of practice), and diligently monitor and document medication use and effects, paying particular attention to medications with increased risk for older adults and polypharmacy.

Level of Evidence = Ia

Discussion of Evidence:

Prudent use of medications in older adults is important, given the risk of serious side effects and the impact that potentially inappropriate medications and polypharmacy[G] may have on delirium, dementia, and depression (Brooks, 2012; Clegg et al., 2014; Conn, Gibson, & McCabe, 2014; Holroyd-Leduc et al., 2010; Inouye et al., 2014; Khan et al., 2012; NICE, 2011; Trangle et al., 2016). Cautious use of psychotropic medications[G] is particularly important in settings that have had high rates of use—namely, hospital and long-term care settings (Conn et al., 2014).

The risks associated with medication use in older adults have been highlighted in moderate and strongly rated reviews and clinical guidelines, and include the following:

- Medications (e.g., psychoactive medications and sedative-hypnotics) and polypharmacy contribute to an increased risk of delirium (Brooks, 2012; Holroyd-Leduc et al., 2010; Inouye et al., 2014; Khan et al., 2012); they may also prolong delirium or cause excessive sedation (Inouye et al., 2014). An increased risk exists when the medications are used with frail, older adults (Clegg et al., 2014).
- Some medications (e.g., steroids) may be associated with major depression (Trangle et al., 2016).
- Among people with depression who are at risk for suicide, potential drug interactions and toxicity in overdose of antidepressants and/or other medications should be considered, and the amount of drugs available limited (as required) (NICE, 2011).
- In general, antipsychotic medications[G] may increase the risk of adverse effects—for example, cerebrovascular events and death (Conn et al., 2014) (see **Recommendation 7.1**).

Despite these risks, pharmacological interventions in people with delirium, dementia, and depression are sometimes appropriate and may be an important aspect of care. Benefits and uses of pharmacological interventions cited in clinical guidelines and one moderately rated systematic review include the following:

- Analgesics for pain management are important, because pain can contribute to delirium (AGS, 2014; CCSMH, 2010; Conn et al., 2014; NICE, 2010) and can precipitate behavioural and psychological symptoms of dementia (Pieper et al., 2013).

- Cautious short-term antipsychotic use may be appropriate for some cases of delirium (see **Recommendation 4.5**).
- Acetylcholinesterase inhibitors and other medications (e.g., memantine) may be appropriate for specific and symptomatic treatment/management of some forms of dementia (Development Group, 2010).
- Pharmacological management of behavioural and psychological symptoms of dementia in specific circumstances may be required to ensure safety (Development Group, 2010; U.S. Preventative Services Task Force, 2014).
- Antidepressant therapy may be an important aspect of treatment, especially for people with severe or persistent depression (Conn et al., 2014; NICE, 2009, 2012b) (see **Recommendation 12.1**).

The expert panel recommends that health-care providers collaborate to reduce the potential harms associated with polypharmacy and potentially inappropriate medications, such as those outlined in Beers Criteria and STOPP/START criteria. For more information, see **Appendix F**, Resources for Optimal Medication Use in Older Adults.

To support appropriate prescribing, administration, monitoring, and documentation of medication in older adults, the expert panel recommends that nurses and other health-care providers consider the following actions. The asterisk symbol (*) indicates content provided by the RNAO expert panel.

- Carefully review all medications, including over-the-counter and "as needed" medications, especially during care transitions (e.g., discharge home from the hospital or admission to a long-term care facility).*
- Participate in medication reconciliation whenever possible. A pharmacist may be needed to support medication review/reconciliation, especially in cases of polypharmacy.*
- Implement non-pharmacological interventions as the first line of care for management of delirium, dementia, and milder forms of depression (Conn et al., 2014; Inouye et al., 2014; Moniz Cook et al., 2012).
- Carefully weigh the potential benefits of pharmacological intervention versus the potential for harm (Conn et al., 2014).
- Consider the metabolism of the drug and how it is affected by other medications, health conditions, and physiological changes (Trangle et al., 2016).
- To help prevent delirium, reduce the number or type of medications used for sedation and for analgesia (Inouye et al., 2014).
- Pharmacological management of BPSD should be used only for severe symptoms (e.g., marked risk/safety, severe agitation, disability, or suffering) (Conn et al., 2014; U.S. Preventative Services Task Force, 2014) and should not be used as a chemical restraint for behaviours such as wandering.*
- Start with the least intrusive and most effective intervention (NICE, 2009, 2012b); aim for the lowest possible effective dosage and optimize a single agent.*
- Document the rationale for pharmacological interventions to manage delirium or BPSD, closely monitor for adverse reactions, and document the effects of medications on target symptoms.*
- Advocate for re-evaluation, change in medication, titration to higher or lower doses, and discontinuation/de-prescribing if pharmacological interventions are ineffective or adverse effects are identified.*

To support uptake of this recommendation and for more detailed information for practitioners who are prescribing medication for older adults, refer to **Appendix F**.

RECOMMENDATION 1.6:

Use principles of least restraint/restraint as a last resort when caring for older adults.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends that health-care providers utilize principles of least restraint and use restraint as a last resort when caring for older adults. Restraints[G] include physical, chemical, or environmental measures to control physical or behavioural activity (CNO, 2009b) (see **Appendix A** for more information). This recommendation is in keeping with recommendations in the previous RNAO BPG on the topic of delirium, dementia, and depression (RNAO, 2010a) and RNAO best practices for minimizing restraint use (RNAO, 2012a).

Physical restraints may be required for people with delirium in certain cases (e.g., risk of extubation); however, restraints are associated with an increased risk of delirium (Brooks, 2012; Inouye et al., 2014) and should be avoided as much as possible. See **Recommendations 1.6** and **4.5** for further discussion regarding pharmacological interventions for people with delirium.

It is also recommended that restraints be used as a last resort for people with dementia. One clinical guideline points out that restraints may be necessary for pronounced and potentially harmful agitation when alternative approaches have been ineffective (Development Group, 2010).

If restraints are deemed necessary, the least restraint (i.e., the least restrictive form of restraint) should be applied (CNO, 2009b). Furthermore, the health-care provider should maintain appropriate documentation (e.g., justification of restraint), actively monitor and reevaluate restraint use, and provide education and reassurance to the person and his/her family.

Health-care providers should also be aware of legislation or policies regarding restraint use that are applicable to their setting and scope of practice.

Refer to RNAO's (2012a) BPG *Promoting Safety: Alternative Approaches to the Use of Restraints* for more detailed information and resources (e.g., de-escalation techniques, ABC Charting, etc.).

RECOMMENDATIONS RELATED TO **DELIRIUM**

2.0 ASSESSMENT

RECOMMENDATION 2.1:

Assess older adults for delirium risk factors on initial contact and if there is a change in the person's condition.

Level of Evidence = Ia & V

Discussion of Evidence:

Older adults at risk for delirium must be identified so that health-care providers can monitor them closely and implement preventative interventions (Inouye et al., 2014). This is important not only because delirium has serious consequences—including an increased risk of dementia and death (NICE, 2012a)—but also because delirium often goes unrecognized by health-care providers (Inouye et al., 2014; Khan et al., 2012; LaMantia, Messina, Hobgood, & Miller, 2014) and is potentially preventable (Martinez et al., 2015).

Delirium is a complex phenomenon. It is rarely caused by a single risk factor, but rather by (1) a combination of multiple predisposing factors that create vulnerability, and (2) various precipitating factors (Clegg et al., 2014; Holroyd-Leduc et al., 2010; Inouye et al., 2014). In the hospital setting, the highest incidence of delirium occurs within acute care and intensive care units and among people with hip fracture, as well as those undergoing cardiac surgery (Martinez et al., 2015). People living in long-term care facilities with moderate to severe cognitive impairment are at particularly high risk for delirium, which may be triggered by a relatively minor occurrence such as a new medication, minor infection, or a change in environment (Clegg et al., 2014).

Health-care providers can use a list of delirium risk factors to assess older adults. Many risk factors have been validated in the literature. These include a variety of *predisposing factors*, such as advanced age, cognitive impairment, and depression, and *precipitating factors*, such as multiple medications, acute illness and associated abnormal blood values, and the use of physical restraints (Brooks, 2012; Inouye et al., 2014; Khan et al., 2012). The expert panel stresses the importance of paying attention to factors in the environment and care delivery that profoundly compound risk—for example, immobility, sleep deprivation, the use of high-risk medications, and poorly controlled pain (AGS, 2014; Brooks, 2012; CCSMH, 2010; Gage & Hogan, 2014; Inouye et al., 2014; NICE, 2010). For a list of common risk factors and interventions, see **Appendix G**.

The National Institute for Health and Care Excellence (2010) guideline *Delirium: Diagnosis, Prevention and Management* recommends that health-care providers assess people for delirium risk factors upon first presentation to a hospital or long-term care facility and remain vigilant for the emergence of risk factors thereafter. Furthermore, because of the severe consequences of delirium, health-care providers must always "think delirium" (NICE, 2010). In other words, they should suspect and be vigilant for delirium among people at risk, especially those at high risk (e.g., advanced age, hip fracture, cognitive impairment, severe illness, and extensive surgery) (AGS, 2014; NICE, 2010).

Literature from the systematic review did not identify recommendations regarding how to assess for delirium in settings outside of hospital or long-term-care facilities. However, the expert panel recommends that health-care providers in community settings, such as home-care and primary care, also "think delirium," and identify and communicate delirium risk factors to other health-care team members, and to older adults and their families.

3.0 PLANNING

RECOMMENDATION 3.1:

Develop a tailored, non-pharmacological, multi-component delirium prevention plan for the person at risk for delirium in collaboration with the person, his/her family/care partners, and the interprofessional team.

Level of Evidence = Ia

Discussion of Evidence:

A comprehensive literature review, rated moderate for methodological quality, found that health-care providers must develop a delirium prevention plan for people at risk for delirium that is tailored to the person's particular risk factors (Inouye et al., 2014). This recommendation is also supported by NICE's (2010) *Delirium: Diagnosis, Prevention and Management* guideline.

The expert panel recommends that prevention efforts be focused on people most at risk for delirium. While there are a range of ways to determine risk, delirium experts on the panel suggest that the following high-risk category, established by Inouye et al. (1999), can be used: **adults 70 years and older with one or more risk factors** (see **Appendix G**).

When developing a prevention plan for a person at risk for delirium, the health-care provider must identify and document why the person is at risk (i.e., which risk factors pertain to the individual). Once the risk factors are identified, a prevention plan that is feasible for the clinical setting, including a range of non-pharmacological measures, can be developed to target the person's risk factors (NICE, 2010; RNAO, 2010a). The prevention plan should be developed collaboratively, because a range of preventative measures involve the person's family and members of the interprofessional team (CCSMH, 2010; Khan et al., 2012; NICE, 2010).

For a list of multi-component interventions to prevent delirium that align with particular risk factors, see **Appendix G**.

4.0 IMPLEMENTATION

RECOMMENDATION 4.1:

Implement the delirium prevention plan in collaboration with the person, his/her family/care partners, and the interprofessional team.

Level of Evidence = Ia

Discussion of Evidence:

Multi-component, non-pharmacological interventions are recommended for the prevention of delirium among at-risk older adults (Holroyd-Leduc et al., 2010; Hshieh et al., 2015; Inouye et al., 2014; Khan et al., 2012; Martinez et al., 2015). A meta-analysis, rated strong in methodological quality, reported that multi-component interventions to prevent delirium caused a relative reduction of 30 percent in incident delirium (i.e., delirium that develops while a person is hospitalized); this finding was applicable across a variety of hospital settings and among people with cognitive decline (Martinez et al., 2015). In addition to preventing delirium, multi-component, non-pharmacological interventions have been found to prevent falls (Hshieh et al., 2015; Martinez et al., 2015), to potentially help reduce the length of stay for those in acute care, and may help avoid institutionalization (Hshieh et al., 2015). For a list of multi-component interventions to prevent delirium that align with particular risk factors, see **Appendix G**.

Non-pharmacological interventions are also recommended because there is insufficient evidence to support the use of pharmacological interventions to prevent delirium (Gage & Hogan, 2014; Holroyd-Leduc et al., 2010). Furthermore, some medications (e.g., psychoactive medications and sedative-hypnotics) and polypharmacy contribute to delirium risk (Brooks, 2012; Holroyd-Leduc et al., 2010; Inouye et al., 2014; Khan et al., 2012). An important part of delirium prevention involves reducing the number and type of certain medications used for sedation and analgesia (e.g., anticholinergic medications) (Inouye et al., 2014).

Less research exists concerning delirium prevention in the long-term care setting (see Research Gaps and Future Recommendations). A Cochrane review regarding the prevention of delirium in long-term care, rated strong for methodological quality, found few prevention studies, although a pharmacist-led medication review program involving software (single intervention) was found to be effective (Clegg et al., 2014). No intervention studies for delirium prevention in the home-care sector were found in the systematic review for this Guideline. Despite this gap, the expert panel points out that many of the preventative interventions (e.g., encouraging mobilization, orientation strategies, promoting optimal bowel function, promoting quality sleep, and ensuring pain control) are a standard of care for all settings.

The implementation of delirium prevention interventions is a collaborative effort. It requires the involvement of various members of the interprofessional team, and may involve family members/care partners—for example, to stay with the person and reduce isolation (AMDA, 2008; CCSMH, 2010; NICE, 2010). For examples of preventative interventions, see **Appendix G**. For information about comprehensive programs to address delirium, see **Recommendation 15.3**.

RECOMMENDATION 4.2:

Use clinical assessments and validated tools to assess older adults at risk for delirium at least daily (where appropriate) and whenever changes in the person's cognitive function, perception, physical function, or social behaviour are observed or reported.

Level of Evidence = Ia & V

Discussion of Evidence:

A moderately rated systematic review found that health-care providers should use a structured approach to identify delirium (Khan et al., 2012). This is important because, among other consequences, delirium can signal a medical emergency that may lead to permanent neurological effects (Inouye et al., 2014), and early recognition enables prompt treatment.

Assessing Older Adults at Risk

As noted in the discussion of evidence for Recommendation 4.1, numerous factors have been identified that put an older adult at risk for delirium (see **Appendix G**). The expert panel recommends that health-care providers focus their efforts on assessing those individuals at risk for delirium. As stated in Recommendation 3.1, the expert panel suggests that this should include adults **70 years and older with one or more risk factors**.

Health-care providers must be able to recognize signs of delirium among older adults (see **Recommendation 14.2**). Table 1 provides an overview of common changes indicative of delirium found in NICE's (2010) guideline *Delirium: Diagnosis, Prevention and Management*, with examples added by the RNAO expert panel.

Table 1: Changes That May Indicate Delirium

TYPE OF CHANGE	EXAMPLES

Note: Changes indicative of hypoactive delirium are italicized. Hypoactive delirium is particularly important because it is common but often overlooked (NICE, 2010). Examples added by the expert panel are indicated with an asterisk (*).

Source: Adapted from NICE, 2010, p. 11.

Frequency of Assessment

The frequency of delirium assessment is not specifically outlined in the literature. NICE's (2010) guideline *Delirium: Diagnosis, Prevention and Management* recommends that health-care providers working in hospital or long-term care settings observe people **at least daily** for recent (e.g., within hours or days) changes or fluctuations in behaviour. The expert panel agrees that assessment in most settings should occur at least daily, but may need to be more frequent (e.g., every shift) in situations or acute settings with known high incidences of delirium (e.g., older adults post-surgery, ICU) or when, based on clinical judgment, the person requires close monitoring. In home-care settings, daily assessments may not be feasible except among those receiving daily home visits or end-of-life care. For detailed guidance on the care of people with delirium at the end of life, see CCSMH's (2010) *Guideline on the Assessment and Treatment of Delirium in Older Adults at the End of Life*.

Overall, it is important to identify and treat delirium early, but the frequency of screening depends on the population and setting. Organizational policies should outline parameters for delirium screening, including which screening tool is appropriate and feasible, based on the population served. See **Recommendation 15.2** for more information.

Choice of Assessment/Screening Tools

Several tools have been developed to assist health-care providers to identify delirium. Most frequently cited and supported in the literature is the Confusion Assessment Method (CAM) tool (Brooks, 2012; Holroyd-Leduc et al., 2010; Inouye et al., 2014; LaMantia et al., 2014; Wong, Holroyd-Leduc, Simel, & Straus, 2010), which examines key features of delirium such as acute change in mental status, inattention, disorganized thinking, and level of consciousness, and the CAM-ICU tool for critical care or recovery room screening (Brooks, 2012; NICE, 2010). The CAM was often found to be an effective tool for use in a variety of clinical settings, although no research was found to support its use within home-care settings or the community (Brooks, 2012; LaMantia et al., 2014; Wong et al., 2010).

In a systematic review by Khan et al. (2012) that was rated moderate for methodological quality, it was suggested that alternative screening tools are needed because the CAM takes time and may be ineffective if used by untrained providers. New tools are emerging (NICE, 2012a), but appropriate tools are lacking for some settings, such as the emergency department (LaMantia et al., 2014; Parke, Beaith, Slater, & Clarke, 2011). The expert panel points out that various other screening tools have been developed. See **Appendix H** for a list of these tools.

Changes Reported by Family

In addition to using a screening tool to identify signs of delirium, Inouye et al., (2014) found that health-care providers must pay attention to observed or reported changes from a person's baseline behaviour, especially when changes are noticed by family or others who know the person well. They emphasized that statements such as "she's just not herself" warrant close attention. Not only are family members familiar with the person's baseline mental status, they often provide important insight into the history and the series of events leading up to the onset of delirium symptoms.

RECOMMENDATION 4.3:

Continue to employ prevention strategies when caring for older adults at risk for delirium who have not been identified as having delirium.

Level of Evidence = Ia & V

Discussion of Evidence:

Health-care providers should maintain prevention efforts for older adults at risk for delirium, even if daily assessments do not indicate that they have delirium. See **Recommendations 2.1, 3.1**, and **4.1** for supporting evidence.

RECOMMENDATION 4.4:

For older adults whose assessments indicate delirium, identify the underlying causes and contributing factors using clinical assessments and collaboration with the interprofessional team.

Level of Evidence = Ia

Discussion of Evidence:

Evidence from a moderately rated meta-analysis encompassing 14 interventional studies highlights the importance of identifying the underlying causal factors of delirium so that interventions can target these causes and the delirium can be actively managed (Hshieh et al., 2015). Delirium is often precipitated by multiple factors and events (Inouye et al., 2014). Health-care providers must investigate which factors are contributing to delirium. These may include factors such as constipation or pain, coupled with disturbed sleep and immobility. See **Appendix G**.

Investigation into the causes and contributing factors of delirium may involve a history-taking with corroboration from family or staff, medication review, pain assessment, physical or neurological examination, and specific laboratory tests or imaging (Inouye et al., 2014). Referrals to primary care providers and to specialists may also be required.

RECOMMENDATION 4.5:

Implement tailored, multi-component interventions to actively manage the person's delirium in collaboration with the person, the person's family/care partners, and the interprofessional team (level of evidence = Ia).

These interventions should include:

- treatment of the underlying causes (level of evidence = Ia),
- non-pharmacological interventions (level of evidence = V), and
- appropriate use of medications to alleviate the symptoms of delirium and/or manage pain (level of evidence = Ia).

Discussion of Evidence:

Delirium must be treated urgently and should be managed actively (AGS, 2014). The following discussion outlines appropriate multi-component interventions that should be tailored to the person.

Treatment of the Underlying Causes

Management of delirium includes addressing the underlying causes and implementing interventions to mitigate or reverse these causes and/or their effects (see **Appendix G**). As with delirium prevention, delirium management strategies should be tailored to address the multiple factors contributing to the delirium, because a single intervention is unlikely to resolve delirium (Inouye et al., 2014).

Non-pharmacological Interventions

There is some discrepancy in the literature about the value of continuing with the implementation of multiple non-pharmacological interventions once delirium is present. Inouye et al. (2014) emphasize that non-pharmacological interventions should be the first-line management strategies for delirium. On the other hand, Martinez et al. (2015) suggest that preventative interventions may not be very effective once delirium is present. This is because multi-component interventions to manage delirium do not appear to decrease mortality or length of hospital stay (Holroyd-Leduc et al., 2010; Martinez et al., 2015), and may not reduce the duration of delirium (Martinez et al., 2015).

The expert panel notes that although little research has been done with respect to how to modify non-pharmacological interventions once delirium is present, many of the non-pharmacological measures (e.g., promoting sleep and mobilization) are a part of basic care. Furthermore, these measures may help reduce the severity or duration of delirium. Therefore, the expert panel recommends continuing with the implementation of multiple non-pharmacological interventions as long as they are still suitable for the individual. In addition, various non-pharmacological approaches and modifications to the environment can help keep the person calm and safe (see **Appendix G** and RNAO's [2012a] BPG *Promoting Safety: Alternative Approaches to the Use of Restraints* for more information).

Appropriate Use of Medications

There is mixed evidence on the use of antipsychotic and sedating medications to manage delirium. In a systematic review rated moderate for methodological quality by Flaherty et al. (2011), it was found that there is insufficient evidence to support the use of antipsychotics to treat delirium in medical and surgical patients. Inouye et al. (2014) found that although antipsychotic and sedating medications may reduce agitation and behavioural symptoms, it is possible that the use of these medications may prolong delirium or convert hyperactive delirium into hypoactive delirium.

Pharmacological management may be appropriate in some people with severe agitation and psychosis, especially if it these symptoms are interfering with care or treatments, such as a person extubating himself/himself (Inouye et al., 2014). If used cautiously, low doses of typical and atypical antipsychotic medications may decrease the duration and severity of delirium in some people (Gage & Hogan, 2014; Inouye et al., 2014; Khan et al., 2012; NICE, 2012a). Analgesics for pain management may also be necessary, because pain can contribute to delirium (AGS, 2014; CCSMH, 2010; Gage & Hogan, 2014; NICE, 2010). For more detailed information, see **Recommendation 1.6** and **Appendix F**, Resources for Optimal Medication Use in Older Adults.

Family Involvement

The presence of a family member or a companion/"sitter" (i.e., a person who stays at the person's bedside to offer reassurance and meaningful activity, and maintain safety) is another strategy that may be used to support the safety of people experiencing delirium. Family members (companions/sitters) can help with reorientation and prevention of self-harm^G, and can be reassuring to the person with delirium (CCSMH, 2010; Inouye et al., 2014). If family members elect to be involved and it is safe/appropriate for them to do so, it is important to provide them with reassurance, support, and education. See the discussion of evidence for **Recommendation 4.6**.

RECOMMENDATION 4.6:

Educate persons who are at risk for or are experiencing delirium and their families/care partners about delirium prevention and care.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends that people who are at risk for or experiencing delirium and their families should be provided with information about delirium that will alleviate fear, improve comprehension, and, for family who are present during a delirium episode, improve their ability to cope with an episode of delirium. This is important because delirium can be a distressing event (CCSMH, 2010; NICE, 2010).

The RNAO expert panel—in accordance with the CCSMH's (2010) *Guideline on the Assessment and Treatment of Delirium in Older Adults at the End of Life* and the NICE (2010) guideline *Delirium: Diagnosis, Prevention and Management*—recommends the following content for educating older adults and their families about delirium:

- what delirium is, and why the person is at risk for delirium,
- strategies to prevent delirium that are appropriate for the person,
- what it is like for a person to experience delirium,
- signs of delirium and the importance of communicating with the health-care team if there are sudden changes or fluctuations in behaviour,
- ways to communicate and reorient the person with delirium (e.g., using a clear, calm voice, short statements, reminding them where they are), and
- the role and benefits of family presence and/or a companion/sitter.

5.0 EVALUATION

RECOMMENDATION 5.1:

Monitor older adults who are experiencing delirium for changes in symptoms at least daily using clinical assessments/observations and validated tools, and document the effectiveness of interventions.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends that nurses and other health-care providers monitor delirium closely to determine the effectiveness of interventions and to assess whether or not the delirium is resolving. In hospital and long-term-care settings, this should occur at least daily. When delirium is acute or is clinically indicated, monitoring may need to occur at least once per shift.

Health-care providers can monitor delirium using validated tools (see **Appendix H**, Screening and Assessment Tools) and document specific findings, including any observed or reported changes in the person's cognitive function, perception, physical function, and/or social behaviour. Health-care providers should also assess and document the status of any underlying causes or contributing factors to the delirium. Ongoing collaboration with members of the health-care team and family remains important.

It is important to note that people may be discharged from the hospital before their delirium has resolved. Because persistent delirium can be associated with or may indicate unrecognized cognitive impairment (see the discussion under Background Context), the expert panel suggests that follow-up with specialized geriatric services may be required.

RECOMMENDATIONS RELATED TO **DEMENTIA**

6.0 ASSESSMENT

RECOMMENDATION 6.1a:

Assess older adults for possible dementia when changes in cognition, behaviour, mood, or function are observed or reported. Use validated, context-specific screening or assessment tools, and collaborate with the person, his/her family/care partners, and the interprofessional team for a comprehensive assessment.

Level of Evidence = Ia & V

RECOMMENDATION 6.1b:

Refer the person for further assessment/diagnosis if dementia is suspected.

Level of Evidence = Ia

Discussion of Evidence:

To date, there is insufficient evidence to support dementia screening among people who do not exhibit signs of dementia (Development Group, 2010; Jackson, Naqvi, & Sheehan, 2013; U.S. Preventative Services Task Force, 2014). Early detection of dementia is important, however, because of the potential benefits for people and for their families, as demonstrated by a moderately rated systematic review (Mukadam, Cooper, Kherani, & Livingston, 2015). These include accessing appropriate treatment, possibly delaying the disease process, managing symptoms (Lischka, Mendelsohn, Overend, & Forbes, 2012), and offering multifaceted supports to reduce burden^{G} for caregivers (Spenceley et al., 2015). The expert panel adds that early detection of dementia is also important so that individuals with dementia and their families can make plans to live well with dementia and begin advanced care planning^{G}. (See also **Recommendation 8.4**.)

Unfortunately, dementia is often overlooked and under-diagnosed, and concerns are often passed off as a normal part of ageing (NICE, 2010). Although health-care providers may be more likely to suspect dementia among people with multiple risk factors (e.g., family history or vascular risk factors) or in settings where dementia is more prevalent (e.g., long-term care settings), it is recommended that health-care providers be alert for the possibility of dementia in *all* older adults.

Assessing for Changes

In keeping with RNAO's (2010a) BPG *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression*, the expert panel recommends that health-care providers assess for possible dementia whenever cognitive, behavioural, and/or functional changes are observed or reported. Changes can include memory complaints, behaviour changes, and/or difficulty carrying out activities of daily living^{G} or instrumental activities of daily living^{G} (Development Group, 2010). The expert panel adds that changes in mood are another common sign of dementia, and should be taken into consideration during the assessment.

Signs of dementia will vary from person to person, depending on the type of dementia and the stage^{G} of the disease (see **Appendix E**, Types of Dementia). Changes in cognition, behaviour, mood, and function may be observed or suspected by the older adult, his/her family, or members of the health-care team (RNAO, 2010a) (see **Appendix I**, Early Warning Signs of Cognitive Change). Family members may be the first to recognize these changes and, whenever a person or his/her family members voice concerns, these should be taken seriously and followed up by appropriate assessments (RNAO, 2010a). Furthermore, family members can provide insight into the person's history and his/her baseline cognition, behaviour, etc.

Screening and Assessment Tools

Health-care providers should use validated^{G} screening and assessment tools to support a comprehensive assessment for dementia (Jackson et al., 2013; U.S. Preventative Services Task Force, 2014). A wide variety of tools for screening for possible dementia are available; however, a meta-analysis and systematic review, rated moderate for methodological quality, found limited evidence on the effectiveness of many of these tools in an acute-care setting (Jackson et al., 2013). To date, no screening tool exists that captures all needs and criteria necessary to be considered a gold standard of care (Lischka et al., 2012). For more information on tools, see **Recommendations 14.2** and **15.2**, and **Appendix H**.

Comprehensive Assessment, Referrals, and Diagnosis

The use of screening and assessment tools is only one small part of a comprehensive assessment, and a positive screen for dementia is not, in itself, conclusive diagnosis of the condition. When dementia is suspected, the person will require a comprehensive assessment, and collaboration and/or referrals to other members of the health-care team will support a diagnosis. Clinical assessments for dementia may require a series of diagnostic tests, additional formal cognitive assessments with validated instruments, and referrals to specialists to rule out differential diagnoses (Clevenger, Chu, Yang, & Hepburn, 2012; Development Group, 2010), such as delirium and depression (see **Appendix D**).

The assessment and diagnosis process for dementia can be lengthy and complex (Jackson et al., 2013; Mukadam et al., 2015). For example, one systematic review, rated moderate for methodological quality, reported that the diagnostic process required six home visits over 30 months, and that memory clinics can support a timely diagnostic process (Mukadam et al., 2015).

For examples of possible tests used to support a dementia diagnosis, see the *Clinical Practice Guideline on the Comprehensive Care of People with Alzheimer's Disease and Other Dementias* (Development Group, 2010). The *DSM–5* criteria are commonly used to diagnose dementia (Development Group, 2010; RNAO, 2010b). The *DSM–5* provides detailed diagnostic criteria for different types of dementia. It no longer uses the classification "dementia," but instead includes different types of dementia under the category "major neurocognitive disorder" (APA, 2013).

If a person is acutely ill or is experiencing delirium, it is recommended that health-care providers postpone in-depth assessments and a diagnosis until the person is stable and reversible causes are addressed (Jackson et al., 2013). Furthermore, clinical guidelines suggest that depression be treated before a dementia diagnosis is made (AMDA, 2008; Development Group, 2010; NICE, 2010).

RECOMMENDATION 6.2:

Assess the physical, functional, and psychological status of older adults with dementia or suspected dementia, and determine its impact on the person and his/her family/care partners using comprehensive assessments and/or standardized tools.

Level of Evidence = V

Discussion of Evidence:

An important part of an assessment for dementia or suspected dementia includes assessing how the condition is affecting the person and his/her family members or care partners. Information gained through interactions, conversations, and assessments will inform a diagnosis and helps to determine the most appropriate ways to support the person and his/her family (Development Group, 2010).

Health-care providers should assess the physical, functional, and psychological status of the older adult with dementia (or suspected dementia) (AMDA, 2012). It is important to assess the impact of dementia on activities of daily living and instrumental activities of daily living (Development Group, 2010; U.S. Preventative Services Task Force, 2014). Various tools have been developed to assess these abilities (see **Appendix H**), and some comprehensive assessments conducted by nurses or other health-care providers will capture physical, functional, and psychological abilities.

The expert panel recommends that health-care providers maintain a strengths-based approach during assessments and *avoid focusing only on the person's deficits*. Health-care providers must identify and emphasize a person's retained abilities and capabilities while identifying the needs, priorities, and/or goals of the person with dementia (see also **Recommendation 8.4**).

Health-care providers should also assess the impact of dementia (or suspected dementia) on the person's family (Development Group, 2010). Family members are often essential partners in care and, as such, health-care providers should assess their level of stress and ability to cope, and identify needs. Health-care providers should also keep in mind that the social determinants of health[G] (e.g., housing, income, education) may add additional challenges for families coping with the impact of dementia. See **Appendix H**, Screening and Assessment Tools, and **Recommendation 8.5a** for a discussion of support and education for individuals' families.

RECOMMENDATION 6.3:

Systematically explore the underlying causes of any behavioural and psychological symptoms of dementia that are present, including identifying the person's unmet needs and potential "triggers." Use an appropriate tool and collaborate with the person, his/her family/care partners, and the interprofessional team.

Level of Evidence = Ia

Discussion of Evidence:

In order for appropriate care planning to take place, health-care providers must understand the reasons for or the underlying causes of behavioural and psychological symptoms of dementia (BPSD) (Development Group, 2010; Livingston et al., 2014; Moniz Cook et al., 2012; U.S. Preventative Services Task Force, 2014). Examples of behavioural and psychological symptoms include changes in mood, delusions, apathy, agitation, wandering, calling out, repetitive questioning, and disinhibition (including sexual disinhibition) (Moniz Cook et al., 2012). For further information and discussion of evolving terminology of BPSD, see the discussion under Background Context, including "Guiding Principles and Assumptions."

Effective management of and response to BPSD is important because these symptoms are common and distressing, can lead to care and family breakdown (Livingston et al., 2014; U.S. Preventative Services Task Force, 2014), and are a frequent cause of need for urgent hospital care and admission to long-term care (Konno et al., 2013; U.S. Preventative Services Task Force, 2014). Furthermore, ineffective management of/response to BPSD can affect the person's quality of life and can lead to isolation, reduced quality of care, overmedication (Livingston et al., 2014), and distress for caregivers (Moniz Cook et al., 2012).

Assessing BPSD

Functional analysis and dementia care mapping are two approaches described in the literature for assessing BPSD. *Functional analysis* involves exploring the meaning behind the person's behaviour with the intention of intervening to reduce distress and behaviours (Moniz Cook et al., 2012). It is seen as a first-line alternative to traditional pharmacological management for agitation and aggression, but may require assistance from people with specialized training (Moniz Cook et al., 2012). Dementia care mapping involves observing and noting which factors promote well-being and which environmental factors trigger behaviours (Livingston et al., 2014). In one systematic review, rated moderate for methodological quality, dementia care mapping had both immediate and longer-term benefits for reducing severe agitation in long-term care (Livingston et al., 2014). The AMDA's (2012) guideline *Dementia in the Long-Term Care Setting* points out that a careful evaluation of the causes of BPSD is particularly important when a person is newly admitted, has recently been hospitalized, or has undergone a significant change in condition.

The expert panel suggests that health-care providers collaborate to identify unmet needs and triggers for BPSD, because people who know the person well or who are participating in his/her care or daily activities can provide valuable insight. Tools have been developed to assist health-care providers to assess and monitor BPSD, and to observe and document trends (see **Appendix H,** Screening and Assessment Tools). Furthermore, programs centred around understanding and effectively addressing BPSD (e.g., Gentle Persuasive Approaches [GPA], P.I.E.C.E.S, U-First, and behavioural support programs) are widely used in practice. See **Appendix J**, Resources, for a list of programs and resources.

RECOMMENDATION 6.4:

Assess older adults with dementia for pain using a population-specific pain assessment tool.

Level of Evidence = Ia

Discussion of Evidence:

Health-care providers must be skilled in assessing for pain in older adults with dementia so that their pain can be managed effectively (Pieper et al., 2013; RNAO, 2010a). This is important because pain in people with dementia is highly prevalent (estimated to be over 50 percent in community and 80 percent in long-term-care settings), but unfortunately it is often overlooked or not identified (Pieper et al., 2013). Furthermore, untreated pain may contribute to BPSD or distress, can affect quality of life (Pieper et al., 2013), and can contribute to an episode of delirium (Inouye, et al., 2014).

Pain assessment is especially important because some people with dementia are unable to communicate pain through words, and expressions of pain might be misinterpreted as "just part of the dementia" (Pieper et al., 2013). Symptoms/expressions of pain in people with dementia might be mistaken for depression, agitation, anxiety, or aggression (Pieper et al., 2013), as suggested in a moderately rated systematic review. Scales are available to support pain assessment in people with dementia who are unable to communicate pain verbally. See **Appendix H**, Screening and Assessment Tools, and the RNAO (2013) guideline *Assessment and Management of Pain* (3rd ed.) for more information. For information on monitoring pain, see **Recommendation 8.2**.

7.0 PLANNING

RECOMMENDATION 7.1:

Develop an individualized plan of care that addresses the behavioural and psychological symptoms of dementia (BPSD) and/or the person's personal care needs. Incorporate a range of non-pharmacological approaches, selected according to:

- the person's preferences,
- the assessment of the BPSD,
- the stage of dementia,
- the person's needs during personal care and bathing,
- consultations with the person's family/care partners and the interprofessional team, and
- ongoing observations of the person.

Level of Evidence = Ia

Discussion of Evidence:

A range of non-pharmacological approaches to care have been found to be effective at managing BPSD (Livingston et al., 2014) and are favoured in the literature. Non-pharmacological approaches are an important alternative to the use of antipsychotic medications, which historically have been overused as a first-line strategy for managing BPSD (Conn et al., 2014; Livingston et al., 2014). Furthermore, psychotropic medications can be ineffective and harmful, and may lead to increased cognitive decline, among numerous other deleterious effects (Livingston et al., 2014) (see **Recommendation 1.6**). In light of this evidence, health-care providers should consider non-pharmacological interventions wherever possible as a first-line approach to the management of BPSD.

The most well-studied and effective non-pharmacological approaches include listening to music/music therapy (Blackburn & Bradshaw, 2014; Hulme, Wright, Crocker, Oluboyede, & House, 2010; Olazaran et al., 2010; Ueda et al., 2013; Wall & Duffy, 2010), effective communication and person-centred approaches (Konno et al., 2013; Livingston et al., 2014), massage, and other sensory stimulation (Moyle, Murfield, O'Dwyer, & Van Wyk, 2013). Light therapy (i.e., bright lights) does not appear to be effective (Forbes et al., 2009; Livingston et al., 2014), and evidence in support of the benefits of aromatherapy is either limited or conflicting (Forrester et al., 2014; Kverno, Black, Nolan, & Rabins, 2009; Livingston et al., 2014).

Several benefits of non-pharmacological approaches are cited in the literature, including reduced agitation (Livingston et al., 2014) and pain (Konno et al., 2013; Pieper et al., 2013), along with more successful completion of activities of daily living (Konno et al., 2013). Effective management of BPSD through these approaches may also help to decrease stress for caregivers and enhance the work environment for staff (Olazaran et al., 2010). Table 2 outlines non-pharmacological approaches that might be used to support a person with dementia (note that the list is not exhaustive).

Developing an Individualized Plan of Care

Not all non- pharmacological approaches are effective or appropriate for everyone, and the selection of approaches must be person-centred (Cabrera et al., 2015; Enmarker et al., 2011; Konno et al., 2013). In other words, care plans should be based on knowledge of the person's preferences and interests, an understanding of the meaning behind the person's behavioural and psychological symptoms, and an understanding of the person's needs and abilities based on the stage of the dementia.

For people with BPSD, approaches must address the underlying causes, or unmet needs and triggers of BPSD (Livingston et al., 2014), and these should be tailored to the individual's arousal patterns (e.g., calming approaches for agitation or stimulating activities for apathy) (Kverno et al., 2009). The selection of approaches may also depend on the type of dementia and the stage of dementia. For example, in a literature review rated moderate for methodological quality by Kverno et al. (2009), it was suggested that some emotion-oriented approaches (e.g., simulated presence of family members via videotaped or audiotaped recordings of conversations, stories, etc.) may be more effective for people who are still able to communicate verbally.

Personal Care and Bathing

Health-care providers should develop individualized care plans for people with dementia that are specific to daily personal care routines and bathing. This is important because bathing, dressing, and toileting (and the approach taken, or circumstances surrounding these activities) can trigger behaviours such as kicking, scratching, grabbing, screaming, and cursing (Konno et al., 2013). Konno et al. (2013) suggest that these behaviours can be exacerbated when staff are rushed or focused only on the task rather than on the person. These physical and emotional responses to personal care are distressing, and may involve risk to the person with dementia and the person providing care.

Examples of effective approaches outlined in the literature include playing preferred music during bathing, providing a private and safe environment, offering alternative bathing approaches (such as a towel bath), and communicating effectively (Konno et al., 2013). For more specific strategies to assist with personal care and bathing, see **Appendix J**.

Consultation and Ongoing Observation

Selecting the right non-pharmacological approaches is a complex task. It requires thorough assessments (see **Recommendation 6.3**); consultation; and collaboration with the person (as appropriate), his/her family/care partners, and members of the health-care team. Developing an individualized care plan also requires flexibility and creativity (Konno et al., 2013). In other words, care plans are not set in stone, but need to be adapted based on the person's reaction to different approaches and modified as the person's needs change or the disease progresses.

Table 2: Non-pharmacological Approaches to Management of the Behavioural and Psychological Symptoms of Dementia (BPSD)

APPROACH	EVIDENCE

8.0 IMPLEMENTATION

RECOMMENDATION 8.1:

Implement the plan of care in collaboration with the person, his/her family/care partners, and the interprofessional team.

Level of Evidence = V

Discussion of Evidence:

After developing a plan of care for people with dementia (see **Recommendation 7.1**), the plan must be implemented in collaboration with the person, his/her family/care partners, and members of the interprofessional team.

Refer to **Appendix J**, Resources, for a list of programs and resources to support people with dementia. Some of these programs suggest interventions, actions, and approaches to support that are specific to behavioural and psychological symptoms of dementia.

RECOMMENDATION 8.2:

Monitor older adults with dementia for pain, and implement pain-reduction measures to help manage behavioural and psychological symptoms of dementia.

Level of Evidence = Ia & V

Discussion of Evidence:

Effective pain management is important, not only for the reduction of suffering, but also as a way to reduce BPSD associated with pain and to make care routines (such as bathing) less challenging (Konno et al., 2013). Pain-reducing interventions may include pharmacological and non-pharmacological measures. See **Recommendations 1.6** and **Appendix F** for more information on appropriate use of medications.

The expert panel recommends that health-care providers monitor for both verbal and non-verbal signs of pain. This includes observing for and documenting changes in any symptoms related to pain, in order to determine whether pain reduction measures are effective. Refer to the pain assessment tools in **Appendix H**, **Recommendation 6.4**, and RNAO's (2013a) BPG *Assessment and Management of Pain* (3rd ed.) for more information.

RECOMMENDATION 8.3:

Employ communication strategies and techniques that demonstrate compassion, validate emotions, support dignity, and promote comprehension when caring for people with dementia.

Level of Evidence = Ia

Discussion of Evidence:

Effective communication with people who have dementia has many benefits. A systematic review of quantitative studies rated moderate for methodological quality found that effective communication enhanced positive behaviour, promoted more satisfying interactions, and improved overall quality of life for the person with dementia (Eggenberger, Heimerl, & Bennett, 2013).

Effective communication has also been shown to reduce agitation and responsive behaviours[G] in persons with dementia (Livingston et al., 2014), and promote the person's dignity and sense of control (Konno et al., 2013). Examples of communication strategies (from a systematic review on mostly qualitative studies, rated moderate for methodological quality) include apologizing, using appropriate humour, distraction, allowing the person to take time to respond to the care provider, and providing reminders of what will happen next (Konno et al., 2013). **Appendix K** outlines communication strategies that are beneficial for dementia care, and the skills, attitudes, and knowledge required to apply these skills.

The expert panel adds that positive communication requires certain knowledge, skills, and competencies. Health-care providers must understand how dementia affects the brain and, by extension, the person's ability to receive, process, and produce language. In addition, they must also have empathy, compassion, and respect for the person; demonstrate cultural competence[G]; and be able to establish a trusting and therapeutic relationship with the person. Other specific techniques include the ability to adjust language (e.g., one-step instructions) to match the person's comprehension abilities, while avoiding yelling or speaking to them in a condescending manner. Furthermore, health-care providers must validate the person's emotions, and recognize and accept their thoughts, feelings, sensations, and behaviours as understandable; this does not necessarily mean agreeing with or endorsing the person's behaviour. See **Recommendation 1.1** for additional information.

RECOMMENDATION 8.4:

Promote strategies for people living with dementia that will preserve their abilities and optimize their quality of life including, but not limited to:

- exercise (level of evidence = Ia),
- interventions that support cognitive function (level of evidence = Ia),
- advanced care planning (level of evidence = Ia), and
- other strategies to support living well with dementia (level of evidence = V).

Discussion of Evidence:

Health-care providers should promote strategies for living well, preserving abilities, and maximizing quality of life for people with dementia. While the literature highlights the benefits of exercise, suggests potential benefits of advanced care planning for people with dementia in long-term care, and indicates various interventions to support cognition, the expert panel notes that there are many other strategies that may benefit people with dementia, especially in the earlier stages of the disese.

Exercise

One strongly and one moderately rated review show that exercise can potentially improve the ability of people with dementia to carry out activities of daily living (Forbes, Thiessen, Blake, Forbes, & Forbes, 2013) and reduce decline in their ability to do so (Littbrand, Stenvall, & Rosendahl, 2011). Exercise may also improve cognition (Farina, Rusted, & Tabet, 2014; Forbes et al., 2013; Fox, Hodgkinson, & Parker, 2014), although this has not been consistently proven (Fox et al., 2014; Ohman, Savikko, Strandberg, & Pitkala, 2014), with only one review showing definitive improvement in quality of life for people with depression and dementia (Tavares, Moraes, & Laks, 2014). Other reviews, which rated weak for methodological quality, have shown general positive effects of exercise (Balsamo et al., 2013; McLaren, Lamantia, & Callahan, 2013; Pitkälä, Savikko, Poysti, Strandberg, & Laakkonen, 2013; Thune-Boyle, Iliffe, Cerga-Pashoja, Lowery, & Warner, 2012).

Interventions that Support Cognition

Cognitive interventions can be described as activities that teach new ways of carrying out cognitive tasks, and strategies to improve functioning or restore abilities in specific domains (Development Group, 2010). A moderately rated systematic review (Zabalegui et al., 2014) found potential benefits of cognitive interventions for people in the early stages of dementia, such as improved activities of daily living and increased satisfaction. The Development Group of the Clinical Practice Guideline on the Comprehensive Care of People with Alzheimer's Disease and Other Dementias (2010) reviewed a wide range of cognitive interventions (e.g., reality counselling techniques, reminiscence[G], memory training, sensory stimulation, and activities of daily living training), and recommends implementing individualized interventions for people with Alzheimer's dementia that are focused on stabilizing cognitive function and functionality; these interventions, they state, must be adapted to the person's cognitive abilities in order to avoid distress and adverse emotional reaction (e.g., anger and frustration).

In addition to these cognitive interventions, the expert panel notes that medications are sometimes prescribed for a limited time to enhance cognition or to treat/manage other symptoms of dementia. For more information on medications, see **Recommendation 1.6**, **Appendix F**, and the Development Group's (2010) *Clinical Practice Guideline on the Comprehensive Care of People with Alzheimer's Disease and Other Dementias*, which provides guidance on specific medications for specific types of dementia.

Advanced Care Planning

Advanced care planning can be described as "a multistage process whereby a patient [person] and their carers achieve a shared understanding of their goals and preferences for future care" (Robinson et al., 2012, p. 263). One systematic review, rated moderate for methodological quality, captured findings from four studies about advanced care planning in long-term care. Benefits of advanced care planning in the long-term-care setting include having documentation of a person's preferences for care, reduction in rates of hospitalization, and increased use of hospice services (Robinson et al., 2012). The authors point out, however, that the long-term-care setting may be too late for some people to discuss advanced care planning if their capacity to discuss issues is inhibited by the disease process (Robinson et al., 2012).

The expert panel recommends that health-care providers promote advanced care planning while a person with dementia is still able to make choices and articulate their individual needs and preferences. The Alzheimer Society of Canada provides guidance on advanced care planning and related topics, including developing a health-care plan, selecting a substitute decision-maker, planning work/volunteer adaptations and living arrangements, planning legal and financial matters, and making end-of-life decisions. For details, refer to the Alzheimer Society of Canada website at www.alzheimer.ca/en

Other Strategies to Support Living Well with Dementia

The expert panel recommends that health-care providers promote other aspects to living well with dementia, such as the following:

- promoting engagement in meaningful and purposeful activities/recreation that align with the person's particular interests;
- promoting social engagement;
- modifying the home/environment to support independent activities of daily living and promote safety;
- addressing issues of safety, such as wandering and driving;
- maintaining a healthy lifestyle (e.g., supporting nutrition, sleep, and regular visits to health-care providers);
- providing routines, reminders, and other strategies to support cognitive challenges;
- providing education about dementia and information about community resources (see also Table 3).

The Alzheimer Society of Canada provides comprehensive information, support, and resources, including guidance for day-to-day living with dementia, and strategies that address specific needs and concerns of people with dementia and their families/care partners. Information is provided for different stages of dementia (not just Alzheimer's), including early, middle, late, and end-of-life. For detailed information, visit the Alzheimer Society of Canada at www.alzheimer.ca/en. See also **Appendix J**.

RECOMMENDATION 8.5a:

Provide education and psychosocial support to family members and care partners of people with dementia that align with the person's unique needs and the stage of dementia.

Level of Evidence = Ia

RECOMMENDATION 8.5b:

Refer family members and care partners who are experiencing distress or depression to an appropriate health-care provider.

Level of Evidence = V

Discussion of Evidence:

Health-care providers should offer effective interventions to those caring for people with dementia, because stress from caregiving can be detrimental to caregivers' physical and psychological well-being (Godwin, Mills, Anderson, & Kunik, 2013; Jensen, Agbata, Canavan, & McCarthy, 2015; McKechnie, Barker, & Stott, 2014). Interventions for caregivers (family caregivers/care partners) must be tailored to the individual needs of those involved (Elvish et al., 2013; Nehen & Hermann, 2015; Topo, 2009). This is important because dementia progresses at different rates, symptoms vary, and the perceived burden of caregiving is interpreted in various ways (Jensen et al., 2015).

A range of interventions to support caregivers have been studied in the literature, including approaches to build skills, increase knowledge about dementia and BPSD, enhance support for caregivers, manage emotions and promote self-care, activity planning, and altering the environment (Brodaty & Arasaratnam, 2012; Corbett et al., 2012; Elvish et al., 2013; Gallagher-Thompson et al., 2012; Laver, Clemson, Bennett, Lannin, & Brodaty, 2014; Marim, Silva, Taminato, & Barbosa, 2013; Nehen & Hermann, 2015; Schoenmakers, Buntinx, & DeLepeleire, 2010). These interventions can be offered directly by health-care providers, over the phone, in group settings, through computer programs, and online.

Benefits of Programs Offering Psychological Support and Education

Although most of the evidence is methodologically weak, one strong systematic review and meta-analysis of randomized controlled trials found that educational interventions for caregivers in the community decreased caregiver burden and depression (Jensen et al., 2015). Other potential benefits may include reduced caregiver depression, reduced caregiver burden, enhanced caregiver well-being (Chien et al., 2011; Elvish et al., 2013; Moon & Adams, 2013; Schoenmakers et al., 2010), improved quality of life (Corbett et al., 2012; Elvish et al., 2013), improved knowledge, improved coping skills or the ability to manage symptoms of dementia, and enhanced interactions with the person with dementia (Corbett et al., 2012; Moon & Adams, 2013). The expert panel suggests that supporting caregivers may be the best way to improve outcomes for people with dementia.

The evidence suggests that caregiver programs may be more effective if they are multifaceted (Corbett et al., 2012; Elvish et al., 2013; Laver et al., 2014)—for example, programs that offer education, support, and skill-building for caregivers (Laver et al., 2014). In a systematic review and meta-analysis by Brodaty & Arasaratnam (2012), it is suggested that programs for caregivers are more successful when they are delivered over a period of time with adequate follow-up.

Referring Family Members and Care Partners with Distress or Depression

Health-care providers can provide psychological support and education directly to caregivers who are caring for people with dementia (Development Group, 2010; U.S. Preventative Services Task Force, 2014; WHO, 2012/2015). For those caregivers experiencing distress or depression, health-care providers should refer them to (or recommend that they see) a primary care provider or mental health specialist (Development Group, 2010). Additional supports or referrals may also be required if caregivers are challenged by other issues associated with the social determinants of health (e.g., inadequate housing, low income, etc.).

It should be noted that although respite care is generally believed to support caregivers and is frequently recommended by health-care providers, one study, rated weak for methodological quality, concluded that it may be associated with an increased feeling of burden (Schoenmakers et al., 2010).

For additional information on supporting caregivers, refer to RNAO's (2006b) BPG *Supporting and Strengthening Families Through Expected and Unexpected Life Events.*

Technology-Based Programs

Health-care providers can consider recommending technology-based programs that offer education and psychosocial support for caregivers (McKechnie et al., 2014). Various technology-based programs are available, including educational videos and connecting with peers or professionals online. Studies about these interventions report favourable outcomes overall, but further research is recommended to confirm benefits (Godwin et al., 2013; Topo, 2009). Stronger studies suggest that computer-mediated programs may reduce caregiver burden, stress, depression, and anxiety, and possibly increase caregivers' self-efficacy (McKechnie et al., 2014).

Educational Content

Table 3 outlines suggested content for educating caregivers about dementia. References are provided as available. Health-care providers may find that some of this education is also important for the person with dementia. See also **Recommendation 8.4**.

Table 3: Content for Educating Caregivers About Dementia

Table continued on next page.

Note: Content added by the expert panel is indicated with an asterisk (*).

9.0 EVALUATION

RECOMMENDATION 9.1:

Evaluate the plan of care in collaboration with the person with dementia (as appropriate), his/her family/care partners, and the interprofessional team, and revise accordingly.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends ongoing monitoring and evaluation of the effectiveness of the plan of care for the person with dementia. Evaluation over time is also important as the disease progresses, as behavioural and psychological symptoms of dementia (BPSD) evolve, and as the needs of the person and of his/her family/care partners change. Therefore, interventions, including education and support, will need to be adjusted over the course of the disease. Collaboration and communication with the person (as appropriate), family and care partners, and members of the interprofessional team is required. The frequency of monitoring and evaluating the plan of care will vary according to the setting and organizational policy.

RECOMMENDATIONS RELATED TO **DEPRESSION**

10.0 ASSESSMENT

RECOMMENDATION 10.1:

Assess for depression during assessments and ongoing observations when risk factors or signs and symptoms of depression are present. Use validated, context-specific screening or assessment tools, and collaborate with the older adult, his/her family/care partners and the interprofessional team.

Level of Evidence = Ia & V

Discussion of Evidence:

Health-care providers must **be vigilant for depression among older adults, and assess for depression whenever risk factors or signs and symptoms are present** (NICE, 2011, 2013; Trangle et al., 2016). Unfortunately, health-care providers often do not recognize depression; it is under-diagnosed and often goes untreated (O'Connor et al., 2009; Trangle et al., 2016). Furthermore, few older adults actively seek treatment or see a mental health specialist to manage their depression (Chang-Quan et al., 2009).

Lack of recognition and treatment is a great concern because of the impact of depression on morbidity and mortality, on the person's quality of life and social functioning, and on his/her ability to manage health conditions (Chang-Quan et al., 2009; Kiosses et al., 2011; Krishna et al., 2011; O'Connor et al., 2009; Samad et al., 2011). Because lack of treatment can lead to significant suffering, early recognition of depression is important (Krishna et al., 2011).

Identifying Risk Factors, Signs, and Symptoms of Depression

Health-care providers must be knowledgeable about signs, symptoms, risk factors, and stressor events that may lead to depression (see Table 4). Identifying depression can be challenging in older adults for a variety of reasons. Medical conditions or medications can cause depressive symptoms (O'Connor et al., 2009), and depression can be masked by co-morbidities (Chang-Quan et al., 2009; O'Connor et al., 2009). Furthermore, older adults might not present with a depressed mood or use the word "depression," but instead may have an atypical presentation (O'Connor et al., 2009), such as insomnia, appetite disturbances, lack of energy, fatigue, chronic pain, constipation, and/or musculoskeletal disorders (Trangle et al., 2016). A person's cultural, ethnic, and religious background can also affect the way he or she expresses and understands depression (NICE, 2009). Examples of terms or phrases that people may use instead of "depressed" include "nerves," "feeling blue," and "low spirits."

Table 4 lists predisposing and precipitating factors for depression, and possible signs and symptoms (the list is not exhaustive). Clinicians commonly use the mnemonic SIGECAPS to remember the signs and symptoms of depression in older adults (Trangle et al., 2016). Finally, diagnosing practitioners routinely apply the criteria outlined in the *DSM–5* to diagnose depression (Trangle et al., 2016; NICE, 2009).

Table 4: Risk Factors and Signs of Depression

PREDISPOSING AND PRECIPITATING RISK FACTORS	SIGNS AND SYMPTOMS

Sources: AMDA, 2011; NICE, 2011; O'Connor et al., 2009; Trangle et al., 2016. Sources: Jenike, 1989, as cited in RNAO, 2010b; Trangle et al., 2016.

Note: Content added by the expert panel is indicated with an asterisk (*).

Assessing for Depression

A detailed assessment for depression should occur when risk factors are present or when depression is suspected (Conn et al., 2014; NICE, 2009; Trangle et al., 2016). Health-care providers should use standardized tools that are appropriate to the setting (NICE, 2009; RNAO, 2010a; Trangle et al., 2016) and to the abilities of the older adult (e.g., taking into account cognitive impairment) (Conn et al., 2014). A variety of tools and approaches have been validated for depression screening and assessment in older adults—for example, depression scales for older adults, scales for self-report and proxy report, tools for assessing depression in people with dementia, tools for those with significant language or communication difficulties, and tools for assessing suicide. For a list of tools, see **Appendix H**, Screening and Assessment Tools.

Other aspects of an assessment may include a history and physical exam, diagnostic testing, an assessment of contributing factors, tests to rule out alternative diagnoses (Conn et al., 2014), and an assessment of functional impairment (NICE, 2009). To conduct assessments, nurses and other health-care providers must exercise clinical judgment, and apply knowledge about depression and other conditions that may coexist, complicate, or exacerbate depression. See **Recommendation 14.2**.

The expert panel emphasizes that a therapeutic relationship is essential when assessing an older adult for depression, and that certain specific skills are required. An essential element is building trust and rapport, because people may not disclose symptoms or feelings of depression in the absence of a strong relationship with the health-care provider who is conducting an assessment. Furthermore, many people may be hesitant to talk about depression because of the associated stigma or as a result of cultural beliefs. Therefore, health-care providers must conduct such assessments with a great deal of sensitivity, and be non-judgmental and culturally sensitive. See **Recommendation 1.1**.

Should Health-Care Providers Routinely Screen for Depression?

Routine screening is not recommended consistently in the literature, and whether or not it is recommended depends on the setting. Three clinical guidelines suggest that organizations *consider* screening processes (AMDA, 2011; NICE, 2009; Trangle et al., 2016), and one recommends screening upon admission to long-term care and at regular intervals or after significant changes (Conn et al., 2014). Furthermore, one moderately rated systematic review examined the benefits and harms of screening older adults for depression (in primary care), and found that screening *without* additional resources for depression care and case management is unlikely to have a positive outcome (O'Connor et al., 2009).

In light of the inconclusive evidence, the RNAO expert panel does not recommend routine screening for depression, but instead recommends that health-care providers assess for depression *when risk factors or signs and symptoms of depression are present*. Due to the high prevalence of depression and the fact that it is often under-diagnosed, health-care providers should remain vigilant for risk factors, signs, and symptoms of depression. In light of the findings by O'Connor et al. (2009), health-care providers should also ensure that follow-up support and resources are available for older adults who are identified as having depression.

RECOMMENDATION 10.2:

Assess for risk of suicide when depression is suspected or present.

Level of Evidence = V

Discussion of Evidence:

Whenever depression is suspected, health-care providers must ask people directly about suicidal ideation and intent (NICE, 2009, 2011). This is important because thoughts of suicide can occur even with milder forms of depression (RNAO, 2010b), and the risk of suicide is high among older adults (O'Connor et al., 2009).

The expert panel points out that in some instances, using the word "suicide" may not be appropriate; alternative wording may include "harming yourself," "wishing away life," "wishing you weren't living," "ending your life," or "hastening death." For such conversations, therapeutic communication skills are essential, and a quiet, private space is recommended for such discussions.

For additional information on suicide, including self-harm, see the RNAO (2009) BPG *Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour*. For a list of resources to support people at risk for suicide, see **Appendix J**, Resources.

RECOMMENDATION 10.3:

Refer older adults suspected of depression for an in-depth assessment by a qualified health-care professional. Seek urgent medical attention for those at risk for suicide and ensure their immediate safety.

Level of Evidence = V

Discussion of Evidence:

Older adults suspected of having depression should be assessed by a qualified health-care professional for diagnosis and treatment (NICE, 2009). The expert panel suggests that qualified health-care professionals may include a primary care practitioner, psychiatrist, or a psychogeriatric/geriatric mental health specialist. Other referrals to members of the health-care team may be necessary, especially to rule out or assess for co-morbid conditions that may mimic depression. Coordinated, interprofessional care may also be required, especially for complex depression and when depression has implications for the management of chronic physical health problems (NICE, 2009).

If there is active suicidal ideation/risk of a person killing himself/herself, or if a person with depression presents a considerable immediate threat or harm to others, it is important to seek urgent attention from a qualified professional (NICE, 2009; RNAO, 2010a). In such cases, the expert panel recommends the following immediate actions:

- Call a crisis line, crisis team, or local emergency phone number, or take the person to the emergency department.
- Determine whether the person has access to a means or has the ability to end his/her life.
- Maintain safety: do not leave the person alone, and consider warning others who may be at risk.

The expert panel recommends the following actions to support a person who is at risk for suicide:

- Assess whether the person has adequate social support.
- Provide the person with information regarding sources of help/support.
- Consider a referral to specialized mental health services.
- Increase the level of support (e.g., more frequent phone contact).
- Assess the potential toxicity in overdose if an antidepressant is prescribed or the person is taking other medication that could be used to end one's life, and, in collaboration with the person and his/her prescribing practitioner, explore the possibility of limiting the dose (NICE, 2009).

For additional information on suicide and self-harm, see the RNAO (2009) BPG *Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour*. See **Appendix J**, Resources, for resources to support people at risk for suicide.

11.0 PLANNING

RECOMMENDATION 11.1:

Develop an individualized plan of care for older adults with depression using a collaborative approach. Where applicable, consider the impact of co-morbid dementia.

Level of Evidence = Ia & V

Discussion of Evidence:

Clinical guidelines state that health-care providers need to develop an individualized plan of care for the management of depression that aligns with the person's preferences and clinical profile (NICE, 2009, 2011; Trangle et al., 2016). In order to do so, the health-care provider must understand the person's preferences and support informed decision-making (NICE, 2011). Evidence from one review, rated weak for methodological quality, suggests that health-care providers identify and address any factors that could affect adherence to the depression treatment plan, and arrange for follow-up care (Dreizler et al., 2014).

Collaboration among members of the health-care team supports effective depression management (Chang-Quan et al., 2009; Cody & Drysdale, 2013; Dreizler et al., 2014; NICE; 2012; O'Connor et al., 2009; Trangle et al., 2016). The plan of care should be documented and communicated to those who are involved in the care. See **Recommendation 1.3**.

Effective care planning requires that health-care providers are knowledgeable about the range of evidence-based options available to manage depression (see the Education Recommendations). The expert panel recommends that health-care providers consider the full range of therapies that are available and that might benefit a person, and not allow their personal opinions or beliefs about particular interventions to influence decision-making regarding particular therapies.

Depression in People with Dementia

Due to the high prevalence of depression in people with dementia (see the discussion under Background Context and **Recommendation 10.1**), health-care providers may need to consider the impact that co-morbid dementia has on individuals with depression (Conn et al., 2014). When these conditions co-exist, NICE (2009) suggests that health-care providers can offer many of the same interventions as they would for a person who only has depression, making any necessary adjustments to the approach and duration of the interventions. A strongly rated systematic review by Orgeta et al. (2014) found that the addition of psychological interventions (e.g., cognitive behavioural therapy[G] [CBT], counselling, and interpersonal psychodynamic therapy) to the care plan of people with dementia can reduce anxiety and symptoms of depression.

12.0 IMPLEMENTATION

RECOMMENDATION 12.1:

Administer evidence-based pharmacological and/or non-pharmacological therapeutic interventions for depression that are tailored to the person's clinical profile and preferences.

Level of Evidence = Ia & V

Discussion of Evidence:

Health-care providers should provide evidence-based therapeutic interventions according to the person's plan of care. A variety of pharmacological and non-pharmacological therapies with varying degrees of efficacy are discussed in clinical guidelines (Conn et al., 2014; SIGN, 2010). When selecting interventions, health-care providers should start with the least invasive and most effective intervention (NICE, 2009, 2011, 2012b).

Pharmacological Interventions

Antidepressant therapies are an important part of treatment for older adults with severe or persistent depression (Conn et al., 2014; NICE, 2009, 2012b). However, because of the potential risks and unclear efficacy in older adults with *mild depression*, antidepressants should not be used routinely (Conn et al., 2014; NICE, 2009). Instead, Conn et al. (2014) suggest starting with psychosocial interventions. Selective serotonin reuptake inhibitors (SSRIs) are generally the antidepressant of choice for older adults with depression (Conn et al., 2014; NICE, 2009, 2012b). One clinical guideline and a systematic review, rated moderate for methodological quality, recommend that antidepressants should be used in combination with other approaches, such as psychotherapy (NICE, 2011; O'Connor et al., 2009).

For people with dementia, the efficacy of antidepressants is unclear. This is supported by one systematic review and meta-analysis, rated weak in methodological quality (Nelson & Devanand, 2011), one clinical guideline (AMDA, 2011), and expert panel opinion.

It is beyond the scope of this Guideline to discuss specific medications or appropriate considerations for prescribing and monitoring medications. For more detailed information, refer to NICE's guidelines *Depression in Adults: The Treatment and Management of Depression in Adults* (2009) and *Common Mental Health Disorders: Identification and Pathways to Care* (2011); the update to CCSMH's *The Assessment and Treatment of Mental Health Issues in Long Term Care Homes* (Conn et al., 2014), and **Appendix F**, Resources for Optimal Medication Use in Older Adults.

Non-pharmacological Interventions

A number of non-pharmacological therapies have been shown to be effective to varying degrees in older adults with depression. Several types of psychological therapies, such as behavioural therapy (Samad et al., 2011) and group cognitive behavioural therapy (Krishna et al., 2011), have shown potential benefits within two moderately rated systematic reviews.

In addition, several reviews have noted that exercise may minimize depressive symptoms in older adults (Bridle, Spanjers, Patel, Atherton, & Lamb, 2012; Chi, Jordan-Marsh, Guo, Xie, & Bai, 2013; Forbes et al., 2013; Mura & Carta, 2013; Park, Han, & Kang, 2014; Tavares et al., 2014). While exercise may improve quality of life for people with dementia and depression (Park et al., 2014), the evidence is limited (Forbes et al., 2013; Potter et al., 2011). The type of exercise recommended should be selected and tailored according to the person's abilities (Bridle et al., 2012), and should align with the person's interests.

Other non-pharmacological therapies for depression that have been discussed in the literature and in guidelines include reminiscence, mindfulness[G], behavioural activation[G], and music therapy. See Table 5 for a list of interventions (the list is not an exhaustive; rather, the table contains examples of interventions and key findings about each particular intervention from the literature). Organizations may need to consider resource implications, because so me therapies require specialized staff and collaboration between staff, and some require significant staff time (Housden, 2009). It is important to note that although some therapies may be outside the scope of practice for nurses (e.g., music therapy), nurses can reinforce the benefits of, advocate for, and support the use of such therapies.

Table 5: Interventions for Depression

NON-PHARMACOLOGICAL INTERVENTIONS
PSYCHOTHERAPY

Table continued on next page.

NON-PHARMACOLOGICAL INTERVENTIONS CONT…

EXERCISE

PSYCHOLOGICAL AND SOCIAL INTERVENTIONS

ELECTROCONVULSIVE THERAPY (ECT)

PHARMACOLOGICAL INTERVENTIONS

RECOMMENDATION 12.2:

Educate older adults with depression (and their families/care partners, if appropriate) about depression, self-management, therapeutic interventions, safety, and follow-up care.

Level of Evidence = V

Discussion of Evidence:

Education is an important aspect of care for people with depression. Depending on the person's wishes, it may also involve the person's family/care partners. Health-care providers should provide education within their scope of practice, and in collaboration with prescribing practitioner, as appropriate. Table 6 outlines educational content for older adults with depression and their families/care partners.

Table 6: Recommended Educational Content for Older Adults with Depression

TOPIC	KEY POINTS

Note: Content added by the expert panel is indicated with an asterisk (*). Sources: ; NICE, 2009, Trangle et al, 2016.

13.0 EVALUATION

RECOMMENDATION 13.1:

Monitor older adults who are experiencing depression for changes in symptoms and response to treatment using a collaborative approach. Document the effectiveness of interventions and changes in suicidal risk.

Level of Evidence =V

Discussion of Evidence:

The expert panel recommends that nurses and other health-care providers monitor the signs and symptoms of depression and evaluate the person's response to treatment. This is important in order to determine the effectiveness of interventions and to promote recovery. One integrative review found that nurses play an essential role with regard to supporting ongoing maintenance of therapies, addressing barriers to adherence, and monitoring for changes in suicidal risk (Dreizler et al., 2014). For people taking antidepressants, it is also important to monitor for side effects (NICE, 2009).

The expert panel points out that health-care providers should monitor and document risk for suicide. Sometimes, when antidepressants begin to take effect and the person has increased energy, a person with suicidal intent may have increased ability to carry out a suicide plan.

If revisions are required to the plan of care, this should be done in collaboration with the older adult, his/her family/care partners (as appropriate), and the interprofessional team. Ongoing documentation and timely, effective communication remains important. See **Recommendation 1.3**.

Education Recommendations

14.0 EDUCATION

RECOMMENDATION 14.1:

All entry-level health-care programs include content and practice education opportunities that are specific to caring for older adults who have or are suspected of having delirium, dementia, and/or depression, and that are tailored to the discipline’s scope of practice.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends that entry-level educational programs for health-care providers contain specialized content related to delirium, dementia, and depression, and caring for older adults who have or may have these conditions. This recommendation aligns with RNAO’s (2010) BPGs *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression* and *Screening for Delirium, Dementia and Depression in the Older Adult*; the Development Group’s *Clinical Practice Guideline on the Comprehensive Care of People with Alzheimer’s Disease and Other Dementias* (2010); and the recommendations in CCSMH’s *Guideline on the Assessment and Treatment of Delirium in Older Adults at the End of Life* (Conn et al., 2014). Entry-level education on these topics provides an important first exposure to the content, and establishes foundational knowledge and skills that can be reinforced and augmented in clinical/care settings.

Curriculum content focused on the care of older adults is particularly important, given the increasing proportion of older adults who are cared for across all health-care settings. The expert panel points out that content related to the care of older adults in general—and content on delirium, dementia, and depression specifically—receives minimal emphasis in many health-care training programs.

Educational content must be tailored to the scope of practice of the health-care provider, but should include, at minimum, content about the following:

- the normal changes associated with aging, versus the signs and symptoms that indicate illness or disease;
- delirium, dementia, and depression;
- person- and family-centred care;
- collaboration with the interprofessional team;
- communication strategies;
- assessments; and
- evidence-based pharmacological and non-pharmacological interventions for older adults with delirium, dementia, and/or depression.

In addition, practice education opportunities should allow for meaningful and direct care of older adults. Depending on the scope of practice of the health-care provider, the expert panel suggests that students have opportunities to practice person- and family-centred care—for example, by tailoring interventions to meet the needs of older people and their families. Refer to RNAO's (2016) BPG *Practice Education in Nursing* for information regarding how to structure appropriate practice education experiences.

RECOMMENDATION 14.2:

Organizations provide opportunities for nurses and other health-care providers to enhance their competency in caring for older adults with delirium, dementia, and depression. Pertinent educational content should be provided during the orientation of new staff and students, and continuously through refresher courses and professional development opportunities.

Level of Evidence = Ia & V

Discussion of Evidence:

Health-care providers require ongoing education to build and maintain their clinical knowledge and skills, and to foster the attitudes necessary for caring for older adults with delirium, dementia, and depression effectively (AGS, 2014; CCSMH, 2010; Development Group, 2010). This is important because delirium, dementia, and depression are complex conditions. For example, health-care providers struggle to distinguish between delirium and dementia, and to manage some of the mood and behavioural symptoms of dementia (Brody & Galvin, 2013; Yanamadala, Wieland, & Heflin, 2013). To address these complex issues, refresher or booster sessions are recommended (AGS, 2014, 2015; Eggenberger et al., 2013). In other words, one-time training programs are unlikely to be effective.

To develop competencies, education must build on (or, in some cases, compensate for a lack of) training provided in college and university programs, and learning needs to be reinforced over time. Therefore, the expert panel recommends that education on delirium, dementia, and depression should be provided during the orientation of new staff and students on clinical placements, and continuously through refresher courses and professional development opportunities to improve skills and promote confidence in providing care.

A range of content is recommended with respect to health-care-provider training. The following is a summary of the key content areas highlighted in reviews specific to health-care-provider training and expert panel recommendations. Table 7 outlines educational content identified from the literature and clinical guidelines.

Resources to support this recommendation include competency frameworks applicable to the region and scope of practice (e.g., the Canadian Gerontological Nursing Association's *Gerontological Nursing Competencies and Standards of Practice)*, and RNAO's (2016) BPG *Practice Education in Nursing.*

Educational Content Recommended by the Literature

The literature supports education focused on communication skills, BPSD, and person-centred care. Findings from a moderately rated systematic review indicate that educating those who work with people with dementia (in a range of institutional and home-care settings) in effective communication skills improves the quality of life and well-being of people with dementia and increases positive interactions. Communication skills training also has a positive influence on health-care-provider knowledge, skills, and attitudes (Eggenberger et al., 2013). Training on the topic of BPSD has, in general, shown positive results in two systematic reviews (Reis, Dalpai, & Camozzato, 2013; Spector et al., 2013), and person-centred training has been found to reduce agitation and the need for antipsychotic medications for people with dementia (Fossey et al., 2014).

The literature indicates that education should focus not only on increasing content knowledge, but should also foster attitudes and practices conducive to the care of people with delirium, dementia, and depression. For example, a moderately rated systematic review and meta-synthesis indicates that education should help health-care providers value and appreciate psychosocial and non-pharmacological interventions, understand the benefits of these interventions, and address fears that learners may have (Lawrence et al., 2012). Education should also promote the value of person-centred care practices that respect and honour the person, and provide opportunities for self-expression (Lawrence et al., 2012). Furthermore, Elliott, Scott, Stirling, Martin, & Robinson (2012) indicated that education should address healthy-work-environment issues, such as stress management and psychological well-being for health-care providers.

Educational Content Recommended by the Expert Panel

Screening and Assessment Tools

The expert panel recommends that health-care providers receive adequate training on the accurate use of screening and assessment tools. Training should emphasize that these tools are only one aspect of care and are to be used as an adjunct to clinical judgment, and that screening occurs within the context of additional follow-up and intervention. Furthermore, health-care providers must learn how to conduct screenings and assessments with sensitivity to the possible effects of stigma, cultural beliefs, or fears the person may have in relation to delirium, dementia, or depression. The expert panel suggests that health-care providers be taught that, before engaging in screening and assessment processes, they should explain what they are doing and why, obtain consent from the person, and proceed in a manner that promotes the person's understanding and dignity.

Self-Care and Safety of the Health-Care Provider

The expert panel recommends that educational programs acknowledge the importance of self-care for health-care providers, given the challenges that caring for people with delirium, dementia, and/or depression may entail (e.g., issues such as work stress and burnout). It is also important to acknowledge the potential safety concerns for health-care providers who are providing care for people whose physical behaviours may put the health-care provider at risk of injury. For more information, see RNAO's Healthy Work Place Environment BPGs (available at www.RNAO.ca/bpg/guidelines/hwe-guidelines) and the de-escalation tips in RNAO's (2012a) BPG *Promoting Safety: Alternative Approaches to the Use of Restraints*.

Table 7: Suggested Topics for Educational Programs for Nurses and Other Health-Care Providers

GENERAL RECOMMENDED CONTENT	REFERENCES
CONTENT APPLICABLE TO DELIRIUM, DEMENTIA, AND DEPRESSION	

Table continued on next page.

ADDITIONAL CONTENT—DELIRIUM	REFERENCES
ADDITIONAL CONTENT—DEMENTIA	
ADDITIONAL CONTENT—DEPRESSION	

Note: Content added by the expert panel is indicated with an asterisk (*).

RECOMMENDATION 14.3:

Design dynamic, evidence-based educational programs on delirium, dementia, and depression that support the transfer of knowledge and skills to the practice setting. Such programs should be:

- interactive and multimodal (level of evidence = Ia),
- interprofessional (level of evidence = Ia),
- tailored to address learners’ needs (level of evidence = V),
- reinforced at the point of care by strategies and tools (level of evidence = Ia), and
- supported by trained champions or clinical experts (level of evidence = Ia).

Discussion of Evidence:

The systematic review conducted for this Guideline found a limited number of strong studies outlining which educational interventions best support the acquisition of knowledge and skills needed to care effectively for older adults with delirium, dementia, and/or depression (Beeber, Zimmerman, Fletcher, Mitchell, & Gould, 2010; Elliott et al., 2012; Rampatige, Dunt, Doyle, Day, & van Dort, 2009). Many reviews show some increase in knowledge or confidence, but the link between these improvements and practice changes leading to improved clinical outcomes or longer-term outcomes is unclear (Beeber et al., 2010; Brody & Galvin, 2013; Sockalingam et al., 2014; Yanamadala et al., 2013).

One moderately rated systematic review found that only 2 percent of training manuals for care of people with dementia were based on evidence (Fossey et al., 2014). Although this study was focused only on dementia care training, it raises the importance of ensuring that educational programs align with evidence-based best practices.

Below is a discussion of evidence that supports the value of educational programs that are interactive and multimodal, interprofessional, tailored to learners' needs, reinforced at the point of care, and supported by clinical experts or trained champions[G].

Interactive and Multimodal Approaches

Educational programs that are interactive and multimodal appear to enhance learning (Perry et al., 2011; Rampatige et al., 2009; Yanamadala et al., 2013). Education should be based on the principles of adult learning (CCSMH, 2010) and should actively engage the learner (Perry et al., 2011). Examples of interactive and multimodal approaches noted in the literature include case-based discussion, practice-based workshops, role plays, vignettes, videos, and small group discussion (AGS, 2014; Chien et al., 2011; Lawrence et al., 2012; Yanamadala et al., 2013). Educators on the expert panel suggest that games and simulation activities may also help support application of knowledge.

Interprofessional Education

Overall, interprofessional education as a strategy for delirium, dementia, and depression knowledge advancement is supported in the literature (Blackburn & Bradshaw, 2014; Brody & Galvin, 2013; Sockalingam et al., 2014). Interprofessional educational programs can be defined as programs that "foster interactive learning between individuals and groups in two or more professions with the goal of improving collaboration and the quality of care" (Sockalingam et al., 2014, p. 34). A systematic review of randomized controlled trials points out, however, that interprofessional education alone is not sufficient; it must be paired with interprofessional clinical activities and an organizational commitment to interprofessional approaches (Sockalingam et al., 2014) (see **Recommendation 15.1**). Comprehensive training and interprofessional collaboration practices within an organization have the potential to improve team performance and collaboration, enhance quality of care, and reduce rates of delirium (Sockalingam et al., 2014). Blackburn & Bradshaw (2014) found interprofessional teams to be the *gold standard of care* for dementia.

Tailored to Address Learners' Needs

Education sessions should also be tailored to address learners' needs (AGS, 2014; CCSMH, 2010; Eggenberger et al., 2013). The expert panel suggests that content be developed to account for variability in expertise, and be adjusted to baseline knowledge, level of education, skill set, and scope of practice of the learner. Furthermore, education sessions should be flexible, taking into account the reality of the workplace, and held at locations convenient to the learner. One-on-one follow-up learning sessions are also helpful because feedback can be tailored for the individual, thereby enhancing learning (Eggenberger et al., 2013).

Reinforcing Learning with Tools, Resources, and Trained Champions or Clinical Experts

Educational programs are more effective when they are combined with strategies that reinforce and support learning (Eggenberger et al., 2013). These include the use of clinical pathways, assessment tools, pocket cards, and tip sheets (AGS, 2014; Yanamadala et al., 2013). Feedback at the point of care—for example, bedside teaching and coaching sessions to identify hypoactive delirium—supports learning (AGS, 2014; Eggenberger et al., 2013). Champions and clinical experts help health-care providers maintain new skills and reinforce best practices (AGS, 2014; Eggenberger et al., 2013; Yanamadala et al., 2013).

Although findings from the systematic review do not cover educational needs for all health-care providers—or for delirium, dementia, and depression in all clinical settings—the expert panel suggests that the delivery of tailored, interactive, and multimodal educational programs to interprofessional groups, reinforced by tools and knowledgeable staff, are sound educational approaches that have been found to be effective in practice. Therefore, the expert panel recommends that these principles be applied across health-care settings and for all three conditions. In settings where formal mentors (e.g., designated clinical educators) do not exist, the organization can train and empower informal champions to act as a peer-to-peer mentors to reinforce ongoing learning at the point of care.

In summary, the expert panel suggests that educational programs be designed so that they effectively build knowledge and skills that can be converted to practice change. Simply attending a lecture or requiring all health-care providers to complete an online course is insufficient to build capacity and the ability to care effectively for persons with complex conditions such as delirium, dementia, and depression. Health-care providers must learn skills over time, and have opportunities to apply those skills in practice within the context of interprofessional care and with support from people with advanced knowledge.

See RNAO's (2016) BPG *Practice Education in Nursing* for additional information and resources on the provision of quality practice education.

RECOMMENDATION 14.4:

Evaluate educational programs on delirium, dementia, and depression to determine whether they meet desired outcomes, such as practice changes and improved health outcomes. Refine programs as required.

Level of Evidence = V

Discussion of Evidence:

Educational programs for delirium, dementia and depression need to be evaluated to determine if they meet desired outcomes. To date, few evaluation studies report on outcomes of educational programs (Beeber et al., 2010; Brody & Galvin, 2013; Sockalingam et al., 2014; Yanamadala et al., 2013). The expert panel points out that although participant satisfaction and staff knowledge are important, educational programs should aim to affect higher-level learning outcomes and examine the extent to which education produces changes in health-care-provider behaviour and health outcomes. Furthermore, educational programs should be revised or redesigned, as needed, to ensure that programs build competency and sustainable practice change.

Resources to support this recommendation include the section on Evaluating and Monitoring This Guideline, which provides structure, process, and outcome indicators; and RNAO's (2012b) *Toolkit: Implementation of Best Practice Guidelines.*

Organization and Policy Recommendations

15.0 ORGANIZATION AND POLICY

RECOMMENDATION 15.1:

Organizations demonstrate leadership and maintain a commitment to foundational principles that support care for older adults with delirium, dementia, and depression, including:

- person- and family-centred care (level of evidence = Ia),
- collaborative, interprofessional care (level of evidence = Ia), and
- healthy work environments (level of evidence = V).

Discussion of Evidence:

Consistent evidence supports the recommendation that caring for people with delirium, dementia, and depression requires person- and family-centred principles and collaborative, interprofessional care. Following is a discussion of evidence to support each concept.

Person- and Family-Centred Care

Person- and family-centred care is highlighted across the literature for delirium, dementia, and depression as an important and effective strategy for supporting people with these conditions (Cabrera et al., 2015; Enmarker et al., 2011; Konno et al., 2013; Lawrence et al., 2012; Livingston et al., 2014; NICE, 2009, 2010; Spenceley et al., 2015). For example, these approaches are important when engaging families in the assessment processes (Inouye et al., 2014; NICE, 2009) and when developing individualized plans of care.

Person- and family-centred care is a broad concept that encompasses various principles, attitudes, behaviours, and approaches to care (RNAO, 2015b). The overarching themes outlined in RNAO's (2015b) BPG *Person- and Family-Centred Care* are consistent with the delirium, dementia, and depression literature. These include:

1. establishing a therapeutic relationship for true partnership, continuity of care, and shared decision-making;
2. care is organized around, and respectful of, the person;
3. knowing the whole person (holistic care); and
4. communication, collaboration, and engagement.

See **Appendix A** for the definition of person- and family-centred care, and see RNAO's (2015b) BPG, P*erson- and Family-Centred Care* for a more extensive discussion and recommendations.

Adopting person- and family-centred approaches to care takes time to plan and coordinate, especially for people with dementia (Konno et al., 2013; Lawrence et al., 2012). Furthermore, adopting a person- and family-centred approach requires training, adequate staffing, supervision, and organizational support (Beeber et al., 2010; Eggenberger et al., 2013; Fossey et al., 2014; Lawrence et al., 2012; Livingston et al., 2014; Seitz et al., 2012; Spector et al., 2013). While the need for organizational support for person- and family-centred care is highlighted primarily in the dementia literature, the expert panel emphasizes that this is a foundational principle for delirium and depression as well, and is applicable for all types of health-care organizations.

Collaborative, Interprofessional Care

Collaborative, interprofessional care is also consistently recommended for the care of people with delirium, dementia, and depression (Brody & Galvin, 2013; Chang-Quan et al., 2009; Cody & Drysdale, 2013; Dreizler et al., 2014; Nguyen & Vu, 2013; NICE, 2009, 2012b; O'Connor et al., 2009; Sockalingam et al., 2014; Spenceley et al., 2015; Thyrian, Wubbeler, & Hoffmann, 2013; Trangle et al., 2016). For example, interprofessional collaboration can reduce rates of delirium, as found in a moderately rated systematic review (Sockalingam et al., 2014). It has also been found to promote quality care for people with dementia (Brody & Galvin, 2013; Dreizler et al., 2014), and improve the effectiveness of depression treatment (Chang-Quan et al., 2009), particularly among people with complex depression and chronic health conditions (NICE, 2009).

Healthy Work Environments

It is well established that work stress and burnout negatively impact care (Elliott et al., 2012). The expert panel recommends that organizations demonstrate leadership and a commitment to promoting healthy work environments^G. This includes addressing the well-being of staff, and ensuring appropriate workloads and staffing levels.

Promoting healthy work environments was recommended in RNAO's (2010a) BPG *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression*. The Guideline suggested that organizations recognize that health-care providers' well-being is vital to the care of older adults with delirium, dementia, and depression (RNAO, 2010a). Furthermore, to support the complex needs of people with delirium, dementia, and depression, workload and staffing decisions should consider the level of complexity of the needs of the population, and the expertise required (Conn et al., 2014; RNAO, 2010a). For in-depth information and guidelines on healthy work environments, see RNAO's Healthy Work Place Environment Guidelines at http://RNAO.ca/bpg/guidelines/hwe-guidelines.

Demonstrating Principles Through Leadership and Commitment

Organizations can demonstrate leadership and a commitment to person- and family-centred care, interprofessional collaborative care, and healthy work environments in various ways. For example, organizations can ensure that principles of person- and family-centred care are embedded in their mission and vision, dedicate resources for education and skill building, and measure and monitor outcomes (RNAO, 2015b). Further information can be found in RNAO's (2012b) *Toolkit: Implementation of Best Practice Guidelines* and among the indicators for monitoring and evaluating the implementation of this Guideline (see the section on Evaluating and Monitoring This Guideline).

RECOMMENDATION 15.2:

Organizations select validated screening and assessment tools for delirium, dementia, and depression that are appropriate to the population and health-care setting, and provide training and infrastructure to support their application.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends that organizations determine which screening and assessment tools should be used in their clinical setting(s). This is important because, while a variety of tools are available, many are not universally appropriate (Clevenger et al., 2012; Jackson et al., 2013; Lischka et al., 2012). It is important to use tools that demonstrate reliability^G and validity for the population and clinical setting (Trangle et al., 2016). For example, organizations should determine which tools should be used if an older adult is unable to participate fully in the assessment process (Conn et al., 2015; RNAO, 2010a).

Culturally appropriate versions of tools should be used whenever possible. If language barriers exist, the expert panel recommends the use of professional translators. Other considerations for tool selection include the context of the clinical setting, the time and resources available, and the clinical skills of staff (Conn et al., 2015; Development Group, 2010; NICE, 2009; RNAO, 2010a; Trangle et al., 2016; U.S. Preventative Services Task Force, 2014).

To optimize implementation of screening and assessment tools, organizations should ensure staff are appropriately trained (see **Recommendations 14.2** and **14.3**), and that supporting infrastructure (e.g., documentation and monitoring systems) is in place. For further information, see RNAO's (2012b) *Toolkit: Implementation of Best Practice Guidelines*. See **Appendix H** for a list of screening tools.

RECOMMENDATION 15.3:

Organizations implement comprehensive, multi-component programs, delivered by collaborative teams within organizations, to address delirium, dementia, and depression (level of evidence = Ia).

These should be supported by:

- comprehensive educational programs (level of evidence = V),
- clinical experts and champions (level of evidence = Ia), and
- organizational processes that align with best practices (level of evidence = V).

Discussion of Evidence:

Comprehensive, multi-component programs have been recommended in the literature and clinical guidelines as a way to effectively address delirium, dementia, and depression. For people at risk for delirium, this includes the delivery of prevention strategies by an interprofessional team throughout the course of hospitalization (AGS, 2014; Khan et al., 2012; Martinez et al., 2015). For example, the Hospital Elder Life Program (HELP), highlighted by a meta-analysis and literature review, is a comprehensive program that uses an interprofessional team and trained volunteers to implement multi-component interventions to prevent delirium and functional decline (Hshieh et al., 2015; Inouye et al., 2014).

For care of people with dementia, the literature highlights the importance of identifying needs and developing individualized plans of care that include a wide range of non-pharmacological interventions to address behavioural and psychological symptoms (see **Recommendation 7.1**).

For the primary-care sector, comprehensive programs for depression management include treatment protocols, patient education, training of all office staff, and arranging referrals and post-visit follow-up care (O'Connor et al., 2009).

The successful delivery of comprehensive multi-component programs for delirium, dementia, and depression can be enabled by various factors. First, health-care providers need to be adequately trained in how to implement the programs, and their training must be reinforced over time with the support of experts and champions (see **Recommendations 14.2** and **14.3**). Second, some aspects of programs may need to be delivered by people with specialized training (e.g., music therapy, reminiscence, and depression therapies) (Housden, 2009; Livingston et al., 2014; NICE, 2012b).

Leadership and commitment at the organizational level is important in order to support the implementation of these programs (see **Recommendation 15.1**), and having specific procedures, processes, and resources in place may facilitate consistent implementation. Examples include the availability of manuals for managers and staff that outline best practices (Livingston et al., 2014), screening processes that are embedded in electronic documentation processes (RNAO, 2010a), and care pathways and order sets.

RECOMMENDATION 15.4:

Establish processes within organizations to ensure that relevant information and care planning for older adults with delirium, dementia, and depression is communicated and coordinated over the course of treatment and during care transitions.

Level of Evidence = Ia & V

Discussion of Evidence:

The expert panel recommends that organizations establish processes to communicate and coordinate care for people with delirium, dementia, and depression within and across care settings. This includes "appropriate processes to transfer information (e.g., appropriate referrals, communication, documentation, policies that support formal methods of information transfer, and networking between healthcare providers)" (RNAO, 2010a, p. 13).

Communication and coordination of care is necessary because care is provided across different settings, throughout the course or progression of illness, and between care providers within individual health-care settings. Communication and coordination are particularly important in order to maintain consistency with personalized, tailored interventions (Lawrence et al., 2012), and for safety (Kuske et al., 2014). RNAO's (2014b) BPG *Care Transitions* outlines various strategies for maintaining safe, effective, coordinated care.

Case management^{G} and case conferencing are two strategies identified in the literature for communicating and coordinating care for people with dementia. For the care of people with dementia, case management can help address both health and social changes, can offer comprehensive support, and can enhance the delivery of multi-component interventions (Zabalegui et al., 2014). Other potential benefits include decreased caregiver burden and reduced institutionalization (Reilly et al., 2015; Zabalegui et al., 2014). Systematic review evidence suggests that case management may be more successful if the caseload is reasonable, if roles are clearly articulated within the interprofessional team, if it is reserved for people with prominent symptoms of dementia (Khanassov, Vedel, & Pluye, 2014), and if there is integration between health and social professionals (Somme et al., 2012).

Two reviews discussed case conferencing, in which health-care providers and care partners meet to discuss and develop a person-centred plan of care (Phillips, West, Davidson, & Agar, 2013). Reuther et al. (2012) found that evidence on the outcomes of case conferencing was not well proven. However, Phillips et al. (2013) outlined several potential benefits for people with advanced dementia living in long-term care. These included enhanced communication, coordination and care planning, and family and health-care-team engagement; and prevention of unnecessary hospitalization or enhanced care transitions if hospitalization was required. The expert panel suggests that case conferencing may be useful in other settings as well.

Research Gaps and Future Implications

The RNAO Best Practice Guideline Program Team and expert panel, in reviewing the evidence for this Guideline, identified the priority areas for research set out in Table 9. They are broadly categorized into practice, outcome, and health-system research.

Table 9: Priority Practice, Outcome, and Health-System Research Areas

CATEGORY	PRIORITY RESEARCH AREA

The above table, though not exhaustive, is an attempt to identify and prioritize the research needed with respect to delirium, dementia, and depression in older adults. Many of the recommendations in this Guideline are based on quantitative and qualitative research evidence; others are based on the other clinical guidelines or RNAO expert panel opinion. Further substantive research is required to validate some of these recommendations. Increasing the research evidence will lead to improved care of older adults with delirium, dementia, and/or depression.

Implementation Strategies

Implementing guidelines at the point of care is multi-faceted and challenging; it takes more than awareness and distribution of guidelines for practice to change. Guidelines must be adapted for each practice setting in a systematic and participatory way, to ensure recommendations fit the local context (Harrison, Graham, Fervers, & Hoek, 2013). The RNAO (2012b) *Toolkit: Implementation of Best Practice Guidelines* provides an evidence-informed process for doing this (see **Appendix L**).

The *Toolkit* is based on emerging evidence that successful uptake of best practice in health care is more likely when:

- Leaders at all levels are committed to supporting guideline implementation;
- Guidelines are selected for implementation through a systematic, participatory process;
- Stakeholders for whom the guidelines are relevant are identified and engaged in the implementation;
- Environmental readiness for implementing guidelines is assessed;
- The guideline is tailored to the local context;
- Barriers and facilitators to using the guideline are assessed and addressed;
- Interventions to promote use of the guideline are selected;
- Use of the guideline is systematically monitored and sustained;
- Evaluation of the guideline's impact is embedded in the process; and
- There are adequate resources to complete all aspects of the implementation.

The *Toolkit* uses the "Knowledge-to-Action" framework (Straus, Tetroe, Graham, Zwarenstein, & Bhattacharyya, 2009) to demonstrate the process steps required for knowledge inquiry and synthesis. It also guides the adaptation of the new knowledge to the local context and implementation. This framework suggests identifying and using knowledge tools, such as guidelines, to identify gaps and to begin the process of tailoring the new knowledge to local settings.

RNAO is committed to widespread deployment and implementation of our Best Practice Guidelines (BPGs). We use a coordinated approach to dissemination, incorporating a variety of strategies, including:

1. the Nursing Best Practice Champion Network®, which develops the capacity of individual nurses to foster awareness, engagement, and adoption of BPGs;
2. nursing order sets[G], which provide clear, concise, actionable intervention statements derived from the BPGs' practice recommendations that can be readily embedded within electronic medical records, but may also be used in paper-based or hybrid environments; and
3. the Best Practice Spotlight Organization® (BPSO®) designation, which supports implementation at the organization and system levels. BPSOs® focus on developing evidence-based cultures with the specific mandate to implement, evaluate, and sustain multiple RNAO BPGs.

In addition, we offer annual capacity-building learning institutes on specific BPGs and their implementation. Information about our implementation strategies can be found at:

- RNAO Best Practice Champions Network®: www.RNAO.ca/bpg/get-involved/champions
- RNAO Nursing Order Sets: www.RNAO.ca/bpg/initiatives/nursing-order-sets
- RNAO Best Practice Spotlight Organizations®: www.RNAO.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: www.RNAO.ca/events

Evaluating and Monitoring This Guideline

As you implement the recommendations in this Guideline, we ask you to consider how you will monitor and evaluate its implementation and impact.

Table 10 is based on a framework outlined in RNAO's (2012b) T*oolkit: Implementation of Best Practice Guidelines* and illustrates some specific indicators for monitoring and evaluating implementation of this Guideline.

Table 10: Structure, Process, and Outcome Indicators

TYPE OF INDICATOR		
STRUCTURE	**PROCESS**	**OUTCOME**
These indicators refer to the supports and resources required by a health system, health service organization, or academic institution to enable the successful implementation of the *Guideline Delirium, Dementia, and Depression in Older Adults: Assessment and Care, Second Edition*.	These indicators evaluate whether best practices directed at the education, training, and practice of health-care professionals to improve the assessment and care of older adults with delirium, dementia, and depression have been implemented.	These indicators evaluate the impact of implementing the Guideline recommendations on health-care organizations, health-care professionals, and client outcomes.
	Health-care-provider education- and training-specific process indicators	**Health-care-provider-specific outcome indicators**

TYPE OF INDICATOR		
STRUCTURE	**PROCESS**	**OUTCOME**

TYPE OF INDICATOR		
STRUCTURE	**PROCESS**	**OUTCOME**

	TYPE OF INDICATOR	
	PERSON-SPECIFIC PROCESS INDICATORS	**PERSON-SPECIFIC OUTCOME INDICATORS**

	TYPE OF INDICATOR	
	PERSON-SPECIFIC PROCESS INDICATORS	**PERSON-SPECIFIC OUTCOME INDICATORS**

Other RNAO resources for the evaluation and monitoring of Best Practice Guidelines:

- Nursing Quality Indicators for Reporting and Evaluation® (NQuIRE®) were designed for RNAO's Best Practice Spotlight Organizations® (BPSO®) to systematically monitor the progress and evaluate the outcomes of implementing RNAO best practice guidelines in their organizations. NQuIRE is the first international quality improvement initiative of its kind consisting of a database of quality indicators derived from recommendations of selected RNAO clinical Best Practice Guidelines. Please visit www.RNAO.ca/bpg/initiatives/nquire for more information.
- Nursing order sets embedded within electronic medical records provide a mechanism for electronic data capture of process indicators. The ability to link structure and process indicators with specific client outcome indicators aids in determining the impact of BPG implementation on specific client health outcomes. Please visit www.RNAO.ca/ehealth/nursingordersets for more information.

Process for Update and Review of the Guideline

The Registered Nurses' Association of Ontario commits to updating its Best Practice Guidelines (BPGs) as follows:

1. Each nursing BPG will be reviewed by a team of specialists in the topic area every five years following publication of the previous edition.
2. RNAO International Affairs and Best Practice Guideline (IABPG) Centre staff regularly monitor for new systematic reviews, randomized controlled trials, and other relevant literature in the field.
3. Based on that monitoring, staff may recommend an earlier revision period for a particular BPG. Appropriate consultation with members of the original expert panel and other specialists and experts in the field will help inform the decision to review and revise the BPG earlier than planned.
4. Three months prior to the review milestone, the staff commences planning of the review by:
    a) Inviting specialists in the field to participate on the expert panel. The panel will be comprised of members from the original panel as well as other recommended specialists and experts.
    b) Compiling feedback received and questions encountered during the implementation, including comments and experiences of Best Practice Spotlight Organizations® and other implementation sites regarding their experiences.
    c) Compiling a list of new clinical practice guidelines in the field and refining the purpose and scope.
    d) Developing a detailed work plan with target dates and deliverables for developing a new edition of the BPG.
5. New editions of BPGs will be disseminated based on established structures and processes.

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World Health Organization. (2016). *What are social determinants of health?* Retrieved from: http://www.who.int/social_determinants/sdh_definition/en/

Yanamadala, M., Wieland, D., & Heflin, M. T. (2013). Educational interventions to improve recognition of delirium: A systematic review. *Journal of the American Geriatrics Society, 61*(11), 1983–1993.

Zabalegui, A., Hamers, J. P. H., Karlsson, S., Leino-Kilpi, H., Renom-Guiteras, A., Saks, K., ... Cabrera, E. (2014). Best practices interventions to improve quality of care of people with dementia living at home. *Patient Education and Counseling, 95*(2), 175–184.

Appendix A: Glossary of Terms

"Activities usually performed in the course of a normal day, including ambulation, eating, dressing, bathing, brushing the teeth, and grooming" (Ross-Kerr, Wood, Astle, & Duggleby, 2014, p. 189).

"A multistage process whereby a patient and their carers achieve a shared understanding of their goals and preferences for future care" (Robinson et al., 2012, p. 262).

Analytical studies test hypotheses about exposure–outcome relationships. The investigators do not assign an intervention, exposure, or treatment, but do measure the association between exposure and outcome over time using a comparison group (Centers for Disease Control and Prevention [CDC], 2013). Analytical study designs include case-control studies and cohort studies.

A study that compares people with a specific disease or outcome of interest (cases) to people from the same population without that disease or outcome (controls) (The Cochrane Collaboration, 2005).

An observational study in which a defined group of people (the cohort) is followed over time either prospectively or retrospectively (The Cochrane Collaboration, 2005).

"Antipsychotic medicines are used primarily to manage psychosis. The word "psychosis" is used to describe conditions that affect the mind, and in which there has been some loss of contact with reality, often including delusions (false, fixed beliefs) or hallucinations (hearing or seeing things that are not really there). It can be a symptom of a physical condition, such as drug abuse, or a mental disorder, such as schizophrenia, bipolar disorder, or very severe depression (also known as "psychotic depression")" (National Institute for Mental Health, 2016).

"A structured, goal-focused, therapeutic approach that encourages engagement in rewarding activities rather than withdrawal and inactivity. Behavioural activation aims to increase the levels of positive reinforcement experienced by the client" (SIGN, 2010, p. 27).

A term used to describe the way a person expresses his/her needs and exhibits symptoms of dementia, including through changes in mood, delusions, apathy, agitation, wandering, calling out, repetitive questioning, and sexual disinhibition (Moniz Cook et al., 2012). Other terms used to describe BPSD include "neuropsychiatric symptoms," "behavioural and emotional symptoms," "needs-driven behaviour," "responsive behaviours," "personal expressions," and "expressive behaviours." See the discussion under Purpose and Scope.

"Behavioural therapy addresses the negative cognitions and emotions associated with depression in an indirect way. It has been described as being different from traditional cognitive approaches in that it seeks to help patients modify their environment, not their thinking" (Samad et al., 2011, p. 1212).

Systematically developed statements to assist practitioner and client decisions about appropriate health care for specific clinical (practice) circumstances (Field & Lohr, 1990); also called clinical practice guidelines.

A term used to describe the challenges associated with caring for a person with an illness/disorder. See the discussion under Purpose and Scope.

"A set of actions designed to ensure the safe and effective coordination and continuity of care as individuals experience a change in health status, care needs, health-care providers, or location (within, between, or across settings)" (Coleman & Boult, 2003, as cited in RNAO, 2014b, p. 66).

In this Guideline, the term caregiver refers to family members, friends, or others who provide care and support for another person. This term is used interchangeably with "care partners" and "family caregivers."

RNAO defines BPG champions as "nurses and other health-care professionals who are educated and trained to better understand evidence-based practice, BPGs and the process of introducing evidence-based practice into clinical settings" (RNAO, 2012b, p. 9). Roles may include mentorship, education, and the facilitation of changes in policy and practice.

A process for making policy decisions, not a scientific method for creating new knowledge. Consensus development makes the best use of available information, be that scientific data or the collective wisdom of the participants (Black et al., 1999).

A clinical trial in which the investigator assigns an intervention, exposure, or treatment to participants who are not randomly allocated to the experimental and comparison or control group (The Cochrane Collaboration, 2005).

"A structured and collaborative therapeutic approach requiring appropriate training and ongoing supervision. CBT aims to make explicit connections between thinking, emotions, physiology and behaviour, primarily through behavioural experiments and guided discovery, in order to achieve systematic change in underlying beliefs and behavioural patterns, which are thought to cause and maintain psychological problems" (SIGN, 2010, p. 27).

"Culture refers to the shared and learned values, beliefs, norms, and ways of life of an individual or group. It influences thinking, decisions, and actions" (RNAO, 2015a p. 71). "An individual's culture is influenced by many factors, such as race, gender, religion, ethnicity, socio-economic status, sexual orientation and life experience. The extent to which particular factors influence a person will vary" (CNO, 2009a, p. 3).

"Cultural competence is the application of knowledge, skills, attitudes or personal attributes required by nurses to maximize respectful relationships with diverse populations of clients and co-workers." Clients may be individuals, families, groups, or populations. (Canadian Nurses Association, 2010, p. 1).

“Awareness, understanding, and attitudes toward culture and place the focus on self-awareness and insight” (RNAO, 2007, p. 71).

Studies that generate hypotheses and describe characteristics of a sample of individuals at one point in time. The investigators do not assign an intervention, exposure, or treatment to test a hypothesis, but merely describe the who, where, or when in relation to an outcome (CDC, 2013; The Cochrane Collaboration, 2005). Descriptive study designs include cross-sectional studies.

A study measuring the distribution of some characteristic(s) in a population at a particular point in time (also called a survey) (The Cochrane Collaboration, 2005).

Statements of educational requirements and educational approaches/strategies for the introduction, implementation, and sustainability of the BPG.

Information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high-quality, methodologically appropriate research provide the most accurate evidence. Because research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to, or stand-ins for, research. The evidence base for a decision is the multiple forms of evidence combined to balance rigour with expedience while privileging the former over the latter (Canadian Health Services Research Foundation, 2005).

“A term used to refer to individuals who are related (biologically, emotionally, or legally) to and/or have close bonds (friendships, commitments, shared households and child rearing responsibilities, and romantic attachments) with the person receiving health care. A person’s family may include all those whom the person identifies as significant in his or her life (e.g., parents, caregivers, friends, substitute decision-makers, groups, communities, and populations). The person receiving care determines the importance and level of involvement of any of these individuals in their care based on his or her capacity” (Saskatchewan Ministry of Health, 2011, as cited in RNAO, 2015b, p. 72).

“In this guideline, the term refers to regulated health-care providers or professionals and, in some cases, to unregulated health-care providers who provide care and services to persons and their families in any setting (acute, long-term care, home health care, primary care, and community)” (RNAO, 2015b, p. 72).

In Ontario, the Regulated Health Professions Act, 1991 (RHPA) provides a framework for regulating 23 health professions, outlining the scope of practice and the profession-specific controlled or authorized acts that each regulated professional is authorized to perform when providing health care and services (CNO, 2014a, as cited in RNAO, 2015b, p. 72).

Unregulated health-care providers (UCPs) fulfill a variety of roles in areas that are not subject to the RHPA. They are accountable to their employers but not to an external regulating professional body (e.g., College of Nurses of Ontario). UCPs fulfill a variety of roles and perform tasks that are determined by their employer and employment setting. UCPs only have the authority to perform a controlled act as set out in the RHPA if the procedure falls under one of the exemptions set out in the Act (CNO, 2013c, as cited in RNAO, 2015b, p. 72).

“A practice setting that maximizes the health and well-being of nurses (and other health-care providers), quality patient outcomes, and organizational performance” (RNAO, 2013b, p. 64).

“In Ontario, under s. 11 of the *Health Care Consent Act, 1996*, consent for care and treatment is informed if, before providing consent, the person receives information about treatment that a reasonable person under the same circumstances would require to make a decision and receives responses to his/her requests for additional information about the treatment. Information must be provided regarding the nature of treatment; material risks and side effects of the treatment; alternative course of action; and likely consequences of not having the treatment. In addition, consent must relate to the treatment, be informed, be voluntary, and must not be obtained through misrepresentation or fraud. A nurse (or other health-care provider) should not provide treatment if in doubt regarding whether the person understands and is able to consent” (CNO, 2013a, as cited in RNAO, 2015b, p. 73).

“These are activities that allow people to adapt to their environment and maintain independence in the community…They include activities such as: telephoning, shopping, cooking, looking after the house, using transport, managing medication, handling money, etc.” (Development Group, 2010, p. 436).

“A time-limited intervention that aims to reduce a person’s symptoms by working on improving the quality of his/her interpersonal relationships. IPT focuses on specific interpersonal problem areas such as grief, role transitions, and interpersonal disputes. A positive therapeutic alliance is encouraged, and a range of therapeutic strategies are employed to encourage the open expression of affect and problem resolution. Patient literacy is not required” (SIGN, 2010, p. 27).

“A team comprised of multiple health-care providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health care and services to people within, between, and across health-care settings” (RNAO, 2015b, p. 73).

This Guideline uses the term long-term care (LTC) generically. The term is used to refer to “any congregate living residence, created for older adults and others with chronic illnesses, disabilities, and/or deficits in activities of daily living (ADL) or instrumental activities of daily living (IADL) that necessitate skilled nursing care on a daily basis. This would include, for example, facilities known as nursing homes and complex care facilities.” (CCSMH, 2006, p. 8).

Mental capacity generally refers to a person’s ability to make decisions, but definitions of mental capacity vary between jurisdictions. Under Ontario’s *Health Care Consent Act, 1996*, the legal definition of mental capacity involves the ability to understand information relevant to making a decision and to appreciate the consequences of a decision or lack of a decision.

A systematic review of randomized controlled trials that uses statistical methods to analyze and summarize the results of the included studies (The Cochrane Collaboration, 2005).

“Mild cognitive impairment (MCI) causes a slight but noticeable and measurable decline in cognitive abilities, including memory and thinking skills. ... [T]he changes are not severe enough to interfere with daily life or independent function” (Alzheimer’s Association, 2016a, para. 1). People with MCI are at increased risk of developing dementia, and MCI in many cases indicates early stages of dementia. (Alzheimer’s Association, 2016a).

“Mindfulness has been defined as paying attention in a particular way: on purpose, in the present moment, and non-judgmentally (in contrast to being absorbed in ruminative thinking)” (SIGN, 2010, p. 27).

“Neuropsychiatric symptoms are common in dementia and the majority of individuals with advanced dementia have one or more, the most common of which are agitation or aggressive behaviour, depression, apathy or withdrawal, psychosis, and aberrant motor behaviour” (Kverno et al., 2008; Zuidema et al., 2007, as cited in Kverno et al., 2009, p. 825).

“Refers to registered nurses, licensed practical nurses (referred to as registered practical nurses in Ontario), registered psychiatric nurses, and nurses in advanced practice roles such as nurse practitioners and clinical nurse specialists” (RNAO, 2013b, p. 64).

A group of evidence-based interventions specific to the domain of nursing. Nursing order sets are ordered independently by nurses (i.e., without a physician’s signature) to standardize the care provided for a specific clinical condition or situation.

In this Guideline, the term refers to adults age 65 years and older. It may also refer to people younger than 65 who have aged prematurely or who have a shortened life expectancy due to factors such as the social determinants of health or chronic disease.

Statements of conditions required for a practice setting that enable the successful implementation of the BPG. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader government or societal level.

“*Person-centred-care attitudes* reflect the health-care provider’s belief in the importance of coming to know the whole person (biopsychosocial and spiritual) when assessing the person’s condition. They also include a belief in the person’s ability to make a decision; the health-care provider therefore promotes autonomy and the sharing of power.

Person-centred-care behaviours are the observed characteristics of health-care providers corresponding to person-centred-care attitudes, including verbal behaviours (e.g., asking questions in a way that shows respect, caring, and interest in what the person is saying) and non-verbal behaviours (e.g., sitting down and facing the person when speaking to them so the person feels like they are in a collegial partnership). Attitudes and behaviours are both important components of patient-centred care” (Duggan et al., 2006, as cited in RNAO, 2015b, p. 74).

"A person- and family-centred approach to care demonstrates certain practices that put the person and their family members at the centre of health care and services. Person- and family-centred care respects and empowers individuals to be genuine partners with health-care providers for their health. The approach includes the following common themes and attributes:

- Fostering relationships and trust;
- Empowering the person to be actively involved in making decisions regarding their health care (independence and autonomy, right to self-determination);
- Sharing of evidence-based options for care, education, and information that is unbiased, clear, and comprehensive to support the person in making decisions;
- Respecting the person and personalizing care by promoting the person's strengths, self-knowledge, preferences, and goals for care based on their beliefs, values, culture, and their experience of health;
- Providing physical comfort within an environment that is conducive to healing;
- Offering emotional support and sympathetic presence;
- Ensuring continuity of care during transitions;
- Ensuring the person's ability to access care and services when needed;
- Partnering with the person and their family in health system reform to improve the quality, delivery, and design of health care and services at all levels (micro, meso, and macro);
- Communicating effectively within a therapeutic relationship to promote true health-care partnerships; and
- Caring for individuals, their families, and communities by addressing determinants of health (health promotion and disease prevention)" (RNAO, 2015b, p. 75).

"The term polypharmacy refers to the group of medications one person may be taking ... It is generally used when that one person is taking too many medications, or when the drugs have been prescribed by many doctors, and may not have been coordinated well" (Rambhade, Chakarborty, Shrivastava, Patil, & Rambhade, 2012, p. 69).

Definitions for polypharmacy vary; often, it is simply referred to as the total number of different medications a person takes concurrently (excluding topical medications and herbal).

Statements of best practice directed at health-care providers that enable the successful implementation of the BPG; ideally, they are based on evidence.

In this Guideline, the term primary care provider refers to a nurse practitioner or physician.

"A brief, focused, psychological intervention that is delivered by an individual trained in problem solving approaches. These are often highly individualized and have a pragmatic focus, in which the professional and individual work through a series of defined steps to clarify the person's problems and desired goals, generate potential solutions, and help implement the chosen solution" (SIGN, 2010, p. 27).

Psychotropic medications fall into several categories, such as antidepressants, antianxiety drugs, antimanic agents (mood stabilizers), antipsychotics, and stimulants (Stanford School of Medicine, 2016).

Research that uses an interactive and subjective approach to investigate and describe phenomena (e.g., lived experience) and to give them meaning. The nature of this type of research is exploratory and open-ended. Analysis involves the organization and interpretation of non-numerical data (e.g., Phenomenology, Ethnography, Grounded Theory, Case Study, etc.) (Speziale & Carpenter, 2007).

"The degree to which health-care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (WHO, 2009).

A study that lacks randomization and a control group and therefore is not considered a "true" experimental design (e.g., a randomized controlled trial). The investigator controls the assignment to the intervention, exposure, or treatment by using some criterion other than random assignment (e.g., pre–post design) (Polit, Beck, & Hungler, 2001).

An experiment in which the investigator assigns an intervention, exposure, or treatment to participants who are randomly allocated to either the experimental group (receives intervention) and the comparison (conventional treatment) or control group (no intervention or placebo) (The Cochrane Collaboration, 2005). The participants are followed and assessed to determine the efficacy of the intervention. Includes double-blind, single-blind, and non-blind trials.

"Recovery is a paradigm that is conceptualized and understood as a process that is unique to each individual. It is not defined as an endpoint, but rather as a journey that is rooted in the cornerstones of dignity, hope, empowerment, and resilience" (Forchuck, 2003; Jacobson & Curtis, 2000, as cited in in RNAO, 2015a, p. 28).

Reflective practice (sometimes referred to as *self-awareness*) is an important component of a therapeutic relationship and can be defined as "the ability to reflect on one's practice, thoughts, feelings, needs, fears, strengths, and weaknesses, and to understand how these might affect one's actions and the nurse–client relationship" (RNAO, 2006a, p. 13).

"An inquiry that is guided by conscious participation with clients using a number of relational skills, including listening, questioning, empathy, mutuality, reciprocity, self-observation, reflection, and a sensitivity to emotional contexts. Relational practice encompasses therapeutic nurse–client relationships and relationships among health-care providers" (Doane & Varcoe, 2007, as cited in CNO, 2014, p. 13).

"A structured groupwork or individual approach to stimulating and talking about personal memories" (Housden, 2009, p. 30).

The Ministry of Health and Long-Term Care defines responsive behaviours as "behaviours that often indicate: (a) An unmet need in a person, whether cognitive, physical, emotional, social, environmental or other, or (b) a response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person" (Ministry of Health and Long-Term Care, 2007, as cited in RNAO, 2012, p. 86).

"The degree of consistency or accuracy with which an instrument measures the attribute it is designed to measure" (Polit et al., 2001, p. 469).

"Physical, chemical or environmental measures used to control the physical or behavioural activity of a person or a portion of his/her body. Physical restraints limit a client's movement. Physical restraints include a table fixed to a chair or a bed rail that cannot be opened by the client. Environmental restraints control a client's mobility. Examples include a secure unit or garden, seclusion or a time-out room. Chemical restraints are any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behaviour or movement. Least restraint means all possible alternative interventions are exhausted before deciding to use a restraint and the least restrictive form of restraint to meet the client's needs should be used" (CNO, 2009c, as cited in RNAO, 2012a, p. 86).

"Scoping reviews have been described as a process of mapping the existing literature or evidence base. ... Scoping reviews can be used in a number of ways, for example identifying research gaps and summarizing findings of research. They can also be used to inform systematic reviews" (Armstrong, Hall, Doyle, & Waters, 2011, p. 147).

"The willful self-infliction of painful, destructive, or injurious acts without the intent to end one's life" (APA, 2003, p. 9).

Sexualized or sexually disinhibited behaviours include behaviours that include intimacy-seeking, sexual comments, and exhibitionism (Tucker, 2010).

The social determinants of health are "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at the global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries." (WHO, 2016, para. 1)

In this Guideline, the term stage is used to be consistent with the terminology currently used in the literature. However, the expert panel points out that terminology is shifting and practitioners may instead refer to the *degree of impairment* or *degree of cognitive* decline associated with dementia.

Alzheimer's disease can also be described as mild Alzheimer's (early-stage), moderate Alzheimer's (middle-stage), or severe Alzheimer's (late-stage) (Alzheimer's Association, 2016c).

An individual, group, or organization that has a vested interest in the decisions and actions of organizations, and may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all of the individuals and groups who will be directly or indirectly affected by the change or solution to the problem.

A substitute decision-maker is a person who makes decisions for another who is not mentally capable. This may include making certain decisions about the person's property or personal care (Wahl, 2009).

Term used to refer to the experience of people with Alzheimer's and dementia of "problems sleeping or increases in behavioral problems that begin at dusk and last into the night" (Alzheimer's Association, 2016b, para. 1).

A review that "attempts to collate all empirical evidence that fits pre-specified eligibility criteria in order to answer a specific research question" (The Cochrane Collaboration, 2011). A systematic review uses systematic, explicit, and reproducible methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the review (The Cochrane Collaboration, 2005, 2011).

"A purposeful, goal-directed relationship between the health-care provider and the person accessing the health system for care and treatment that is grounded in an interpersonal process directed at advancing the best interest and outcome of the person" (CNO, 2013b; RNAO, 2006a, as cited in RNAO, 2015b, p. 78).

In this Guideline, the term *valid* or *validated tool* is used to be consistent with current terminology in the literature and clinical guidelines. Validity is defined as "the degree to which an instrument measures what it is intended to measure" (Polit et al., 2001, p. 473). The expert panel recognizes that *reliability* is another important factor that should be considered when using tools.

Appendix B: Guideline Development Process

The Registered Nurses' Association of Ontario (RNAO) has made a commitment to ensure that every BPG is based on the best available evidence. To meet this commitment, a monitoring and revision process has been established for each Guideline every five years.

For this Guideline, RNAO assembled a panel of experts who represent a range of sectors and practice areas (see the RNAO Expert Panel section at the beginning of this Guideline). A systematic review of the evidence was based on the purpose and scope, and was supported by the four research questions listed below. The systematic review captured relevant peer-reviewed literature and guidelines published between January 2009 and March 2015.The following research questions were established to guide the systematic review:

1. What are the most effective ways for nurses to screen or assess older adults for delirium, dementia, and depression?
2. What are the most effective approaches for management of older adults with delirium, dementia, and depression?
3. What education and training strategies (taught in basic curricula, advanced practice education or ongoing professional development programs) do nurses need to be effective during the assessment and management of older adults with delirium, dementia, and/or depression?
4. What organizational policies and structures are required to enable nurses to assess and manage older adults with delirium, dementia, and/or depression?

This Guideline is the result of the RNAO Guideline development team and expert panel's work to integrate the most current and best evidence, and ensure the validity, appropriateness, and safety of the Guideline recommendations with supporting evidence and/or expert panel consensus^{G}.

Appendix C: Process for Systematic Review and Search Strategy

Guideline Review

The RNAO Guideline development team's project coordinator searched an established list of websites for guidelines and other relevant content published between January 2009 and March 2015. The resulting list was compiled based on knowledge of evidence-based practice websites and recommendations from the literature. Furthermore, expert panel members were asked to suggest additional guidelines. (See the **Guidelines Review Process Flow Diagram** on page 125). Detailed information about the search strategy for existing guidelines, including the list of websites searched and inclusion criteria, is available at www.RNAO.ca

The BPG program manager and nursing research associates appraised 21 international guidelines using the *Appraisal of Guidelines for Research and Evaluation Instrument II* (Brouwers et al., 2010). Guidelines with an overall score of three or below were considered weak and were excluded. Guidelines with a score of four or five were considered moderate, and guidelines with a score of six or seven were considered strong. The following 17 guidelines (rated moderate or strong) were selected to inform the recommendations and discussions of evidence:

American Geriatrics Society Expert Panel on Postoperative Delirium in Older Adults. (2014). *American Geriatrics Society Clinical Practice Guideline for Postoperative Delirium in Older Adults*. New York, NY: American Geriatrics Society.

American Geriatrics Society Expert Panel on Postoperative Delirium in Older Adults. (2015). Postoperative delirium in older adults: Best practice statement from the American Geriatrics Society. *Journal of the American College of Surgeons, 220*(2), 136–148.

American Medical Directors Association. (2008). *Delirium and acute problematic behavior in the long-term care setting*. Columbia, MD: Author. [Note: The AMDA reaffirmed the currency of this guideline in 2013.]

American Medical Directors Association. (2011). *Depression in the long-term care setting*. Columbia, MD: Author.

American Medical Directors Association. (2012). *Dementia in the long-term care setting*. Columbia, MD: Author.

Canadian Coalition for Seniors' Mental Health. (2010). *Guideline on the assessment and treatment of delirium in older adults at the end of life*. Toronto, ON: Author.

Development Group of the Clinical Practice Guideline on the Comprehensive Care of People with Alzheimer's Disease and Other Dementias. (2010). *Clinical Practice Guideline on the comprehensive care of people with Alzheimer's disease and other dementias*. Retrieved from http://www.guiasalud.es/GPC/GPC_484_Alzheimer_AIAQS_comp_eng.pdf

Gage, L., & Hogan, D. B. (2014). *2014 CCSMH guideline update: The assessment and treatment of delirium*. Toronto, ON: Canadian Coalition for Seniors' Mental Health. Retrieved from http://ccsmh.ca/wp-content/uploads/2016/03/2014-ccsmh-Guideline-Update-Delirium.pdf

National Institute for Health and Clinical Excellence. (2009). *Depression in adults: The treatment and management of depression in adults*. London, UK: Author.

National Institute for Health and Clinical Excellence. (2010). *Delirium: Diagnosis, prevention and management*. London, UK: Author.

National Institute for Health and Clinical Excellence. (2011). *Common mental health disorders: Identification and pathways to care*. London, UK: Author.

National Institute for Health and Clinical Excellence. (2012). *Delirium: Evidence update April 2012*. London, UK: Author.

National Institute for Health and Clinical Excellence. (2012). *Depression: Evidence update April 2012*. London, UK: Author.

National Institute for Health and Clinical Excellence. (2013). *Common mental health disorders: Evidence update March 2013*. London, UK: Author.

Scottish Intercollegiate Guidelines Network (SIGN). (2010). *Non-pharmaceutical management of depression in adults*. Edinburgh, UK: Author.

Trangle, M., Gursky, J., Haight, R., Hardwig, J., Hinnenkamp, T., Kessler, D. ... Myszkowski, M. (2016). *Adult depression in primary care*. Retrieved from Institute for Clinical Systems Improvements website: https://www.icsi.org/_asset/fnhdm3/Depr.pdf

U.S. Preventative Services Task Force. (2014). *Cognitive impairment in older adults: Screening*. Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cognitive-impairment-in-older-adults-screening

World Health Organization. (2012/2015). *Evidence-based recommendations for management of dementia in non-specialized health settings*. Retrieved from http://www.who.int/mental_health/mhgap/evidence/dementia/en/

World Health Organization. (2012/2015). E*vidence-based recommendations for management of depression in non-specialized health settings*. Retrieved from http://www.who.int/mental_health/mhgap/evidence/depression/en/

Systematic Review

A comprehensive search strategy was developed by RNAO's research team and a health sciences librarian, based on inclusion and exclusion criteria created with the RNAO expert panel. A search for relevant articles published in English between October 2009 and April 2015 was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), MEDLINE, MEDLINE In Process, Cochrane Library (Cochrane Database of Systematic Reviews and Cochrane Central Register of Controlled Trials), EMBASE, and PsychINFO; Education Resources Information Center (ERIC) was used for question three only. In addition to this systematic search, panel members were asked to review personal libraries for key articles not found through the above search strategies.

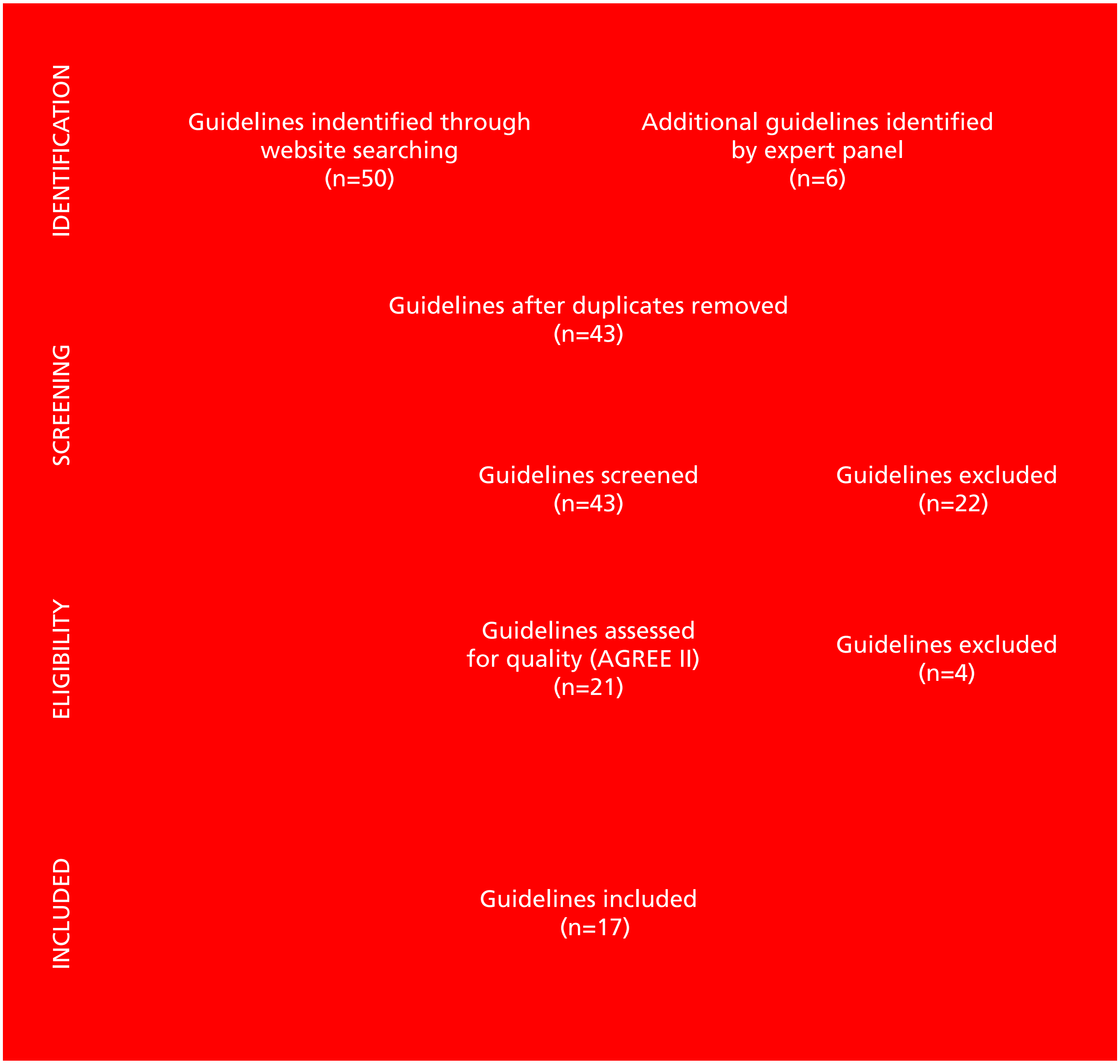
Detailed information about the search strategy for the systematic review, including the inclusion and exclusion criteria as well as search terms, is available at www.RNAO.ca/bpg/Delirium-Dementia-Depression

Once articles were retrieved, two RNAO nursing research associates (nurses holding master's degrees) independently assessed the eligibility of the studies according to established inclusion/exclusion criteria. Any disagreements at this stage were resolved through tie-breaking by the project manager.

Quality appraisal scores for 24 articles (a random sample of approximately 20 percent of the total articles eligible for data extraction and quality appraisal) were independently assessed by RNAO nursing research associates. Quality appraisal was assessed using AMSTAR (A Measurement Tool to Assess Systematic Reviews; see http://amstar.ca/index.php) and RNAO's scoring system that rates reviews as weak, moderate, or strong, depending on their quality scores. The nursing research Aassociates reached acceptable inter-rater agreement (kappa statistic, K=0.81), which justified proceeding with quality appraisal and data extraction for the remaining studies. The remaining studies were divided equally between the two research associates for quality appraisal and data extraction (Fleiss, Levin, & Paik, 2003). A final narrative summary of literature findings was completed. The comprehensive data tables and narrative summary were provided to all expert panel members for review and discussion.

A complete bibliography of all full text articles screened for inclusion is available at www.RNAO.ca/bpg/Delirium-Dementia-Depression

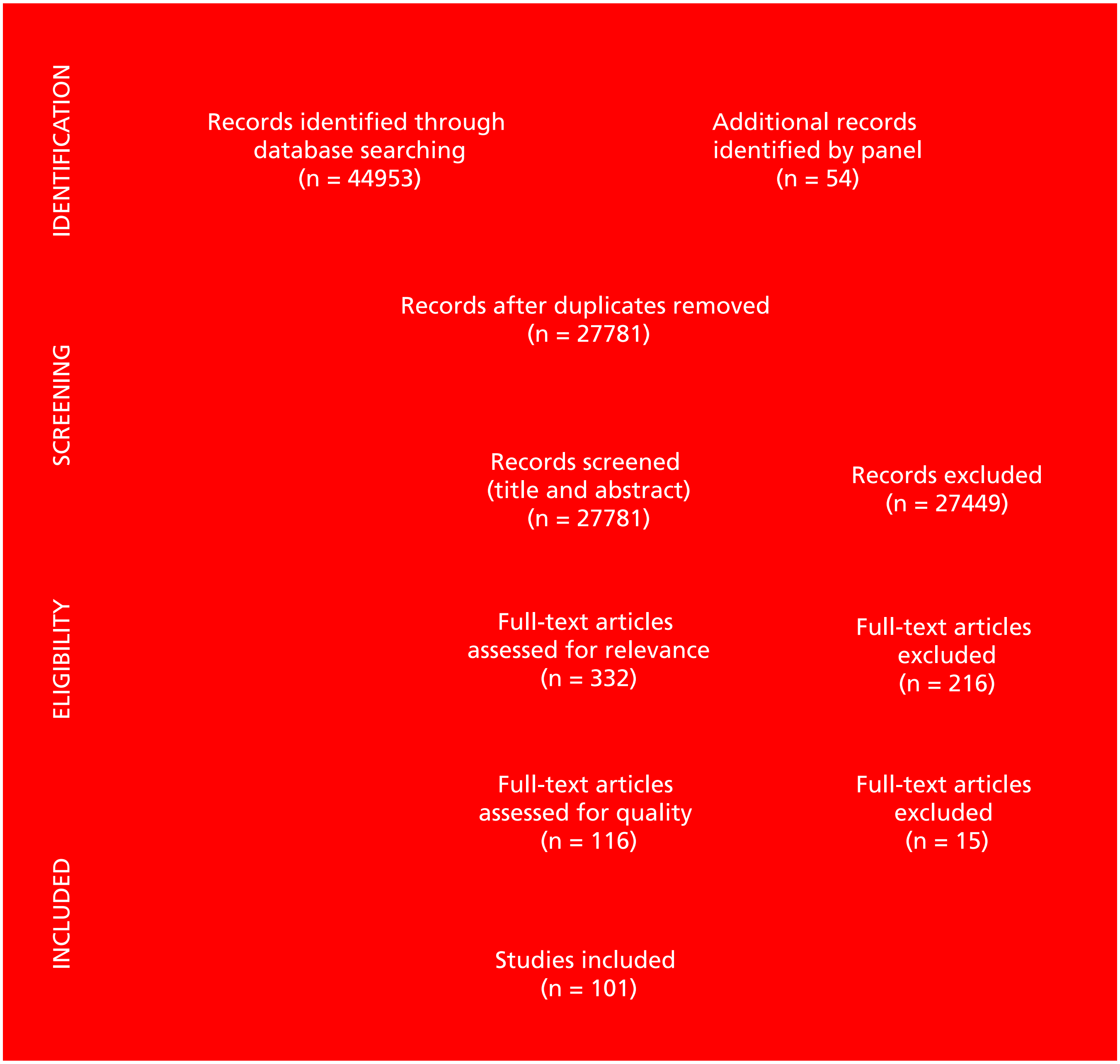
Guidelines Review Process Flow Diagram



Included guidelines had an overall AGREE II score of four or more (out of seven).

Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, and The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *BMJ 339*, b2535, doi: 10.1136/bmj.b2535

Article Review Process Flow Diagram



Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, and The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *BMJ 339*, b2535, doi: 10.1136/bmj.b2535

Appendix D: Comparison of the Clinical Features of Delirium, Dementia, and Depression

FEATURE	DELIRIUM	DEMENTIA	DEPRESSION

Source: Created by Dianne Rossy and Laura Wilding. The Ottawa Hospital. Reprinted with permission.

Appendix E: Types of Dementia

Dementia describes the symptoms that occur when the brain is affected by certain diseases or conditions. This table outlines some of the most common types of dementia. It is important to remember that the symptoms and progression of dementia can vary greatly among individuals.

TYPE OF DEMENTIA	DESCRIPTION

TYPE OF DEMENTIA	DESCRIPTION

TYPE OF DEMENTIA	DESCRIPTION

Note: Content added by the expert panel is indicated with an asterisk (*).
Source: Adapted from Alzheimer's Society, 2016.

Appendix F: Resources for Optimal Medication Use in Older Adults

The following is not an exhaustive list of resources, but rather a selection of resources identified within the systematic review, AGREE II-appraised guidelines, and by the expert panel or external stakeholder feedback. Inclusion in this list does not constitute an endorsement by RNAO.

RESOURCE	DESCRIPTION OF RESOURCE	WEBSITE ACCESS

RESOURCE	DESCRIPTION OF RESOURCE	WEBSITE ACCESS

Appendix G: Delirium Risk Factors and Interventions

The literature and clinical guidelines list various predisposing and precipitating risk factors for delirium.

Bolded text indicates factors of particularly high risk. Health-care providers can apply a variety of preventative interventions tailored to the specific precipitating risk factors. In the second table, examples of specific interventions outlined in the literature are listed alongside the related risk factors. This list is not exhaustive, but includes the risk factors and interventions most frequently cited in the literature. Some risk factors and interventions are more relevant to certain health-care sectors than others.

RISK FACTORS **Note: see below for risk factors with associated interventions**

RISK FACTORS AND INTERVENTIONS

Table continues on next page.

RISK FACTORS AND INTERVENTIONS

Sources: AGS, 2014; AMDA, 2008; Brooks, 2012; CCSMH, 2010; Clegg et al., 2014; Gage & Hogan, 2014; Holroyd-Leduc et al., 2010; Inouye et al., 2014; Khan et al., 2012; NICE, 2010.

Appendix H: Screening and Assessment Tools

The following is not an exhaustive list of screening and assessment tools but rather suggestions of tools identified within the systematic review, AGREE II appraised guidelines, by the expert panel or external stakeholder feedback.

Note: Inclusion of a tool in this list does not constitute an endorsement by RNAO. Please refer to **Recommendation 15.2** and the related discussion of evidence for considerations when selecting and using tools. It is important to select a tool that is appropriate for use in the setting in which you practice and suitable for your scope of practice.

Some tools may be validated only in specific settings. In the far right column, a check mark is provided where validation studies could be located.

TOOL	DESCRIPTION	SOURCE/WEBSITE	VALIDATION STUDIES LOCATED
TOOLS APPLICABLE TO DELIRIUM, DEMENTIA, AND/OR DEPRESSION			

TOOL	DESCRIPTION	SOURCE/WEBSITE	VALIDATION STUDIES LOCATED
DELIRIUM TOOLS			

TOOL	DESCRIPTION	SOURCE/WEBSITE	VALIDATION STUDIES LOCATED

TOOL	DESCRIPTION	SOURCE/WEBSITE	VALIDATION STUDIES LOCATED
DEMENTIA TOOLS			

TOOL	DESCRIPTION	SOURCE/WEBSITE	VALIDATION STUDIES LOCATED
DEMENTIA BEHAVIOUR			

TOOL	DESCRIPTION	SOURCE/WEBSITE	VALIDATION STUDIES LOCATED
PAIN			

TOOL	DESCRIPTION	SOURCE/WEBSITE	VALIDATION STUDIES LOCATED
CARE PROVIDERS & CAREGIVERS			
DEPRESSION TOOLS			

TOOL	DESCRIPTION	SOURCE/WEBSITE	VALIDATION STUDIES LOCATED

Source: Adapted from RNAO, 2010b.

Appendix I: Early Warning Signs of Cognitive Change

The following table outlines some of the early warning signs of cognitive challenges that caregivers and health professionals can detect. The signs can be used to identify individuals who should be assessed for dementia.

Table 8: Early Warning Signs Suggesting Cognitive Challenges

SIGNS CAREGIVERS CAN DETECT	SIGNS HEALTH PROFESSIONALS CAN DETECT

Source: Reprinted from "Dementia and Screening Assessment," by Regional Geriatric Program of Eastern Ontario, n.d. Retrieved from http://giic.rgps.on.ca/sites/default/files/1b%20Dementia%20screening%20overview.pdf Reprinted with permission.

Seven A's of Dementia

Some health-care providers also use the Seven A's of dementia to identify common signs. The A's are: anosognosia, agnosia, aphasia, apraxia, altered perception, amnesia, and apathy. For more information, visit the Alzheimer Society of Canada website at: http://www.alzheimer.ca/en/york/About-dementia/What-is-dementia/Seven-A-s-of-dementia

Appendix J: Resources

The following table, compiled by the RNAO Best Practice Guideline Program Team and members of the expert panel, and with input from external stakeholder reviewers, lists some of the main organizations that provide information or resources on delirium, dementia, and depression. Other resources may be available at a local level. Clinicians are also encouraged to research local supports to which they can refer people.

Links to websites are provided for information purposes only; RNAO is not responsible for the quality, accuracy, reliability, or currency of the information provided through these sources. Further, RNAO has not determined the extent to which these resources have been evaluated. Questions regarding these resources should be directed to the source.

ORGANIZATION, PROGRAM, OR RESOURCE	DESCRIPTION	LINK
GENERAL		

ORGANIZATION, PROGRAM, OR RESOURCE	DESCRIPTION	LINK
DELIRIUM		

ORGANIZATION, PROGRAM, OR RESOURCE	DESCRIPTION	LINK
DEMENTIA		

ORGANIZATION, PROGRAM, OR RESOURCE	DESCRIPTION	LINK

ORGANIZATION, PROGRAM, OR RESOURCE	DESCRIPTION	LINK
DEPRESSION		
SUICIDE		

ORGANIZATION, PROGRAM, OR RESOURCE	DESCRIPTION	LINK

Mental Capacity (Ontario-Based Resources)

*This information is included as an example. Practitioners in other jurisdictions should refer to relevant organizations and legislation.

TITLE	LINK

Sample Videos

There are many videos on the topics of delirium, dementia, and depression. This is a list of videos suggested by the expert panel. This list is not exhaustive.

Note: cost may be associated with some resources.

TOPIC	RESOURCE TITLE	ORGANIZATION	DESCRIPTION	LINK

TOPIC	RESOURCE TITLE	ORGANIZATION	DESCRIPTION	LINK

Appendix K: Attitudes, Skills, and Knowledge That Are Beneficial for Communication in Dementia Care

Table 9 lists suggested content of communication skills training in dementia care.

Table 9: Content of Communication Skills Training in Dementia Care

	SKILLS, ATTITUDES, AND KNOWLEDGE

SKILLS, ATTITUDES, AND KNOWLEDGE

Source: Reprinted from “Communication skills training in dementia care: A systematic review of effectiveness, training content, and didactic methods in different care settings,” by E. Eggenberger, K. Heimerl, & M. I. Bennett, 2013, *International Psychogeriatrics, 25*(3), 345–358. Reprinted with permission.

Appendix L: Description of the Toolkit

Best practice guidelines can only be successfully implemented if planning, resources, organizational, and administrative supports are adequate and there is appropriate facilitation. To encourage successful implementation, an RNAO expert panel of nurses, researchers, and administrators has developed the *Toolkit: Implementation of Best Practice Guidelines* (2012b). The *Toolkit* is based on available evidence, theoretical perspectives, and consensus. We recommend the *Toolkit* for guiding the implementation of any clinical practice guideline in a health-care organization.

The *Toolkit* provides step-by-step directions for the individuals and groups involved in planning, coordinating, and facilitating the guideline implementation. These steps reflect a process that is dynamic and iterative rather than linear. Therefore, at each phase, preparation for the next phases and reflection on the previous phase is essential. Specifically, the Toolkit addresses the following key steps, as illustrated in the "Knowledge-to-Action" framework (Straus et al., 2009):

1. Identify the problem: Identify, review, and select knowledge (best practice guideline).
2. Adapt knowledge to the local context:
   - Assess barriers and facilitators to knowledge use, and
   - Identify resources.
3. Select, tailor, and implement interventions.
4. Monitor knowledge use.
5. Evaluate outcomes.
6. Sustain knowledge use.

Implementing guidelines to effect successful practice changes and positive clinical impact is a complex undertaking. The Toolkit is one key resource for managing this process. It can be downloaded at www.RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

Endorsements

ACCREDITATION
AGRÉMENT
CANADA
Better Quality. Better Health.
Meilleure qualité. Meilleure santé.

January 9, 2017

Doris Grinspun, RN,MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON M5H 1L3

Letter of Support: ***Delirium, Dementia, and Depression in Older Adults: Assessment and Care***

Dear Doris,

Accreditation Canada is thrilled to work with people who share our passion for achieving quality health services for all. It is in that spirit that we were pleased to review the new Best Practice Guideline by the Registered Nurses' Association of Ontario (RNAO), titled *Delirium, Dementia, and Depression in Older Adults: Assessment and Care*.

As you know well, Accreditation Canada's standards and assessment programs are designed to improve the quality, safety, and efficiency of health services, and to reduce risk for (and with) patients. In recent months, we have redoubled our efforts to use the best available evidence, expertise, and experience to inform the development of global standards, to support a culture of innovation, and to listen to all voices (to name just a few areas in which we have been hard at work). RNAO's Best Practice Guideline with respect to delirium, dementia and depression are compelling companions in this regard.

We congratulate you on the development of this guideline, which will hopefully help nurses and other health-care providers ensure high-quality care to older adults across the spectrum of care.

We are pleased to continue our constructive collaboration with RNAO and believe that Ontario nurses are key contributors to the activation of health standards across the province.

Sincerely,

Leslee Thompson

Leslee J. Thompson
Chief Executive Officer
Accreditation Canada & Accreditation Canada International

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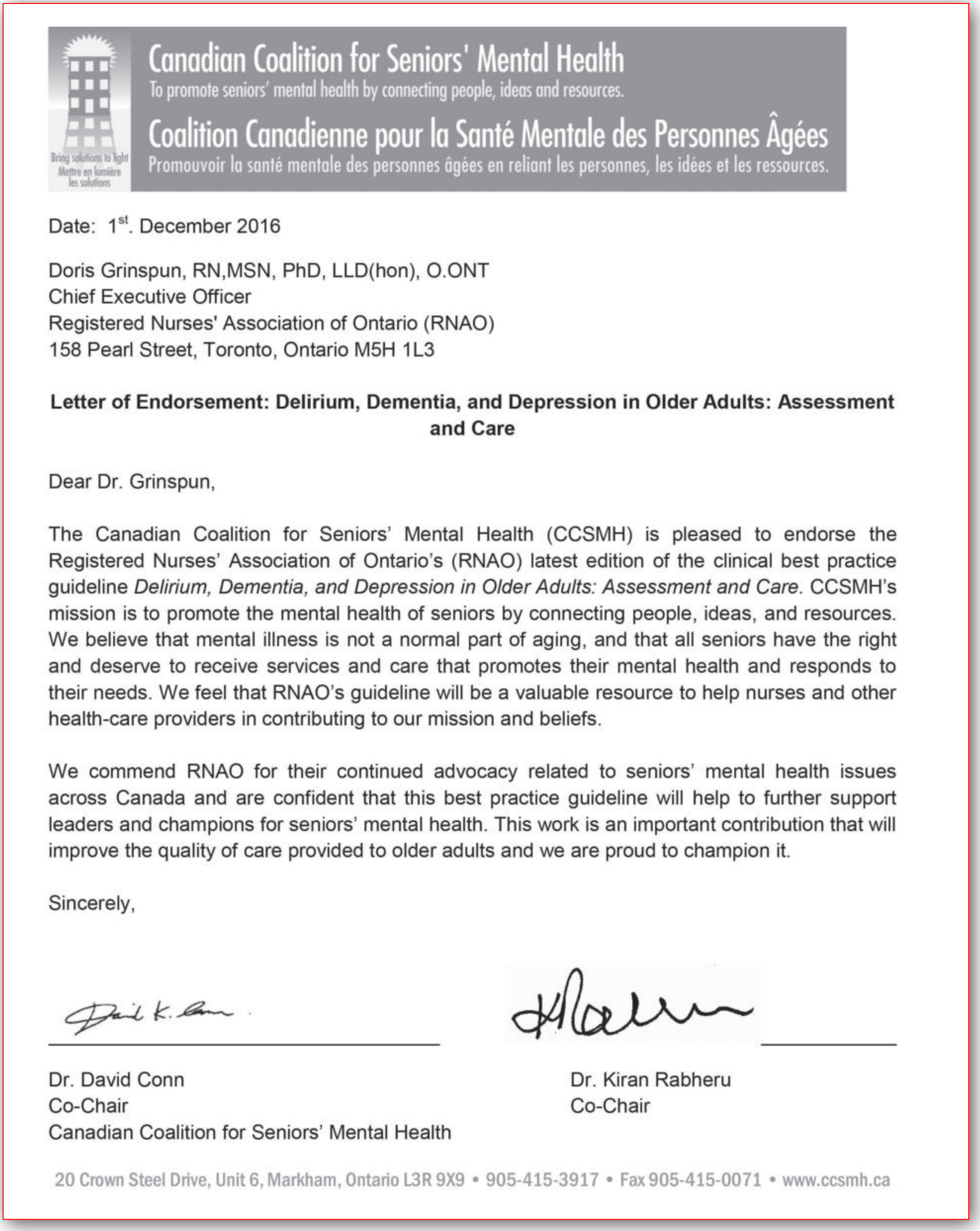


Canadian Coalition for Seniors' Mental Health
To promote seniors' mental health by connecting people, ideas and resources.
Coalition Canadienne pour la Santé Mentale des Personnes Âgées
Promouvoir la santé mentale des personnes âgées en reliant les personnes, les idées et les ressources.
Bring solutions to light
Mettre en lumière les solutions

Date: 1st. December 2016

Doris Grinspun, RN,MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street, Toronto, Ontario M5H 1L3

Letter of Endorsement: Delirium, Dementia, and Depression in Older Adults: Assessment and Care

Dear Dr. Grinspun,

The Canadian Coalition for Seniors' Mental Health (CCSMH) is pleased to endorse the Registered Nurses' Association of Ontario's (RNAO) latest edition of the clinical best practice guideline *Delirium, Dementia, and Depression in Older Adults: Assessment and Care*. CCSMH's mission is to promote the mental health of seniors by connecting people, ideas, and resources. We believe that mental illness is not a normal part of aging, and that all seniors have the right and deserve to receive services and care that promotes their mental health and responds to their needs. We feel that RNAO's guideline will be a valuable resource to help nurses and other health-care providers in contributing to our mission and beliefs.

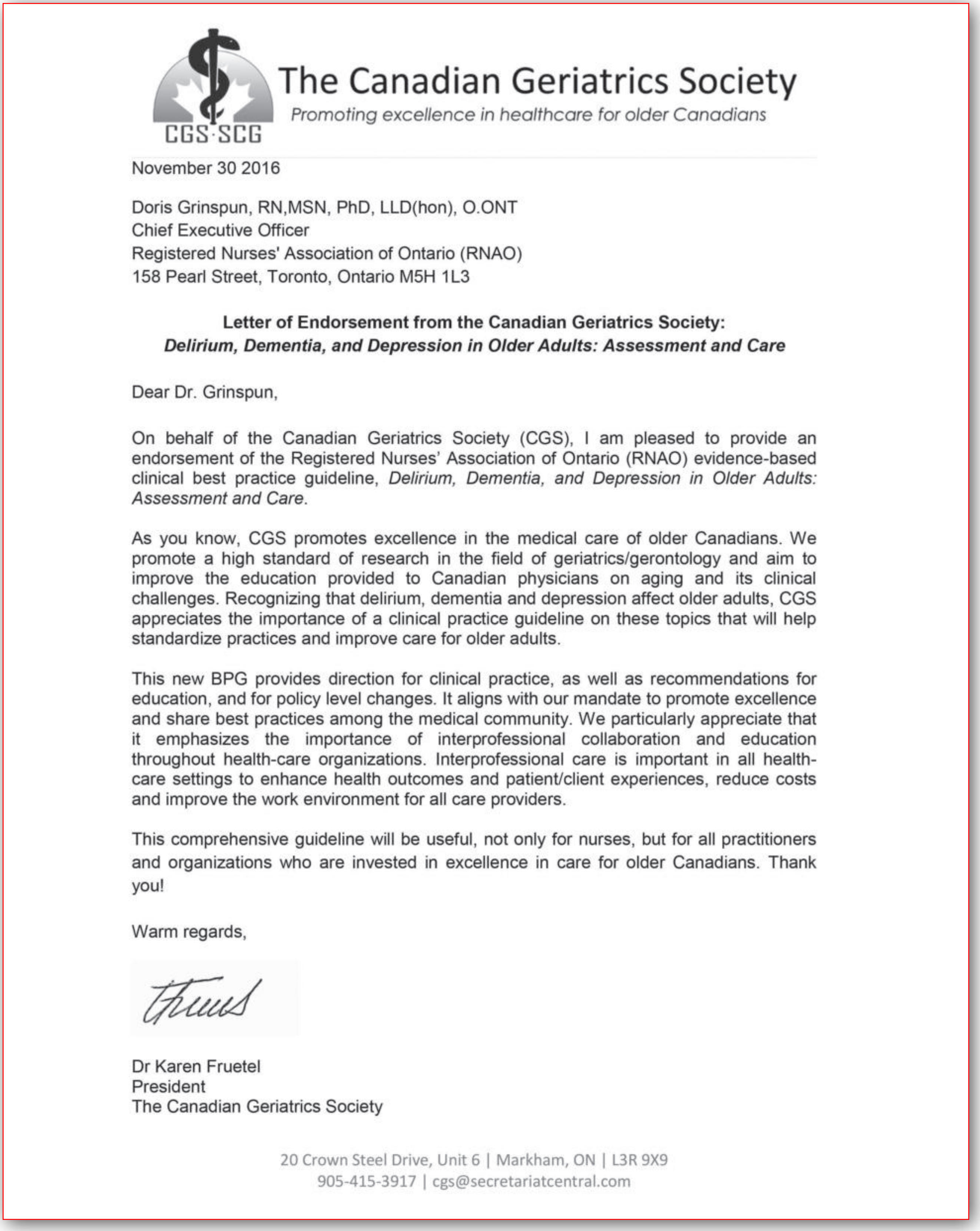
We commend RNAO for their continued advocacy related to seniors' mental health issues across Canada and are confident that this best practice guideline will help to further support leaders and champions for seniors' mental health. This work is an important contribution that will improve the quality of care provided to older adults and we are proud to champion it.

Sincerely,

Dr. David Conn
Co-Chair
Canadian Coalition for Seniors' Mental Health

Dr. Kiran Rabheru
Co-Chair

20 Crown Steel Drive, Unit 6, Markham, Ontario L3R 9X9 • 905-415-3917 • Fax 905-415-0071 • www.ccsmh.ca



CGS·SCG
The Canadian Geriatrics Society
Promoting excellence in healthcare for older Canadians

November 30 2016

Doris Grinspun, RN,MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street, Toronto, Ontario M5H 1L3

Letter of Endorsement from the Canadian Geriatrics Society:
Delirium, Dementia, and Depression in Older Adults: Assessment and Care

Dear Dr. Grinspun,

On behalf of the Canadian Geriatrics Society (CGS), I am pleased to provide an endorsement of the Registered Nurses' Association of Ontario (RNAO) evidence-based clinical best practice guideline, *Delirium, Dementia, and Depression in Older Adults: Assessment and Care*.

As you know, CGS promotes excellence in the medical care of older Canadians. We promote a high standard of research in the field of geriatrics/gerontology and aim to improve the education provided to Canadian physicians on aging and its clinical challenges. Recognizing that delirium, dementia and depression affect older adults, CGS appreciates the importance of a clinical practice guideline on these topics that will help standardize practices and improve care for older adults.

This new BPG provides direction for clinical practice, as well as recommendations for education, and for policy level changes. It aligns with our mandate to promote excellence and share best practices among the medical community. We particularly appreciate that it emphasizes the importance of interprofessional collaboration and education throughout health-care organizations. Interprofessional care is important in all health-care settings to enhance health outcomes and patient/client experiences, reduce costs and improve the work environment for all care providers.

This comprehensive guideline will be useful, not only for nurses, but for all practitioners and organizations who are invested in excellence in care for older Canadians. Thank you!

Warm regards,

Dr Karen Fruetel
President
The Canadian Geriatrics Society

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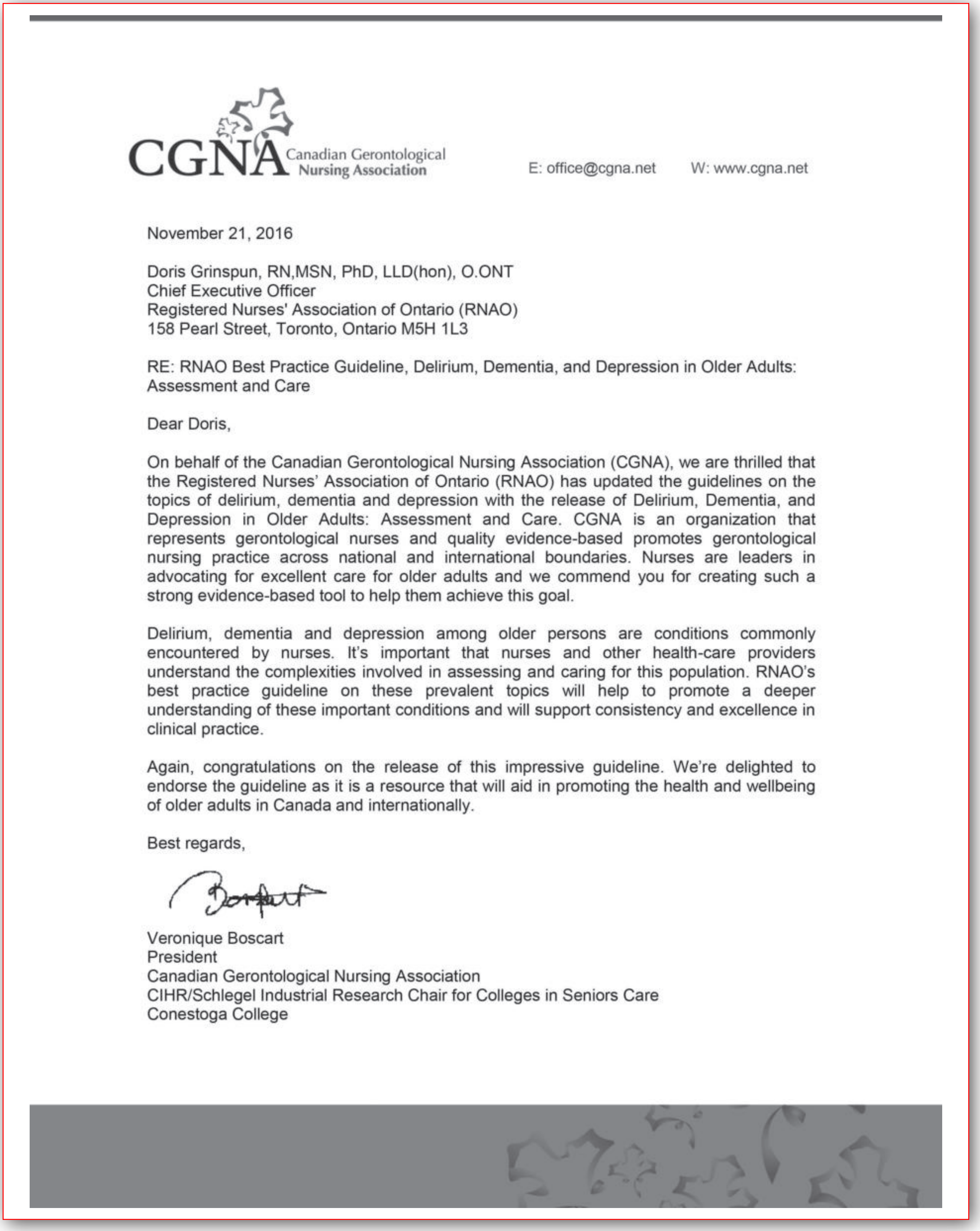

CGNA Canadian Gerontological Nursing Association
E: office@cgna.net W: www.cgna.net

November 21, 2016

Doris Grinspun, RN,MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street, Toronto, Ontario M5H 1L3

RE: RNAO Best Practice Guideline, Delirium, Dementia, and Depression in Older Adults: Assessment and Care

Dear Doris,

On behalf of the Canadian Gerontological Nursing Association (CGNA), we are thrilled that the Registered Nurses' Association of Ontario (RNAO) has updated the guidelines on the topics of delirium, dementia and depression with the release of Delirium, Dementia, and Depression in Older Adults: Assessment and Care. CGNA is an organization that represents gerontological nurses and quality evidence-based promotes gerontological nursing practice across national and international boundaries. Nurses are leaders in advocating for excellent care for older adults and we commend you for creating such a strong evidence-based tool to help them achieve this goal.

Delirium, dementia and depression among older persons are conditions commonly encountered by nurses. It's important that nurses and other health-care providers understand the complexities involved in assessing and caring for this population. RNAO's best practice guideline on these prevalent topics will help to promote a deeper understanding of these important conditions and will support consistency and excellence in clinical practice.

Again, congratulations on the release of this impressive guideline. We're delighted to endorse the guideline as it is a resource that will aid in promoting the health and wellbeing of older adults in Canada and internationally.

Best regards,

Veronique Boscart
President
Canadian Gerontological Nursing Association
CIHR/Schlegel Industrial Research Chair for Colleges in Seniors Care
Conestoga College

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Ontario
Health Quality Ontario
Qualité des services
de santé Ontario

December 15, 2016

Dr. Doris Grinspun, RN,MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street,
Toronto, Ontario
M5H 1L3

Doris,

Dear Dr. Grinspun,

Health Quality Ontario (HQO) is very pleased to congratulate the Registered Nurses' Association of Ontario on the publication of the newest edition of the nursing best practice guideline, *Delirium, Dementia, and Depression in Older Adults: Assessment and Care.*

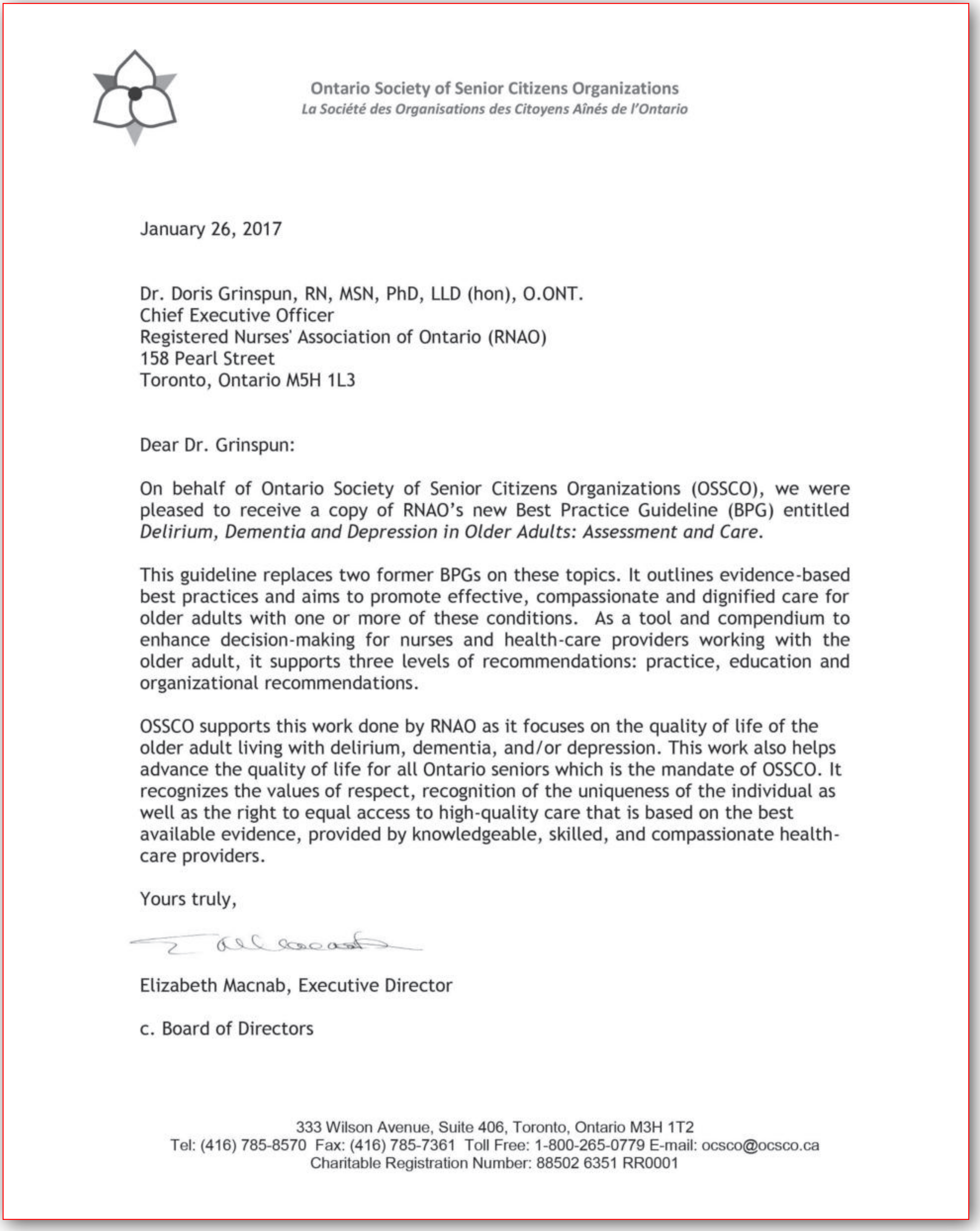
As the province's advisor on health care quality we work together with partners like the RNAO to bring about meaningful improvement in health care. RNAO's guideline on the topics of delirium, dementia and depression in older adults has the potential to help improve the quality of health care for these individuals across the province.

I would like to congratulate you on the wide range of individuals consulted in the development of your guideline. Similarly, we are always grateful when you or members of the RNAO participate in our advisory committees, provide feedback on our work and support initiatives such as quality standards and quality improvement plans.

Again, many congratulations on the successful publication of this guideline. We look forward to working with you to improve health and health care for every Ontarian.

Sincerely,

Dr. Joshua Tepper, MD, MPH, MBA
President & Chief Executive Officer



Ontario Society of Senior Citizens Organizations
La Société des Organisations des Citoyens Aînés de l'Ontario

January 26, 2017

Dr. Doris Grinspun, RN, MSN, PhD, LLD (hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, Ontario M5H 1L3

Dear Dr. Grinspun:

On behalf of Ontario Society of Senior Citizens Organizations (OSSCO), we were pleased to receive a copy of RNAO's new Best Practice Guideline (BPG) entitled *Delirium, Dementia and Depression in Older Adults: Assessment and Care*.

This guideline replaces two former BPGs on these topics. It outlines evidence-based best practices and aims to promote effective, compassionate and dignified care for older adults with one or more of these conditions. As a tool and compendium to enhance decision-making for nurses and health-care providers working with the older adult, it supports three levels of recommendations: practice, education and organizational recommendations.

OSSCO supports this work done by RNAO as it focuses on the quality of life of the older adult living with delirium, dementia, and/or depression. This work also helps advance the quality of life for all Ontario seniors which is the mandate of OSSCO. It recognizes the values of respect, recognition of the uniqueness of the individual as well as the right to equal access to high-quality care that is based on the best available evidence, provided by knowledgeable, skilled, and compassionate health-care providers.

Yours truly,

Elizabeth Macnab, Executive Director

c. Board of Directors

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INTERNATIONAL
AFFAIRS & BEST PRACTICE
GUIDELINES

TRANSFORMING
NURSING THROUGH
KNOWLEDGE

Clinical Best
Practice Guidelines

JULY 2016

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

Second Edition

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Registered Nurses' Association of Ontario
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