Development of a Curriculum for Long Term Care Nurses to Improve Recognition of Depression in Dementia

Christine L. Williams, DNSc, RN, BC
Victor Molinari, PhD
Jennifer Bond, PsyD
Michael Smith, MS
Kathryn Hyer PhD, MPP
Julie Malphurs, PhD

Affiliations:
1. Associate Professor, University of Miami School of Nursing, Coral Gables, FL 33143, 305-284-6025, 305-284-5686, cwilliams@miami.edu (corresponding author).
2. Professor, Department of Aging and Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida
3. Post-doctoral Fellow, Department of Aging and Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida
4. Research Associate, Stein Gerontological Institute, Miami Jewish Home and Hospital for the Aged
5. Associate Professor, School of Aging Studies, College of Arts and Sciences, University of South Florida
6. Veterans Administration Medical Center, Miami, FL, Assistant Professor of Research, Department of Psychiatry and Behavioral Sciences, Miller School of Medicine at the University of Miami

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Abstract
There is increasing recognition of the severe consequences of depression in long term care residents with dementia. Most health care providers are unprepared to recognize and to manage the complexity of depression in dementia. Targeted educational initiatives in nursing homes are needed to address this growing problem. This paper describes the development of competencies, learning objectives, and learning outcomes for a curriculum on depression in dementia for nurses working in nursing home settings. This work provides the foundation for a curriculum to improve learning for nurses and ultimately to advance health care outcomes for residents with co-occurring depression and dementia.

Curriculum for Depression in Dementia

Over the last few years, there has been an increasing recognition that depression in older adults with dementia is a serious problem (Agronin, 2004; Evers et al., 2002; Snowden et al., 2003). One author suggests that 50% of individuals with Alzheimer’s disease will manifest depressive symptoms during the course of their illness. Co-occurring depression and dementia yields significant personal and public health consequences. Frailty, poorer quality of life, heightened impairment in ADLs, and greater language and motor deficits occur for those afflicted with both conditions. Persons with both dementia and depression are often institutionalized, have the highest rates of hospitalization, more medical comorbidities, highest disease severity, greatest prevalence of pain, higher levels of physical and verbal aggression, and receive the most psychiatric medications (Bartels et al., 2003; Kales et al., 1999; Menon et al., 2001). Increased depression and burden create negative consequences for the caregivers as well (Lykestos & Lee, 2004).

Recognizing the importance of reducing depression in nursing homes, the Nursing Home Compare Website promulgated by The Centers for Medicare and Medicaid Services (CMS) reports facility-specific rates of depression or anxiety worsening as one of the 10 long-stay quality measures for nursing home residents. Using the Resident Mood Scale Score (MSS) section of the required resident assessment, the depressed or anxious worsening measure counts the number of depressive symptoms and tracks the number of residents whose mood or anxiety worsens with each quarterly assessment. The public availability of outcome measures is expected both to guide quality improvement efforts of long-term care providers and to help residents and families select a nursing home based on the quality outcome (Harris & Clauser, 2002). Diagnostic criteria for depression in dementia have recently been proposed (Olin et al., 2002), and a standardized scale has been validated (Cornell Scale for the Assessment of
Depression in Dementia: Sunderland, Hill, Lawlor & Molchan, 1988). Guidelines have been developed by the American Psychiatric Association to manage depression in those with Alzheimer’s disease (APA, 1997), and to improve the quality of mental health care in nursing homes by assessing and treating depression and behavior problems in those with dementia (AGS & AAGP, 2003). However, in one study, only one-third of those residents who were depressed in long term care (LTC) settings actually improved with treatment (Boyle et al., 2004). The authors note that although many of these residents were initially screened and treated, the follow-up monitoring process was deficient because changes were not made in the treatment plan if improvement did not occur after the first few weeks of treatment. Because depression is the most common reversible illness observed in the nursing home setting, its identification and management in persons with dementia will substantially improve health outcomes and enhance quality of life in these residents. Recently, the Teaching Nursing Home (2004) delivered a report on the identification of best practices and standards of care to address ‘depression in dementia’ in Florida LTC settings. Screenings for depression on admission and every 6 months thereafter were described as best practices that could yield timely treatment. Consistent with the MDS quality measures emphasis, a main conclusion was that “the recognition and appropriate treatment of depression can improve the quality of life for the resident” (Teaching Nursing Home, p. 9). The TNH report also recommended that the “training and educational interventions of depression in dementia patients should initially target persons providing the most direct care [i.e., Certified Nursing Assistants (CNAs) and Licensed Practical Nurses (LPNs)], but educational curricula should be modifiable to any population” (Teaching Nursing Home, p. 9). The current research project followed up on this recommendation regarding the training of LPNs for the detection of depressive symptoms in LTC residents with dementia. A review of the medical (Pub Med) and nursing (CINAHL) literature reveals voluminous writings on the detection and/or differentiation of depression, dementia, and delirium by psychiatrists, psychologists, social workers, registered nurses, or nurse practitioners across a variety of older patient populations in community, hospital, and LTC settings (Brymer,
Cavanaugh, Denomy, Wells, & Cook, 2001; Protchard & Dewing, 2000). Indeed, a nursing standard of practice protocol for depression in geriatric patients has been published (Kurlowicz, 1997). However, there are only a few articles that address both depression and dementia in the same individual, and these reflect more anecdotal than evidence-based approaches. In one nursing journal article, Cleeland and Davis (1997) provided guidelines for healthcare nurse generalists to assess depression for those with dementia living at home. In a more recent article, Murphy et al. (2005) describe a Pennsylvania Department of Health initiative to improve the recognition and management of depression in nursing home residents by utilizing nurse educators to teach nursing home staff to implement best practices. However, only observational evidence of its effects is presented in the report. Surprisingly, there is a dearth of literature on the identification of depression by LPNs; hence, there are virtually no empirical studies on the identification by frontline staff of depression in those with dementia in institutional settings, where it has been estimated that perhaps as many as 80% of the residents have some dementia (Rovner & Katz, 1993). A review of the literature further reveals no research on how to train LPNs for such screenings. Fortunately, there are some studies (particularly with nursing assistants in nursing home settings) that can be extrapolated to LPNs that yield some guidance in how to investigate this problem.

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Qualitative research suggests that many non-RN nursing staff feel like ‘second-class citizens’ in LTC settings. They are over-worked and under-paid for jobs managing difficult residents, leading to high turnover rates. Further, despite the fact that they by far spend more time with resident care than any other LTC staff, they are virtually ignored in clinical decision-making rather than being used to enhance the quality of life for those they serve (Kramer & Smith, 2000). Although variably trained and sophisticated in both mental health and geriatrics, research has shown that non-RN LTC nursing staff (primarily nursing assistants) retain what they learn during in-services. They implement this learning to improve patient care, and this learning is sustained over time when the LTC administrative staff is supportive of the training efforts (Brannon, Smyer, & Cohn, 1992; Burgio et al., 1990; Stevens et al., 1996). A novel computer-based, interactive, self-paced mental health training video (Rosen et al., 2002) has been found to instill and retain knowledge for registered nurses, licensed vocational nurses, and nursing assistants better than a conventional lecture format. Perhaps most important, educational efforts appear to be successful when non-RN nursing staff are actively engaged in training and when they are recognized for being the repositors of vast of personal knowledge regarding LTC residents. However, these key staff members are nonetheless poorly utilized in care planning meetings (Kramer & Smith, 2000).
The extent of depression in nursing home residents with dementia suggests a serious need for its early recognition so that timely treatment can occur. There is a growing corpus of knowledge on the assessment of depression and dementia and a standardized scale for its screening. The main training issue is to educate frontline nursing staff regarding the practical aspects of this knowledge so that they may assist in identification and detection, communicate their observations, and monitor mood and behavior to enable proper diagnosis and an effective treatment process that includes periodic follow-up. Given the findings in the literature suggesting the efficacy of a more hands-on approach utilizing the collective wisdom of non-RN staff to brainstorm solutions to resident problems, the authors decided to concentrate their initial efforts on conducting focus groups to solicit basic information regarding LPN’s understanding of 1) depression, dementia, and depression in those with dementia and 2) barriers to the recognition and management of depression in those with dementia. Following from this, we solicited ideas from LPNs, nurse administrators, and LPN educators about what should be included in their training. Our intention was to determine the attitudes, knowledge and skills that could be increased to augment the detection of depression in this population, to facilitate communication regarding the problem to supervising RNs and other interdisciplinary team members, and to improve management of depression when detected. Communication is important since deficient monitoring by frontline staff may limit the effectiveness of follow-up care. Given the success of self-paced computer training (Rosen et al., 2002), we considered using an online format to structure, implement, and ultimately evaluate the training module. In summary, a basic goal of this project was to make use of input and feedback from LPNs, LPN educators, LTC Nurse Administrators, and LTC experts in Florida to generate and validate competency-based learning objectives for LPNs to 1) foster recognition and care related to depression in residents with dementia and 2) develop a curriculum plan encompassing learning objects and assessments to advance the mental health and quality of care for nursing home residents. We plan to implement the curriculum in select nursing home facilities, determine if LPNs can effectively and reliably achieve the competencies, and ultimately conduct a program evaluation to verify whether the curriculum actually increases interventions that improve health outcomes and quality of life for those residents with depression and dementia.
Methods

The state of Florida is demographically the oldest in the nation with the number of older adults, the highest LTC utilizers, growing steadily (Florida Commission on Mental Health and Substance Abuse, 2001). Recognizing the need to address this problem, the Florida legislature enacted significant reforms in 2001, establishing new nurse staffing levels, training for staff, and tort reform (Williams et al., 2005; Polivka et al., 2003). The state-funded Teaching Nursing Home (TNH) was created via Florida House bill #1971 to link community based LTC resources with professionals and researchers throughout the state to educate health care providers about how to “formulate, implement, advocate, and disseminate best practices” (Senate Bill 1202) for elders in LTC settings. In 2001, the TNH Advisory Committee initiated a project to develop a curriculum for the purpose of meeting the new dementia training requirements. A statewide Advisory Committee of Dementia Care Experts was convened comprising representatives from the Agency for Health Care Administration, Department of Elder Affairs, Alzheimer’s Association, Florida Association of Homes for the Aging, Florida Health Care Association, Department of Veteran’s Affairs (DVA), and from Florida’s leading universities and professional organizations. The committee’s mission was to create a model for the development, dissemination, evaluation, and validation of dementia training materials (Williams et al., 2005).

As part of this overall mandate, a special ‘depression in dementia’ task force was constituted to explore the development of specific curriculum materials to train LPNs to detect depression in residents with dementia.

Curriculum Development

Competency-based education focuses on measurable outcomes that allow one to assess differences in quality of care administered by a care provider (Ballantine et al., 1998; Ozcan & Shukla, 1993; Regenstreif, Brittis, Fagin, & Rieder., 2003; Taylor, 1995; Zhang, Luk, Arthur, & Wong, 2001). To implement the state of Florida directive and also to improve LTC delivery, the ‘depression in dementia’ task force emphasized the development of competencies that could yield testable outcomes yoked to the content areas of the curriculum. The rest of this paper describes the process used to refine a set of competencies and learning objectives to guide comprehensive, outcome-based LPN staff training for depression in dementia.

Competencies

A review of LPN curricula, relevant nursing publications, and Florida scope of practice for LPNs was first conducted in order to develop competencies and learning objectives appropriate to
LPNs’ previous learning, experience, knowledge, skills, and attitudes. A series of assessments were then completed. First, the Director of Nursing and the Clinical Educator at a Miami nursing home were interviewed regarding their ideas on nurses’ need for training on depression in dementia. From their points of view, nurses were less aware of residents’ psychiatric and emotional problems as compared to physiological problems such as dehydration and infection. They also identified the need for improved knowledge of appropriate terminology to describe psychiatric symptoms to other members of the interdisciplinary team. The following learning needs were delineated: 1) understanding and appreciation of the seriousness and importance of depression in dementia, and its consequences; 2) skill in the use of standardized assessments for depression; 3) skill in differentiating delirium, dementia, and depression; 4) knowledge about what to report (symptoms of depression and improved mood); and 5) ability to communicate observations to RNs, MDs, and family members. Focus groups were then planned with LPNs to assess their attitudes and knowledge relevant to caring for depressed residents with dementia. Two one-hour focus groups of approximately six nurses each [one group consisting of nurses who worked on the day shift, and another of LTC nurses who worked evenings] were conducted at nursing homes in Miami and Tampa (total of four) to answer the following questions (see Table 1 for a complete list of focus group questions): 1) What do LPNs already know about depression in dementia? 2) What additional knowledge and skills are needed? 3) What do they see as their role in identifying, reporting, and intervening with depression in dementia? 4) What obstacles do they see in using knowledge and skills in a practice environment? For the LPNs in the Miami nursing home, the participants worked in a variety of units including dementia units, a unit for physically frail residents, and a rehabilitation unit. Experience ranged from 9 months to 18 years. LPN respondents were very aware of behavior problems associated with dementia. They were less clear about depression-related behaviors versus dementia-related behaviors. They felt better prepared to recognize depression in the resident who is cognitively intact. They acknowledged that assessment becomes easier when the LPN knows the resident well and can compare present with past behavior. They also understood that cultural differences can lead to communication breakdown. Respondents expressed reluctance to suggest a referral for a psychiatric consult or the use of antidepressant medication, perceiving this as a last resort rather than a routine intervention for a resident who is depressed. Attendees were concerned that anti-depressants were ineffective in advanced dementia. Participants voiced some confusion about the differences among psychoactive drugs, e.g.,
antidepressants, antipsychotics and anti-anxiety drugs. LPNs in the Tampa nursing home had on average 3.5 years of experience, with a range from 6 months to 14 years. These LPNs generally felt somewhat comfortable with identifying depressive symptoms in dementia residents and in making referrals to mental health professionals. They preferred hands-on training with practical examples. The Tampa LPNs viewed family members as very important in the overall care of the resident, but believed that at times family members too often blamed the nurses for the resident’s problems rather than the illness.

Given these results, we viewed changing attitudes as a high priority to dispel the stigma related to mental illness, and to expand awareness and empathy for those with depression in dementia. Better awareness of the importance of the problem could be achieved through increased knowledge of the negative consequences of untreated depression, enhanced skill in using rating scales specific to depression in dementia such as Cornell Depression in Dementia Scale, and greater understanding of the benefits of pharmacological and non-pharmacological interventions for depression in dementia.

Next, telephone interviews were conducted with three LPN educators (two faculty members from a local LPN Program and a Program Director) to discuss their expectations for graduates of their program regarding knowledge of depression and dementia. They shared a topical outline of didactic content in their program that was related to the two conditions depression and dementia. The two conditions are treated separately and not linked in classroom presentations. Further, concurrent clinical experiences are in acute rather than LTC settings, where the opportunity to work with residents with depression in dementia may be less available.

Following the above assessment, competencies were drafted to guide curriculum planning. The proposed competencies were reviewed by TNH experts and subsequently revised and simplified. The final version includes three basic competencies:

Competency 1. Recognizes depression in residents with dementia.
Competency 2. Manages depression in dementia.
Competency 3. Communicates effectively regarding depression in dementia.

Learning objectives.

Following the development of the above competencies, learning objectives were constructed to achieve the competencies (see Table 2). To follow up on plans for curriculum development, a review process was initiated to examine the validity of the learning objectives.

Using the literature and the combined experience of the TNH members, a consensus was reached regarding the appropriateness of the content (Olin et al., 2002; Zubenko et al., 2003). The
objectives were compared to the original competencies and reviewed by the TNH members with
the following questions in mind: a) Would staff who can meet these learning objectives satisfy
your organization’s need regarding the assessment and management of depression in people with
dementia? b) Would you consider staff members who meet these learning objectives to be
competent at providing appropriate care for residents with dementia and depression?

Insert Table 2 about here

Learning Objectives

The following strategies were proposed to achieve the learning outcomes (See Table 3).

Insert Table 3 about here.

The final curriculum product will be adapted for online presentation, CD ROM delivery, and written format. It was decided that the information would best be delivered over the internet in order to take advantage of the flexibility of linking content to supplementary materials, review previously learned content, and step-by-step demonstrations. However, some learners may not have easy access to a computer or access to the Internet. With a computer but no Internet access, the CD ROM can be used. The CD will provide some of the same advantages such as allowing

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for demonstrations as well as video presentations of residents and families. For learners without access to a computer, written programmed instruction in a manual format with an accompanying instructor’s manual will allow learners to work independently or along with an instructor. The content will be presented as a “programmed instruction” so that the learner can proceed at his/her own pace and refer to additional information as needed.

The curriculum will be evaluated using the model suggested by Kirkpatrick’s (1996), in which the summative evaluation is organized into four categories or levels: Response, Learning, Performance, and Results.

Response: The responses of learners including their impressions of the instructional activities, satisfaction with, and usability of the instructional materials will be an important part of this evaluation level. Post-training focus groups will be conducted using the questions in Table 1.

Learning: Pre-tests and post-tests will be administered to students in order to measure the impact of the training on students’ knowledge, skills, and abilities. Question and answer format will be used to evaluate knowledge of facts, concepts and processes.

Performance evaluation: This third level refers to the impact of the training on job performance. Student performance in realistic simulations will evaluate the impact of the training on
performance of assessment and management of depression in dementia. Case studies will be used to assess the learners’ ability to apply their knowledge of procedures and principles. Attitude change will be assessed by opinion questions, and by demonstrations of newly acquired skills in computer simulations.

Results: The evaluation of the results of the instructional program for the organization and for the health care recipients it serves, constitutes the fourth level. Evaluation at this level will include long-term studies comparing baseline rates of identification of depression with rates after full implementation of the training curriculum, or a comparison of these rates between matched institutions (those receiving the new training and comparison institutions receiving an unrelated educational program). Such studies will proceed only after evaluation results confirm that the curriculum was accepted by students; enhanced their specific knowledge, skills, and abilities; and improved role performance.

Conclusion
Depression in residents with dementia is a significant problem that needs to be addressed at a statewide public health level via coordinated stakeholder efforts. When completed, the curriculum will be available through the TNH GeriU (www.GeriU.org), an online educational site specifically dedicated to provide updated state-of-the-art information on the care of older adults for health care professionals. Modifications may render it appropriate for use with all nursing home staff, including registered nurses and certified nursing assistants. Ongoing training efforts must solicit input from LPN faculty and frontline LPNs in LTC settings every step of the way to insure adequate buy-in from all the constituents who may provide and/or utilize competency-based training.

Future research efforts will examine whether the training curriculum is effective by conducting controlled evaluations based on the above-described assessment of learning criteria.

Ultimately, we hope to show how this curriculum increases the number of residents with dementia who are treated for depression, and how such treatment positively affects health outcomes and quality of life. Only with concerted and steady training efforts will residents with dementia receive optimal mental health care.

References


Florida Commission on Mental Health and Substance Abuse (January, 2001). *Oldest adult workgroup report*. Tampa, FL: Department of Aging and Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida.


State of Florida Senate Bill 1202 page 62, section 26


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**Table 1. Depression in Dementia Focus Group Questions**

*Introduction:* We are interested in learning more about nursing care of depressed residents with dementia. According to some experts, depression is a problem for many residents and those with dementia present special challenges. We would like to get your perspective on the problem.

*Opening questions*

1. How long have you been working in ________?

*Introductory questions*
2. What sort of emotional and psychological problems do your residents with dementia struggle with?

Transition questions
3. What experiences have you had with residents with dementia suffering from depression?

Key questions
4. How prepared do you feel to recognize depression in your residents with dementia?
5. What are the behaviors and symptoms that you look for? Does this differ from how depression might be detected in other residents?
6. When you compare yourself to nurses from other long term care facilities, do you feel more prepared in this area? Less prepared? About the same?
7. When you detect symptoms or behaviors that might be depression, what do you do next?
8. Name one thing about the work environment/organization or work processes on _______ that helps with the recognition and management of depression in dementia.
9. Name one thing about the work environment/organization or work processes on _______ that makes the recognition and management of depression in dementia more difficult.
10. What role, if any, does medication play in the management of depression in dementia?
11. What is something that you or other nurses could do differently or better that would help with the recognition and management of depression in dementia?

Ending question
12. What training activities do you think would be useful for helping you to recognize and manage depression in residents with dementia?
13. Would you use online learning resources?
Poor self image
6. Describes similarities and differences between behavior related to depression in late life and behaviors associated with depression in dementia
7. Compares presentation of symptoms of depression in late life with presentation of D/D
Examples:
Depression in Late Life
1. Depressed mood,
hopelessness
and helplessness
2. Decreased interest in all or mostly all activities
3. Anxiety
4. Suicide ideation
5. Psychomotor retardation
Examples:
Depression in Dementia
1. Sadness,
discouragement,
tearfulness,
Resistance to care
Lack of participation in care
2. Decreased positive affect or pleasurable response to usual activities
3. Agitation,
catastrophic behavior
4. Preoccupation with death
5. Lethargy,
sedentariness
7.1. Recognizes psychological/behavioral symptoms of D/D
Increasing dependency
Social withdrawal
Self depreciation
Guilt
Delusions

1. Poor appetite
and nutrition
2. Sleep
disturbances:
difficulty falling
asleep, staying
asleep
3. Vague physical
complaints
4. C/O pain
1a. Refusing to eat
1b. Delusions about
being poisoned
2. Agitated at night
3. Agitation,
delirium
4. Guarding,
resistance to being
turned, moved,
yelling
7.2. Recognizes somatic symptoms of D/D
1. Unable to make
decisions
2. Complaints of
memory loss
1. Delirium, acute
change in mental
status
2. Rapid
deterioration of
functional abilities
7.3. Recognizes cognitive changes
associated with depression

**Competency 2. Manages depression in dementia**

**Learning Objectives**

8.1. Recognizes risk related to situational
factors (e.g. relocation)
8.2. Seeks information re: resident’s prior
history of depression, if applicable
8.3. Recognizes increased risk due to poor
health (e.g. chronic pain)
8. Intervenes: Collects data, reports,
documents risk for and symptoms of
depression
8.4. Identifies threat to resident safety
posed by suicidal ideation
9. Collects resident information with accuracy and when indicated
Geriatric Depression Scale
Cornell Depression in Dementia Scale
Observed Affect Scale
10. Identifies behavior indicating positive/negative affect and mood
11. In collaboration with interdisciplinary team, implements nursing actions to achieve
short and long term goals:
11.1. Administers medications and monitors resident response
   Antidepressants
   Mood stabilizers
   Antianxiety drugs
   Antipsychotics

11.2. Administers non-pharmacological interventions and monitors resident response
   Structured activities
   Meaningful activities (spirituality)
   Music
   Pets
   Sensory stimulation
   Supportive therapies
   Exercise
   Suicide safety protocol

11.3. Documents response to interventions

Competency 3. Communicates effectively regarding depression in dementia.

Learning Objectives
12. Communicates re: mood with IDT, family and resident
13. Communicates with IDT re: risk for depression, mood symptoms, and suicidal ideation
14. Communicates with resident to motivate and build self esteem
14.1 Actively listens and responds to resident’s emotions
14.2. Verbally acknowledges resident’s self care initiatives
14.3. Validates emotions
15. Communicates with family to assess and educate
15.1. Communicates with family to obtain information and assess for potential problems
15.1 Shares information re: resident mood with family
15.2 Educates family about mood and quality of life

Table 3. – Competency-Based Learning Outcomes, Strategies and Assessments

Competency Learning Outcomes

Strategy
Assessment of Learning
1. Recognition
   a. Create heightened awareness:
      • Prevalence
      • Significance
      • Consequences
The learner will gain improved
knowledge and as a result, will develop increased awareness of D/D.

A brief presentation of facts on “Prevalence” and “Significance” will be provided in text and statistics. To create empathy among the learners, possible consequences will be listed (with statistics). Scenarios will be presented that depict how residents and their families suffer from depression in dementia (D/D). Video or voice recordings of interviews with residents and family members will be incorporated. Multiple choice questions and answers will be included in written format or as a part of the PowerPoint presentation. In CD ROM or online format, the learner will receive immediate feedback on responses. Answers and rationales for incorrect answers will also be provided in the instructor’s manual.

b. Define the problem

The learner will distinguish between depression in dementia and dementia.
without depression.

*Depression as an illness*

Clinical examples will be presented to illustrate why depression can be considered an illness. Cases will be used to define “illness” and “depression” and to create a relationship between the two.

*Neuroanatomy/physiology*

Facts will be presented along with pictorial explanations of alterations in neurotransmitters associated with depression.

*Emotion, mood, affect, mental health*

Each of the concepts will be differentiated according to how they relate to functional abilities in

For evaluation, three vignettes will be presented: 1) an older person with depression; 2) an older person with dementia; and 3) an older person with depression co-morbid with dementia.

Learners will be able to correctly identify the problems and justify their determinations on the basis of the previous didactic module. One of these vignettes will include a minority resident, so that the learner will be able to address diversity issues as they relate to such assessment.

residents with dementia.

Examples of how depression affects residents’ functioning will be illustrated with real life
activities that occur in long
term care settings.

**Influence of cultural beliefs**
Contrasting case examples will be used to illustrate how emotion and depression may be expressed differently by elders from different cultural groups. Video presentations will generate interest thus assisting the LPN to identify the symptoms in each case.

2. **Management**
   
   **a. Assessment**
   
   In a simulated situation, the learner will perform an assessment of a resident with D/D. This section will be broken down into several units given the scope. Examples and non-examples will be used to reinforce the contrasts between D/D and depression and dementia, as well as typical and atypical presentations. There are 3 assessment tools that will be introduced briefly in this module. The learner will be referred to an advanced module for an in-depth demonstration of the tools. The learner will also be referred to another module for associated assessment tools such as pain. For each tool, the main focus for evaluation, case studies will be used in
which the learner will perform the assessment. At each decision point, the learner will make the assessment after listening to an audio response by the “resident.” Decision branching may occur in the process. A summary feedback for each case study will be presented to compare their final assessment with the correct one.

is on how to apply to a realistic case, and thus, emphasis will be placed on the LPN’s required actions. The actions will be related to the underlying principles. Video or audio clips will be used to demonstrate the application process.

b. Planning, Intervention, Evaluation

In a simulated situation, the learner will participate in care planning. Procedures and underlying principles will be presented with examples that are relevant and realistic for the LPN in long term care. Actions (such as alerting the interdisciplinary team to the need for a change in the plan of care) will be emphasized and related to the underlying principles. For resident evaluation,
there will be a short scenario at the end of every sub-section (e.g. planning or evaluation) to test that particular component of the case only. At the end of the entire module, a final scenario will be used to test the learner’s skill in performing the entire process of assessment to evaluation. This activity will help merge all the skills learned into one cohesive unit during the process of application. For evaluation, case studies will be used in which the learner will participate in the planning, intervention and evaluation of care. At each decision point, the learner will select the appropriate actions from the alternatives presented. A summary feedback for each case study will be presented to compare their final care plan with the model care plan.

3. Communication In a simulated situation, the learner

*With interdisciplinary team*

Each new term will be illustrated by examples For evaluation, a vignette will be used and the learner will verbally explain and document the
to verbally explain and to document depression and the resident’s response to treatment.

and non-examples. Following a case example, documentation using appropriate terms will be demonstrated. Exceptional cases where certain terms will be inappropriate will be highlighted.

*With family*
A scenario will be used to improve the learner’s skill in communicating with the family about depressed mood, potential causes, and courses of action. The importance of engaging the family in the process will be illustrated.

*With CNA*
Using a scenario, a video clip will be used to illustrate how the LPN would instruct the CNA to report potential symptoms of D/D.

*With Resident*
Using a scenario, a video clip of a nurse interacting with a resident will be used to illustrate how the LPN could be supportive to the resident with D/D. The learner will select the appropriate documentation from the alternatives presented. For evaluation, a vignette will be used in which the learner will communicate to the family or CNA
about the resident’s mood. The learner will select the appropriate statements from the alternatives presented. For evaluation, a vignette will be used in which the learner will communicate to the resident using appropriate language to validate emotions and express support. The learner will select the appropriate statements from the alternatives presented.