The Three Ds: Dementia, Delirium, and Depression
THE THREE Ds: DEMENTIA, DELIRIUM, AND DEPRESSION

Target Audience
Nurses

Learning Objectives
This learning activity should enable you to:
• Define dementia, delirium, and depression
• Differentiate dementia, delirium, and depression
• Recognize nursing interventions for each condition, especially dementia

Defining the Three Ds
Dementia, delirium, and depression, also commonly referred to as the “three Ds” are a set of separate conditions that are not a normal part of aging. However, as people age, the risk for each of these conditions increases. Furthermore, the symptoms of each condition can mimic the other, making it difficult to determine which one, or combination, of the conditions the resident is experiencing. This in-service will define and differentiate the three Ds from one another and provide insight into the nursing interventions.

Dementia
Dementia is a progressive, irreversible deterioration in intellectual function, memory, and ability to learn and solve problems due to loss or changes in brain cells. Judgment declines and social behaviors may become inappropriate. Emotions are flat, and delusions and hallucinations may be present. The ability to understand speech and remember proper words diminishes. Speech becomes incoherent and communication is significantly impaired. The loss of cognitive skills leads to a decline in the ability to engage in activities of daily living (ADLs). Increasingly, the person with dementia is dependent on others for the most basic tasks. There are several different conditions associated with the development of dementia, the most common of which is Alzheimer’s disease.

Delirium
Delirium is an acute disturbance in mental status that is reversible if the root cause is treated. The Mayo Clinic explains the three types of delirium as follows:

• Hyperactive delirium. Probably the most easily recognized type, this may include restlessness (for example, pacing), agitation, rapid mood changes or hallucinations, and refusal to cooperate with care.

• Hypoactive delirium. This may include inactivity or reduced motor activity, sluggishness, abnormal drowsiness, or seeming to be in a daze.

• Mixed delirium. This includes both hyperactive and hypoactive signs and symptoms. The person may quickly switch back and forth from hyperactive to hypoactive states.

Depression
Major depressive disorder is a persistent state of feeling sadness, loss of interest or apathy, and hopelessness. The onset of depression usually occurs over weeks to months, but a person’s mood is chronically depressed. Sometimes an elderly person is thought to have dementia when in fact they are suffering from depression. This is called pseudodementia. This assumption is made because the person may be neglecting basic activities of daily living, or they may communicate much less frequently and are apathetic and disconnected when they do. These symptoms are due to mood rather than damaged or lost brain cells. There is evidence to suggest that depression precedes the onset of dementia.

Differentiating the Three Ds
It can be difficult to determine which of the three Ds is affecting a person, given that the symptoms of each condition can mimic the other. It is also possible that a person can be afflicted by all three of the Ds or a combination. The table below helps to distinguish between each of the three Ds. The physician diagnoses which condition(s) a resident has, but the nurse should understand how they are alike and different so that during the assessment of the resident, the nurse can pay keen attention to even the subtlest of symptoms and share this information with the physician. This can help the physician diagnose the problem.
Nursing Interventions
Once the physician makes a diagnosis, a care plan should be developed that includes various nursing interventions to help the resident.

Dementia
One of the foremost considerations is safety. Altered judgment and misperceptions can lead to serious behavioral problems and mishaps. A safe, structured environment is essential, including consistency of caregiving staff.

- Symbols and photographs for the resident on the bedroom and bathroom doors or on personal possessions may help to trigger memory and reduce frustration.
- High levels of noise, activity, and lighting can overstimulate the resident and further decrease function. These environmental factors need to be controlled.

Delirium
Disruption in brain function due to an underlying cause such as infection, medication side effects, dehydration, or surgery.

Depression
Many possible causes including faulty mood regulation by the brain, genetic vulnerability, stressful life events, medications, and medical problems.

Cleaning solutions, pesticides, medications, and nonedible items that could be ingested accidentally must be stored in locked cabinets.

Coverings should be applied to unused sockets, electrical outlets, fans, motors, and other items into which fingers may be poked.

Matches and lighters should not be accessible; if the resident smokes, it must be under close supervision.

Resident wandering must be managed. Rather than restrain the resident or restrict wandering, it is best to provide a safe wandering area. Protective gates can be installed to prevent residents from wandering away; alarms and bells on doors can signal when residents are attempting to exit.

It is important to monitor the residents’ physical care needs, as these can easily be overlooked when residents are unable to communicate their needs.
to express them. For example, they may not complain that they are hungry, so it goes unnoticed that they have consumed less than one quarter of the food served; they may not remember to drink water, so they become dehydrated. They may wander and become fatigued but don’t recognize how tired they are. Residents may also wander so much they get blisters but ignore the discomfort, or they don’t exhibit a change in behavior that would alert staff of the issue. These residents’ physical needs must be closely monitored and care planned to ensure consistency of care and physical well-being. In addition, staff must monitor these residents for subtle changes, as dementia may inhibit their ability to communicate their needs.

As residents regress, their dignity, personal worth, freedom, and individuality may be jeopardized. Loved ones may view the family member with dementia as a stranger living inside the body that once housed the person they knew. Staff may see a dependent or total-care resident without having an awareness of that person’s unique life history. When residents with dementia lose their family identity and sense of personal self, they may be seen as less familiar by those who knew them and may ultimately be treated in a dehumanizing or infantilizing manner. It is important to maintain and promote the following qualities:

- **Individuality** – Staff should learn the personal history and uniqueness of the resident and incorporate it into caregiving activities.

- **Independence** – Even if it takes three times longer to guide residents through dressing than it would take to dress them, they should receive every opportunity possible to provide self-care.

- **Freedom** – As major freedoms become limited, minor choices and control become especially important. Staff must be careful to avoid imposing restrictions, in the name of efficiency and safety, that are so severe the resident’s quality of life becomes minimal.

- **Dignity** – It is never appropriate to become angry or to laugh at the behaviors of a resident with dementia, nor is it appropriate to dress them in undignified clothing. These residents must be afforded the respect given to any adult, including attractive clothing, good grooming, adult hairstyles, use of their name, privacy, and confidentiality. It is never appropriate to take a photograph or video of these residents. Doing so puts the caregiver at significant risk of breaking the law, as the Centers for Medicare & Medicaid Services (CMS) considers such actions abuse.

- **Connection** – Remember that residents with dementia continue to be valued human beings who are members of families and communities and must be given regard for the lives they have lived and the people they have touched. Offering them opportunities to interact and connect with other people and with nature shows recognition and respect for the spiritual beings that live within the altered bodies and minds.
Delirium
Nursing care for the resident with delirium is focused on interventions that help to resolve the underlying cause of the delirium. The nurse can also apply the interventions summarized for a resident with dementia to maintain safety, ensure physical needs are met, and honor the person as an individual. The table below summarizes three common causes of delirium and the associated nursing interventions.

<table>
<thead>
<tr>
<th>Causes</th>
<th>Interventions</th>
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<tbody>
<tr>
<td>Infection</td>
<td>• Maintain hydration&lt;br&gt;• Support sleep and rest&lt;br&gt;• Avoid sensory overload—keep the environment calm and quiet&lt;br&gt;• Assess for changes in the resident’s condition and response to treatment&lt;br&gt;• Practice infection control and prevention during care&lt;br&gt;• Administer antibiotics or antivirals as prescribed&lt;br&gt;• Offer care specific to symptoms, e.g., turn, cough, and deep breath for respiratory infection</td>
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<tr>
<td>Adverse reaction to medication</td>
<td>• Maintain hydration&lt;br&gt;• Support sleep and rest&lt;br&gt;• Avoid sensory overload—keep the environment calm and quiet&lt;br&gt;• Assess for changes in the resident’s condition and response to treatment&lt;br&gt;• Consult with the pharmacist&lt;br&gt;• Administer medication to counteract the reaction, as ordered by the physician</td>
</tr>
<tr>
<td>Recent hospitalization or acute medical condition</td>
<td>• Maintain hydration&lt;br&gt;• Support sleep and rest&lt;br&gt;• Avoid sensory overload—keep the environment calm and quiet&lt;br&gt;• Assess for changes in the resident’s condition and response to treatment&lt;br&gt;• Administer treatment and medication that corresponds to the medical condition</td>
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Depression
Nursing interventions for the person with depression are based upon how the depression manifests itself. If the resident is stable with antidepressants and counseling, then the nurse would ensure that the resident receives the medication and would monitor for adverse side effects or for a change in the effectiveness of the medication. The nurse would also ensure the resident was ready for counseling sessions and assist him or her to participate as needed. If the resident is not stable and is experiencing a depressive episode, supportive care may include interventions such as encouraging the resident to share feelings while the nurse listens or taking them outside to enjoy the outdoors if that is something that comforts them. The nurse may also coordinate with the medical team and pharmacist to adjust medications and monitor their effectiveness. Any problems should be reported as well as the resident’s progress. If the nurse suspects the level of depression is severe and is concerned about self-harm, the nurse should notify the physician immediately as well as the responsible party and facility leadership. Interventions to prevent self-harm should also be implemented immediately—follow the facility policy in these instances.
Knowledge Check

1. The nurse is caring for a new resident who has confusion and short-term memory loss. The nurse isn’t sure if the resident has dementia, delirium, or both. What should the nurse do?
   a. Assess the resident and be observant of even subtle symptoms that can give the physician information needed to make a diagnosis.
   b. Call the on-call physician to ask what the diagnosis is for this new resident the physician has not yet assessed.
   c. Ignore the symptoms as it doesn’t matter if it’s delirium or dementia because both are treated the same.
   d. Write down both dementia and delirium in the charts so that both diagnoses are covered in case the physician asks what diagnosis the resident was admitted with.

2. Which of the following is one of the differences between dementia and delirium?
   a. The onset of dementia is slow, while the onset of delirium is rapid.
   b. The onset of dementia is rapid, while the onset of delirium is slow.
   c. The onset of dementia is rapid but reversible, while the onset of delirium is slow and not reversible.
   d. There is very little difference between dementia and delirium, and usually a blood test is required to differentiate them.

3. Depression can be confused with dementia because:
   a. Depression can cause the person to lose the ability to feel hunger.
   b. Depression can cause the person to feel apathetic and neglect activities of daily living.
   c. Depression is progressive and results in severe cognitive loss.
   d. Depression has the same underlying cause as dementia.

4. Nursing interventions for delirium primarily focus on:
   a. Offering counseling
   b. Practicing infection control and prevention
   c. Encouraging the person to perform activities of daily living
   d. Treating the underlying cause of the delirium

5. Nursing interventions for dementia include:
   a. Medication to reverse the dementia
   b. Counseling to reverse the dementia
   c. Care to ensure physical needs are meet, dignity is honored, and safety is maintained
   d. Treating the underlying cause of the acute phase of dementia

Answers

1. a
2. a
3. b
4. d
5. c