



*Connecting you with care
Votre lien aux soins*

**South West
CCAC**
Community
Care Access
Centre

CASC
Centre d'accès
aux soins
communautaires
du Sud-Ouest

e-learning Tool for the RNAO BPGs on Delirium, Dementia and Depression

Laurie McKellar RN(EC), BScN
NP on Advanced Home Care Team
SW CCAC
LHSC

History about development of the RNAO 3Ds e-learning Course

- BPSO funding received to implement RNAO BPGs:
 - *'Screening for Delirium, Dementia and Depression in Older Adults'* at London Health Sciences Centre
 - *'Caregiving Strategies for Older Adults with Delirium, Dementia and Depression'* at St. Joseph's Health Care London
- Advanced Practice Nurses at SJHC and LHSC partnered to form the London 3Ds Group

History about development of the RNAO 3Ds e-learning Course

London 3Ds Group:

- Primarily APNs. Members worked in multiple geriatric roles: Acute Care (ACE Unit, Geriatric Consult-Liaison team, GEM), geriatric medicine (community outreach and clinics), geriatric mental health (community and hospital) and geriatric rehabilitation.
- Decided to use an interdisciplinary city-wide approach to implement both of the 3Ds BPGs at SJHC and LHSC to enhance consistency in elder care and to minimize gaps
- Identified need to develop a sustainable strategy as ongoing workshops would be expensive and labour intensive

History about development of the RNAO 3Ds e-learning Course

London 3Ds Group:

- Partnered with RNAO to develop an e-learning about the 3Ds based on content from the RNAO BPGs
- Designed the 3Ds e-learning so it could be used:
 - as self-directed learning strategy
 - as a ‘just-in-time’ resource in clinical practice
 - by all interdisciplinary team members
 - in any health care sector

RNAO e-learning Course on Delirium, Dementia and Depression

- Nine Modules
- Consistent format in each module
- ‘Certificate of Achievement’ if participant achieves at least 80% on quiz at the end of a Module
- User friendly navigation
- Multiple strategies used:
 - Video case studies and vignettes
 - Voice over case studies
 - Pop up boxes for information
 - Ability to print off information
 - Practical application of tools and flow diagrams in a clinical scenario
 - Links to other sites
- Web link <http://elearning.rnao.ca/>

3Ds e-learning Completion Stats

As of March 19, 2012, the numbers of participants who completed the modules to receive a certificate:

- Module 1 - 1213
- Module 2 – 1061
- Module 3 – 954
- Module 4.1 – 810
- Module 4.2 – 742
- Module 4.3 – 735
- Module 8 – 688

Obtained from Mike Watson
RNAO eLearning administrator

E-learning on delirium, dementia and depression

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

iaBPG

Home | Introduction | Background | Assessment | Caregiving | Client and Family Education | Communication | Education and Policy | Review | Frameworks, Tools and Resources

Delirium, Dementia and Depression

RNAO Nursing Best Practice Guidelines

Jump to...

RNAO ► DDD Update this Resource

Module 1: Introduction

Course Description, Aim and Objectives
Course Overview
Self-Reflection Practice
Case Study
Case Study Quiz
General Quiz
Guiding Principles – Assumptions
Recommendations
Tenets of Care
Introduction Module Certificate
Next Module

Administration

Turn editing on
Settings

MODULE 1. Introduction

Course Description, Aim and Objectives

Description

This module contains:

1. An overview and description of the e-learning course
2. Self-reflection practice
3. Case presentation
4. RNAO Guiding Principles-Assumptions and Recommendations for screening and caregiving strategies in older adults with delirium, dementia and depression
5. A description of the 'Tenets of Care' that are the basis of care strategies

Aim

To provide an overview of the e-learning course on the RNAO best practice guidelines for the screening and care strategies for delirium, dementia and depression.

Objectives

E-learning on delirium, dementia and depression

RNAO ► DDD Update this Resource


Previous Module
Module 3: Assessment
Introduction
Screening Assessment Flow Diagram for Delirium, Dementia and Depression
Clinical Features
Clinical Features – Table
More About Delirium, Dementia and Depression
Case Presentations
Case Presentations Review
Clinical Assessment
Clinical Assessment Review - Screening Assessment Flow Diagram & Kaleidoscope of Care Strategies
Assessment Tools (Overview)
Confusion Assessment Method (CAM) Instrument
Mental status exam
Mini Mental Status Exam (MMSE)
Clock Drawing Test
Cohen-Mansfield Agitation
SIGECAPS
Geriatric Depression Scale (GDS)
Suicide Risk in the Older Adult
Prevention of Delirium
Primary Prevention - Targeting Risk Factors
Quick Tips
Assessment of Delirium, Dementia & Depression Quiz

MODULE 3. Assessment of Delirium, Dementia and Depression

Case Presentations

Here is a chance for you to review and practice your assessment skills of the 3Ds based on what you have learned so far. What do you think is happening in the following case scenarios.

CASE 1



Case 1 : Mrs. S

The Person:

- Age 84
- Widowed
- Retired teacher
- Lives in nursing home for 2 years

Daily Functioning:

- Delivers mail
- Waters plants
- Reads to others
- Plays piano

Medical History:

- Fall resulting in fractured pelvis
- Glaucoma
- Osteoporosis
- Urinary tract infections

Presenting Features:

- Woke up confused after sleeping
- Believed she was in her childhood house
- Angry and agitated with care providers
- Restless, trying to climb out of bed
- Attempting to escape the 'policemen on horses'
- Highly distractible and unable to focus attention
- Fluctuates between sleeping and yelling and tying sheets
- Found on the floor crying
- Believed something bad was about to happen

Listen to case
Listen to the case study.

After listening to the case, answer the question below.

Case 1: Which one of the following conditions best describes what is happening?

a) Delirium

b) Dementia

E-learning on delirium, dementia and depression

The screenshot shows a web browser window displaying an e-learning module. The browser's address bar shows 'RNAO ► DDD'. In the top right corner, there is a button labeled 'Update this Resource'. The main content area is titled 'MODULE 3. Assessment of Delirium, Dementia and Depression' and 'Clinical Assessment'. A sidebar on the left lists various topics, with 'Clinical Assessment' highlighted. The main text discusses the steps for clinical assessment and lists several key recommendations. A green oval on the right side contains the 'TENETS OF CARE'.

RNAO ► DDD Update this Resource

Previous Module
Module 3: Assessment
Introduction
Screening Assessment Flow Diagram for Delirium, Dementia and Depression
Clinical Features
Clinical Features – Table
More About Delirium, Dementia and Depression
Case Presentations
Case Presentations Review
Clinical Assessment
Clinical Assessment Review - Screening Assessment Flow Diagram & Kaleidoscope of Care Strategies
Assessment Tools (Overview)
Confusion Assessment Method (CAM) Instrument
Mental status exam
Mini Mental Status Exam (MMSE)
Clock Drawing Test
Cohen-Mansfield Agitation
SIGECAPS
Geriatric Depression Scale (GDS)
Suicide Risk in the Older Adult
Prevention of Delirium
Primary Prevention - Targeting Risk Factors
Quick Tips
Assessment of Delirium, Dementia & Depression Quiz

MODULE 3. Assessment of Delirium, Dementia and Depression

Clinical Assessment

These are some steps you may find useful as you assess someone to determine if they have delirium, dementia and/or depression. The sequence of what you do will vary with each case as you assess the person.

- [Obtain Collateral history](#)
- [Assess for delirium](#)
- [Assess for dementia](#)
- [Assess for depression](#)
- [Obtain health history to identify possible causes and risk factors of delirium, dementia, depression](#)
- [Review medications](#)
- [Assess test results](#)
- [Assess Risk](#)
- [Use an Interdisciplinary Team Approach](#)
- [Make a referral if necessary](#)
- [Do ongoing assessment](#)

TENETS OF CARE

- [Know the Person](#)
- [Relate Effectively](#)
- [Recognize Retained Abilities](#)
- [Manipulate the Environment](#)

Obtain Collateral history

The following recommendations support the importance of obtaining collateral history and knowing the person with delirium, dementia and/or depression in order to implement appropriate care strategies that will meet the client's needs.

Recommendation 1

Nurses should maintain a high index of suspicion for delirium, dementia and depression in the older adult ([reference 123](#)).

E-learning on delirium, dementia and depression

RNAO ► DDD
Update this Resource

Previous Module

Module 3: Assessment

Introduction

Screening Assessment Flow Diagram for Delirium, Dementia and Depression

Clinical Features

Clinical Features – Table

More About Delirium, Dementia and Depression

Case Presentations

Case Presentations Review

Clinical Assessment

Clinical Assessment Review - Screening Assessment Flow Diagram & Kaleidoscope of Care Strategies

Assessment Tools (Overview)

Confusion Assessment Method (CAM) Instrument

Mental status exam

Mini Mental Status Exam (MMSE)

Clock Drawing Test

Cohen-Mansfield Agitation

SIGECAPS

Geriatric Depression Scale (GDS)

Suicide Risk in the Older Adult

Prevention of Delirium

Primary Prevention - Targeting Risk Factors

Quick Tips

Assessment of Delirium, Dementia & Depression Quiz

MODULE 3. Assessment of Delirium, Dementia and Depression

Primary Prevention of Delirium - Targeting Risk Factors

Primary prevention of delirium should address risk factors ([reference 68](#)).

The Hospital Elder Life Program - Risk Factors for Delirium and Intervention Protocols ([reference 71](#)) is a comprehensive program of preventative interventions for delirium that reduced delirium by about 25% in the medically complex or surgical hospitalized older adults ([reference 68](#)).

The Hospital Elder Life Program - Risk Factors for Delirium and Intervention Protocols ([reference 71](#)) targets 6 risk factors in the elderly:

- Cognitive impairment
- Sleep deprivation
- Immobility
- Visual impairment
- Hearing impairment
- Dehydration

Hospital Elder Life Program - Risk Factors for Delirium and Intervention Protocols

The Mini-Mental State Examination (MMSE) may be used as a validated baseline assessment tool but is not a screening tool for delirium.

Factor and Eligible Clients	Standardized Intervention Protocols	Targeted Outcome for Reassessment
Cognitive impairment* All clients, protocol once daily;	Orientation protocol: board with names of care-team members and day's schedule;	Change in orientation score.

E-learning on delirium, dementia and depression

Previous Module

Module 5: Client and Family Education

Introduction

Teaching Information

Next Module

MODULE 5. Client and Family Education

Teaching Information

The 3Ds Diagram © has been mentioned in previous Modules to illustrate the complexity of delirium, dementia and depression. As care providers, it is essential to provide accurate and appropriate information to clients and their family.

Click on each of the circles and in the central area common to all three conditions to obtain educational information for the older person and the family.

[click on circles below]

DELIRIUM

DEMENTIA

DEPRESSION

All three conditions

Administration

- Turn editing on
- Settings
- Assign roles
- Grades
- Groups
- Backup
- Restore
- Import
- Reset
- Reports
- Questions
- Files
- Unenrol me from DDD
- Profile

Key messages about the RNAO 3Ds e-learning Course

- Is based on the RNAO Best Practice Guidelines for delirium, dementia and depression in older adults
- Is a self-directed learning strategy
- Can be used for reflective practice
- Can be used as a 'just-in-time' resource in clinical practice
- Can be used by educators for clinical teaching
- Provides an opportunity to practice transferring knowledge learned about the 3Ds into a complex clinical case study
- Can be used by all interdisciplinary team members
- Is applicable to any health care sector
- Is free and can be used at any time anywhere in the world