The number of old and very old patients that we encounter is significantly on the rise. Never has the need been so great for nurses to view their older patient population base as a true specialty. With the responsibility of caring for our older patients comes the need and responsibility to know and use correct assessment parameters for this unique group. A geriatric assessment is a comprehensive evaluation designed to explore and gain information about the older person’s functional abilities or limitations in order to help improve overall quality of life and enable him or her to live independently for as long as possible. Such a comprehensive assessment includes physical, psychological, and social dimensions.

As with other adult life cycles, the geriatric population is not immune to mental health disorders such as depression or anxiety. Assessment and diagnosis of late-life mental disorders are especially challenging for today’s home health nurse. The symptoms presented by older adults may be different from those found more commonly in younger patients, making the disorder more difficult to determine. Additionally, many older patients are reluctant to report symptoms, afraid of the social ramifications and the stigmas attached to an aging mind. The elderly are more likely to seek medical attention for physical symptoms than for feeling depressed. Comorbidity with other medical disorders, and even the effects of normal aging, may result in misdiagnosis and inappropriate plans of care. This article is intended to explore three distinctive disorders in the elderly that often mimic each other, sharing some basic symptoms, and to assist the home healthcare nurse to differentiate between the three: dementia, depression, and delirium.

The Home Health Nurse’s Role in Geriatric Assessment of Three Dimensions:

DEPRESSION, DELIRIUM, AND DEMENTIA
Detection of mental disorders in older adults is complicated by high comorbidity with other medical disorders. A complete and thorough physical assessment is absolutely essential before concluding that the symptoms of depression, delirium, or dementia are present in the older patient. Nurses must first understand the physiology of normal aging before distinguishing abnormal findings. Also, the symptoms of somatic disorders may mimic or mask the symptoms of dementia, depression, or delirium, making diagnosis more difficult. When is a complete geriatric assessment needed? A request for a geriatric assessment would be appropriate when there are persistent or intermittent symptoms such as memory loss, confusion, or other signs of possible dementia. Often, what looks like Alzheimer’s disease or dementia could be the result of medication interactions or other medical or psychiatric problems. Because of the thoroughness of the geriatric assessment, it is one of the best ways to determine the actual cause of the problem (Table 1).

Depression Overview
Nurses specializing in the field of geriatric nursing or home healthcare nurses with older patients can frequently expect to have patients presenting with clinically significant symptoms of depression. It is estimated that symptoms of depression occur in more than 30% to 50% of all older patients; it is the mental health problem of greatest frequency and magnitude in this population (Tabloski, 2006). Symptoms of depression may include loss of energy, variations in sleep patterns, loss of appetite, chronic headaches, rise in somatic complaints, and difficulty in...
concentrating. Sometimes, older patients with depression also report excessive or inappropriate feelings of guilt, suicidal ideation, or a preoccupation with death. Unfortunately, because many medical conditions that are present in the elderly also produce similar symptoms, depression may exacerbate over time before the health team considers depression as a diagnosis. Additionally, many common medicines prescribed to the older age group also produce similar symptoms. These include sedatives, corticosteroids, antihypertensives, anticonvulsants, anti-Parkinson drugs, and nonsteroidal anti-inflammatory drugs (NSAIDs) (http://www.pdrhealth.com, 2006).

All people feel sad or unhappy at times during their lives, but persistent sadness may be depression, a serious illness affecting 15 out of every 100 adults older than 65 in the United States (Unutzer et al., 2002). Depression is not a normal part of growing old but rather a treatable medical illness that impacts more than 6 million of the more than 40 million Americans older than 65 (Center for Elderly Suicide Prevention, 2006). When depression occurs in late life, it may be a relapse of an earlier depression. If it is a first-time occurrence, it may be triggered by another illness, hospitalization, or placement in a nursing home. Unlike the onset of depression in nonelderly populations, depression in the elderly is often triggered by specific stressors, such as medical illness or the death of a loved one such as a spouse or friend (Gallo et al., 2006).

To assist in diagnosing depression, the nurse should determine if the elderly patient has experienced multiple signs of depression for more than 2 weeks. Many clinicians consider a loss of interest or pleasure in daily activities to be the essential feature of depression. Depression is a principal risk factor for suicide in older adults. Often, the nurse can better assess the older patient using a methodical, organized data collection approach. There are several useful and respected tools that can assist the nurse in correct assessment, including the Geriatric Depression Scale (GDS), which is a self-report assessment developed in 1982 by J.A. Yesavitch and coworkers. The GDS is a 30-item self-report assessment designed specifically to identify depression in the elderly. The items may be answered as yes or no, which is thought to be simpler than scales that use a five-category or Likert-like response set. However, a diagnosis of clinical depression should not be made on the basis of the GDS results alone, but in conjunction with other clinical

<table>
<thead>
<tr>
<th>Table 1. Common Physical Findings of Normal Aging</th>
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<tbody>
<tr>
<td><strong>Cardiac</strong></td>
</tr>
<tr>
<td>Heart loses elasticity</td>
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<tr>
<td>Systolic murmurs common</td>
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<tr>
<td>Common presence of some arteriosclerosis</td>
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<tr>
<td>Significant increase in systolic pressure (at or above 140 mm Hg), which may suggest hypertension</td>
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<tr>
<td>Integumentary</td>
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<tr>
<td>Loss of elasticity</td>
</tr>
<tr>
<td>Cooler extremities</td>
</tr>
<tr>
<td>Thinning hair distribution</td>
</tr>
<tr>
<td>Presence of multiple age spots</td>
</tr>
<tr>
<td><strong>Musculoskeletal</strong></td>
</tr>
<tr>
<td>Bones are more porous</td>
</tr>
<tr>
<td>Loss of 2 inches in height from young adulthood</td>
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<tr>
<td>Joints are less mobile, with limitations on range of motion</td>
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<tr>
<td>Posture changes, often with kyphosis</td>
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<tr>
<td><strong>Gastrointestinal</strong></td>
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<tr>
<td>Decreased saliva production, making swallowing more difficult</td>
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<tr>
<td>Decreased peristalsis</td>
</tr>
<tr>
<td>Weaker anal sphincter control</td>
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<tr>
<td><strong>Sensory</strong></td>
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<tr>
<td>Decreased peripheral vision</td>
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<tr>
<td>Yellowing of lens, causing decreased discrimination of colors</td>
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<tr>
<td>Decreased tearing, causing dry eyes</td>
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<tr>
<td>Diminished sense of balance</td>
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<tr>
<td>Diminished thermal regulation</td>
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<tr>
<td>Diminished sense of taste</td>
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*Note. Data from Gallo et al., 2006 and Ebersole et al., 2004.*
findings (Sheikh & Yesavitch, 1986; Gale Encyclopedia, 2005).

Older people have the highest rates of suicide in the US population: suicide rates increase with age, with older white men having a rate of suicide up to six times that of the general population (Table 2). Eighty-five percent of all persons dying from suicide are men older than 65 years (Center for Elderly Suicide Prevention, 2006). Despite the prevalence of depression and the risk it confers for suicide, depression is neither well recognized nor treated in primary care settings, where most older adults seek and receive healthcare (Unutzer et al., 2002). Consider case study 1.

**Case Study 1**
Joe Tubbs, an elderly male veteran, lives in a small home on Elm Street. Joe is 80 years old, with a history of congestive heart failure and diabetes. Daily medications include Lasix, Glucophage, and Digoxin. Joe is currently battling gout. Since the death of his wife, Ethyl (then aged 53) 7 months ago, Joe spends his days alone, occasionally visited by one WWII Army buddy. Although Ethyl always prepared their meals around a strict American Dietetic Association diet, Joe finds he does not have much of an appetite these days, preferring to simply snack on saltines, sardines, and eggs. For the past 10 days, Joe has been unable to fall asleep, struggling with an overwhelming sense of loneliness and sorrow. Today, Joe awakes to find his first toe, or hallux, inflamed, stiff, and painful to touch. He coughs up an abundance of frothy sputum, and realizes he forgot to take yesterday’s Lasix. Rubbing his throbbing toe, Joe remembers a previous episode of gout when he and Ethyl went to Niagara Falls on their silver anniversary. As Joe sits down to look over an old photo album of that trip, his telephone rings with news of his Army buddy’s death early this morning. Joe feels so alone in the world. He feels that his body is old and falling apart, with frequent bouts of congestion, and now this flare-up of gout. Thinking of how much he wishes to be with his wife and friend, Joe begins to form a plan...and thinks of a way to tell his home healthcare nurse goodbye....

**Points to Ponder**
- What are the clinical symptoms of depression presented by Joe?

**Table 2. Suicide Among the Elderly**
- The highest suicide rates of any age group occur among persons aged 65 years and older.
- There is an average of one suicide among the elderly every 90 minutes.
- Suicide disproportionately impacts the elderly. In 1998, this group represented 13% of the population but suffered 19% of all suicide deaths.
- Firearms (71%), overdose (liquids, pills, or gas, 11%), and suffocation (11%) were the 3 most common methods of suicide used by persons aged 65+ years.
- Risk factors for suicide among older persons differ from those among the young. In addition to a higher prevalence of depression, older persons are more socially isolated and more frequently use highly lethal methods. They also make fewer attempts per completed suicide, have a higher male-to-female ratio than other groups, have often visited a healthcare provider before their suicide, and have more physical illnesses.
- It is estimated that 20% of elderly (>65 years) persons who commit suicide visited a physician within 24 hours of their act, 41% visited within a week of their suicide, and 75% have been seen by a physician within 1 month of their suicide.
- Suicide rates among the elderly are highest for those who are divorced or widowed.
- Several factors relative to those older than 65 years will play a role in future suicide rates among the elderly, including growth in the absolute and proportionate size of that population; health status; availability of services; and attitudes about aging and suicide.

*Note. Data from National Strategy for Suicide Prevention, United States Department of Health & Human Services, 2006.*

- Which of Joe’s medications may produce similar symptoms to depression?
- What comorbid physical findings should be further assessed before a diagnosis of depression is established?
Because patients with delirium often have symptoms of confusion, the nursing assessment and corresponding documentation of patients’ conditions are paramount to the interdisciplinary plan of care.

- As a home healthcare nurse, if upon visiting Joe, he manifested the above clinical picture, how would you assess his risk for suicide?
- What steps would the home healthcare nurse take next?

Delirium Overview

The term delirium is derived from the Latin words de lira meaning “off the path.” Delirium is characterized by disturbances in levels of consciousness and cognition, and is often associated with an underlying medical condition (Life Steps, n.d.). Therefore, the causes of delirium may be reversible. Patients with delirium frequently present with agitation, somnolence (fatigue), withdrawal, and psychosis. To determine dementia in an elderly patient, it is important to obtain the history of the onset and course of the condition from family members or caregivers. Although low doses of antipsychotic drugs are often ordered to assist in controlling symptoms of agitation, this strategy should be used only when nonmedication strategies fail. Environmental interventions, including frequent reorientation of patients by nursing staff and education of patients and families, should be first implemented rather than providing a quick fix through medications alone.

There are four basic tenets that help form the diagnosis of delirium:

- laboratory data, which confirm a problematic underlying medical condition;
- change in baseline level of consciousness;
- changes in cognition, such as acute memory disturbance; and
- fluctuations of cognition throughout a 24-hour period.

Additionally, often there are changes in psychomotor activities, either obvious or subtle. Useful screening methods to identify attention problems include asking patients to spell a word backwards or perform “serial 7s” (counting backward from 100 by sevens) (Folstein et al., 1975). Early diagnosis and resolution of symptoms are critical to achieve the most favorable outcomes. Approximately 14% to 56% of elderly patients who are hospitalized show symptoms of delirium (Life Steps, n.d.). This may cause an increased length of hospital stay, increased costs to the patient, and increased medical complications.

Considering that patients with delirium often have symptoms of confusion, the nursing assessment and corresponding documentation of patients’ conditions are paramount to the interdisciplinary plan of care. The home healthcare nurse should routinely obtain a detailed history from family, caregivers, or other sources, and should carefully and accurately document these baseline data in the patient’s clinical record. Episodes of hallucinations, disorientation, or other abnormal behaviors should be detailed. Patients with delirium often have episodes of persecutory delusions and may be unwilling to share their feelings with the healthcare team. Because of the high risk of suicidal behaviors in persons with delirium, the patient should never be left alone or unattended, and the suicide risk should always be considered (case study 2).

Case Study 2

Maria Sanchez is a 71-year-old Hispanic female, who is accompanied to the community health clinic by her daughter, Lucia, and great grandson, Juan. Maria has the following medical diagnoses: mild arthritis, hypertension, and peripheral vascular disease.

Lucia, the daughter, is 53 years old with multiple health problems. She is trying to care for her mother while working full time as a nurse’s aide. Additionally, Lucia is caring for little Juan, who is an active 3-year-old toddler. Juan’s mother is deployed in Iraq on active duty with the Marines. It is obvious that Lucia is irritable and tired and needs help with caregiver stress.

According to Lucia, who tends to do all of the talking for the family, her mother is “out of control” for the past 2 weeks. She states that her mother is not sleeping and is keeping the rest of...
the family up at night because of her “constant roaming through the house.” She states that though Maria has been very forgetful for the past few years, she has now forgotten the grandson’s name. She states that last night her mother burned the tortillas at supper, yet seemed unaware of the danger when the burned tortillas filled their little kitchen with smoke. Two days ago, her mother was bitten by “some bug” and has a problem with her ankle since that time.

Maria presents to the clinic this morning with the following symptoms: swollen left ankle with a large area of cellulitis. Huge scratch marks are present around the site of the bite. Elevated temperature is at 100.4°F orally. Blood pressure is 138/94. As you examine her ankle, Maria yells out that she wants to go home now, as she needs to get breakfast for her husband, Manny. Lucia explains that Manny has been dead for 12 years. Maria becomes very agitated at this time.

**Points to Ponder**

- What are the clinical symptoms for delirium that are presented by Maria?
- How does the cellulitis influence the diagnosis of delirium?
- What are some basic teaching points about delirium that may be useful in reducing Lucia’s stress?
- What are some home safety tips that could be easily implemented to decrease risk of injury to Maria?

### Table 3. Conditions That May Cause or Simulate Confusion or Dementia

- AIDS
- Parkinson’s disease
- Huntington’s disease
- Brain tumor
- Hydrocephalus
- Heat stroke
- Alcohol and drug abuse
- Thiamin, niacin, and vitamin B12 deficiencies
- Hyperthyroidism
- Hypercalcemia
- Liver failure
- Kidney failure
- Pernicious anemia
- Infection
- Dehydration

**Dementia Overview**

Dementia is defined as a loss of mental ability, severe enough to interfere with normal activities of daily living, lasting more than 6 months, not present since birth, and not associated with a loss of alteration of consciousness (Life Steps, n.d.). Wold (2004) defines dementia as a slow, insidious process that results in a progressive loss of cognitive function and may be caused by damage to the cerebral cortex that is most commonly a result of disease conditions. Alzheimer’s disease is the most well-known form of dementia. The essential feature of this disease is impairment in short-term and long-term memory.

In the elderly patient, delirium and dementia may coexist owing to multiple medications and electrolyte imbalance (Ebersole et al., 2004). Five to eight percent of all persons aged between 65 and 74 and up to 20% of those older than 75 are affected by dementia (Life Steps, n.d.). Home healthcare nurses should be aware that medications may cause side effects that simulate dementia. These include the drug categories of sedatives, hypnotics, anticonvulsants, antiarrhythmics, and drugs with anticholinergic effects (www.pdrhealth.com, 2006). Table 3 lists conditions that may cause or simulate confusion or dementia.

### Three Levels of Dementia

Although dementia does not progress through distinct stages, there are some general levels of the disease that have distinct features and symptomology.

**For Further Reading**


Depression in older adults guidelines. Available at: www.guideline.gov.


Level 1
• Hallmarked by forgetfulness, poor judgment, and loss of spontaneous emotional response. During this initial level, caregivers and family often notice decreased ability to perform simple verbal and math skills commonly associated with activities of daily living.

Level 2
• Usually ushers in advanced episodes of forgetfulness, significantly impaired judgment, and episodes of irritability and mild agitation. Family and caregivers may now notice some confusion to place and time and bouts of incontinence.

Level 3
• Patients often manifest a total inability to communicate verbally and also experience a loss of contact with reality of their situation. Patients in the later levels are dependent on caregivers for all physical needs. During the later disease levels, patients are at high risk of infection, malnutrition, dehydration, falls, and skin breakdown and need close assessment and detailed care planning.

Home Care Nursing Implications
Home care nurses working with the elderly should be familiar with normal aging changes and expectations. This allows the nurse to better separate abnormal symptoms that merit further assessment and scrutiny. Our geriatric patients are at high risk to experience depression, delirium, and dementia at some point of the elder life span. The home healthcare nurse can play a pivotal role in recognizing symptoms at their earliest stages and referring the patient for further medical workup and treatment. Medication regimens should be assessed frequently to determine possible side effects that may mimic clinical pictures of depression, delirium, and dementia. Laboratory values should also be closely monitored. The home healthcare nurse’s complete, accurate, and detailed baseline history and physical examination will also assist the health team in determining an accurate diagnosis and effective plan of care. Early intervention and treatment reduce morbidity and increase quality of life.  

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The authors of this article have no significant ties, financial or otherwise, to any company that might have an interest in the publication of this educational activity.

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