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**DEVELOPMENT OF A CURRICULUM FOR LONG-TERM  
CARE NURSES TO IMPROVE RECOGNITION  
OF DEPRESSION IN DEMENTIA**

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*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 cooccurring depression and 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, Sato, & Roy-Byrne, 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 activities of daily living (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 (Lyketsos & 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, Katz, Meyers, Schneider, & Lebowitz, 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 to improve the quality of mental health care in nursing homes by assessing and treating depression and behavior problems in those with dementia (American Geriatrics Society & American Association for Geriatric Psychiatry, 2003). However, in one study, only 1/3 of those residents who were depressed in long-term care (LTC) settings actually improved with treatment (Boyle et al., 2004). The authors note that many of these residents were initially screened and treated. However, 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 Minimum Data Set (MDS) quality measures emphasis, a main conclusion was that "the recognition and appropriate treatment for depression can improve the quality of life for the resident" (Teaching Nursing Home, p. 9). The Teaching Nursing Home (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; Pritchard & Dewing, 1999). 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. The initiative encourages 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. 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. These studies yield some guidance on how to investigate this problem.

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 on resident care than any other LTC staff, they are virtually ignored in clinical decision-making. Their knowledge and experience is not 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 repositories of vast 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. In this way 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. The findings in the literature suggest the efficacy of a more hands-on approach utilizing the collective wisdom of non-RN staff to brainstorm solutions to resident problems. The authors, therefore, decided to concentrate their initial efforts on conducting focus groups to solicit basic information regarding LPNs' understanding of (a) depression, dementia, and depression in those with dementia and (b) 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. The goal was to generate and validate competency-based learning objectives for LPNs to (a) foster recognition and care related to depression in residents with dementia and (b) develop a curriculum plan encompassing learning objectives 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 and 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, Hyer, Kelly, Leger-Krall, & Tappen, 2005; Polivka, Salmon, Hyer, Johnson, & Hedgecock, 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" (State of Florida 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, Cheek, O'Brien, & Pincombe, 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: (a) understanding and appreciation of the seriousness and importance of depression in dementia and its consequences; (b) skill in the use of standardized assessments for depression; (c) skill in differentiating delirium, dementia, and depression; (d) knowledge about what to report (symptoms of depression and improved mood); and (e) 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 1 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): (a) What do LPNs already know about depression in dementia? (b) What additional knowledge and skills are needed? (c) What do they see as their role in identifying, reporting, and intervening with depression in dementia? (d) 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

**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?

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; they perceived this as a last resort rather than a routine intervention for a resident who is depressed. Attendees were concerned that antidepressants 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 the Cornell Depression in Dementia Scale, and greater understanding of the benefits of pharmacological and nonpharmacological 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 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?

### *Learning Objectives*

The strategies shown in Table 3 were proposed to achieve the learning outcomes.

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, reviewing 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 for demonstrations as well as video presentations to 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.

**Table 2. Competency-based learning objectives for depression in dementia****Competency 1. Recognizes depression in residents with dementia**

## Learning Objectives

1. Discusses the prevalence of depression in dementia (D/D) in nursing home population
2. Identifies the relationship of mood and affect to quality of life in dementia
- 3a. Defines common mood related terminology
- 3b. Describes how cultural/ethnic background influences beliefs and reactions to emotional expression and dementia
4. Describes impact of D/D on
  - Resident well-being
  - Caregiver stress and burden
  - Cost of care
5. Lists potential physical & psychological consequences of unrecognized and untreated D/D
  - Deconditioning, increasingly sedentary
  - Increased dependency
  - Increased health risks (e.g. infections, pressure ulcers or PU)
  - Increased risk of hospitalization
  - Increased pain
  - 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	Examples: Depression in Dementia	7.1. Recognizes psychological/behavioral symptoms of D/D
1. Depressed mood, hopelessness and helplessness	1. Sadness, discouragement, tearfulness, Resistance to care Lack of participation in care	Increasing dependency Social withdrawal Self depreciation Guilt Delusions
2. Decreased interest in all or mostly all activities	2. Decreased positive affect or pleasurable response to usual activities	
3. Anxiety	3. Agitation, catastrophic behavior	
4. Suicide ideation	4. Preoccupation with death	
5. Psychomotor retardation	5. Lethargy, sedentariness	

*(Continued)*

Table 2. Continued

1. Poor appetite and nutrition	1a. Refusing to eat 1b. Delusions about being poisoned	7.2. Recognizes somatic symptoms of D/D
2. Sleep disturbances: difficulty falling asleep, staying asleep	2. Agitated at night	
3. Vague physical complaints	3. Agitation, delirium	
4. C/O pain	4. Guarding, resistance to being turned, moved, yelling	
1. Unable to make decisions	1. Delirium, acute change in mental status	7.3. Recognizes cognitive changes associated with depression
2. Complaints of memory loss	2. Rapid deterioration of functional abilities	
<b>Competency 2. Manages depression in dementia</b>		
<b>Learning Objectives</b>		
8. Intervenes: Collects data, reports, documents risk for and symptoms of depression		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) 8.4. 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		

(Continued)

Table 2. Continued

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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
<b>Competency 3. Communicates effectively regarding depression in dementia.</b>
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

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The curriculum will be evaluated using the model suggested by Kirkpatrick (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*

Pretests and post-tests will be administered to students in order to measure the impact of the training on students' knowledge, skills, and abilities. A 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

Table 3. Competency-based learning outcomes, strategies and assessments

Competency	Learning Outcomes	Strategy	Assessment of Learning
1. Recognition a. Create heightened awareness:	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.	<i>Depression as an illness</i> 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. <i>Neuroanatomy/physiology</i> Facts will be presented along with pictorial explanations of alterations in neurotransmitters associated with depression. <i>Emotion, mood, affect, mental health</i> Each of the concepts will be differentiated according to how they relate to functional abilities in residents with dementia. Examples of how depression affects residents' functioning will be illustrated with real life activities that occur in long term care settings.	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.

*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.

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 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.

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.

(Continued)

Table 3. Continued

Competency	Learning Outcomes	Strategy	Assessment of Learning
b. <i>Planning, Intervention, Evaluation</i>	In a simulated situation, the learner will participate in care planning.	<p>Procedures and underlying principles will be presented with examples that are relevant and realistic for the LPN in long term care.</p> <p>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.</p> <p>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.</p>	<p>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.</p>

### 3. Communication

In a simulated situation, the learner will use appropriate language to verbally explain and to document depression and the resident's response to treatment.

#### *With interdisciplinary team*

Each new term will be illustrated by examples 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.

For evaluation, a vignette will be used and the learner will verbally explain and document the resident's mood. 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.

evaluate the impact of the training on the 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, there may be 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](http://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. Such input must be sought 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.

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