Standardised care process (SCP): depression

health

Topic

Identifying and responding to symptoms of depression

Objective

To promote evidence-based practice in how staff identify and respond to symptoms of depression

Rationale

Depression is a common problem in older people, including those living in residential aged care facilities. It is not part of normal ageing and can have a negative impact on the health and quality of life of the resident. Appropriate identification of, and responses to, symptoms of depression can improve the health and quality of life of the resident (Kurlowicz & Harvarth, 2008; RNAO, 2003).

Definitions

Depression: a syndrome affecting mood and functioning

Depression may be categorised as mild or major depending on the number of symptoms present.

- **Mild depression** may exist if the resident presents with fewer than five symptoms, which must include depressed mood or lack of reaction to pleasurable events.
- **Major depression** may exist if the resident presents with five or more symptoms.

Symptoms of depression: anxiety; sadness; lack of reaction to pleasant events; irritability; agitation; slowing of movements; multiple physical complaints; loss of interest in usual activities; loss of appetite; unexplained weight loss; lack of energy; mood variations; sleep disturbances; poor self-esteem; suicidal thoughts

(Kurlowicz & Harvarth, 2008).

Symptoms that interfere with memory and concentration can be mistaken for symptoms of dementia. People with dementia can also suffer from depression. A correct diagnosis is essential because the treatments for depression and dementia are very different. (beyondblue (2008). Depression and dementia. Fact sheet 25. Retrieved 6 February 2009 <www.beyondblue.org.au>)

Team

Manager, RNs, ENs, PCAs, GP, resident and/or family, activities worker, diversional therapist, and psychiatric services if deemed necessary

Evidence base for this SCP

Alexopoulos GS, Abrams RC & Shamolan, CA 1988, 'Cornell scale for depression in dementia', *Biological Psychiatry,* 23(3), 271–284.

beyondblue 2008, *Depression and dementia*. Fact sheet 25. Retrieved 8 March 2012 <http://www.beyondblue.org.au/index.aspx?link_id=7.980&http://www.beyondblue.org.au/index.aspx?link_id=6.1068&tmp=FileDownload&fid=1125>

Harvarth TA, McKenzie G 2012, Depression in Older Adults. In M. Boltz, E. Capezuti, T. Fulmer & D. Zwiker (Eds.), *Evidence-based geriatric nursing protocols for best practice* (4th Edition), Springer, New York.

Llewellyn-Jones RH, Baikie KA, Castell S, Andrews CL, Baikie A, Pond CD, Willcock S, Snowden J & Tennant C 2001, 'How to help depressed older people living in residential care: a multifaceted shared-care intervention for late-life depression', *International Psychogeriatrics*, 13(4), 477–492.

Registered Nurses Association of Ontario 2004, *Caregiving strategies for older adults with delirium, dementia and depression*, Registered Nurses Association of Ontario, Canada.

Royal Australian College of General Practitioners (RACGP) 2006, *Medical care of older persons in residential aged care facilities* (4th edition), RACGP, Melbourne.

Brief SCP: depression

Recognition and assessment	• On admission, conduct a depression screen using the Cornell Scale for Depression • Ask the resident and/or family if there is a past history of depression • Monitor residents continually for presence of symptoms of depression that persist for more than two weeks • If symptoms are detected at any time: – repeat the Cornell Scale for Depression – repeat the Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS) to assess cognitive status and to identify changes from previous assessments – re-assess functional ability (for example, ADLs, mobility) – refer to GP.
Interventions	If any of the above symptoms are identified on completion of the Cornell Scale for Depression (if resident scores more than 0 on a question): • refer to GP for diagnosis • develop an individualised care plan incorporating recommended interventions.
Referral	• GP • Psychiatric services if symptoms are severe or do not respond to intervention or treatment • Life style co-ordinator/activities worker to develop structured activities • Physiotherapist if possible to develop structured exercise program • Pastoral care • Volunteers
Evaluation and reassessment	• Monitor the effectiveness of medication or other treatments • Monitor symptoms • Keep GP informed of the resident's condition and report any deterioration in symptoms or suicidal thoughts immediately • Monitor the resident for the presence of symptoms and repeat the Cornell Scale for Depression every three months
Resident involvement	• Provide information about depression and the treatment plan to the resident and/or family • Emphasise that depression is an illness and that it is common and able to be treated
Staff knowledge and education	Depression: levels of depression, causes of depression, symptoms of depression, treatment and intervention options

Full SCP: depression

Recognition and assessment	On admission: • Assess the presence of risk factors for depression: – medical conditions – functional decline, increased dependency – social isolation – widow/widower. • Conduct a depression screen using the Cornell Scale for Depression. It is important to note that the Cornell Scale for Depression is not diagnostic of depression but higher scores indicate a need for further investigation (Alexopoulos, Abrams & Shamolan, 1988) • Ask the resident and/or family if there is a history of depression • Check medications to assess their potential for causing current or future problems as some drugs commonly used in older people can contribute to depression (for example, steroids, antihypertensives, antipsychotics, sedatives, beta-blockers, narcotic analgesics) • Assess functional ability • Assess cognitive status using the Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS) • Monitor resident continually for presence of symptoms of depression that persist for more than two weeks: – anxiety – sadness – lack of reaction to pleasant events – irritability – agitation – slowing of movements – multiple physical complaints – loss of interest in usual activities – altered appetite – unexplained weight loss – lack of energy – mood variations – sleep disturbances – poor self-esteem – suicidal thoughts – refusal of food, fluid, medication or life sustaining treatments. • If symptoms are detected at any time: – repeat the Cornell Scale for Depression – repeat the PAS to assess cognitive status and to identify changes from previous assessments – re-assess functional ability (ADLs, mobility) – refer to GP.

Interventions	If any of the above symptoms are identified on completion of the Cornell Scale for Depression (resident scores more than 0 on a question): • report symptoms to the resident's GP for further assessment and diagnosis • if severe depression is diagnosed or suicidal thoughts or psychosis is present, referral to psychiatric services is recommended – if mild depression is diagnosed, discuss with GP if referral to psychiatric services is needed – if suicidal thoughts or psychosis are present, referral to psychiatric services is recommended • develop an individualised care plan • in conjunction with GP, check medications to assess their potential for causing current or future problems as some drugs commonly used in older people can contribute to depression (such as steroids, antihypertensives, antipsychotics, sedatives, beta-blockers, narcotic analgesics) • implement strategies to monitor resident's safety if a risk of suicide is identified • promote social support by encouraging participation in activities, visits from family/friends or volunteer visitors • involve appropriate pastoral care • assess and monitor sleep patterns, nutritional intake, pain and elimination and address any problems identified • encourage socialisation, outings and pleasurable events – staff, volunteers • consult with appropriate cultural groups • maximise the resident's self-esteem and control by reinforcing their capabilities, involving them in setting short-term goals and determining daily routine as able • implement an individualised exercise program.
Referral	• GP • Psychiatric services if symptoms are severe or do not respond to intervention or treatment • Life style co-ordinator/activities worker to develop structured activities • Physiotherapist if possible to develop structured exercise program • Pastoral care • Volunteers
Evaluation and reassessment	• Monitor the effectiveness of medication or other treatments • Monitor resident continually for improvement or deterioration of symptoms • Document presence and severity of symptoms in resident's medical record at least daily • Keep GP informed of the resident's condition and report any deterioration in symptoms or suicidal thoughts immediately. Liaise with GP regarding need for referral to psychiatric services • As there is a high risk of further episodes of depression, continue to monitor the resident for the presence of symptoms and repeat the Cornell Scale for Depression every three months
Resident involvement	• Provide information about depression and the treatment plan to the resident and/or family • Emphasise that depression is an illness and that it is common and able to be treated • Identify pleasurable activities with the resident and enlist the help of family or volunteers to undertake activities
Staff knowledge and education	• Depression: levels of depression, causes of depression, symptoms of depression, differentiating depression from delirium and dementia, treatment and intervention options, and preventing relapse • Available resources

Disclaimer: This Standardised Care Process (SCP) was prepared by the Department of Health and then subject to a pilot program to determine its suitability for use in public sector residential aged care settings. The research that informs this document was conducted from 2008 to 2009. This document is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. The Department of Health and the State of Victoria do not represent or warrant that the content of this document is accurate, current, or suitable for the use to which it may be put. To the extent allowed by law the Department of Health and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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