NETWORK OF EXCELLENCE FOR GERIATRIC SERVICES

BEST PRACTICES FOR NURSING CARE OF THE OLDER ADULT

TITLE: **DEPRESSION**

DATE: October 2005

CONTENT: 10 pages

RELEVANT TOOLS:

- For use in the cognitively intact: Geriatric Depression Scale [Short Version—15 item] (attached)
- Depression Information Sheet (attached)
- Cornell Scale for Depression in Dementia [useful if cognitive impairment; facility settings] (see Geriatric Assessment Tool Binder)
- Hamilton Rating Scale for Depression [useful if cognitive impairment; community settings] (see Geriatric Assessment Tool Binder)

PURPOSE

This clinical practice guideline will help the nurse to:

- Identify older persons who are at risk for depression.
- Enable early identification and early treatment to protect quality of life and prevent morbidity and mortality.
- Recognize the complexities in assessing for depression in older persons who also suffer from dementia.
- Protect the safety of the depressed older person.
- Meaningfully support the older person and family.
- Take quick action to coordinate appropriate, evidenced-based care.

KEY POINTS ABOUT DEPRESSION IN LATER YEARS

- Studies have shown that depression is highly prevalent in the elderly population (13 percent in community, 24 percent in outpatients, 30 percent in acute care, and 43 percent in long term care), yet it is often under-recognized and under-treated (Kurlowicz, 1997).
- Depression is **not** a normal part of aging. With treatment, it is often reversible, restoring quality of life.
- Many factors contribute to depression, including a variety of medical and psychiatric illnesses. Other causes include multiple losses and grief, chronic pain, stress and loss of independence.
- Depression may be superimposed on dementia. This co-morbidity significantly complicates the assessment process because symptoms of depression may appear to be typical of changes related to dementia.

- Depression may be confused with early cognitive symptoms of dementia such as poor concentration or memory loss.
- Without treatment, depression can lead to:
  - Impairment in physical health, cognitive ability and function.
  - Suicide.

STANDARDS

- All elderly persons are screened for depression upon admission to residential care. Acute and Community clients will be assessed as indicated. Reassessment is carried out as indicated.
- The Geriatric Depression Scale (GDS short form) is completed as part of the depression assessment for those who are able to comprehend the questions (MMSE >/=17) and communicate.
- Observational tools will be used in situations where the elderly person is unable to respond to the GDS:
  - The Cornell Scale for Depression in Dementia (CSDD) will be used in facility settings.
  - The Hamilton Rating Scale for Depression Observation (Ham-D) will be completed in community settings.
  - Suicide Level of Risk Chart
- Where the nurse recognizes evidence of depression and/or suicidal intent, assessment data are presented promptly to the geriatrician or attending physician.

NURSING ASSESSMENT

- **Risk Factors:**
  - Aged > 65 years.
  - History of depression or psychiatric illness.
  - Recent losses and/or stresses (e.g., death of a family member/pet, loss of independence).
  - Admission to residential care.
  - Poor physical health.
  - Alcohol and/or substance abuse.
  - Previous suicide attempts.
  - Medications that contribute to depression (e.g., alcohol, cardiac drugs, sedatives, analgesics, steroids, anti-Parkinson agents).
  - Medical illness (e.g., CVA, chronic infection, metabolic disease, brain lesions).

❖ **Clinical Presentation:**

- Apathy, withdrawn behaviour, anxiety, fatigue, loss of joy in usual activities.
- Sleep disturbances (e.g., early morning awakening and trouble getting to sleep).
- Somatic complaints (e.g., changes in appetite, weight gain or loss, chronic pain, headaches and gastrointestinal problems).
- Impaired cognition (e.g., memory loss, poor concentration, indecisiveness).
- Behavioural manifestations, including aggression, anger, restlessness, tearfulness.
- Sense of hopelessness, worthlessness, low self-esteem, guilt.
- Decreased ability to perform ADL's, lack of attention to hygiene and grooming.

❖ **Supporting Data:**

- Psychosocial history.
- Mini Mental Status Examination (MMSE) if indicated and possible.
- Geriatric Depression Scale (GDS – short form): for those able to comprehend and communicate.
- Observational tools: for use in situations of cognitive impairment:
  - Cornell Scale for Depression in Dementia (CSDD) – use in facility.
  - Hamilton Rating Scale for Depression Observation (Ham-D) – use in community.
  - Suicide Levels of Risk Chart.
- Minimum Data Set (MDS) Assessment from Case Manager or facility admission.
- Collateral information from family or friends.
- Sleep Record.
- Intake and Output Record.
- Weight Chart.
- Behaviour Chart.

SUICIDE

❖ **Risk Factors for Suicide in the Elderly:**

- Previous attempt.
- Depression.
- Male, Caucasian, 65 – 80 years.
- Family history of suicide.
- Social isolation, physical illness, severe pain.

- Major change in role or loss of independence.
- Use of alcohol or substances.
- Recent death of someone close.
- Available method and ability to carry out the plan.

❖ **Warning Signs of Suicide:**

- Looks and acts depressed.
- Gives away possessions; says good-byes; puts affairs in order.
- Takes unusual risks.
- Sudden interest or avoidance of religion.
- Deterioration of self-care and attention to physical health.
- Expresses intent (develops a plan, acquires a weapon).

SUICIDE LEVELS OF RISK CHART

Level 1:	Has thoughts that life not worth living or better off dead
Level 2:	Has had thoughts of suicide
Level 3:	Has a plan for suicide
Level 4:	Has had recent suicide attempt and/or present means and is willing to use them

At Levels 3 and 4 the person should be seen by a physician and assessed for committal under the Mental Health Act.

NURSING INTERVENTIONS FOR THE DEPRESSED OLDER PERSON

❖ Protect the safety of the depressed older person.

❖ Don't ignore warning signals. If you are concerned, ask directly about suicide: "Have you thought about hurting yourself?" "Do you have a plan?"

❖ Promptly report depression and suicidal ideation/intent to the physician; ask for psychiatric evaluation and treatment.

❖ Provide non-judgmental support and education to the older person and family.

❖ Encourage hope, support self-esteem, focus on personal strengths, encourage maintenance of a usual daily routine.

❖ Encourage participation in activities that are meaningful to the person and encourage contact with friends and family.

❖ Address physical complaints (e.g., pain, gastrointestinal problems).

❖ Encourage visitors and volunteers to spend quality time.

- Apply principles of sleep hygiene. Develop a bedtime routine, maintain darkness and quiet, do not use the bed for other activities (e.g., reading and watching TV).

Nursing Interventions Related to Medical Treatment of Depression

- Monitor the efficacy and side effects of antidepressant therapy.
- Continue to monitor indicators of both physical and mental health.
- Ensure the older person and family are provided with information about medications and treatments.
- Support the older person and family if electroconvulsive therapy is chosen as a treatment.

Nursing Interventions for Possibility of Suicide

- Protect the older person's safety:
  - Place in a secure environment (e.g., observation room).
  - Transfer to a higher level of care if required.
  - Determine level of observation related to risk.
  - Remove access to items such as medications, sharps.
  - Monitor medications.
  - Evaluate need for committal under the Mental Health Act.
- Communicate suicide risk to interdisciplinary team.
- Conduct ongoing assessment.
- Discuss a "no suicide" contract.
- Communicate with family.

Evaluation

- The safety of the older person is protected.
- Evidence that the depression is beginning to resolve is noted within a reasonable timeframe (6 to 8 weeks with antidepressants; very soon after treatment with ECT).
- The person and family express satisfaction with their knowledge about preventing and managing depression.
- Prescribed medication is monitored on an ongoing basis and decreased or discontinued as soon as feasible.

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Web Sites

- Alzheimer Society of Canada
  www.alzheimer.ca
- The Briggs Institute for Evidence Based Nursing
  http://www.joannabriggs.edu.au
- Canadian Health Network
  www.canadian-health-network.ca
- Canadian Mental Health Association
  www.cmha.ca/english/olinks/htm
- Cochrane Collaboration
  http://www.cochrane.org
- Evidence Based Nursing Journal
  http://evidencebasednursing.com
- Feelingblue.com
  www.feelingblue.com
- John A. Hartford Foundation Institute for Geriatric Nursing
  www.hartfordign.org
- Mid-Florida Area Agency on Aging
  www.mfaaa.org
- National Guideline Clearinghouse
  http://www.guidelines.gov
- National Library of Medicine
  http://text.nlm.nih.gov
- Registered Nurses Association of Ontario
  http://www.rnao.org/bestpractices/
- University of Iowa
  http://www.nursing.uiowa.edu/centers/gnirc/protocols.htm
- University of Sheffield
  http://www.shef.ac.uk/~scharr/

GERIATRIC DEPRESSION SCALE

Choose the best answer for how you felt this past week:

Question		
1. Are you basically satisfied with your life?	YES	NO.
2. Have you dropped many of your activities and interests?	YES.	NO
3. Do you feel that your life is empty?	YES.	NO
4. Do you often get bored?	YES.	NO
5. Are you in good spirits most of the time?	YES	NO.
6. Are you afraid that something bad is going to happen to you?	YES.	NO
7. Do you feel happy most of the time?	YES	NO.
8. Do you often feel helpless?	YES.	NO
9. Do you prefer to stay at home, rather than going out and doing new things?	YES.	NO
10. Do you feel you have more problems with memory than most?	YES.	NO
11. Do you think it is wonderful to be alive now?	YES	NO.
12. Do you feel pretty worthless the way you are now?	YES.	NO
13. Do you feel full of energy?	YES	NO.
14. Do you feel that your situation is hopeless?	YES.	NO
15. Do you think that most people are better off than you are?	YES.	NO

GERIATRIC DEPRESSION SCALE
SCORING KEY

- Count number of "depressed" answers with a period at end (e.g., YES. or NO.)
- Score = number of "depressed" answers __________
  - Normal = 0 – 5
  - Suggests depression = 6-15

References:

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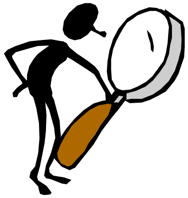
INFORMATION SHEET

DEPRESSION

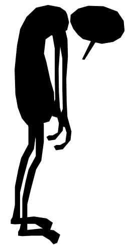
Did you know that…



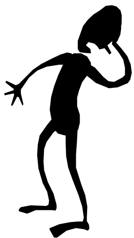
- Depression is **not** a normal part of aging! For many reasons, it is often not recognized and under-treated.
- The rate of depression in seniors is high, but with treatment it is often reversible.
- Many factors contribute to depression, including a variety of medical and psychiatric illnesses, multiple losses and grief, persistent pain and stress.
- A person with dementia (e.g., Alzheimer's Disease) can also become depressed. This complicates assessment, because symptoms of depression can be confused with mental changes related to dementia.
- Without treatment, depression in later years can lead to impaired physical health, mental health, and suicide.

Who is at risk for depression? People who…

- Are older than 65 years of age, especially those in poor health.
- Have a history of depression or who have experienced a previous suicide attempt.
- Have experienced a recent loss (e.g., death of a family member or pet, loss of independence).
- Have been recently admitted to a residential care facility.
- Use alcohol or other substances.
- Take prescription medications that contribute to depression (talk to your doctor).



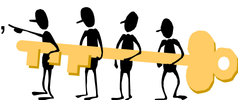
Depressed people may experience…



- Anxiety, feeling tired all the time, the need to withdraw.
- Trouble falling asleep and early morning wakening.
- Physical complaints such as changes in appetite, weight gain or loss, persistent pain, headaches, stomach upsets.
- Mental changes such as memory loss, poor concentration, indecisiveness, anger, restlessness, tearfulness.
- A sense of hopelessness, worthlessness, low self-esteem, guilt.
- Trouble taking care of their normal activities of daily living.

What will the health care team do to help?

- Help to keep the depressed person safe.
- Conduct an evaluation and recommend treatment (e.g., medications, therapy).
- Provide hope, support, education and reassurance to the person and family.
- Address physical complaints.
- Monitor the effectiveness and side effects of medications, if used.



If you or someone you know is seriously depressed or having thoughts of self harm, please talk to a nurse, doctor or counselor immediately!