Depression

Standardised care process

Objective

To promote evidence-based practice in the assessment and management of depression for older people who live in residential care settings.

Why the identification and management of depression is important

Depression is a common problem in older people, including those living in residential aged care facilities. It is often under-recognised, under-diagnosed and under-treated. 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 (McKenzie & Sexson 2020).

Definitions

Depression: is a syndrome affecting mood and functioning.

Symptoms of depression include low mood, lack of reaction to pleasurable events, marked changes in weight or appetite, changes to sleep pattern, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, difficulty thinking and concentrating, suicidal thoughts or attempts (APA 2013).

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 low mood or lack of reaction to pleasurable events.
- **Major depression** may exist if the resident presents with five or more symptoms, which must include depressed mood or lack of reaction to pleasurable events for most of the day, every day for two weeks (McKenzie & Sexson 2020).

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 (McKenzie & Sexson 2020).

Team

Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), leisure and lifestyle staff, general practitioner (GP), allied health professionals (such as a physiotherapist, speech pathologist, occupational therapist and exercise physiologist), residents and/or family/carers.

Acknowledgement

This standardised care process (SCP) has been developed for public sector residential aged care services (PSRACS) by the Australian Centre for Evidence Based Care (ACEBAC) at La Trobe University through the Department of Health and Human Services Strengthening Care Outcomes for Residents with Evidence (SCORE) initiatives. This SCP is one of a series of priority risk areas reviewed based on the best available evidence in 2020.

Brief standardised care process

Recognition and assessment

- Always be alert for signs of depression among residents.
- On admission, assess for risk factors for depression.
- Conduct a depression screen using the Cornell Scale for Depression.
- Ask the resident and/or their family/carers about any history of depression.
- Review the resident's medication.
- 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)
  - re-assess the resident's functional ability
  - refer the resident to a 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 or a total of 6 or above):

- refer to a GP for diagnosis
- develop an individualised care plan incorporating the recommended interventions.

Referral

- GP
- Pharmacist
- Psychiatric services
- Psychologist
- Lifestyle coordinator or activities worker
- Physiotherapist
- Pastoral care
- Volunteers

Evaluation and reassessment

- Monitor the effectiveness of medication or other treatments.
- Keep the 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 their family/carers.
- Emphasise that depression is a common and treatable illness.
- Enlist the support of family/carers or volunteers to encourage the resident to participate in pleasurable activities.

Staff knowledge and education

- Depression: levels of depression, causes of depression, symptoms of depression, treatment, and intervention options, and preventing relapse
- Signs and symptoms of depression unique to older people
- Available resources

Full standardised care process

Recognition

Remain alert for signs of depression amongst residents.

Assessment

On admission, assess the presence of risk factors for depression:

- history of depression
- medical comorbidity and chronic pain
- medical conditions with associated depression (stroke, cardiovascular disease, Alzheimer's disease, Parkinson's disease)
- palliative phase
- functional decline, increased dependency
- social isolation
- accumulation of negative life events, losses and bereavement.

Assess for depression when risk factors or signs and symptoms are present:

- Conduct a depression screen using the Cornell Scale for Depression. It is important to note that the Cornell Scale for Depression is not a diagnostic tool, but higher scores indicate a need for further investigation.
- Continue to monitor residents for symptoms of depression that persist for more than two weeks:
  - sadness/low mood
  - irritability/crying
  - restlessness
  - loss of interest in usual activities
  - lack of reaction to pleasant events
  - sleep disturbances
  - unexplained weight change, or altered appetite
  - lack of energy
  - poor concentration and problems with decision making
  - slowing of movements, speech or thinking
  - poor self-esteem and self-confidence
  - multiple physical complaints
  - suicidal thoughts, plans or attempts
  - refusal of food, fluid, medication or life-sustaining treatments.
- Ask the resident and/or their family/carers about any history of depression.
- Identify recent losses (physical and social) and changes in relationships.
- In conjunction with a GP and pharmacist, check the resident's 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, psychotropic medications, sedatives, beta-blockers and narcotic analgesics).
- Check the resident's alcohol use (and substance abuse where appropriate).
- Assess the resident's functional ability and quality of life.
- Conduct a cognitive screen using the PAS to determine the presence of cognitive impairment.
- Assess and monitor the resident's sleep patterns, nutritional intake, pain, bladder/bowel function and address any problems identified.

If symptoms are detected at any time:

- repeat the Cornell Scale for Depression
- repeat the PAS to identify any changes in cognition
- reassess the resident's functional ability (activities of daily living, mobility)
- refer to a GP.

Interventions

If any symptoms of depression are identified via the Cornell Scale for Depression (resident scores more than 0 on a question or a total of 6 or above):

- report symptoms to the resident's GP for further assessment and diagnosis.

The type of symptoms and their severity will inform the intervention:

- if severe depression (with or without suicidal thoughts or psychosis), refer to psychiatric services
- if suicidal thoughts are present, seek urgent psychiatric support
- if less severe depression is identified, discuss the pharmacological and non-pharmacological options with a GP.

Important: if a risk of suicide is identified, implement strategies to keep the resident safe.

Treatment options

- Pharmacological
  - Residential Medication Management Review (RMMR)
- Non-pharmacological
  - psychological therapies, such as cognitive behaviour therapy, mindfulness-based cognitive therapy, behavioural activation therapy and reminiscence therapy
  - walking and physical activity programs
  - encourage participation in activities and outings
  - pleasant activities, such as relaxation and music therapy
  - social support from family/carers/friends or volunteer visitors
  - emotional support
  - pastoral care
  - create a person-centred environment
  - maximise the resident's self-esteem and control by reinforcing their capabilities, involving them in setting short-term goals and determining a daily routine as much as possible
- Support adequate nutrition, bladder/bowel function, sleep patterns and rest
- Alleviate pain and discomfort
- Develop an individualised care plan, ensuring interventions are culturally appropriate. Consult with appropriate cultural groups such as cultural and language groups, First Nations groups, LGBTIQ groups.

Referral

- GP
- Pharmacist
- Psychiatric services if symptoms are severe or do not respond to intervention or treatment
- Psychologist for cognitive/behavioural therapies
- Lifestyle coordinator or activities worker to develop structured activities
- Physiotherapist to develop a structured exercise program
- Pastoral care
- Volunteers

Evaluation and reassessment

- Monitor the effectiveness of pharmacological and non-pharmacological interventions.
- Monitor the resident continually for improvement or deterioration of symptoms.
- Document the presence and severity of symptoms in the resident's health record at least daily.
- Keep the GP informed of the resident's condition and report any deterioration in symptoms or suicidal thoughts immediately.
- Liaise with the GP about the need for referral to psychiatric services.
- Due to a high risk of relapse, continue to monitor the resident even after recovery for the presence of depression 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 their family/carers.
- Emphasise that depression is an illness and that it is common and treatable.
- Identify pleasurable activities with the resident and enlist the help of family/carers 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
- Signs and symptoms of depression unique to older people
- Available resources

Evidence base

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Important note: This standardised care process (SCP) is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. 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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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISBN 978-1-76096-814-4 **(pdf/online/MS word)**

Available from the department's website at <www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/standardised-care-processes>.