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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

MEMORANDUM

DATE: October 10, 2006

TO: Long Term Care Facilities

FROM: MDCH/Clinical Advisory Panel
Quality Improvement Nurse Consultants

RE: Clinical Process Guideline: Depression

Best clinical practice is only worthwhile to the extent that we use it to guide care for our residents.

Collaboratively, we are striving to improve assessment for and treatment of depression in nursing home residents in Michigan. The purpose of the Guide is to clarify how to apply the **Depression Process Indicator Checklist**. Electronic copies are available for reprint at www.michigan.gov/qinc under the Best Practice heading.

This optional "best practice" tool was presented to you at the Fall 2006 Joint Provider/Surveyor Training on October 10, 2006. Effective date for usage of the tool is November 13, 2006. Both facilities and surveyors will have the opportunity to use the Checklist when depression is of concern. Facilities will be accorded the opportunity to demonstrate that they have followed the steps in this guideline, as evidence to support an appropriate care process related to depression.

A workgroup including doctors (geriatricians, psychiatrist, and psychologist), nurses, pharmacists and social workers with experience in geriatrics and nursing home care discussed the topic in depth. They used generally accepted, current references in preparing these documents. The Process Indicator Checklist contains a series of steps related to depression.

Best clinical practice information helps each facility provide the best possible care throughout the year. Along with information in the Federal OBRA regulations, our surveyors will use these Process Guidelines to review how your facility is managing depression. We encourage you to examine your process regarding depression to consider the application of the following information.

The Basic Care Process

The management of all conditions and problems in a nursing home should follow these basic steps:

Assessment/recognition: The purpose of this step is to provide a rational basis for deciding whether there is a need, risk, or problem and what to do about it. The facility's staff and practitioners collect relevant information about the resident (history, signs and symptoms, known medical conditions, personal habits and patterns, etc.) and then a) evaluate and organize that information to identify whether the individual has a specific need, condition, or problem; and b) describe and define the nature (onset, duration, frequency, etc.) of the risk, condition, or problem.

Diagnosis/cause identification: The facility's staff and practitioners attempt to identify causes of a condition or problem, or explain why causes cannot or should not be identified.

Treatment/management: The facility's staff and practitioners use the above information to decide how to manage a resident's condition, symptom, or situation. Where causes may be identifiable and correctable, they seek and address them or explain why they could not or should not have done so.

Monitoring: The facility's staff and practitioners evaluate the individual's progress over time in relation to a risk, need, problem, condition, or symptom, consider the effectiveness of interventions, and make a systematic determination about what to do next.