DEPRESSION

CARE PROCESS STEP	EXPECTATIONS	RATIONALE
ASSESSMENT/PROBLEM RECOGNITION		
1. Did the staff and physician seek and document risk factors for depression and any history of depression?	- The staff and practitioner should document the presence of any history of depression, a positive depression screening test, other psychiatric disorder(s), psychiatric treatment or hospitalizations, or suicide attempts; and conditions that may predispose to depression (AMDA CPG Table 3, 6).	- Depression is a spectrum of mood disorders characterized by a sustained disturbance in emotional, cognitive, behavioral, or somatic regulation and associated with significant functional impairment and a reduction in the capacity for pleasure and enjoyment. - Many older adults living in long-term care facilities (an estimated 30 to 50 percent) have depression (major or minor) (Nursing Home Compare 2005, Rosen, et al 2000), and others may have adjustment disorders, bereavement, or other mood disorders (for example, sad, blue, irritable, or depressed mood). - Useful information about mood disorders may come from various sources; for example, family, the resident, hospital discharge summaries, PASSAR screens, complete medication history, and other historical data as available, such as outpatient mental health records.
2. Did staff identify residents with signs and symptoms of depression?	- On admission and periodically thereafter, the direct care staff and practitioner should screen for depression by being alert to symptoms that could represent possible depression. - The staff and practitioner should observe individuals with a history of depression, other psychiatric disorder(s), a positive screening test for depression, and other at-risk individuals for current signs and symptoms of depression (AMDA CPG Tables 1 and 2).	- It is important to tailor assessment approaches to the resident. - Alternative approaches, including detailed observation and interviews with relevant individuals who know the resident, may be needed to recognize depression in individuals with impaired cognition, who may be unable to answer questions that would give clues to depression. - The use of a depression rating scale at the beginning of treatment is the only reliable way to obtain an objective measure of the severity of a patient's depression. Such information is essential to monitoring the effectiveness of treatment and to decisions about whether to continue,

	- The staff should describe disordered mood and related symptoms in detail. - The staff and practitioner should use pertinent tools and approaches to screen for, or monitor, depression.	change, or terminate treatment. - Examples of appropriate screening tools include Geriatric Depression Scale (GDS; Appendix 1). Cornell Scale for Depression in Dementia (CSDD; Appendix 2). Center for Epidemiologic Studies of Depression Scale (CES-D; Appendix 3). Patient Health Questionnaire 9 (PHQ 9; Appendix 4).
3. Did the staff and physician clarify the nature of signs and symptoms of depression and attempt to differentiate other possible explanations for the symptoms?	- The staff and practitioner should collaborate to confirm the diagnosis of depression, identify the severity and any complications, and differentiate the symptoms from other possible explanations; for example, apathy, weakness, or lethargy due to other medical conditions. - The practitioner, with consultative support as needed, should clarify the diagnosis; for example, the category of depression (major depression: mild, moderate, or severe; depression with psychotic features; minor depression disorder, adjustment disorder, etc. (DSM-IV and AMDA CPG Figure 1). - The staff and practitioner should identify situations warranting additional input from individuals with special knowledge of geriatric mental health and psychiatric disorders.	- The implementation of an effective individualized care plan that includes both nonpharmacologic and pharmacologic interventions requires an accurate interpretation of depressive symptoms. - Medical or neurological conditions may mask or imitate depression. Some medical illnesses can cause symptoms including apathy or lethargy that suggest depression. However, the presence of such symptoms does not necessarily mean that an individual is suffering from depression. - Depressive disorders should not be confused with depressed or sad mood, which may be a normal, transient response to specific losses or disappointments or to loneliness or boredom. - Having symptoms of possible depression is not the same as having depression. Therefore, identified symptoms generally require additional evaluation (see preceding steps) before instituting treatment. - Facility staff should identify and describe symptoms in detail, not prematurely diagnose clinical depression. - Depression can often be diagnosed and managed readily by primary care practitioners and staff who follow appropriate protocols and guidelines. Consultation may be warranted for more non-specific symptoms or complex cases (AMDA CPG Table 7). - Guidance from pertinent references and sources should be used to help make the diagnosis of depression.

4. Did the staff and physician seek and identify complications of depression?	- The staff and practitioner should identify complications of depression, including weight loss, sleep disturbances, worsening of co-morbid conditions, functional decline, failure to thrive, social isolation, serious grief or bereavement issues, and psychiatric disorders (such as psychosis) that may complicate a depressive episode. - The staff and practitioner should identify individuals with suicide risk.	- Depression may be associated with diverse complications affecting many organ systems and disease states and may impair functional status. - Suicide risk increases with the severity of depression. Suicide risk increases for all elderly persons when depression is severe or is compounded by psychosis, a recent loss or bereavement, or a recent physical disability, as well as in patients with alcohol dependency or those who abuse sedatives or hypnotics.
DIAGNOSIS/CAUSE IDENTIFICATION		
5. Did the staff and physician seek medical and non-medical causes of depression or indicate why causes could not or should not be sought or identified?	- The staff and practitioner should identify additional diagnostic workup to help define the category, severity, complications, or causes of depression, or document why one was not indicated. (AMDA CPG Table 4). - The staff and practitioner should review the existing medication regimen for medications known to affect mood, affect, and level of consciousness. (AMDA CPG Table 5).	- Especially in the elderly, other significant medical illnesses or conditions (e.g., stroke, Parkinson's Disease, dementia, pain, etc.) may cause or predispose to depression. Those illnesses may worsen depression and more severe depression may increase disability and mortality. - Some medications may cause or contribute to depression. Therefore, it is important to look at the "big picture" when managing depression and when managing other conditions in someone who is depressed. - The nature and extent of an appropriate medical work-up should depend on the patient's condition, prognosis, and advance care directives, as well as on the expressed preferences of the patient/ responsible party/legal medical decision maker.
TREATMENT/PROBLEM MANAGEMENT		
6. Did the staff and physician address underlying causes of depression?	- The staff and practitioner should take appropriate action if medical diagnoses or conditions or nonmedical conditions are suspected of contributing to depressive symptoms or increasing the likelihood of depression. - The practitioner should manage depression	- To the extent possible, address underlying medical and non-medical causes of depression and related conditions, and evaluate the impact of such measures before adding more medications to the patient's regimen. If these measures fail to improve symptoms, assess the patient for treatment of the depression itself.

	and any coexisting medical conditions. - If a drug used to treat a coexisting condition is suspected of contributing to depressive symptoms: 1) to the point that additional treatment for depression is being considered or instituted, 2) or the resident has not responded to existing treatment for depression, then, the practitioner and staff should consider switching to an alternative medication that is less likely to have this adverse effect, or document why a medication was so essential that it could not be switched even though it may have been causing or contributing to depression.	- For example, initiate treatment of thyroid disorders, pain, or vitamin B12 deficiency, if present. However, doing so may not resolve the patient's depressive symptoms. - Evaluate the possibility of environmental or facility-specific factors and care practices that may affect resident function, mood, and quality of life.
7. Did the staff and physician identify and initiate appropriate interventions for treatment of depression?	- The staff and practitioner should identify and implement appropriate nonpharmacologic and medication interventions, individualized to the extent possible. - The staff should consistently and correctly implement the individualized plan of care related to managing depression. - The staff and practitioner should manage complications of depression, including suicide risk, appropriately.	- Once diagnosed, depression should be treated with medications, psychotherapy, or a combination of both. Additional modalities (for example, electroconvulsive therapy [ECT]), may also be indicated. - The overall goals of treatment of a depressive episode are to achieve full remission (complete resolution of symptoms) and prevent relapse. Full remission may require repeated modifications of the treatment plan. - Examples of nonpharmacologic treatment options may include psychosocial and environmental approaches such as minimizing institutional aspects of the environment, facilitating interaction with family members and friends important to the individual, and providing age-and gender-appropriate socialization interventions and physical and intellectual activities. (AMDA CPG Table 10)
8. Were any medications given for depression selected and utilized appropriately?	- The staff and practitioner should select and implement interventions in accordance with guidance on the topic from recognized, reputable organizations or associations.	- Medications should be selected and adjusted based on widely accepted principles of medication management for antidepressants, including consideration of pertinent resident-specific factors including age, other existing

		medications in the regimen, safety profile, prior history of responses to treatment, target signs and symptoms, and comorbid conditions. (AMDA CPG Tables 11, 14, 15, and Pharmacotherapy Companion CPG). - There are algorithms (flow charts) for selecting appropriate medications and augmentation. [MIMA Guidelines, Exhibit 4]. - Doses should be increased gradually, but repeatedly until the desired response is attained or until side effects become intolerable. - Older patients in general are more sensitive than younger adults to the adverse effects of antidepressant medications, and may require closer monitoring. However, to obtain a therapeutic response, older patients may require drug concentrations similar to those that generally produce a therapeutic response in younger patients.
MONITORING		
9. Did the staff appropriately monitor the progress of the resident's symptoms?	- The staff and practitioner should monitor the resident's response to treatment, using the same tools and approaches as initially, or explain why changes were warranted. - The staff and practitioner should monitor for, and manage, complications of depression. - The staff and practitioner should reevaluate the diagnosis and current treatment in non-responders.	- Recovery may occur in stages or phases (AMDA CPG Tables 8, 9). - Four categories of treatment response have been identified, including 1) a rapid, sustained response; symptoms quickly decline and remain under control; 2) a slower but ultimately sustained response; 3) a partial or mixed response, and 4) no response during the observed period. - The literature consistently reports that only some individuals will respond to their first trial of an antidepressant. The remainder may need additional or modified interventions. [MIMA Guidelines, Exhibit 3] - Suicide risk may increase in the period after treatment has been implemented, or pending implementation.
10. Did the staff and physician evaluate and document the progress of a resident's depression and either modify existing	- Monitoring should include: responsiveness to treatment, possibility for modifying the intervention, and resident satisfaction with	- It may take several weeks to see an appreciable response to an antidepressant medication or non-pharmacologic interventions.

approaches or justify continuing existing ones?	treatment. - The staff and practitioner should adjust interventions based on the resident's response and on factors that are known to affect response. - The staff and practitioner should identify residents for whom tapering or stopping an antidepressant is indicated.	- The practitioner should assess the patient's response within 2 weeks of initiating therapy for depression, and make an informed decision about changing or continuing treatment at 4 and at 6 weeks. (follow pertinent treatment algorithms) - At least four studies suggest that older individuals do not respond to treatment more slowly. Neither time to response nor the percentage of patients responding to therapy were significantly different in younger vs. older patients. - There are circumstances when antidepressants should be tapered or discontinued; for example, non-major depression, intolerable side effects and clinically significant drug interactions (MIMA Guidelines, Exhibit 5). Monitoring for the return of depressive symptoms should occur subsequently. Short-term withdrawal symptoms (for example, nausea, headache, dizziness) related to tapering the medication may also occur.
11. Did the staff and physician monitor and address complications of treating depression?	- The staff and practitioner should monitor for, and manage, each resident carefully for side effects specific to each class of medication as well as for interactions between antidepressants and other classes of medications and medical conditions.	- Side effects of depression medications can include, but are not limited to, lethargy, falls, dry mouth, constipation, orthostatic hypotension, confusion, and agitation. - Serotonin syndrome has been identified as a potentially serious complication arising from the use of antidepressants, especially in conjunction with other medications affecting neurotransmitters and central nervous system function. [Lantz, Melinda S.]