Depression – Clinical Protocol

Assessment and Recognition

1. Identify individuals who have a history of depression, other psychiatric disorder(s), psychiatric treatment or hospitalizations, or suicide attempts.

    a. The staff and physician will document in the admission medical record the presence of these conditions or events in the resident's history.

2. In addition, the nurse shall assess and document/report the following:

    a. Vital signs
    b. Description of affect, level of activity and responsiveness
    c. Pain assessment
    d. If suicidal ideation is present, see suicide potential
    e. Resident's age and sex
    f. Onset, duration, frequency, severity of signs and symptoms
    g. All current medications, especially those known to be associated with depression
    h. All active diagnoses
    i. Recent or current medical, psychological or social episodes related to condition
    j. Any known previous psychiatric consults or treatments

3. Using appropriate screening tools, the staff will screen residents for depression on admission and subsequently if suggested by changes in mood, function, or behavior.
4. Staff will observe residents for possible signs and symptoms of depression; especially individuals who have a history of depression, other psychiatric disorder(s), a screening test result that indicates possible depression, or those with significant risk factors.

    a. Signs and symptoms may include, among others, depressed mood most of the day, almost every day; diminished interest or pleasure in most activities, most of the time; thoughts of death or suicide; feelings of helplessness, worthlessness or hopelessness; psychomotor agitation or retardation not attributable to other causes; change in sleep patterns or appetite; or avoidance of social interactions.
    b. Examples of risk factors for depression include alcohol or substance abuse, current use of a medication associated with a high risk of depression, hearing or vision impairment severe enough to affect function, history of attempted suicide, history of psychiatric hospitalization, a personal or family history of depression or mood disorder, a medical diagnosis associated with a high risk of depression, new admission or change in environment, and new stressful losses including loss of autonomy, privacy, functional status, a body part, or a family member or friend.

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Cause Identification

1. The physician will help evaluate whether a workup for causes of depression and related factors is indicated based on coexisting medical conditions, availability of recent diagnostic data, and findings from previous assessments and consultations.

    a. Examples of conditions that may increase the likelihood of depression or that may cause depressive symptoms include neurodegenerative disorders (for example, Alzheimer's disease, Parkinson's disease, multiple sclerosis), substance abuse, cancer, chronic pain, and endocrine disorders (for example, thyroid disease).

2. The physician and staff will review whether the resident is taking medications that might cause or contribute to depression; for example, some cardiac medications, carbidopa/levodopa, and antihypertensive medications such as clonidine and beta blockers.
3. The physician will help clarify the diagnosis; for example, distinguish categories of depressive disorders such as mild, moderate, or severe episode of major depression; severe episode of major depression with psychotic features; minor depressive disorder; bipolar disorder; dysthymic disorder; or adjustment disorder with depressed mood or with mixed anxiety and depressed mood.
4. The physician will identify the need for additional testing and/or consultation (psychiatric, psychological, etc.) to help define the nature, severity, causes, and complications (for example, psychosis or suicide risk) of any mood disturbance.

Treatment/ Management

1. The staff will provide pertinent non-pharmacologic interventions for the individual with depression; for example, address related environmental, spiritual, and family issues.
2. The physician will address underlying causes and related comorbidities.

    a. If the resident has been taking medications that are known to cause depression, the physician will identify those medications that could be tapered, stopped, or switched.

3. With consultative support as needed, the physician will order appropriate non-pharmacologic and pharmacologic interventions, based on the preceding assessments.

    a. The staff and physician should also identify target symptoms and, if medications are ordered, an approximate treatment timetable.

4. The physician should consider possible non-pharmacologic interventions for depression; for example, cognitive-behavioral therapy, interpersonal therapy, supportive therapy, etc.

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Monitoring and Follow-Up

1. Monitor the resident's response to treatment for depression and will document approaches, timetables, and goals of treatment in the interdisciplinary care plan and progress notes.

    a. Possible monitoring criteria might include resolution of signs and symptoms of depression, improvement of scores on depression screening tests, improved attendance at (and participation in) usual activities, and improved sleep pattern.

2. The staff and physician will monitor the resident carefully for side effects specific to each class of medication as well as interactions between antidepressants and other classes of medications.
3. If antidepressant medications have been used, the physician will identify situations for tapering or stopping the medications; for example, after 6 months to 1 year of treatment for a first episode of major depression.