Complete Summary

GUIDELINE TITLE

Depression. In: Evidence-based geriatric nursing protocols for best practice.

BIBLIOGRAPHIC SOURCE(S)

Kurlowicz L, Harvath TA. Depression. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008 Jan. p. 57-82. [95 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Kurlowicz LH. Depression in older adults. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 185-206.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Depression

GUIDELINE CATEGORY

Evaluation
Management
Risk Assessment
Treatment

CLINICAL SPECIALTY

Geriatrics
Nursing

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians
Social Workers

GUIDELINE OBJECTIVE(S)

To provide a standard of practice protocol for assessment and management of depression by nurses in practice settings

TARGET POPULATION

Hospitalized older adults

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment

1. Identification of high risk groups
    - Standardized assessment tool (e.g., Geriatric Depression Scale-Short Form)
2. Focused depression assessment
3. Medical history and physical examination
4. Medication history
5. Contributing systemic and metabolic processes
6. Cognitive function/dysfunction
7. Functional status

Management/Treatment

1. Individualized plan of care for all levels of depression
    - Depression management
    - Safety precautions
    - Etiologic agents
    - Nutrition, elimination, rest/sleep
    - Physical function
    - Social and emotional support
    - Autonomy/personal control/self efficacy
    - Strengths and capabilities
    - Response to medications
    - Activities of daily living

- Information and education
- Community resources

2. Referrals and treatment options for severe and less severe depression

MAJOR OUTCOMES CONSIDERED

- Prevalence of depression among older adults
- Symptoms of depression
- In-hospital suicide attempt rate
- In-hospital suicide mortality rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Although the AGREE instrument (which is described in Chapter 1 of the original guideline document) was created to critically appraise clinical practice guidelines, the process and criteria can also be applied to the development and evaluation of clinical practice protocols. Thus the AGREE instrument has been expanded for that purpose to standardize the creation and revision of the geriatric nursing practice guidelines.

The Search for Evidence Process

Locating the best evidence in the published research is dependent on framing a focused, searchable clinical question. The PICO format—an acronym for population, intervention (or occurrence or risk factor), comparison (or control), and outcome—can frame an effective literature search. The editors enlisted the assistance of the New York University Health Sciences librarian to ensure a standardized and efficient approach to collecting evidence on clinical topics. A literature search was conducted to find the best available evidence for each clinical question addressed. The results were rated for level of evidence and sent to the respective chapter author(s) to provide possible substantiation for the nursing practice protocol being developed.

In addition to rating each literature citation to its level of evidence, each citation was given a general classification, coded as "Risks," "Assessment," "Prevention," "Management," "Evaluation/Follow-up," or "Comprehensive." The citations were organized in a searchable database for later retrieval and output to chapter authors. All authors had to review the evidence and decide on its quality and relevance for inclusion in their chapter or protocol. They had the option, of course, to reject or not use the evidence provided as a result of the search or to dispute the applied level of evidence.

Developing a Search Strategy

Development of a search strategy to capture best evidence begins with database selection and translation of search terms into the controlled vocabulary of the database, if possible. In descending order of importance, the three major databases for finding the best primary evidence for most clinical nursing questions are the Cochrane Database of Systematic Reviews, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Medline or PubMed. In addition, the PsycINFO database was used to ensure capture of relevant evidence in the psychology and behavioral sciences literature for many of the topics. Synthesis sources such as UpToDate® and British Medical Journal (BMJ) Clinical Evidence and abstract journals such as *Evidence Based Nursing* supplemented the initial searches. Searching of other specialty databases may have to be warranted depending on the clinical question.

It bears noting that the database architecture can be exploited to limit the search to articles tagged with the publication type "meta-analysis" in Medline or "systematic review" in CINAHL. Filtering by standard age groups such as "65 and over" is another standard categorical limit for narrowing for relevance. A literature search retrieves the initial citations that begin to provide evidence. Appraisal of the initial literature retrieved may lead the searcher to other cited articles, triggering new ideas for expanding or narrowing the literature search with related descriptors or terms in the article abstract.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/Consensus panels

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC): In this update of the guideline, the process previously used to develop the geriatric nursing protocols has been enhanced.

Levels of evidence (I –VI) are defined at the end of the "Major Recommendations" field.

Assessment Parameters

Several studies support the use of an interdisciplinary geriatric assessment team for late-life depression (Boult et al., 2005 **[Level II]**; Callahan et al., 2005 **[Level III]**; Harpole et al., 2005; Unutzer et al., 2002 **[Level II]**) with the following being specific parameters of assessment:

- Identify risk factors/high risk groups:
    - Current alcohol/substance use disorder (Hasin & Grant, 2002 **[Level III]**).
    - Medical comorbidity (Alexopoulos, Schulz, & Lebowitz, 2005 **[Level VI]**). Specific comorbid conditions: dementia, stroke, cancer, arthritis, hip fracture, myocardial infarction, chronic obstructive pulmonary disease, and Parkinson's disease (Alexopoulos, Schulz, & Lebowitz, 2005; Butters et al., 2003 **[Level VI]**).
    - Functional disability (especially new functional loss). Disability, older age, new medical diagnosis, and poor health status (Cole, 2005; Cole & Dendukuuri, 2003 **[Level I]**).
    - Widows/widowers (National Institute of Health [NIH], 1992 **[Level I]**)
    - Older family caregivers, especially those caring for persons with dementia (Pinquart & Sorensen, 2004 **[Level I]**).
    - Social isolation/absence of social support (Kraaij, Arensman, & Spinhoven, 2002; NIH, 1992 **[Level I]**).
    - Psychosocial causes for depression in older adults include cognitive distortions, stressful life events (especially loss), chronic stress, low self-efficacy expectations (Blazer, 2002 **[Level VI]**; Blazer, 2003 **[Level VI]**; Blazer & Hybels, 2005 **[Level VI]**; Kraaij, Arensman, & Spinhoven, (2002) **[Level I]**).
- Assess all at-risk groups using a standardized depression screening tool and documentation score. The Geriatric Depression Scale-Short Form (GDS-SF) (Sheikh & Yesavage, 1986) is recommended because it takes approximately 5 minutes to administer, has been validated and extensively used with medically ill older adults, and includes few somatic items that may be confounded with physical illness (Pfaff & Almeida, 2005 **[Level IV]**; Watson & Pignone, 2003 **[Level I]**).
- Perform a focused depression assessment on all at-risk groups and document results. Note the number of symptoms; onset; frequency/patterns; duration (especially 2 weeks); changes in normal mood, behavior and functioning (American Psychiatric Association, 2000 **[Level VI]**):
    - Depressive symptoms:
        - Depressed or irritable mood, frequent crying
        - Loss of interest, pleasure (in family, friends, hobbies, sex)
        - Weight loss or gain (especially loss)
        - Sleep disturbance (especially insomnia)
        - Fatigue/loss of energy
        - Psychomotor slowing/agitation
        - Diminished concentration
        - Feelings of worthlessness/guilt
        - Suicidal thoughts or attempts; hopelessness
        - Psychosis (i.e., delusional/paranoid thoughts, hallucinations)
        - History of depression; current substance abuse (especially alcohol); previous coping style
        - Recent losses or crises (e.g., death of spouse, friend, pet; retirement; anniversary dates; move to another residence,

nursing home); changes in physical health status, relationships, roles

- Obtain/review medical history and physical/neurological examination (Alexopoulos, Schulz, & Lebowitz, 2005 **[Level VI]**).
- Assess for depressogenic medications (e.g., steroids, narcotics, sedatives/hypnotics, benzodiazepines, antihypertensives, histamine-2 antagonists, beta-blockers, antipsychotics, immunosuppressives, cytotoxic agents).
- Assess for related systematic and metabolic processes that may contribute to depression or might complicate treatment of the depression (e.g., infection, anemia, hypothyroidism or hyperthyroidism, hyponatremia, hypercalcemia, hypoglycemia, congestive heart failure, and kidney failure) (Alexopoulos, Schulz, & Lebowitz, 2001 **[Level VI]**).
- Assess for cognitive dysfunction.
- Assess level of functional ability.

Care Parameters

- For severe depression (i.e., GDS score 11 or greater, five to nine depressive symptoms [must include depressed mood or loss of pleasure] plus other positive responses on individualized assessment [especially suicidal thoughts or psychosis and comorbid substance abuse]), refer for psychiatric evaluation. Treatment options may include medication or cognitive-behavioral, interpersonal, or brief psychodynamic psychotherapy/counseling (individual, group, family), hospitalization, or electroconvulsive therapy (Arean & Cook, 2002; Hollon et al., 2005 **[Level VI]**).
- For less severe depression (i.e., GDS score 6 or greater, fewer than five depressive symptoms, plus other positive responses on individualized assessment), refer to mental-health services for psychotherapy/counseling (see above types), especially for specific issues identified in individualized assessment and to determine whether medication therapy may be warranted. Consider resources such as psychiatric liaison nurses, geropsychiatric advanced practice nurses, social workers, psychologists, and other community- and institution-specific mental-health services. If suicidal thoughts, psychosis, or comorbid substance abuse are present, a referral for a comprehensive psychiatric evaluation should always be made (Arean & Cook, 2002; Hollon et al., 2005 **[Level VI]**).
- For all levels of depression, develop an individualized plan integrating the following nursing interventions:
    - Provide an approach to depression management (Arean et al., 2005 **[Level VI]**; Harpole et al., 2005 **[Level II]**; Hegel et al., 2005 **[Level II]**; Unutzer et al., 2002 **[Level II]**).
    - Institute safety precautions for suicide risk as per institutional policy (in outpatient settings, ensure continuous surveillance of the patient while obtaining an emergency psychiatric evaluation and disposition).
    - Remove or control etiologic agents:
        - Avoid/remove/change depressogenic medications.
        - Correct/treat metabolic/systemic disturbances.
    - Monitor and promote nutrition, elimination, sleep/rest patterns, and physical comfort (especially pain control).

- Enhance physical function (i.e., structure regular exercise/activity; refer to physical, occupational, recreational therapies); develop a daily activity schedule.
- Enhance social support (i.e., identify/mobilize a support person(s) [e.g., family, confidant, friends, hospital resources, support groups, patient visitors]); ascertain need for spiritual support and contact appropriate clergy.
- Maximize autonomy/personal control/self-efficacy (e.g., include patient in active participation in making daily schedules and setting short-term goals).
- Identify and reinforce strengths and capabilities.
- Structure and encourage daily participation in relaxation therapies, pleasant activities (conduct a pleasant activity inventory), and music therapy.
- Monitor and document response to medication and other therapies; readminister depression- screening tool.
- Provide practical assistance; assist with problem-solving.
- Provide emotional support (i.e., empathic, supportive listening; encourage expression of feelings and hope instillation), support adaptive coping, and encourage pleasant reminiscences.
- Provide information about the physical illness and treatment(s) and about depression (i.e., that depression is common, treatable, and not the person's fault).
- Educate about the importance of adherence to prescribed treatment regimen for depression (especially medication) to prevent recurrence; educate about specific antidepressant side effects due to personal inadequacies.
- Ensure mental-health community linkup; consider psychiatric, nursing home care intervention.

Definitions:

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

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Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/Consensus panels

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Patient

- Personal safety
- Evaluation by psychiatric services for severe depression
- Reduction of symptoms indicative of depression (e.g., reduction in the Geriatric Depression Scale [GDS] score and resolution of suicidal thoughts or psychosis)
- Improved daily functioning

Health Care Provider

- Early recognition of patient at risk, referral, and interventions for depression
- Improved documentation of outcomes

Institution

- Increased number of patients identified with depression
- No increase in the number of in-hospital suicide attempts
- Increased referrals to mental-health services
- Increased referrals to psychiatric nursing home care services
- Improved staff education on depression recognition, assessment, and interventions

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 (revised 2008 Jan)

GUIDELINE DEVELOPER(S)

Hartford Institute for Geriatric Nursing - Academic Institution

GUIDELINE DEVELOPER COMMENT

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of The John A. Hartford Foundation Institute for Geriatric Nursing.

SOURCE(S) OF FUNDING

Supported by a grant from The John A. Hartford Foundation.

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: Lenore H. Kurlowicz and Theresa A. Harvath

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Available from the Hartford Institute for Geriatric Nursing Web site.

Copies of the book *Geriatric Nursing Protocols for Best Practice*, 3rd edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- The geriatric depression scale (GDS). Try this: best practices in nursing care to older adults. 2007. Electronic copies available from the Hartford Institute for Geriatric Nursing Web site. Electronic copies also available in Spanish from the Hartford Institute for Geriatric Nursing Web site.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on February 26, 2004. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI Institute on November 2, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs. This summary was updated by ECRI Institute on June 18, 2008. The updated information was verified by the guideline developer on August 4, 2008.

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