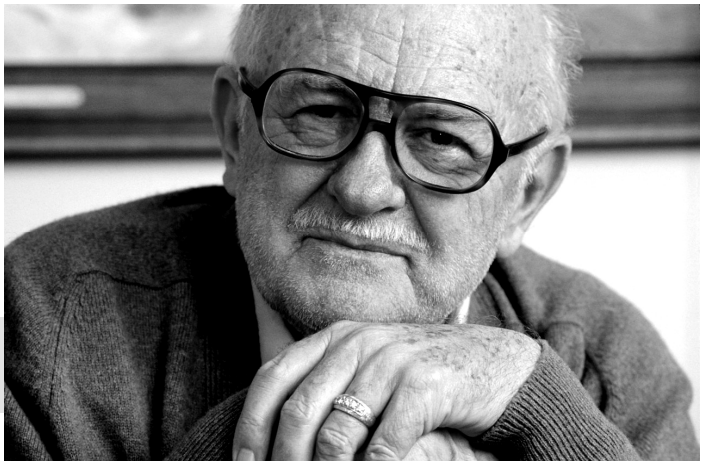
Quick Reference Guide

Residential Care

DEPRESSION



This Quick Reference Guide Will Help The Nurse To

- Identify older persons who are at risk for depression.
- Recognize the complexities in assessing for depression in older persons who also suffer from dementia.
- Protect the safety of the older person with depression.
- Take quick action to coordinate appropriate care where suicide is a possibility.

Key Points About Depression

- The rate of depression and suicide in the elderly is high. It is often undiagnosed and under-treated.
- Depression is **not** a normal part of aging. With treatment, it is usually reversible, restoring quality of life.
- Many factors contribute to depression, including a variety of medical and psychiatric illnesses. Other causes include multiple losses, grief, chronic pain, stress and loss of independence.
- Depression may be confused with early cognitive symptoms of dementia.
- People with dementia are more susceptible to developing depression. Co-morbidity complicates the assessment process as symptoms of depression may be diagnosed as onset of dementia.
- Without treatment, depression can lead to:
    - Poorer physical health, cognitive ability, function, and quality of life.
    - Suicide.

Risk Factors for Suicide

- ✦ Depression
- ✦ Male, Caucasian, 65-80 years
- ✦ Family history of suicide
- ✦ Social isolation, physical illness, severe pain
- ✦ Major change in role
- ✦ Use of alcohol or substances
- ✦ Death of someone close
- ✦✦ Available method and ability to carry out the plan

Warning Signs of Suicide

- ✦ Looks and acts depressed
- ✦ Gives away possessions, says goodbye, puts affairs in order
- ✦ Takes unusual risks
- ✦ Sudden interest in, or avoidance of, religion
- ✦ Deterioration in self-care and attention to physical health
- ✦ Expresses intent (develops a plan, acquires a weapon)

Nursing Assessment of Depression

Risk Factors ➔

- Age > 65 years.
- History of depression, psychiatric illness, family history of depression.
- Recent loss (e.g. death of family member or pet).
- Admission to residential care.
- Alcohol and/or substance abuse.
- Medications that contribute to depression.
- Poor physical health, medical illness.

Clinical Presentation ➔

- **S** – SLEEP; disturbances (e.g. early morning awakening and trouble getting to sleep)
  I – Interest; loss of interest in previously enjoyed activities.
- **G** – GUILT; inappropriate guilt, feelings of worthlessness.
- **:** - COLON; constipation, continuous complaints re: bowels
- **E** – ENERGY; loss of, fatigue
- **C** – CONCENTRATION; diminished ability to think, indecisive.
- **A** – APPETITE; increases or decreases, weight gain or loss.
- **P** – PSYCHOMOTOR; agitation (e.g. fidgeting,) or retardation (e.g. slow response)
- **S** – SUICIDAL IDEATION; plans/previous attempts
- Also behavioural manifestations (e.g. aggression, anger, restlessness, tearfulness)

Supporting Data ➔

- Psychosocial history.
- Geriatric Depression Scale.
- Gather MMSE.
- Collateral information from family or friends.
- Sleep Record, Intake and Output Record.
- Weight Chart.
- Behaviour Chart.

Nursing Interventions

For Depression ➔

- Protect the safety of the depressed older person.
- Don't ignore warning signals. Where concern exists, the nurse asks directly about suicide: "Have you thought about hurting yourself?" "Do you have a plan?"
- Promptly report depression and suicidal intent to the physician.
- Refer resident to the Mental Health Team if indicated.
- Encourage hope and support self-esteem, focus on personal strengths.
- Encourage maintenance of a usual daily routine and continuation of activities.
- Address physical complaints (e.g. pain, gastrointestinal problems).
- Encourage visitors and volunteers to spend quality time.
- Monitor the efficacy and side effects of antidepressant therapy.
- Ensure older person and family are provided with information about treatment.
- Ensure older person and family are provided with information about medications.
- Provide non-judgmental support and education.
- Support the older person and family if E.C.T. is chosen as a treatment.

For Suicide Prevention ➔

- Place in a secure environment (e.g. remove medications, sharps).
- Determine level of observation related to risk.
- Evaluate need for committal under the Mental Health Act.
- Communicate suicide risk to interdisciplinary team.
- Provide non-judgmental support to the older person.
- Discuss a "no suicide" contract.
- Communicate with family.