

Systems Investigative Audit – Depression Symptoms Detection /Treatment

Purpose: To evaluate the decision-making process and adequacy of the facility's process in the detection of symptoms of depression and appropriateness of treatment protocols.

- NOTE: the following audit criteria are broad. Select a current clinical practice guideline or utilize the Facility Assessment Checklists tool for Depression to guide your detailed audit.

Criteria:

1. Resident was screened within 7 days of admission for potential symptoms of depression using a validated screening tool (e.g., Geriatric Depression Scale or Cornell Scale for Depression in Dementia).
2. Depression screening, using a valid tool, was repeated with each readmission, MDS and after a change in condition.
3. If screening was positive, nursing documentation included results and the medical provider, DON and care plan team were notified. If screening was negative, resident was evaluated for risk factors according to CPGs.
4. A comprehensive evaluation was conducted to either confirm or rule out the diagnosis of depression and identify comorbid conditions or medications that may increase the likelihood or cause symptoms of depression.
5. Interventions were included in care plan to address symptoms of depression or to include risk factors and maintain an awareness of the potential for depression.
6. Care plan interventions were implemented as indicated and documentation indicated resident responses or lack of responses.
7. If treatment was initiated, the resident was monitored at least weekly for 6 to 12 weeks for any change or lack of change in symptoms. If the resident was ordered to have on-going observation ("watchful waiting"), symptoms were re-evaluated in 2 weeks. A monitoring format was utilized that provided consistent tracking data.
8. If no improvement was noted within 4 to 6 weeks (or as recommended by CPGs) after treatment begins, the resident was reassessed for possible change in treatment modality.
9. Routine evaluation for treatment efficacy was conducted at 3-month intervals and cessation of treatment considered according to type of depression and CPGs (e.g., 6 to 12 month treatment duration for initial major depression episode; 3-month duration for minor depression).
10. Care plan was consistently evaluated and revised, based on current resident assessed needs and responses to treatment and nursing interventions.
11. Documentation of interventions, resident behaviors and responses to interventions, or interventions for risk factors, was timely, consistent and followed recommended CPGs.
12. An appropriate system for communicating to all direct-care staff skin risk factors, interventions and changes in the plan of care was in place and functioned properly.
13. Responsibility and accountability was assigned for each phase of the depression screening, evaluation/re-evaluation and monitoring process.
 - Those designated as responsible and accountable for monitoring the processes carried out their responsibilities in a timely manner.
14. A policy with protocols for depression screening, evaluation and monitoring is in place and are updated and communicated to all staff according to current CPGs.
15. The QA/CQI committee had processes in place to routinely audit the depression management process.
 - Identified solutions are system-oriented.
 - Ongoing education on depression and depression management is provided for staff, families and residents.

Reviewer: _____

Date of Review: _____

	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Comments
1. Depression screening completed with appropriate tool within 7 days of admission							
2. Re-screenings completed according to CPGs							
3. Follow-up and documentation of positive screening were appropriate, or risk factors were identified if screening negative							
4. Comprehensive evaluation completed if screening positive							
5. Care plan included interventions for symptoms or addressed all risk factors							
6. Interventions were implemented as indicated							
7. Resident was monitored weekly for treatment response							
8. Reassessment of treatment was done within 4-6 wks if no improvement							
9. Routine evaluation of treatment was done per CPG							
10. Care plan shows evidence of timely revisions based on resident assessments							
11. Nursing documentation of interventions and resident responses timely and complete							
12. Staff demonstrates awareness/understanding of care plan content							
13. Accountability evidenced by those responsible for screening, evaluations and monitoring							
14. Depression policy/protocols current & followed consistently							
15. QA/CQI meetings focus on root-cause analyses							
13.Ongoing resident, family and staff education is provided							