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Increasing Depression Risk Screening in Hospice and Palliative Care Patients

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Executive Summary: Staff Education Project

Increasing Depression Risk Screening in Hospice and Palliative Care Patients

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Summary

This doctoral project was conducted as a staff education project. The practice problem involved inconsistent depression risk screening in hospice and palliative care patients. It was crucial to address this, as depression can be pervasive in this population. The practice-focused question was, For registered nurses who work in a palliative or hospice care unit, does education on depression risk screening increase depression screening rates as compared 12 weeks before to 12 after the education? The project aimed to improve depression risk screening rates through staff education. The Johns Hopkins nursing evidence-based practice model was used to assess 13 supporting articles for this project. The facility provided the pre- and post-de-identified data, including Patient Health Questionnaires (PHQ-2 and PHQ-9), Geriatric Depression Scales (GDS), and Cornell Scales for Depression in Dementia (CSDD). Quantitative analysis involved descriptive and inferential statistics. The paired sample *t* test evaluated whether the educational intervention increased depression screening by comparing screening rates before and after. The pre-education group ($N = 12$) had a mean score of 1.58 ($SD = 0.515$), showing variability. In contrast, the posteducation group ($N = 9$) had a mean score of 2.00 with no variability ($SD = 0.000$), as all participants achieved the maximum score ($p = .0024$). Findings emphasized the need for standardized depression screening protocols in hospice and palliative care, along with ongoing staff education for better recognition of depression risk. This approach may enhance patient care and promote diversity, equity, and inclusion by ensuring all patients received necessary mental health support.

Background

A comprehensive evaluation of depression in hospice and palliative care patients involved assessing both psychological and physical symptoms, as depression could worsen health and complicate symptom management (Grotmol et al., 2019). The emotional toll of terminal illness often heightened depressive symptoms, impacting patients' well-being and decision making. Inconsistent depression risk screening in this population stemmed from factors like a lack of tailored tools, time constraints, emphasis on physical comfort, knowledge gaps among staff, ethical concerns, and misconceptions about depression being a natural part of dying (Lee et al., 2022). Stressful events, such as a terminal diagnosis, can trigger depression, exacerbating physical suffering (Antunes, 2020; Kredentser & Chochinov, 2020). Therefore, implementing educational sessions to improve depression risk assessments could enhance access to care.

The evidence-based question for this project was: For registered nurses who work in a palliative or hospice care unit, does education on depression risk screening increase depression screening rates as compared 12 weeks before to 12 after the education? Therefore, I aimed to determine if an education session could improve depression risk assessments in hospice and palliative care patients, a population that has struggled with consistent assessment. Its primary goal was to equip staff with the knowledge to conduct thorough assessments, enabling earlier detection of depression and better symptom management.

I used the Johns Hopkins nursing evidence-based practice model to effectively translate evidence related to depression assessment and management in hospice and palliative care patients. The evidence was categorized by strength and relevance,

highlighting the importance of frequent depression risk assessments within this patient population.

In the area of depression screening for older adults, Level I evidence underscored the efficacy of specific assessment tools tailored to this demographic. A systematic review with meta-analysis conducted by Park and Kwak (2021) identified the Geriatric Depression Scale 15 (GDS-15) as a highly effective tool for detecting depression, particularly among older adults with normal cognitive function. Expanding on this topic, Park and Cho (2022) examined the reliability and validity of the Cornell Scale for Depression in Dementia (CSDD). Their research demonstrated that the CSDD is a practical assessment instrument for elderly patients, regardless of their cognitive status. Together, these studies highlighted the critical role of using appropriate depression screening tools based on patients' cognitive conditions, thereby ensuring accurate and effective identification of depression in older adults.

There were two articles in Level II evidence. The first one was by Rodríguez-Mayoral et al. (2020), who advised that it was paramount to identify ways to improve early diagnosis of major depressive disorder (MDD) in palliative care patients to improve their quality of life. He added that catching depression symptoms before they worsen was essential because it was one burden that could be relieved. The second piece of evidence was by Lee et al. (2022), who explained that the lack of screening and the variations in the assessment of depression in palliative care patients created a challenge in intervention. This was why there should be an evidence-based screening tool that was uniformly used in screening for depression in hospice and palliative care patients. These findings highlighted the necessity of implementing timely and uniform screening

methods to improve intervention strategies and ultimately enhance patient outcomes in palliative care.

Level III evidence consistently supported the importance of depression screening in palliative care to address psychological burdens and enhance patients' quality of life. Rahnea-Nita et al. (2019) highlighted that depression tends to worsen over time in palliative care patients, advocating for continuous screening to manage symptoms effectively. Grotmol et al. (2019) revealed that cancer patients with depression experienced a higher overall symptom burden, emphasizing the need to alleviate depression to enable patients to make clear decisions during end-of-life care. Similarly, Antunes (2020) stressed the importance of regular screening, treatment, and follow-up for patients with advanced illnesses to prevent the added distress of untreated depression. Graham-Wisener et al. (2021) reinforced the view that psychological assessment should be an ongoing process, integrating depression screening as a routine component of care to identify those needing additional support. Finally, Acosta et al. (2021) validated the GDS-15 as a quick and effective tool for identifying depression, further underscoring the feasibility of regular screening in palliative care settings. Collectively, these findings highlighted the critical role of timely and continuous depression screening in improving the psychological well-being of patients in palliative and end-of-life care.

Levels IV and V evidence further emphasized the critical role of mental health management, particularly depression, in palliative and hospice care. Arnold (2022) highlighted that palliative and hospice care prioritizes aggressive symptom management, including addressing mental health challenges like anxiety and depression. Kredentser and Chochinov (2020) noted that approximately 20% of terminally ill patients suffer from

depression, which is often misunderstood, underdiagnosed, and undertreated due to difficulties in distinguishing between emotional and physical symptoms and hesitancy to prescribe psychotropic drugs in medically complex patients. They emphasized that untreated depression exacerbates physical symptoms, diminishes quality of life, and impairs decision-making, such as finding meaning and saying goodbye. Kozlov et al. (2019) underscored the importance of managing psychological symptoms at the very end of life, noting that nearly half of hospice patients experience anxiety or depression in their final days. Larkin (2020), a Level V source, advocated for depression screening at every patient encounter, reinforcing the necessity of frequent and routine assessments to address mental health challenges promptly.

Staff Education Project Development

Assessing depression risk in hospice and palliative care patients was essential for improving the patient's quality of life. In this project, conducted in Austin, Texas, I focused on patients in memory care and skilled nursing units. I aimed to systematically evaluate and address depression risks through evidence-based, patient-centered practices. The initial phase included a planning and needs assessment to identify gaps in current practices and involved a literature review to understand the prevalence and impact of depression among these patients. Stakeholder engagement helped pinpoint specific needs, leading to clear goals for early depression detection and tracking screening rates using tools like PHQ-9, CSDD, and GDS. Standardized depression screening procedures were developed, incorporating a frequency schedule and workflow for administering results. An educational program for staff emphasized recognizing and assessing depression in terminally ill patients (see Appendix). A team of nursing experts conducted a thorough

program evaluation, assessing the educational materials for clinical accuracy and relevance. Workshops provided feedback on content and structure, with Likert scores for the educational program averaging 4.63/5, indicating robustness but suggesting minor refinements for interactivity. A group of 11 healthcare professionals, which included nurse practitioners, registered nurses, licensed vocational nurses, and nursing assistants, participated in five in-person group sessions covering the project's objectives and implementation strategies.

Following the presentations, the facility provided a series of retrospective de-identified assessment data collected over 12 weeks to evaluate the project's impact. Data logged on a tracking form (by patient were de-identified), enabled the identification of trends in depression risk screening practices before and after the education session.

The data analysis was conducted using quantitative methods and descriptive statistics. This analysis involved calculating response frequencies, means, and standard deviations for the depression tools to help identify trends. Additionally, inferential statistics, including *t* tests, were employed to assess whether any changes were statistically significant after the education session.

Results

To evaluate the effectiveness and feasibility of the educational program, I conducted a comprehensive analysis using data collected by the facility on existing patient care records, a robust foundation for presenting the results. Participants ($N = 11$) were aged between 18 and 69 years. The age distribution was as follows: 27.3% were 18-30 years, 27.3% were 30-39 years, 18.2% were 40-49 years, 9.1% were 50-59 years, and 18.2% were 60-69 years. The sample was evenly distributed by gender, with 54.5% male

and 45.5% female participants. Regarding ethnicity, 45.5% identified as White, 45.5% as Black or African American, and 9.1% as Asian. The participants' education levels ranged from high school (9.1%) to graduate degree holders (9.1%), with the majority (45.5%) holding a diploma.

The results of the *t* test indicated a significant improvement in depression risk assessments following the educational sessions, underscoring the effectiveness of the intervention. Before the education sessions, only five out of 12 screening tools (42%) were completed. In contrast, after the educational sessions, all nine screening tools the facility provided were completed, achieving a 100% screening rate. The *t* test revealed a mean score of 1.58 with a standard deviation of 0.515 for pre-education screenings, while the posteducation mean score was 2.00, with a standard deviation of zero. This zero-standard deviation indicated that all nine patients participated in screening posteducation (see Table 1). The findings highlight the necessity of educational sessions for successfully meeting the project's objective of enhancing depression risk assessments. Furthermore, the *t* test yielded a *p* value of 0.0024, confirming a statistically significant difference between the pre-and post-education sessions.

Table 1

t *Test Depression Risk Assessment*

Pre- and posteducation	Total screening tools provided	Total patients screened	Mean	Std. deviation	Std. error mean
1 Pre	12	5	1.58	.515	.149
2 Post	9	9	2.00	.000	.000

In an evaluation of the pre- and postscreening data, I assessed the educational program's effectiveness and feasibility. My analysis revealed a significant improvement in screening practices after the session, demonstrating that a single educational session can effectively enhance depression risk screening.

The project faced several limitations that impacted its results. Scheduling educational sessions was challenging due to varying staff schedules and high turnover among contracted agency staff. This spread out the dissemination of information and likely delayed the collection of post-education de-identified data. The facility's use of PHQ-2 and PHQ-9 tools for depression risk assessment was not suitable for all patients, as some were overlooked due to their default settings, particularly for nonverbal patients. Implementing the CSDD tool ensured comprehensive assessments without excluding anyone.

However, adopting new assessment tools would necessitate overhauling the organization's charting system, so screenings were done manually, complicating tracking. Additionally, some staff believed patients were too ill for screening, leading to resistance from those unmotivated to take on extra paperwork amidst their heavy workloads. Also, participation in the educational sessions was voluntary, resulting in low attendance due to a lack of motivation among staff.

Caring for depression in terminally ill patients is challenging and requires resources, education, and an interdisciplinary approach (Lee et al., 2022). Depression significantly impacts a palliative care patient's survival and quality of life (Rodríguez-Mayoral et al., 2020). This project was vital as hospice and palliative care patients are cared for in various settings. Staff must adopt a holistic mindset since depression can worsen physical symptoms. As a result, early depression risk screening allows for timely intervention, reducing unnecessary suffering in this vulnerable population.

Conclusions

In summary, in hospice and palliative care, patients need to focus on their legacy and the meaning of their lives while minimizing the impact of depressive symptoms. Conducting screenings for depression risk is a vital practice in this patient population, as it significantly affects the quality of care provided by healthcare organizations and their daily operations. Research indicates that the presence of depression can worsen both behavioral and physical symptoms (Grotmol et al., 2019). Therefore, implementing depression risk screenings was crucial for early detection of symptoms, enabling timely interventions that can enhance patients' overall quality of life.

By screening for depression risk, healthcare providers can better tailor care plans, improving patient comfort and satisfaction. Organizations need to invest in staff education to ensure that adequate mental health care is delivered to this population. A comprehensive approach to care, which includes screening, intervention, and follow-up, ensures that patients receive the necessary support to enhance their quality of life.

Additionally, screening for depression risk has significant implications for nursing practice. It improves patient outcomes, promotes positive social change, and supports

diversity, equity, and inclusion (DEI) initiatives. Continued education for nurses is crucial, as they must remain current on evidence-based practices related to medical management and therapeutic communication. Both are key in providing care in these sensitive settings (Larkin, 2020). Furthermore, highlighting the importance of cultural sensitivity and addressing implicit biases during depression risk screenings plays a significant role in advancing equity in healthcare practice among all patients (American Psychological Association, 2019). Consequently, ensuring that all patients in hospice and palliative care are screened enables healthcare providers to address the needs of marginalized individuals more effectively, resulting in more personalized and impactful care plans.

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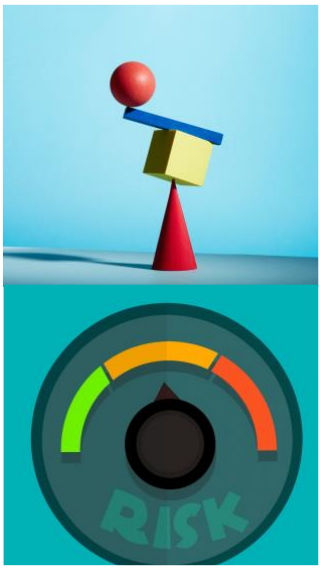
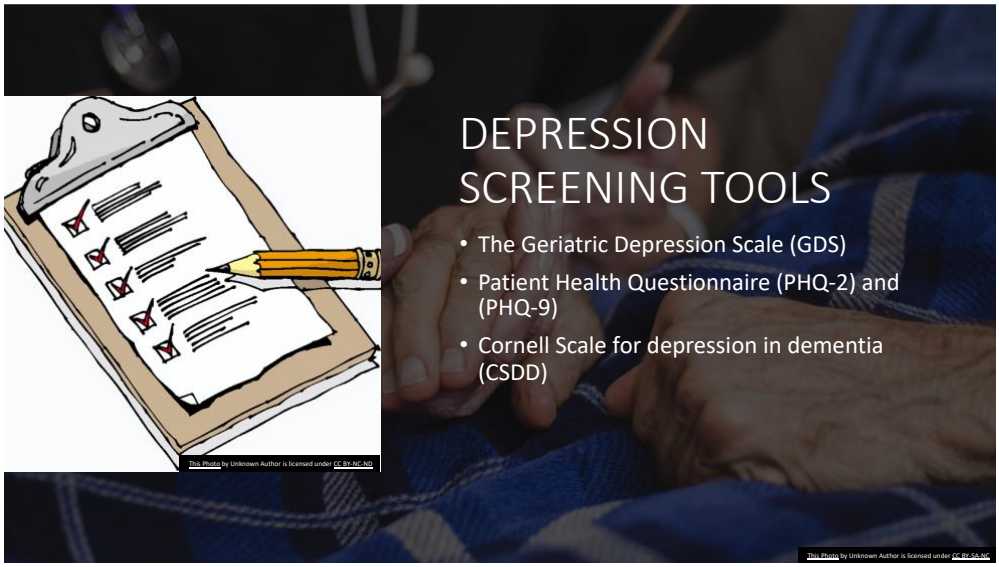
Appendix: Education PowerPoint Presentation

RISK ANALYSIS

- In older adult patients receiving end-of-life care, anxiety and depression are reported as the number one mental health concerns (Arnold, 2022).
- Depression increases the severity of physical symptoms and suffering (Antunes, 2020).





Cornell Scale for Depression in Dementia (CSDD)

GERIATRIC DEPRESSION SCALE: Short Form (GDS)

- (Kurlowicz & Greenberg, 2007)

Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
10. Do you feel you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression.
A score ≥ 10 points is almost always indicative of depression.
A score > 5 points should warrant a follow-up comprehensive assessment.

Source: http://www.stanford.edu/~yesavage/GDS.html
This scale is in the public domain.

The Hartford Institute for Geriatric Nursing would like to acknowledge the original author of this Try This, Lenore Kurlowicz, PhD, RN, CS, FAAN, who made significant contributions to the field of gerogeopsychiatric nursing and passed away in 2007.

try this:

Quick Depression Risk Assessment Sheet (QDRAS)

- **A Quick Depression Risk Assessment Sheet**

1. Patient name and Room number:
2. Date:
3. Symptoms:
4. Refer to RN or NP

In-Service Flier

Depression Risk Assessment

Please complete the Quick Depression Assessment Sheet if your patient has the following symptoms.

Depression Symptoms from CDC.gov (2022) and ADAA (2024).

- A decrease or increase in appetite.
- Insomnia or hypersomnia.
- Restlessness
- Constant fatigue.
- Decreased energy.
- Persistent aches or pains.
- Feelings of worthlessness or excessive and inappropriate guilt.
- Crying a lot
- Recurrent thoughts of death and suicidal ideation with or without specific plans for committing suicide.
- New or worsening cognitive difficulties, such as a diminished ability to think, concentrate, and make decisions.

Once completed, please leave it in the white tub.

Thank you so much!

If you have any questions regarding the paperwork, please text Liz at [redacted] Otherwise, follow your facility's process if the patient is in crisis or distress.

BENEFITS

- Improve the quality of life
- Early detection = early intervention
- Optimize decision making
- Promote dignity
- Depression is reversible

CONCLUSION

The gap in practice is the lack of consistently assessing depression risk.

The educational session aims to increase the screening rates for depression in hospice and palliative care patients.

The risk analysis shows depression as the primary concern.

Tools that can be used to screen for depression quickly.

Benefits include reduced suffering due to early intervention, promotion of dignity, and improved quality of life.