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Cutting Through the Foggy Myths Using Best Practice Guidelines in Long Term Care

BP Blogger

Myth Busting: Stroke 4 Depression Issue

Myth 1: Depression is normal after a stroke

A stroke can affect residents in many ways such as having problems communicating or using their affected arm or leg. A stroke can also cause changes in memory, thinking, feelings and mood. These impacts are not so easy to see making it difficult to tell if a resident with stroke might be depressed. The resident may not realize or even want to admit they are depressed thinking it's normal to be sad after a stroke. Staff can "miss" the signs of depression and think that the changes they are seeing are because of the stroke. The signs of depression are more often overlooked when a resident with stroke has thinking, or communication difficulties. It is also important to understand the differences between depression, delirium and dementia. Staff have a valuable role in recognizing the signs and symptoms of depression and reporting these to the care team.

Signs and Symptoms of Depression

Physical signs
- Trouble sleeping or insomnia or other changes in sleep patterns
- Less energy
- Easily tired
- Decreased appetite with weight loss or increased appetite and weight gain

Attitudes
- Less interest or enjoyment in usual activities
- On-going sadness or loss of interest in everything; being gloomy
- Difficulty connecting or socializing with others

Emotions
- Hopelessness about the future
- Low self-worth or guilt
- Thoughts of death or suicide

Mental Functioning
- Difficulty concentrating
- Short – term memory problems
- Difficulty with decision making

Remember if a resident has 2 or more of these symptoms for more than 2 weeks they may be depressed.

Myth 2: Feeling the "blues" is depression

There is a difference between "having the blues" and a clinical depression. Clinical depression will not go away without treatment. It is important that you recognize and acknowledge how the resident is feeling and share that information with the team. It is critical that residents who may be clinically depressed receive proper assessment and treatment. Early recognition is key!

"The Blues"	Clinical Depression
Everybody feels sad sometimes.	Estimated prevalence of depression in individuals over the age of 65 is about 20% and after stroke 33%.
Definite beginning: people know when and why they began to feel sad.	Gradual beginning: people don't really know when or why it started.
Feeling sad is an emotional response to an event.	Depression is a medical illness due to chemical changes in the brain.
The feeling goes away on its own.	Depression does not go away without treatment (medications +/- counseling).
The mood lasts a few days or weeks.	Depression lasts months or years.

Inside this issue:

More information on This and Other Best Practices

- **Contact** your **Regional LTC Best Practices Coordinator.** They can help you with Best Practices Info for LTC. **Find them at:**
  - **www.rnao.org** Click on Nursing Best Practice Guidelines and select LTC BP Initiative
  - **www.shrtn.on.ca** Click on Seniors Health
- **Check out Long-Term Care and Geriatric Resources at www.rgpc.ca**
- **Surf the Web** for BPGs, resources and sites are listed on pg 2.
- Review back issues of the BP Blogger for related topics **www.rgpc.ca**

RGP central

Regional Geriatric Program Central and SHRTN Library Service Hamilton & Area

shrtn

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Find it on the Web at www.rgpc.ca or www.shrtn.on.ca

Ontario Stroke System
Fewer strokes. Better outcomes.

Myth 3: You can "snap out" of post-stroke depression

The causes of post-stroke depression can be both biological (due to injury to certain areas of the brain) and psychological. Unless depression is identified and treated, the resident will not just "snap out" of it. All residents showing signs and symptoms of depression must be screened for depression and if indicated, assessed by mental healthcare professional such as pyschiatrist or geriatrician to obtain appropriate assessment and treatment recommendations. The most common treatments include anti-depressant medications and counseling. Sometimes a resident may be reluctant to accept treatment as they think that medication may change their personality or have side effects. You have an important role in providing support at this time. If a resident voices thoughts about death, dying or ending their life, this information must be reported to your supervisor immediately. Post -stroke depression can affect a resident physically and emotionally. If not treated, it can affect a resident's ability to enjoy activities, participate in their own care, interactions with family and friends; and can lead to decreased quality of life.

The 2010 Canadian Best Practice Recommendations for Stroke Care suggest that all persons with stroke should be considered at high risk for depression.

- The greatest risk is in the first six months following a stroke, but depression can develop up to two years later.
- Depression may affect 1 in every 3 people who have had a significant stroke
- Less than half of people who have post stroke depression are diagnosed

How you can help a resident with post stroke depression

Connect:
- Get to know the resident you look after. It can help you identify mood changes
- Take the time to listen
- Talk to family and friends. Find out what the resident was like before the stroke so you can recognize changes
- Have team discussions. Learn about the residents you look after from other staff

Communicate :
- Always communicate with caring and hope. Be accepting, not judgmental
- Learn how to communicate with residents who have aphasia. Using supportive communication techniques can help a resident with aphasia tell you how they are feeling. For more information on Supportive Communication and Aphasia visit www.aphasia.ca
- Ask survivors how they are feeling.
- If they are experiencing pain, make sure they get treatment to relieve the pain

Observe:
- Look for the signs and symptoms of depression

Promote:
- Help them plan and structure their day. Routine can help people adjust.

Encourage:
- Encourage residents to do things
- Help them get to activities they enjoy
- Spend time with them in activities such as playing cards or board games
- Find activities that make them feel better, such as listening to music, watching videos, or reading

Support:
- Encourage emotional expression
- Allow residents to express their grief and sadness about what they have lost
- Always give them hope that things can improve
- Share what you learn with the rest of the team

Myth 4: There's nothing you can do to help with post-stroke depression

Treating depression requires a team approach. You play a key role in supporting the resident during your daily interactions.

Check out these Best Practices, Guidelines & Websites Answers to the Myths came from them. Find out more!

Canadian:

Strokengine http://strokengine.ca/

Canadian Best Practice Recommendations: Lindsay MP, Gubitz G, Bayley M, et al. **Recommendations for Stroke Care (Update 2010)** On behalf of the Canadian Stroke Strategy Best Practices and Standards Writing Group. 2010. Ottawa, ON Canada. www.strokebestpractices.ca

Evidence-Based Review Stroke Rehabilitation www.ebrsr.com

Heart & Stroke Foundation of Ontario. (2010) **Tips and Tools for Everyday Living: A Guide for Stroke Caregivers.**
www.heartandstroke.on.ca/site/c.pvI3IeNWJwE/b.5385217/k.E8DF/HCP_Tips_and_Tools.htm

Reach Community & LTC Coordinators at local Regional Stroke or Enhanced District Stroke Centres or go to www.ontariostrokenetwork.ca

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