LIABILITY
landscape

BY LINDA WILLIAMS, RN

Dealing with depression

It is estimated that of the 32 million people age 65 and older, 5 million suffer from depression. In fact, the rate of depression among nursing facility residents can run as high as 50%, according to some studies, with about 10 to 15% of residents suffering major depression and 25 to 35% suffering milder forms. Because societal attitudes consider it normal in the elderly, depression often goes untreated. Treatment also can be hindered because signs of depression in the elderly are often masked by other factors, such as physical infirmity, chronic pain, or dementia.

The need for caregivers to effectively communicate with their residents is most important when evidence suggests that residents feel imprisoned by the anguish of depression and can't find relief. Please take the time to review the circumstances surrounding the following situation and make changes as appropriate at your facility.

The Situation

A 76-year-old woman with a long history of major depressive disorder was admitted to the assisted living facility (ALF) of a CCRC. The woman was able to function independently and primarily needed assistance with her medications. Her history included four suicide attempts and several psychiatric hospitalizations, as well as a history of insomnia and prescription drug abuse. She was scheduled to receive psychiatric services on a routine basis while at the ALF.

The woman seemed to adapt well to her new environment and often socialized with her neighbors. Her daughter lived nearby and visited her every day, often taking her for walks on the campus or on overnight weekend trips to her home. The CCRC had a large campus that included walkways and a nearby fenced riverfront recreational area. The fence was kept unlocked so the independent and ALF residents could access and enjoy a riverfront area whenever they desired.

Facility policy required guests to sign residents in and out when leaving the facility, but the policy often wasn't enforced. As a result, the daughter seldom signed her mother out, but she always asked the staff for her mother's medications if she planned an overnight trip.

A month after her admission to the ALF, the woman began abruptly to make statements about killing herself. She was taken to a hospital and released a short time later. Her physician felt that her depression was related to her insomnia, and so adjustments were made to her medications.

After the hospitalization, the woman seemed to be adjusting well, so staff members were not alarmed when she stopped seeing her psychologist just four months later. For the next several weeks, the woman's daily activities seemed routine, until one Saturday evening when the staff noticed that she did not show up for supper. The staff paged her and checked her room but did not find her. Two days earlier, the woman's family had taken her shopping for new shoes and to the beauty parlor to get her hair styled. The staff concluded that the woman must be with her daughter on another weekend trip. A staff member left her medications in her room and attempted to call her daughter several times throughout the weekend but was not able to reach her.

The following Monday morning, the daughter called the facility explaining that she had just returned from an out-of-town trip and was unable to contact her mother at the ALF. The authorities were summoned and a missing person investigation was immediately started. The woman's lifeless body was soon discovered in the river with her new shoes neatly placed on the dock. A note was found in her room with something written on it about the river. The woman did not know how to swim, and her death was ruled a suicide.

Both the staff and the woman's family were devastated by this tragic event. The administrative personnel at the ALF immediately chained and locked the gate, in-serviced staff on missing person procedures, and began to strictly enforce the sign-in and -out policy. Meanwhile, the family sought legal counsel and filed a wrongful death lawsuit against the facility for waiting two days before launching a search for their mother. Their demand to settle the case was $750,000.

The defense hired a medical doctor who was a well-respected expert in geriatric suicides to review the case. The doctor felt that the woman's care was appropriate and stated that choosing between life and death is deliberate and can be impulsive. A person with suicidal tendencies will often use whatever is available to carry out the act. In this case, the river was available. The doctor did express concerns with the psychiatric care that the woman received; however, that was not the responsibility of the facility. The case was later mediated and settled for a fraction of the demand amount.

How to Protect Your Residents and Facility

As this case demonstrates, caregivers need to be alert to the possible threat of suicide among elderly residents with chronic illnesses, particularly those with symptoms of depression or other risk factors that can lead to suicide. Seniors make up approximately 13% of the population, but account for almost 20% of all suicides. In the general population, only one in 20 suicide attempts is successful, but among seniors, one in four attempts succeed. Warning signs of a resident's suicidal thinking may include the following:

- any mention of dying, disappearing, jumping, or other type of self-harm
- a recent loss, such as death of a loved one; decrease in health; separation; or a broken relationship
- a change in sleep patterns or eating habits

- low self-esteem
- expressions of hopelessness about the future

Caregivers need to be alert to statements indicating hopelessness, such as, "Life is no longer worth living," or, "I wish my life could end tomorrow." Indirect communication can be manifested in self-destructive behaviors, such as refusing food, fluids, or lifesaving medications. Other worrisome behaviors include writing good-bye letters, giving away valued possessions, not attending activities or engaging in therapeutic programs, collecting sharp objects, or hoarding medications. A sudden change from a demeanor of suffering to one of contentment also can indicate a decision to end one's life.

Caregivers have an obligation to intervene and attempt to seek treatment for residents whose words or actions indicate depressive hopelessness. The following are some steps that caregivers can take:

- Listen to the resident in a compassionate and nonjudgmental way to try to understand his or her predicament and how he or she can be helped.
- Encourage communication by asking open-ended questions that cannot be answered with a simple yes or no answer.
- Inquire about any suicidal thoughts or plans as the resident opens up, if it is appropriate to do so.
- Assess the seriousness of the resident's responses. If suicidal tendencies are apparent, ask the resident, "What can be done or changed to help you from acting on these thoughts?"
- Protect the resident by safeguarding his or her room or environment against injurious objects or accessibility to medications. If symptoms are sufficiently pronounced, it may be necessary to keep the resident under one-on-one surveillance until outside help arrives.
- Contact the resident's physician and report your concerns. In some cases, it may be necessary to arrange for an immediate transfer to an acute psychiatric facility.
- Consult with social services or chaplain services that are available within the facility.
- Maintain a heightened vigilance as to the resident's whereabouts and confirm supervised outings.

With appropriate intervention by caregivers, residents may be able to find the treatment needed to ease their depression or manage their chronic pain or illnesses to a greater comfort level.

If a resident chooses to end his or her life despite your best interventions, remember the loved ones that he or she left behind. Surviving the suicide of a friend or family member can often lead to feelings of guilt or blame for their loved one's death. Thoughts such as, "If only I had the foresight to see what was happening, I could have intervened in time" can be overwhelming. Many survivors find it easier to tolerate their own failings or to redirect the blame toward others rather than to accept that someone they loved has died by his or her own will. You can help survivors with your attitude (empathy, kindness, active listening), your professional responses about losing someone to suicide, and suggestions of community resources.

By taking these necessary precautions, you can protect your residents and facility, now and into the future. ■

Linda Williams, RN, is a Long-Term Care Risk Manager for the GuideOne Center for Risk Management's Senior Living Communities Division. She previously served as Director of Nursing in a CCRC and as a nurse consultant for two corporations with numerous long-term care facilities in Iowa. The GuideOne Center for Risk Management is dedicated to helping churches, seniors living communities, and schools/colleges safeguard their communities by providing practical and timely training and resources on safety, security, and risk-management issues. For more information, contact Williams at (877) 448-4331, ext. 5175, or slc@guideone.com, or visit www.guideonecenter.com.