AN INTERVENTION TO MANAGE DEPRESSION AFTER HIP FRACTURE

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Depression can have a negative effect on recovery following hip fracture. In a large trial a psychiatric nursing intervention proved effective in reducing mental health difficulties and promoting recovery. This article outlines how the intervention can be applied in practice and includes a comprehensive case study.

Hip fracture is a common problem in older adults, affecting 750,000 people per year in the UK. Low mood can have a detrimental effect on recovery following hip fracture (Holmes and House, 2000). However, there has been little evidence to demonstrate if intervention can be successful with orthopaedic patients. Our study attempted to discover whether treating depression in post-operative patients can improve functional and psychiatric outcomes (Burns et al, 2007). The results suggest that intervention can be beneficial to this cohort.

THE INTERVENTION
In a large study carried at four hospital sites in Greater Manchester (Burns et al, 2007), we identified 121 hip fracture patients aged over 60 who met the criteria for depression using the Geriatric Depression Scale (Yesavage et al, 1983). Of these, 61 were randomised to the nursing intervention.

All patients scored above 15 on the Mini Mental State Examination (MMSE), a tool for measuring cognitive functioning (Folstein et al, 1975). The MMSE uses a scale of 1–30, with 25–30 considered normal and 1 indicating severely impaired cognition. The cut-off score of 15 was chosen to screen out participants with severe cognitive impairment, while allowing for the fact that performance on this measure can be affected negatively by depressive symptoms.

SUMMARY OF RESULTS
At six-week follow-up, 28 (52%) of the control group remained depressed, compared with 17 (34%) of the intervention group. Scores on the Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983) and the Geriatric Depression Scale were significantly lower in the group that received the nursing intervention, although a logistic regression used to estimate the treatment effect of the intervention was not statistically significant.

However, Burns et al (2007) acknowledged that measuring differences in outcome in hospital patients can be difficult, and trials often return negative results that may be at odds with clinical opinion. From a nursing viewpoint we observed that individuals did benefit from the intervention that was not part of the usual care package (see Burns et al, 2007 for full details of the study results).

CASE EXAMPLE: MRS SMITH
Following referral, we assessed the patient’s needs in more depth, including a formal measure of depression, the Hamilton Rating Scale (Hamilton, 1960). This allowed us to focus the intervention on an individual basis. Details have been changed in order to ensure patient confidentiality.

Mrs Smith, a 68-year-old woman, lived with her husband in their own home. Her husband had health difficulties and relied on her to care for him and drive him to appointments. She led an active life and was a former ballroom-dancing champion. She fell while shopping and broke her left hip. She was operated on two days later and given a hemiarthroplasty. The physiotherapist told her she would have to follow strict guidelines to ensure full recovery. When assessed, she reported worries about coping in the future.

Session 1
We assessed Mrs Smith in hospital two weeks after her operation. Her mood was low but it was decided that she did not need medication. However, she did require psychiatric intervention and guidance. Mrs Smith expressed concern about being the main carer for her spouse.

Intervention:
- Engagement and building rapport;
- Assessment to ascertain degree of depression/need for medication;
- This intervention was carried out by a research team and was not part of the usual clinical care for patients following hip fracture. However, we feel that the intervention could be adopted by nurses in this field.
- It is recognised that it may not be possible for patients to receive the intervention from a named nurse on a one-to-one basis in all settings.
- Increased liaison between ward and community-based nurses could be encouraged to identify patients who may benefit from the intervention and to ease the transition to discharge and beyond.
- We feel that our intervention goes beyond what is currently available for hip fracture patients in routine care, and highlights specific areas where care could be improved to alleviate symptoms of depression.

IMPlications for practice
Identification and discussion of problems and agreement on present and future needs to be met.

Session 2
We visited Mrs Smith at home and met her husband. He voiced concerns about getting their shopping and attending a hospital appointment at the end of the month. Mrs Smith’s mood remained low, although we felt she was encouraged by our support.

Intervention:
- Assessment of activities of daily living in home environment;
- Assessment of support network;
- Practical help, such as booking ambulance transport;
- Solution to weekly shopping (neighbours offered to do this);
- Positive reinforcement and counselling.

Session 3
There were fewer practical concerns following the arrangements for shopping and hospital visits. Mrs Smith was concerned that she was unable to sleep upstairs and about discomfort in her hip. This was because she was not fully aware of the precautions necessary following the operation. Her mood remained low due to immobility and she expressed frustration and boredom, and felt hopeless about the future.

Intervention:
- Arranged for occupational therapy department to fit a handrail;
- Arranged a visit from the community physiotherapy team for further guidance on precautions and exercises;
- Supportive counselling around mood and feelings of frustration, such as substituting physically demanding activities for achievable ones.

Session 4
Mrs Smith reported that she had followed our suggestions and had begun to take up activities that were achievable. She stated that she felt more motivated and not as low, and wanted to start driving the car against medical advice (12 weeks is recommended and wanted to start driving the car against that she felt more motivated and not as low, and felt more motivated and not as low, and felt more motivated and not as low).

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Session 5
Mrs Smith had decided to refrain from driving for the recommended time. We reinforced alternative options and discussed how problem-solving skills could be useful in tackling other difficult decisions. Her mood remained lifted so we discussed planning for the future and setting achievable goals. Mrs Smith decided to book a holiday for her and her husband, and to aim to be fully recovered to travel in five months’ time.

Intervention:
- Counselling and forward planning;
- Encouragement, for example focusing on holiday brochures;
- Discussion with spouse (with permission), looking at his thoughts and feelings on his wife’s progress and how he was coping;
- Preparing for the end of the intervention’s regular visits.

Session 6
At the final session, Mrs Smith expressed concern about her ability to cope without our visits. We discussed coping mechanisms and reinforced our previous work. We reminded her that weekly phone calls would follow for six weeks, and any potential difficulties could be discussed then.

Intervention:
- Discussion of coping mechanisms and reinforcement of previous work;
- Assessment of mood to see whether or not onward referral to psychiatric services was required;
- Feedback to other health professionals, including GP, to ensure consistency of care.

FOLLOW-UP – SIX WEEKS OF SUPPORTIVE PHONE CALLS
These phone calls were arranged between Mrs Smith and myself. Themes that emerged included:
- The benefit of continuing positive reinforcement and supportive counselling;
- The importance of open and honest discussion about her feelings and how she was coping;
- The opportunity to identify any remaining practical difficulties that occurred and to implement coping strategies.

REFERENCES


CONCLUSION
Patients and staff found this a worthwhile experience. As nurses we feel that we made a positive difference to the recovery of those involved and have demonstrated the need for psychiatric interventions on an orthopaedic ward. We were pleased at how, despite initial barriers, the care teams supported us and this intervention was integrated easily into the care plans.

We believe it would be benefit patients identified as having low mood to have access to this service. It is clear that identifying mental health issues and implementing treatment has a positive effect on recovery.