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Implementing the Edinburgh Postnatal Depression Scale in the Emergency Department and Family Care Settings

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Executive Summary

Introduction

Postpartum depression (PPD) and postpartum psychosis (PPP) are serious mental health conditions with potentially catastrophic effects. Although both conditions can arise during the postpartum period, they are distinctly different in clinical features, severity, and treatment. PPD can create ongoing depression, anxiety, exhaustion, and overwhelming sadness following birth. At its worst, this condition can lead to self-harm and suicidal behavior. Conversely, PPP is a rarer condition and can cause hallucinations, confusion, delusions, homicidal and suicidal ideations and is considered a psychiatric emergency (CDC, 2022). While treatments are available for both conditions, many of the most vulnerable of these patients are not identified, in part, due to a lack of screening procedures. Departments devoted to caring for women and children, such as pediatric and obstetric departments, are often the only areas offering screening for postpartum depression. Numerous professional organizations recommend universal screening, which will help reach all patients and facilitate changes that need to occur in clinic and emergency department settings (Yeaton-Massey & Herrero, 2019).

This quality improvement project implemented a screening program to identify postpartum patients in the emergency department and family care settings. The project goal was to increase the identification and treatment of patients at risk for postpartum depression and psychosis through the implementation of CERNER (EMR) "hard stops" to prompt providers to screen with the Edinburgh Postnatal Depression Scale (EDPS). When a patient had a positive screening, the provider could assess her, and interventions could be offered to mitigate the negative outcomes often associated with these conditions.

Literature Review

Primary care and emergency department providers are essential in identifying postpartum depression and psychosis. Postpartum depression affects approximately 10% to 20% of mothers and impairs a mother's ability to engage with her child at an emotional and cognitive level, placing the child at greater risk for impaired development (Waldrop, et al., 2018). Russomagno and Waldrop (2019) showed PPD rates of upwards of 60% in the United States in low-income and teen mothers, but this percentage is difficult to validate due to differing reporting metrics, assessment tools, and cultural norms.

Postpartum depression is predominantly tracked through pediatric and obstetric departments, but it could prove helpful if screening occurred in the emergency department (ED) and clinical settings (Yeaton-Massey & Herrero, 2019). Postpartum psychosis is a rare complication of PPD, affecting 1-2 per 1000 women (Friedman et al., 2022). This condition is detrimental to not only the mother but the child as well, as 5% of mothers commit suicide, and 4% commit infanticide (Walsh, 2019).

Although several well-known postpartum screening scales measure depression, the EPDS has been identified as the most frequently validated instrument to screen for perinatal depression (Smith-Nielsen, et al., 2018). Part of the success of this screener is its brevity. Additional factors that make the EPDS suitable for further implementation are its appropriate reading level and the fact that it is the shortest validated screening instrument specifically designed for the postpartum period (Russomagno & Waldrop, 2019). This ten-item questionnaire is available in over 18 languages and takes less than five minutes to administer (Waldrop, et al., 2018). The host hospital currently utilizes this screening model in its obstetric and pediatric settings.

Methods

The project's design encompassed utilizing the EPDS to screen prospective patients for postpartum depressive disorders. A proposal of the project was submitted to the Southern Illinois University Edwardsville institutional review board (IRB) and the host facility's IRB. The project was deemed quality improvement (QI) and thus, not subjected to further IRB approval. The implementation took place over eight weeks, from Sept. 6 – October 20, 2023.

Due to differences in the setups of the EMR's for both facilities, the design method had to differ slightly. In the ED, the IT staff made changes to CERNER, without affecting the EMR in the rest of the hospital. These changes involved putting hard stops on the qualifying question, "Have you been pregnant or delivered a baby in the past year?" Unfortunately, it was impossible to make this change at one clinic without implementing the change and all clinics within the same healthcare organization. As a result, at the clinic level, the RN had to ask this qualifying question without the aid of the CERNER prompt. If the patient was between the ages of 18 to 55, she was asked if she had been pregnant or given birth within the last year.

Once a patient was identified as qualifying, the patient was asked to complete an EPDS. In the ED the patient was asked by the triage nurse, after a prompt presented in the triage note due to the CERNER hard stop. The EPDS score was then calculated by the RN and entered into the EMR. In the clinic, staff asked the qualifying question without the aid of the CERNER prompt and gave the screener to the appropriate patients to complete. In both settings, a score greater than or equal to 10 was deemed positive. If the patient had a positive score, this was communicated both on the EMR in red (in the ED) and verbally by the RN to the provider (in both settings). This allowed the provider to assess the patient, knowing that she had a high likelihood of PPD. If appropriate, the provider could then provide interventions. Education on

the EPDS and how to administer the screening was provided to all ED and family care clinic staff pre-project, with a post-project survey offered at completion.

Evaluation

The evaluation of this project was conducted through a multi-step process. One of the DNP project team members employed by the hospital had access to patient data. De-identified patient data was accessed only by members of the project team. The patient data examined included the (1) date of service; (2) age of the patient; (3) if the EPDS screening tool was given; (4) the patient's EPDS score; and (5) interventions. All HIPAA guidelines were followed throughout the duration of the project. The information was analyzed using descriptive data, utilizing Excel, including the percentage of females between 18-55 and those who had given birth in the last year. Those deemed *postpartum* or “at-risk” were given the EPDS. Those patients receiving a positive score were given educational material, referred, or given counseling, prescribed medication, or, in one case, hospitalized for psychiatric care.

Table 1

Interventions

	Positive Score on EPDS ≥ 10	Prescribed Meds	Counseled or Referral	Not Counseled or Referred	Hospitalized	Not Hospitalized
ED	2	1 (50%)	1 (50%)	1 (50 %)	1 (50%)	50 %
Clinic	1	1 (100%)	0	1(100%)	0	1 (100%)

The total number of ED patients seen over the eight weeks was 10,337, with 2866 women (27.8%) fitting the age criteria of 18-55. Approximately 1% (n=30) of these female patients

qualified based on postpartum status, and 33% (n=10) received the EPDS screening form. Of the patients receiving the EPDS screener, 20% (n=2) patients had positive scores indicating PPD, with 10% (n=1) receiving medication, counseling, and hospitalization interventions for suicidal ideations (See Table 1). The total number of family care patients during the 8 weeks could not be obtained, which limited the ability to calculate these same statistics for this facility. Two patients qualified for the EPDS screening at the clinic, with 50% (n=1) having a positive score of ≥ 10 and receiving intervention (See Table 1).

A follow-up survey was completed by staff to gauge the usefulness of the screening method in their respective departments. The survey yielded 16 results from the emergency department and three responses from the family care clinic, showing overwhelming support for the project. Staff were asked how important it is to screen PPD and PPP in the ED and FC settings, with 67% of the ED staff and 100% of the FC staff deeming it very important. Barriers to completing the EPDS screening were 56.25% and 33.33%, respectively, for the ED and clinic due to lack of time/too much charting. A majority of staff, 62.5% for the ED and 100% for the FC clinic, reveal that they or someone they cared about have been affected by PPD/PPP. An overwhelming majority of both facilities, 87.5% for the ED and 100% for the FC clinic, felt that screening for these conditions positively impacts patient care/outcomes.

Limitations

Incorporating the Edinburgh Postnatal Depression Screening into patient care for these facilities does increase the workload for the nursing staff and the providers. Staff identified two of the most significant barriers to completing this screener: lack of time and current charting exceeding time available. Methods to decrease this barrier include examining charting requirements to eliminate charting redundancies and examining the nurse-to-patient ratio.

While the impact of a life improved or saved cannot be quantified in numbers, the small sample sizes indicate that 50% of the ED patients and 100% of the FCC patients with positive scores received help regarding medication, counseling, hospitalization, and follow-up. However, to fully demonstrate whether this intervention produces statistically significant outcomes, nurse compliance is necessary with completing the EPDS screening process on all patients who qualify in the emergency department, and a larger sample size is needed in the family care setting.

Impact

Implementing postpartum depression and psychosis screening programs in the emergency department and family care clinic settings could potentially have positive, life-altering benefits for patients through the detection and treatment of these disorders. While limitations existed in this study due to barriers of time and technology variations, the IT department verified that, if the host facility approves, the project could be permanently implemented entirely with CERNER at the family care clinics if all facilities are involved. This could positively affect the number of at-risk patients identified as it would automatically flag the nurse to ask the screening question. In identifying patients at risk for these serious disorders, interventions can be offered before there are negative outcomes. The host site will hear the findings of the project in April and will then determine the usefulness of implementing the EPDS screening tool at all of its family care clinics and the emergency department permanently.

Conclusion

Both groups of patients seen at the emergency department and the family care clinic settings yielded documented positive results in terms of offering interventions to patients who were suffering from postnatal mental health disorders. Implementing the Edinburgh Postnatal Depression Screening tool universally can be a valuable method to identify the most at-risk

patients. With prompt identification, providers can offer interventions and help when clinically necessary to mitigate the adverse outcomes associated with both postpartum depression and postpartum psychosis.

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