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Implementation of the Edinburgh Postnatal Depression Scale in a Midwest Primary Care Clinic

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Executive Summary

Introduction

Postpartum depression (PPD) is defined as a mood disorder that causes physical, emotional, and behavioral changes experienced by women after giving birth to a child.

According to the World Health Organization (2019), the prevalence of postpartum depression is about 10% worldwide in pregnant women and 13% in women after giving childbirth. One of the greatest barriers to postpartum depression recognition and treatment is lack of continuous follow up screening by healthcare providers in the postpartum period (Bass & Bauer, 2016). Postpartum depression often occurs around the first few weeks of a child being born, but symptoms can progress for up to a year (National Institute of Mental Health, 2018). It is important to increase the frequency of postpartum depression screenings to be able to recognize and treat the many patients that potentially go undiagnosed in the months after their child is born. The American Academy of Pediatrics recommends integrating postpartum depression screening at the 1-, 2-, 4-, and 6-month well-child visits (2019). While the literature strongly supports the screening of postpartum patients, many facilities including the Midwestern facility where this project is based, do not have the appropriate protocols in place.

Literature Review

The purpose of this literature review was to discuss postpartum depression, identify the barriers to treatment, and then use that data to implement interventions to improve this problem. After reviewing the literature, it has been learned that one of the biggest barriers on the provider's end is the lack of routine and follow up screenings for postpartum depression. The most widely utilized screening mechanism for PPD is the Edinburg Postnatal Depression Scale

(EPDS). According to Shrestha, Pradhan, Tran, Gualano, & Fisher (2016), the EDPS, originally developed in the United Kingdom, had excellent reliability and validity. A study completed in the United Kingdom portrayed that this screening tool had an 86% sensitivity to correctly identifying true cases, 78 % specificity to correctly identifying patients with this illness, and 73 % positive predictive value (Shrestha et. al., 2016). Currently, this scale is being used in OBGYN clinics, pediatric care clinics, and some primary care clinics. Most women are often screened initially after the baby is born, but many clinics fail to screen several weeks following. In 2016, a group of researchers developed a study that encouraged the U.S. Task Force to implement a postpartum screening protocol for pregnant and postpartum women in the primary care setting (Connor, Rossom, Henninger, Groom, & Burda, 2016). Their clinical trial results portrayed that primary care clinics that routinely screened pregnant and postpartum women for depression were able to increase their ability to recognize and treat accordingly for individuals diagnosed (Connor, Rossom, Henninger, Groom, & Burda, 2016).

Project methods

The main purpose of this project was to increase early identification of women with postpartum depression (PPD) at a specific Midwestern primary care clinic. This was completed by increasing the frequency of the Edinburgh Postpartum Depression Scale (EPDS) and evaluating the adherence of the recommended protocol. A nurse practitioner and her nursing staff received education on the clinical relevance of postpartum depression, applicable guidelines of the Edinburg Postpartum Depression Scale, and the importance of routine postpartum depression screening at all well-child visits under 12 months old. After the 6-8 week implementation period of routine screening, data was collected and evaluated from the electronic health record report on well child visits. In addition to examining data on the screening tool usage, there was also short

open-ended interview with the participating provider at the end of the implementation period to assess the satisfaction with implementing the screening tool, the perceived barriers of not implementing the tool, and the receptivity to implementing this screening protocol in the future.

Evaluation

This project was completed in a pilot study format with a nurse practitioner and her office staff to set as a positive example going forward for the entire clinic. The nurse practitioner, nursing staff, and office staff were given an oral presentation that included the clinical relevance of postpartum depression, the clinical validity of the Edinburg Postpartum Depression screening tool, and the recommendation of evidence based practice guidelines for routine postpartum screening. Prior to the routine implementation of the Edinburg Post-Partum Depression Screening tool, relative data was collected by chart review method. Over an 8 week period (July 1st-September 1st), there were 28 eligible well-child checks for patients under 12 months old. Out of these 28 well child visits, there was a 0% completion rate of Edinburg screenings. After the educational intervention to the appropriate staff along with bi-weekly check ins, the implementation of screening tool rates increased significantly. During, the 8 week period of implementation (Sept 20th-November 20th) there were 32 well-child visits under the age of 12 months. Of these 32 well-child visits, five did not show up for their appointment and four children were with foster care parents. This left an eligible 23 well-child visits appropriate for routine postpartum depression screening for the mothers. There were thirteen (56.5%) completed screenings out of the 23 eligible candidates. There were 7 missed opportunities (30.5%) by the staff to implement screenings and three incomplete screenings (13%) by the mothers. Of the thirteen completed screenings, two (15.4%) of the screenings were positive for postpartum depression. The patients that tested positive for postpartum depression were offered immediate

counseling and then promptly referred to additional support and recommended services the same day.

Open-ended discussion with the nurse practitioner and one of the office staff members was completed after implementation. Overall, the implementation period was very successful considering the increase of routine screening went from 0% just 2 months prior to 56.5% afterwards. This increased in screening led to the identification of postpartum depression, which most likely would have been missed without the intervention. Recognition of postpartum depression greatly impacted the quality of patient care by early diagnosis and treatment. This itself led to provider satisfaction with the recommended protocol of routine Edinburg screening.

The barriers to screening included lack of time, busyness of clinic, and quick turnover of staff. The turnover of staff seemed to create the majority of limitation. Many employees of the office and nursing staff are shuffled around between several providers, which leads to an inconsistency in workflow. However, the inconsistency of office staff also allowed the nurse practitioner to recognize when a screening tool wasn't given to a patient by supporting staff, which then increased her habit of administering the screening tool herself.

Impact on Practice

This project was clinically relevant in early identification of postpartum depression due to appropriate screening recommendations. Before this project was implemented, providers in this primary care clinic were only screening mothers on an as needed basis. The impact of increased screening led to two mothers receiving intervention for post-partum depression. These results increased the awareness of implementing the screening tool on a mandatory, regular basis for every mother at well-child check under 12 months old. Going forward this provider in the pilot study is continuing to implement the routine protocol of screening mothers at every well-child

visit under the age of 12 months due to the impact of our findings. While it is a slow process to implement this as mandatory protocol for all the rest of the clinic's staff members and providers, this was most certainly a step in the right direction. A few additional providers individually adopted the protocol after reviewing the positive progress of this project. This pilot study set a high standard and example for the clinic going forward to improve practice.

Conclusion

The implementation of this protocol shows promise for the future of this clinic, but still needs to be refined. The literature review and clinical guidelines reveal the importance of screening and the impact that they have on the quality of patient care. This project was successful at supporting this. Not utilizing the recommended routine screening can lead to a missed opportunity of identifying postpartum depression and getting the patient the help they may need. As evidence by the literature and supporting project results, routine screening proves to be one of the most effective interventions for early identification of postpartum depression.