Type					
☐	Emanate Health- ALL	☐	Emanate Health Home Care	☐	Emanate Health Pediatrics
☐	Emanate Health Medical Center	☐	Emanate Health Hospice	☐	Emanate Health Orthopedics
☐	Emanate Health– ICH	☐	Emanate Health Foundation	☐	Emanate Health Medical Group
☒	Emanate Health-QVH	☐	Emanate Health-CVMI	☐	Department
☐	Emanate Health-FPH	☐	Emanate Health Sports Medicine & Rehabilitation	☒	Policy
☐	Emanate Health Imaging	☐	Emanate Health Glendora Surgery Center	☒	Procedure
☐	Emanate Health MSO	☐	Emanate Health Family Practice	☒	Attachment(s)

Title: EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS) SCREENING		Policy #: #: E-105 LDR/MBCU
Type: LDR, , MBCU		
Effective: 11/1/2018	Revised: 11/20	Reviewed:
Approved by: Director, LDR		Date:
Approved by: Director, MBCU		Date:
Approved by: Director, Perinatal		Date:
Approved by Board of Directors:		Date:

Scope of Responsibility

Registered Nurse (RN)

Statement of Policy

All postpartum patients will be screened for possible symptoms of perinatal depression using the EPDS.

Interventions based on the EPDS score will be implemented.

Declarations

Perinatal depression includes major and minor depressive episodes which occur during pregnancy or in the first 12 months after delivery. Perinatal depression is one of the most common medical complications during pregnancy and postpartum affecting as many as one in seven women.

Risk Factors for Postpartum Depression

- Previous history of depression
- Depression during pregnancy
- Anxiety during pregnancy
- Traumatic birth
- Stressful life events during pregnancy or in the early postpartum period
- Preterm birth/infant admission to neonatal intensive care
- Breastfeeding problems
- Low levels of social support

Procedure

1. All postpartum patients will be screened using the EPDS prior to discharge, ideally at least 12 hours following delivery (See Appendix A).

2. The EPDS is not a diagnostic tool; rather it is a screening tool that aims to identify women who may benefit from follow-up care, such as mental health assessment.

3. The EPDS is a 10-item questionnaire validated for screening for perinatal depression and anxiety. Questions are answered in terms of the past 7 days.

4. Questions 3, 4 and 5 relate to possible symptoms of anxiety disorders, while question 10 may indicate risk of harm to self or others.

5. It is recommended that women are screened at least once during the perinatal period and again 6-12 weeks after the birth during the postpartum care provider visit.

6. Clinical judgment is integral to interpretation of EPDS scores. Scores may be influenced by several factors:

    a. Patient's understanding of the language used
    b. Any fear of consequences if depression is identified
    c. Differences in emotional reserve
    d. Perceived degree of stigma associated with depression

7. A total score of 13 or more is considered a flag for the need for follow-up of possible depressive symptoms.

8. Any score >0 on question 10 requires immediate intervention. Screen for suicide risk per hospital policy – Suicidality Screening, NPSG# 15 and follow appropriate interventions.

9. All postpartum patients regardless of the EPDS score will be given verbal and written education on perinatal depression.

Use the chart below for interventions based on the EPDS scoring.

Total Score	Interventions
EPDS Score <10	Normal/Negative Screen - likely not suffering at this time • Provide verbal and written education about risks/incidence • Use clinical judgment regardless of EPDS score
EPDS Score 10-12	At Risk for Depression and/or Anxiety • Discuss results and provide education • Social work referral • Notify OB Provider
EPDS Score >13	Positive Screen – likely suffering from depression and/or anxiety • Discuss results and provide education • Social work referral • Notify OB Provider
>0 on Question #10	Maternal Crisis – At risk of harm to self or others • Screen for suicide risk using the Columbia Suicide Severity Rating Scale and follow interventions accordingly • Notify OB provider immediately • Social work referral

<u>Documentation</u>

1. The RN will complete the EPDS screen in the EMR and document any interventions in nursing notes.
2. The RN will document education on the teaching record and will document that written material was provided to the patient.

a. Written patient resources include the “Speak Up When You’re Down” brochure and available with discharge instructions, search for Postpartum Depression/Blues, Suicide, Resources, Counseling.

References

American College of Obstetricians and Gynecologists (2018). Perinatal depression. ACOG Committee opinion No. 757. Obstetrics & Gynecology, 132, 208-212

Centre of Perinatal Experience (2020). Using the EPDS as a screening tool. Retrieved from https://www.cope.org.au/health-professionals/health-professionals-3/calculating-score-epds/

Cox, J.L., Holden, J.M., & Sagovsky, R. (1987). Edinburgh postnatal depression scale (EPDS). British Journal of Psychiatry, 150, 782-786.

Viguera, A. (2020). Postpartum unipolar major depression: Epidemiology, clinical features, assessment and diagnosis. Retrieved from Up to Date

Cross Reference
Hospital Policy, Suicidality Screening, NPSG #15.

Appendix A

The EPDS is a 10-item questionnaire. Women are asked to answer each question in terms of the past seven days.	
1. I have been able to laugh and see the funny side of things	**As much as I always could** (score of 0) **Not quite so much now** (score of 1) **Definitely not so much now** (score of 2) **Not at all** (score of 3)
2. I have looked forward with enjoyment to things	**As much as I ever did** (score of 0) **Rather less than I used to** (score of 1) **Definitely less than I used to** (score of 2) **Hardly at all** (score of 3)
3. I have blamed myself unnecessarily when things went wrong	**Yes, most of the time** (score of 3) **Yes, some of the time** (score of 2) **Not very often** (score of 1) **No, never** (score of 0)
4. I have been anxious or worried for no good reason	**No, not at all** (score of 0) **Hardly ever** (score of 1) **Yes, sometimes** (score of 2) **Yes, very often** (score of 3)
5. I have felt scared or panicky for no very good reason	**Yes, quite a lot** (score of 3) **Yes, sometimes** (score of 2) **No, not much** (score of 1) **No, not at all** (score of 0)
6. Things have been getting on top of me	**Yes, most of the time I haven't been able to cope at all** (score of 3) **Yes, sometimes I haven't been coping as well as usual** (score of 2) **No, most of the time I have coped quite well** (score of 1) **No, I have been coping as well as ever** (score of 0)
7. I have been so unhappy that I have had difficulty sleeping	**Yes, most of the time** (score of 3) **Yes, sometimes** (score of 2) **Not very often** (score of 1) **No, not at all** (score of 0)
8. I have felt sad or miserable	**Yes, most of the time** (score of 3) **Yes, quite often** (score of 2) **Not very often** (score of 1) **No, not at all** (score of 0)
9. I have been so unhappy that I have been crying	**Yes, most of the time** (score of 3) **Yes, quite often** (score of 2) **Only occasionally** (score of 1) **No, never** (score of 0)
10. The thought of harming myself has occurred to me	**Yes, quite often** (score of 3) **Sometimes** (score of 2) **Hardly ever** (score of 1) **Never** (score of 0)

Source: Edinburgh Postnatal* Depression Scale (EPDS Cox et al 1987).
(*Developed as the Edinburgh Postnatal Depression Scale but can be used in both pregnancy and postnatal period to assess for possible depression and anxiety. Questions 3, 4 and 5 relate to possible symptoms of anxiety disorders)