

## 2017 AAG Conference – Poster Presentations: Abstracts

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## Qualitative evaluation of pole walking exercise using monitoring camera images

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**Purpose:** Pole walking, a fitness exercise using two poles, was designed in Japan for rehabilitating clients with gait disturbance. It is known to effectively improve ambulation activity in comparison with simple walking among older adults. Gait parameters have been utilized for daily living activity-related evaluation and extension of healthy life expectancy. Recent studies have reported that using the gait analyzed through recorded images of walking motion as feedback to learners is applicable to the analysis and evaluation of various motions, and therefore, has been requested in various fields. However, the learner's stress of being present across the recording device may cause different movement in comparison with usual movement. Therefore, in a nursing home for older adults, we attempted a qualitative evaluation of pole walking by using images from a monitoring camera with an intelligence function, which is a person perception recording system. Unlike shooting with hand-held cameras, monitoring cameras can reduce the stress of learners who are being recorded. We attempted a qualitative evaluation of the potentiality of pole walking movement using a monitoring camera without stressing the learner.

**Methods:** A scale of mood states, body composition, muscular strength, timed up and go test (TUG), and gait speed; step length; cadence; and walking ratio were measured pre- and post-pole walking exercise as quantitative evaluation. Gait speed, step length, cadence, walking ratio, and postures of walking/standing were measured with a monitoring camera as qualitative evaluation.

**Results:** The pole walking exercise indicated quantitative improvement in the scale of mood states, body composition, muscular strength, TUG, gait speed, cadence, and walking ratio ( $p < 0.05$ ). Moreover, abnormal gait could be observed through monitoring camera images. Our results indicated that the qualitative evaluation of movement using a monitoring camera could be utilized for medical care and health promotion based on the walk coaching in older adults.

## Dementia: To tell or not to tell?

**Author/s:** Dr Angela Crombie, Bendigo Health, Victoria, Australia

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**Abstract:** GP attitude toward dementia diagnosis and management plays a large part in its early detection, diagnosis and management. The increasing prevalence of dementia in coming years in Australia will be felt most keenly in rural communities where there are already shortages of GPs and dementia-specific services to manage growing demand. Evidence suggests that dementia is often not diagnosed by GPs and that this is a global issue. There are many barriers to the diagnosis of dementia and its disclosure in general practice, including time constraints, diagnostic uncertainty, denial of symptoms by patients and families, and stigma. This presentation will examine these barriers and their impact on making and disclosing a dementia diagnosis from a rural general practice perspective. Identification of these practice issues and their influence on service delivery is essential to inform relevant policy decisions and to improve dementia management in rural general practice.

## Refurbishing Residential Aged Care Facilities - Where do we start?

Author/s: Ms Samantha Neylon, The University of Notre Dame, Western Australia

**Abstract:** Funding limitations and changing consumer expectations heralds a new era for residential aged care requiring facilities to be responsive to consumer choice. As new builds may not always be possible due primarily to costs, this study examines the evidence base on refurbishment of existing structures with the focus of minimising age-related impairments.

A review of the current literature identified minor refurbishment themes of lighting, noise/sound, wayfinding, furniture, flooring, colour/contrast and signage. Ten environment assessment tools were systematically reviewed and examined for applicability. Three tools addressed all seven themes with an additional tool proposed by one of the authors for consideration.

Further research is required to improve the rigour of these tools which can then be considered as a first step in assessing aged care facilities for refurbishment projects in a uniform and consistent manner. This will ensure the facility improvements are evidence based and support the functional abilities of the people who reside there

## Cortical automatic threshold estimation and dementia: An alternative hearing test

**Author/s:** Ms Anthea Bott , School of Health and Rehabilitation Sciences, The University of Queensland, Queensland, Australia & The HEARing CRC

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**Abstract:** Untreated hearing loss and dementia both adversely impact communication. Improvements to communication via audiological rehabilitation may lessen the disability experienced by the individual. Prior to the recommendation of audiological rehabilitation an accurate assessment of hearing status must be obtained. However, 32% of individuals with dementia living in aged care homes are unable to complete the traditional behavioural hearing test, pure-tone audiometry (PTA), calling for a need to explore the feasibility of alternative objective non-behavioural hearing tests. The cortical auditory evoked potential (CAEP), an electrical response from the auditory cortex, is one non-behavioural alternative electrophysiological diagnostic test that has been used to determine hearing thresholds and measure the output of hearing aids in infant and adult populations. CAEPs have been widely shown to be a suitable tool to diagnose hearing loss, especially in adults. Cortical Automatic Threshold Estimation (CATE) is an automated implementation of hearing threshold estimation using CAEPs in the form of a clinically usable computer program. It allows completely automated threshold estimation (4 frequencies, both ears) in adults with a hearing loss in less than 35 minutes with an  $r^2 \geq 0.8$ , and with specificities and sensitivities  $>95\%$ . This study aimed to explore the feasibility of CATE as an alternative hearing assessment to PTA in individuals with a dementia diagnosis who live in an aged care home. Data collection will commence in May 2017 across aged care homes in Queensland. Descriptive and summary statistics will report the mean and standard deviation of audiometric data. A paired t-test will compare mean thresholds at each frequency for each ear recorded using PTA and CATE and significance will be set at  $p < .05$ . Where assumptions have been satisfied, linear regression analysis will be used to examine the relationship between dementia severity and the ability to perform either hearing test.

## Daily activity patterns are associated with cognition in older adults

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**Abstract:** In the absence of effective treatment for dementia, health interventions have shifted towards reducing dementia risk by modifying lifestyle risk factors. One factor that has gained a lot of attention is engagement in physical activity (PA). Regular PA may reduce cognitive impairment and dementia risk in old age. Additionally, engaging in long periods of sedentary behaviour (sitting, lying awake) may negate the positive effects of PA on brain health. What is needed is a comprehensive understanding of activity patterns (PA, sedentary behaviour and sleep) on indices of brain health. The purpose of this study was to use sensitive cognitive assessments (assessed with the Addenbrooke's Cognitive Exam (ACE-III) and novel analytical approaches (called compositional data analyses) to characterise the relationships between daily activity patterns and cognitive performance in older adults. As a part of a larger study, 7-days of objectively measured 24 h activity data were captured using GENEActiv wrist-worn tri-axial accelerometers in 72 adults (range 50-80 years, mean age  $65.5 \pm 7.52$ , 52 females). Using 60-s epochs, average daily time spent in sleep, sedentary behaviour, light PA and moderate to vigorous PA was calculated using pre-defined cut-points using custom software (COBRA, UniSA). To investigate the relationship between daily activity patterns and cognition, daily time spent in different activities (i.e. the activity composition) was expressed as isometric log ratios and regressed against ACE-III score. When adjusted for age and sex, activity composition significantly predicted ACE-III score ( $P=0.03$ ). Individuals with the best cognitive performance spent >30% of their day engaged in light, moderate and vigorous PA. Findings from this study provide evidence of activity patterns for optimal cognitive performance in older adults and may provide the foundations for the development of PA guidelines, specifically focussed on brain health for older adults.

## Examining elder abuse using a socio-ecological lens: developing targeted interventions

**Author/s:** Dr Barbara Blundell, School of Occupational Therapy & Social Work, Curtin University, Western Australia, Australia

**Abstract:** Elder abuse affects people from all walks of life, including people with dementia, those living in residential care, and those with good decision-making capacity living in their own homes, with an average prevalence of 14.3% of the older population. There are many different risk factors for elder abuse, and some of these also vary by type of abuse. Risk factors for people experiencing elder abuse include being 75 years old or older, having a physical or mental disability, and coming from an Aboriginal or Torres Strait Islander background or culturally or linguistically diverse community. Also, women generally are at higher risk of abuse than men. Past lifetime abuse may also be a risk factor for future abuse, and people who have experienced abuse as children have been reported to have increased vulnerability to further intra-familial and extra-familial abuse later in life.

Socio-ecological models and systems theory are often applied in social work as useful frameworks for the analysis and understanding of complex social issues. It is suggested that responses and interventions to elder abuse utilise a socio-ecological framework that takes into account the complex characteristics of victims, perpetrators, the relationship between the two, as well as contextual factors of family, living arrangements and community and societal influences. It is acknowledged that elder abuse is a complex phenomenon, with Australian responses to it somewhat fragmented and under-developed. Applying this perspective to elder abuse is useful in allowing examination of factors related to individual older people experiencing abuse and mistreatment and perpetrators of abuse within context of the relationship, family, community and society.

## The Support Loop: Supporting older people through improved communication systems

**Author/s:** Ms Carolyn Bolton, Hume Whittlesea Primary Care Partnership, Victoria, Australia

**Abstract:** The provision of services for older people in their homes is a core component of community aged care. These essential services provide the support needed to enable people to remain active and independent in their own homes for longer periods. Assessment, care and support planning and review for older people is undertaken by an Assessment Officer. Planned review is typically conducted on an annual basis, although a review may be triggered at any time by a change in a person's circumstances, health or capacity. The role of the Community Support Worker is to support the person by undertaking tasks and activities designated in the care/support plan. The relationship which develops between the Community Support Worker and the older person through regular and routine contact provides a unique opportunity to monitor a person's progress towards support plan goals as well as changes in their physical, emotional and mental health and well being. Opportunities and methods for the Community Support Worker to report progress, feedback, observations or concerns, in a timely manner, through supervision or other processes varies considerably across organisations.

The concept of a support loop was developed within the former Victorian Home and Community Care system. Led by the Hume Whittlesea Primary Care Partnership and supported by the statewide Active Service Model Industry Consultant group, over 30 funded providers contributed their knowledge and experiences, ideas and enthusiasm to a project designed to create a communication system that acknowledges the important role of the Community Support Workers in supporting older people through improved monitoring and feedback systems.

This communication system, which includes ideas and approaches for implementation is called The Support Loop. The Support Loop resource available for download <http://www.hwpcp.org.au/wp-content/uploads/2016/06/The-Support-Loop-Resource-1.pdf>

## Food first addresses malnutrition to provide multifactorial benefits in residential-aged-care

**Author/s:** Mrs Cathy Thesing, Leading Nutrition Pty Ltd, Victoria, Australia

**Abstract:** Nutrition and hydration for residents is crucial for good quality of life and optimal health. It is well recognized that the risk of malnutrition in residential aged care ranges between 40-60%. (ref 1)  
Dietitians can play an important role in reducing supplement use and promoting food first. Supplements are expensive and often poorly tolerated by residents. They are used frequently and wastage is high. A Food first approach and focussing on minimising and streamlining supplements has great benefits to improve resident's appetite and therefore quality of life as well as reduce supplement use and associated cost. Once established the benefits are manifold:

- Reduced cost for supplements with a streamlined effective system (up to \$30 000 pa)
- Educated, empowered site staff provide home made foods and fluids to enhance nutrition via food first
- Improved appetite for residents with associated improved meal consumption and social interaction at meals-> improved QOL
- An established functional system that needs review but not reinvention
- More stable body weights of residents (weight loss reduced from 40% to 20% in the first 12 months then to 15% over 5 years)
- Cost and clinical intervention hours for dietitian consultation reduced-> ability to focus on quality improvement activities

This process to get there involves:

- Functional communication systems between food service staff, personal care attendants, facility manager and clinical staff
- Deliberate focus on food, reducing supplement use and cost savings with goals reviewed monthly
- Monthly Nutrition and Hydration meetings attended by clinical rep, food service rep, dietitian and facility manager
- Nominated "nutrition assistant" to support the visiting dietitian
- Nutrition Education as needed for all staff
- Annual menu review

Reference: Australian Wound management and New Zealand wound care Society. Australian and New Zealand Clinical Practice guideline for the prevention and management of venous leg ulcers. 2011 (accessed feb 13th at: [http://www.awma.com.au/publications/2011\\_awma\\_vlug](http://www.awma.com.au/publications/2011_awma_vlug))

Dance isn't therapy. That's why it works.

**Author/s:** Mrs Cherie Toubia, D is for Dance, South Australia, & Dance! WITH Parkinson's/Contemporary Dance for Seniors, Black Forest, South Australia

**Abstract:** Practical and/or theoretical implications of this presentation: The presentation synthesises research supporting dance for people with a range of ageing-related brain changes. It challenges clinicians to capture the full therapeutic benefit of dance when designing interventions with clients, whilst preserving its essential non-medical aesthetic.

Dance as a mode of therapeutic intervention is gaining traction across the world among allied health professionals, but particularly in the wellness service stream in community and residential aged care contexts. There has traditionally been delineation between the use of dance in therapeutic and leisure contexts, whereby the former seeks to achieve symptom reduction and prevention and the latter targets social-emotional needs. This delineation does not harness the full potential of dance that is demonstrated in the literature, particularly where individuals are living with progressive conditions such as Parkinson's disease and dementia. The presentation reflects on the growing body of evidence supporting dance as an effective intervention for people living with changes in their brain that have cognitive, psychological, physical and social implications. Specifically, this presentation considers:

- Core components of dance that determine its effectiveness
- Validity of a non-medical intervention toward treatment goals
- Pathways for multidisciplinary collaboration, including between community based and clinic based dance services and across disease progression

## Aged care reform at high speed: what time for reflection?

**Author/s:** Dr Debbie Faulkner, The University of Adelaide, Centre for Housing, Urban and Regional Planning (CHURP), South Australia, Australia & Anglicare SA: Resthaven SA: ACH Group: Uniting Care Wesley Port Adelaide: COTA Australia: Care Connect

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**Abstract:** In light of the ongoing aged care reforms, this study set out to investigate consumer attitudes to, and experiences of, the aged care system – specifically as relates to in-home care. The study involved three strands of investigation: the knowledge and understanding of the aged care reforms of people aged 50 years and over who are not currently engaged with the aged care system; older people who transitioned from the previous in-home care package model to a CDC model; and people who have only received aged care under the new CDC model, i.e. since 1st July 2015.

Findings from the study indicate that there is much confusion and uncertainty in the community, and highlights the difficulties people confront in accessing and understanding a complex system such as aged care. Even those people who were already in the system have found navigating the system troublesome since the reforms.

While all new systems and models need time to develop and 'fit' with what is required, this study suggests the aged care reforms have progressed too quickly. There has been little time for ongoing review, reflection and potential revision to allow service providers and users to feel confident and at ease with the changes.

## Leading the way: Metropolitan Palliative Care Cosultancy Service

**Author/s:** Mr Ed Gaudoin, Metropolitan Palliative Care Consultancy Service, Bethesda Health Care, Western Australia, Australia

**Abstract:** Palliative Ambulatory Service North & South Metropolitan Palliative Care Service combined in 2015 to form the Metropolitan Palliative Care Consultancy Service (MPaCCS). This presented an invaluable opportunity to revise and renew the team's focus and services.

The team consists of medical consultants, senior nurses and social workers who facilitate the transition of palliative patients between health care providers.

A renewed focus on residential aged care facilities was identified. A core service for the team is capacity building within facilities. Working with the Palliative Care Network, Palliative and Supportive Care Education (PaSCE) arm of Cancer Council & Program of Experience in the Palliative Approach (PEPA) a concerted effort has been made to lay the foundations of Palliative Care from ground level to head offices. Introduction of Link teams, bedside learning and bereavement reviews has allowed for greater job satisfaction for staff and ultimately best outcomes for residents and their families.

Feedback shows it to be a valuable service for the community due the ability to be flexible and responsive to the aged care facility palliative care needs. MPaCCS will continue to be reviewed and evaluated against various outcomes including the cost effectiveness of advanced care planning to help reduce avoidable hospital & emergency admissions. Continuing evaluation on the up skilling, competence and confidence of staff within facilities after training and mentoring was also captured.

MPaCCS is currently being reviewed by the Cancer Palliative Care Research Evaluation unit at UWA (CaPCREU)

## ‘Not a priority’ post hospitalisation falls intervention

**Author/s:** Ms Emma Renehan, Royal District Nursing Service Institute, Victoria, Australia

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**Abstract:** There is limited evidence for interventions targeting older adults on return to the community post hospitalisation for a fall. Over the past two decades, less than 10 studies have evaluated community-based interventions for this high-risk falls group. Currently there is no evidence for the physical or psychosocial effects of multi-factorial interventions implemented in this high-risk falls group. Additionally, of the limited studies conducted, the majority were evaluated in an experimental setting and not as a part of existing community health care services.

The objectives of this pilot study were to determine: whether a multi-factorial intervention (home based balance and strength training, targeted medication review, ongoing education) could be integrated and implemented within an existing community home nursing organisation; and, if the intervention had any effect on quality of life or falls related outcomes. This pilot study utilised a parallel pragmatic randomised controlled trial design with equal numbers randomised to each group. Semi-structured interviews were included to explore participant’s experiences. Findings revealed that a multi-factorial intervention could be implemented within an existing community home nursing organisation, however the study refusal rate was high with only 13 people were randomised. Participants in this study were a complex cohort with high degrees of multi-morbidities, polypharmacy and frailty. Overall, quality of life for the cohort was rated as lower than age related norms across the study period. The control group showed a significant improvement in quality of life scores at 6-months with social restraints indicated more strongly in the intervention group. Falls prevention messages were primarily met with indifference and no significant differences were found in any of the falls related outcomes. This presentation will discuss recommendations for this high-falls risk cohort particularly focusing on implementation in real-life settings, falls prevention messages and quality of life.

## The impact of commercialisation on quality-care-delivery in aged residential care

**Author/s:** Mrs Esther Ngocha-Chaderopa, Business Management, Toi Ohomai Institute of Technology, New Zealand

**Abstract:** This study examined the extent to which the commercialised operating environment Aged Care provider institutions aided or hindered delivery of ideal quality care. The aim was to explore care workers' perceptions of the rhetoric and practice of patient centred care in a commercialised service delivery environment in New Zealand. Quality has come to be recognized as a strategic tool for attaining operational efficiency and improved business performance. However, the commercialised operating environment brings tension to the delivery of this idealised model of quality care. Most of these facilities are privately owned and for them to remain in operation they need to make a profit. This for profit goal is not always supportive of the delivery of quality care as defined by the residents and care workers.

Twenty eight care workers were interviewed and thematic analyses was used to analyse the data. The study found out that there was pressure for these facilities to make profit by turning managers from being people oriented to task oriented. Care workers noted that managers perceived those who finished the given tasks on time as hard workers and tended to be allocated more shifts than those who spent more time with residents. This task oriented approach to the execution of care duties undermined the ability of care workers to spend more time with the residents. Care workers also revealed that the most managers held on to residents instead of transferring them to higher care levels and this made it harder to give these residents the ideal care due to less time, training, staff on duty and skills available for their care level.

## Making choices, finding solutions through assistive equipment and home modifications

**Author/s:** Ms Francine Snadden, Independent Living Centre of WA, Western Australia, Australia

**Co-author/s:** Ellen Bragger, Independent Living Centre of WA, Western Australia, Australia; Francine Snadden, Independent Living Centre of WA, Western Australia, Australia

**Abstract:** "Everything we do really has something to do with aids, assistive equipment. The ordinary things that we use all the time become part of our lives and it is very awkward without them" Hal and Freda (97yrs)  
This guide has been developed to assist people to find simple assistive technology, equipment and basic home modification solutions available in local stores and online. It contains a range of useful tips and advice to help individuals better manage everyday tasks and common frustrations.

The Independent Living Centre of WA and provides information, advice, assessment, training, funding and hire services that enable Western Australians of all ages and abilities to live more independent and fulfilling lives. The ILC's experienced health professionals have been providing Western Australians with information and advice about assistive equipment options for over 35 years.

Previous research carried out by the ILC with Deakin University identified a number of barriers for people who are aging from finding and using assistive equipment solutions. Specifically the research showed a willingness for people to find their own solutions and a gap in tools to assist this process. This guide is underpinned by extensive clinical expertise and experience in reablement. It focusses on simple assistive equipment and common every day solutions often found in local pharmacies, supermarkets and hardware stores.

The guide also provides education and indications on when it would be beneficial to seek further assistance. This includes resources such as the National Equipment Database of which the ILC is the lead agency for Australia. Also a free App developed by the ILC with assistive technology users called Equip Myself. Potential end users have been positioned at the forefront of this guide to create an easily accessible and practical guide that supports people who are ageing to be well and independent.

## Models of dental care in aged care facilities in NSW

**Author/s:** Mr Garry Law, Centre for Education and Research on Ageing, Concord Repatriation General Hospital, New South Wales, Australia

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**Abstract:** Introduction: Frail older people living in residential aged care facilities have limited access to on-site oral health care. The aim of this study was to identify the number of NSW dentists and dental prosthetists currently providing oral health care services to clients in residential aged care facilities in NSW and to identify the perceived barriers that practitioners have to providing this care. These barriers will be evaluated against current models of oral health care in NSW and in particular the Inner West Oral Health Outreach Program that operates out of Concord Hospital, Sydney.

**Methods:** Dentists (approx. n=4 000) and Prosthetists (approx. n=400) who are members of their respective NSW Associations were invited to participate in a survey to ascertain the type and frequency of oral health care they provide to their clients in aged care facilities. Barriers to providing care were also identified. Results: Only a small percentage of dentists and dental prosthetists provided any regular oral health care to residents in aged care facilities.

**Conclusions:** Even though the residents who live in aged care facilities are the most vulnerable and frail there is still an expectation that they should travel to private or public dental clinics in order to receive oral health care. Mobile, outreach or hub and spoke models of oral care into aged care facilities appear to be ad hoc and poorly coordinated in NSW. The Inner West Oral Health Outreach Program has collected three years of data from ten aged care facilities that shows that a resident's oral health outcomes can be improved with access to regular dental services. Options are also available to enable this model to be transitioned into a state-wide service.

## The Fiona Stanley Hospital Falls Pathway

**Author/s:** A/Prof Glenn Arendts, Emergency Department, Fiona Stanley Hospital, Western Australia, Australia; & Emergency Medicine, Univeristy of Western Australia, Crawley, WA

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**Abstract:** Falls are one of the most common reasons older people present to an emergency department (ED), yet many falls patients are given a low priority for care and their assessments are often delayed and suboptimal. At Fiona Stanley ED, at least fifty older people a week present with “low risk” falls, and almost as many again with falls associated with serious illness or injury. The objective of this work was to comprehensively rework our assessment of falls to a) reduce the ED length of stay; b) maximise safe discharge rates; c) manage common issues associated with falls such as cognitive impairment and polypharmacy; and d) improve the inpatient care of admitted falls patients.

We established a multidisciplinary committee to address the management of falls patients and used evidence from the literature and clinical expertise to create a falls pathway for all patients aged 65 and over presenting to emergency with a fall. Our pathway utilises environmental management strategies, nursing risk screen, cognitive assessment, and reviews of medications, mobility and function for all falls patients. We have specific streams for admission and discharge to maximise safety and outcomes for the patient and the hospital system. In this presentation we will present data related to the first twelve months of the pathway, present our wins and losses, and discuss lessons learned in a whole of hospital reform initiated from the emergency department.

## Asking the right questions when seeking residential aged care

**Author/s:** Mrs Helen Macukewicz, Professional Services, NSW Nurses and Midwives' Association, New South Wales, Australia; & NSW Aged Care Roundtable - no department

**Co-author/s:** Professor Dimity Pond, Fellow, Royal Australian College of General Practitioners NSW Faculty, North Sydney, New South Wales, Australia, Rita Martin, NSW Nurses and Midwives' Association, Waterloo, New South Wales, Australia

**Abstract:** Will I be able to keep my own GP? Do staff know how to cook traditional Lebanese food? Are LGBTI events celebrated? Will I be cared for by a registered nurse overnight and weekends? Navigating the aged care system is challenging and those seeking residential aged care are often making life-changing decisions in a time of crisis. The decision to enter residential aged care is often the hardest that older people will face; further complicated by choice and expectation. Often, once a contract with an aged care provider is signed there are financial implications and long term commitment to 'age in place'. Making informed choices is therefore central to empowerment at the end of life.

In 2015/16 the NSW state parliament held two Inquires. One determining if legislation mandating registered nurses on site at all times in nursing homes should be retained; the second investigating elder abuse. The Inquires brought together medical, nursing and community advocacy organisations who shared a common view that dilution of skills mix in residential aged care diminishes the quality of care that older people receive. Also that consumers seeking residential aged care are poorly informed prior to entering into contracts.

A NSW Aged Care Roundtable representing 19 organisations was established and collaborated on a series of consumer facing leaflets based on the simple concept of "10 Questions to Ask.." to raise consumer expectation and drive quality. This is the first time information has been co-produced and endorsed by medical, clinical and community advocacy experts in aged care. Each leaflet focuses on a different aspect of care, allowing consumers to choose which are appropriate to their individual needs. Leaflets have been distributed widely in GP surgeries, community centres and Hospitals across NSW.

## The conversation we must have - death and dying

Author/s: Ms Hope Alexander, [hopealexander.com](http://hopealexander.com) , Western Australia, Australia

**Abstract:** "I look after people who are dying all the time. People go all funny in the head when relatives die. In my experience it is rarely the person who is dying who feels distressed. It is the person watching them" quote

Method: Literature search, Advance Health Directive WA (AHD)

Discussion: An AHD [legal document] contains your decisions about future treatment: medical, surgical, dental, other health care.

An AHD cannot require / authorise a doctor or other health professional to take active steps to unnaturally end your life.

Euthanasia: Key point: what is the intent? If the intent is to make the patient comfortable. and this speeds up the dying process, this is ethical and humane. Active euthanasia where the intent is to kill the patient is illegal (in Australia) quote.

Findings: From a man who had an AHD. and had effective palliative care in a public hospital: "This is eerie ... what is? ... this dying bit ... He died a week later, "calm, comfortable and supported".

Quote from a person whose partner died after eight months, without an AHD.

"I wish I had known ... did I listen to my wife, when trying to give advice? How do you say this is unlikely / never going to work without taking the patient's hope? But we were submarined by the surgeon's and oncologists' forecasts".

No-one said death had to be fun, but it can be. When someone in the hospital has a good death, you hear laughter coming from the room. When it's a bad death, it's a complaint often well after the fact".

Conclusion: More open and factual information for those who choose to become aware / informed about death and dying.

## Does your patient understand you?

Author/s: Ms Hope Alexander, [hopealexander.com](http://hopealexander.com), Western Australia, Australia

**Abstract:** Health literacy defined as "the degree to which individual have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions".

"Patients are increasingly being expected to become active partners in their care, but health literacy isn't always taken into account".

**Methods:** Literature search, journal articles, case studies, author's research on "Medication labelling for seniors" at UWA.

**Findings:** "Low health literacy significantly increases the risk of mortality in older adults ...and it's more common than thought ..."

"Both prescribers and pharmacists had a shared responsibility to ensure the public were given information in 'everyday common language'".

The language used by [some] medical people - is not language that patients understand ... and is often misinterpreted".

What can happen? ... frightened patients too often sign consent forms without clearly understanding what they're doing ...

Even apparently plain language could pose a problem.

They [consumers] either do not understand what they are being told, or are unable to act on the information.

"Even in an educated patient population, it is estimated that around 59% will have dysfunctional health literacy. More than two-thirds of people older than 60 years, perhaps higher in Indigenous, migrant or low socioeconomic populations.

**Conclusion:** Implications for policy and research

So how can one increase adherence to health messages?

A few basic principles may help:

Accept that what you tell a patient is not necessarily what is heard, or understood.

Appreciate that health illiteracy doesn't mean being illiterate in general.

Understanding health facts and the health system is not necessarily an easy thing to do in an increasingly complex environment.

Unless otherwise convinced, assume a reading / understanding level of around 12-14 years of age, and work up from there.

## Complaints: Golden opportunities for improvement

**Author/s:** Ms Jan McGregor, Clinical Unit, Aged Care Complaints Commissioner, Victoria, Australia

**Co-author/s:** Samantha Scott, Clinical Unit, Aged Care Complaints Commissioner

**Abstract:** The Aged Care Complaints Commissioner assists in resolving complaints about the quality of care or services delivered to people receiving Australian Government funded aged care. Such resolution processes are golden opportunities for improving care.

This presentation provides data and anecdotes about complaints of a clinical nature which were referred to the Commissioner's Clinical Unit during the period 1 July 2016 to 31 June 2017. Review of the data shows most of the complaints issues involved clinical care in residential facilities. Such complaints often resulted in the service providers improving their clinical care of older Australians.

Examination of the clinical evidence provided to the Clinical Unit demonstrates frequent gaps in the application of clinical judgement and decision making to the assessment and care planning components of care, including poor documentation and lack of communication with substitute decision makers. These gaps result in failure to deliver appropriate care, often due to failure to recognise acute episodes requiring escalation, or failure to communicate reasonable expectations to family members.

Most complaints are resolved to the satisfaction of the complainants. With the wellbeing of the people receiving care as a priority, complaints resolution occurs through a range of mechanisms including contacting service providers who act to resolve complaints. Other mechanisms include investigation, Directions Notices and referral to external agencies including the Australian Health Practitioner Regulation Agency, the Department of Health and the Australian Aged Care Quality Agency.

Service providers are encouraged to value complaints as opportunities to make positive changes. Opportunities for improvement are lost when service providers do not actively engage in the complaints resolution process; however, review of the outcomes of the complaints shows that most service providers respond by improving their policies, procedures and education to align with accepted contemporary standards, resulting in better outcomes for people receiving care.

## Why timely diagnosis of dementia matters

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**Abstract:** Timely diagnosis of dementia is a discussion that may see a range of health care professionals with varying perspectives and opinion on the topic. This paper will explore why timely diagnosis is said to be beneficial and even a human right - as supported by the 2016 Australian Clinical Practice Guidelines on dementia and other published evidence and clinical experience. This is explained by considering seven factors underpinning both the clinical and fiscal benefits achievable simultaneously via a timely diagnosis.

It is accepted that underdiagnosed neurocognitive disorders result in more frequent hospital admissions, and higher hospital costs than those diagnosed. This supports the benefit of investigation and diagnosis being completed in the community in preference to piecing together dementia diagnoses during a long and often traumatic hospital admission where the person is in unfamiliar territory adding to their confusion. Risk factors for remaining undiagnosed include social isolation, advanced age and earlier disease. The paper will also discuss clinical barriers to timely diagnosis including time pressures, lack of knowledge or diagnostic confidence, fear of patient distress following disclosure and concerns about lack of disease-modifying therapies.

For these reasons a timely dementia diagnosis has the potential to benefit not only the individual but also society by avoidance of catastrophic and prolonged hospital admissions as well as costly, predictable community crises in isolated people with advanced dementia - including self-neglect, impending financial ruin, car accidents and fires making it a worthwhile discussion. Multidisciplinary case examples will also be presented

## Pathways in aged care: Program use before entering permanent care

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**Abstract:** Linking individual episodes of aged care use to form ‘pathways’ is important to understanding how people navigate through aged care. The Pathways in Aged Care (PIAC) linkage map connects data on key aged care programs, ACAP assessments and causes of death (derived from the National Death Index), all linked together at the person level. This allows us to follow individuals from assessment or initial service use to the end of their journey and provides other unique opportunities for analysis.

Understanding the different trajectories people take through aged care—and key factors associated with different trajectories—presents a wider context for aged care service use beyond single episodes of care. We examine a specific cohort of people (those who first entered permanent residential aged care in 2013–14), and explore the main aspects of their demographics, care needs, health conditions and service use patterns, with a particular focus on the aged care program people last used before entering permanent residential aged care. The results of these analyses are discussed, and we illustrate further uses for PIAC to drive evidence-based policy and better outcomes for older Australians.

## Technological falls-prevention in hospitalised older people: Our journey so far

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**Abstract:** Despite best practice, falls and injury rates in hospital remain high especially in wards where there are large numbers of frail older patients and patients with cognitive impairment. There is a need to investigate technology based alarm solutions that don't rely on patients raising the alarm but also have low false alarm rates. Wearable sensor technology allows monitoring of multiple patients in multiple locations supported by smart software. We have developed the AmbiGeM system which will be investigated, using a stepped wedge pragmatic trial with an embedded evaluation of patient and staff acceptability and safety in two Geriatric Evaluation and Management Unit wards and one general medicine ward in South Australia and Western Australia. Patients aged 65 years and older will be recruited and changes to falls rate will be reported.

Many technology innovations however are not developed in partnership with end-users, the consumers and the clinicians that ultimately utilize these interventions. In the long run, this can be a barrier to evidence translation into practice. We discuss here how we decided on the various elements of our wearable sensor alarm system, the AmbiGeM system and how we progressed the trial within the complex healthcare environment.

To ensure that our system was user friendly, we worked closely with clinicians to develop a patient and sensor enrollment system, risk assessment system to activate the alarm, a staff alert system and an alarm deactivation system. We worked with consumers to determine their garment and comfort preference whilst ensuring that the sensor is held in a stable position over the sternum. We liaised with hospital infrastructure and information technology staff to deploy the technology. Additionally, to ensure that the trial gained necessary approvals, we have collaborated closely with hospital administrators, safety and quality teams and the ethics committees to meet key requirements.

## Research priorities in residential aged care facilities: A state-wide survey

**Author/s:** Dr Jo-Anne Rayner, Australian Centre for Evidence Based Aged Care, La Trobe University, Victoria, Australia

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**Abstract:**

Introduction

Providing nursing care in residential aged care facilities (RACFs) has become more complex given the greater age and increased acuity of residents, and the high prevalence of dementia. To ensure that research is relevant and can make a difference to those who work in the sector, all Victorian RACFS were invited to complete a brief anonymous survey about research priorities, participation in research and preferred methods of feedback of results and recommendations to the sector.

**Method:** The survey with a covering letter and reply paid envelope was mailed to the Director of Nursing/Manager at all 754 Victorian RACFs, each allocated a unique identifier for tracking purposes. Two weeks after the mail-out a reminder postcard was sent to non-responders and three weeks later a 10% random sample of non-responders received a follow-up reminder telephone call.

**Results:** 162 (21.5%) surveys were returned, mainly from rural, public sector facilities. Research priorities listed in order of importance were:

1. Managing residents with dementia - dealing with behavioural and psycho-social problems.
2. Staff/resident ratios- recruitment/retention of skilled staff, workforce stress/sick leave, and the impact of staff skills mix on resident quality of life.
3. Inadequacy of funding to the sector - how to deal with increasing workload and decreasing funding.

Most responding facilities like research participation and prefer multiple forms of feedback to report findings i.e. researcher presentations and written materials.

**Conclusions:** The findings suggest RACFs welcome research into staffing and workforce issues and their impact on care quality, particularly for residents with dementia. These are challenging priorities and may in part explain the low response rate - perhaps staff were just too busy to reply.

## Living life to the full: The golden opportunity

**Author/s:** Dr Judy McCrow, Seniors and Supported Living, Churches of Christ Care, Queensland, Australia

**Abstract:** Ageing need not be a period of continuous decline and removal from society. Rather, greater emphasis must be placed on more productive and successful ageing. Caring for older people should include maintaining and/or building capabilities and potential through enabling them to continue to participate in meeting their needs and lifestyle choices.

Previous models of care have focused on reducing negative outcomes however; these do not necessarily foster positive states. At Churches of Christ Care we strive to deliver high quality care plus preserve and promote quality of life through enhancing wellbeing. We believe that by eliciting a positive wellbeing focus there will be a corresponding reduction in previously recognised negative outcome measures.

This presentation will provide an overview of a positive wellbeing approach to care for older people. It is influenced by the underlying principles of positive psychology and capabilities theory. Within this model, older people, including those living with dementia, are viewed as an individual person with the right to enjoy the best possible quality of life.

The model recognises that all of us are individuals with our own unique personalities, skills and knowledge. We all experience a greater sense of wellbeing when we are able to actively participate in a community which fosters a culture of comfort, identity, occupation, inclusion and attachment.

It is not solely about how we care for people living in our aged care facilities or receiving assistance from our community services, it is more about how we collectively care for each other. We expect that as you seek to increase the wellbeing of others in a community you will also experience an abundant enriched life yourself: “living life to the full”.

## Ahead of the game: Active volunteering in dementia

**Author/s:** Dr Judy McCrow, Seniors and Supported Living, Churches of Christ Care, Queensland, Australia

**Abstract:** Volunteers are a valued member of aged care teams. However, there is little empirical evidence surrounding volunteer training programs to support people with dementia living in residential aged care. Churches of Christ Care are addressing this gap through an Active Volunteering in Dementia (AViD) project. AViD prepares volunteers to engage in meaningful interactions with people living with dementia and tailor leisure activities to meet their preferences, through a structured training program.

Training includes education, mentorship, peer-support and workplace activity initiatives. Four volunteers and nine people with dementia living in residential aged care services were initially recruited. Outcomes were assessed pre-training and again six months later. Pilot results are promising and include increasing positive attitudes towards people with dementia and volunteer satisfaction. As suggested by others, positive attitudes to people living with dementia promotes quality care. We are now replicating the program in a larger sample to determine more generalised outcomes.

## Championing change in hospital care

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**Abstract:** In hospitals, “20% of patients... aged over70 have dementia”(www.safetyandquality.gov.au/abetterwaytocare). Poor clinical outcomes (complications such as delirium, pressure ulcers and falls as well as increased length of stays, readmission and high mortality rates) are more likely in patients with dementia.

The Dementia Champion in Hospital Program is a unique train-the-trainer initiative that targets hospital staff who lead the development of best practice and optimal dementia care. The dementia champion becomes an essential resource person in their workplace. The program consists of a two day mandatory workshop involving a 15 minute presentation, an environmental audit and two work-based activities. Workplace visits and networking meetings are also part of the program for a period of 18 months whereby champions receive ongoing support and mentoring with access to information and resources and further education opportunities. This program builds sustaining relationships and forms partnerships between Alzheimer’s Australia WA and hospital staff throughout Western Australia. Hospitals are busy places with acutely ill patients with complex medical, physical and social needs. It is not surprising then that people with cognitive impairment struggle in hospital whilst in an alien physical and social environment, with staff that may not have dementia-related education. The dementia champion program supports better outcomes for patients with dementia. The program promotes care that is non-judgemental and emphasizes the importance of well-being using a person-centred approach. The Dementia Champion in Hospital Program prepares the participant to be a leader, educator, informer, visionary, pioneer, change agent, mentor and advocate.

Dementia Champions are able to facilitate high quality outcomes for patients with cognitive impairment which includes making hospitals more dementia friendly. As of April 2017, there are 64 dementia champions in Western Australian hospitals.

## Caregiver implications and timing of dementia diagnosis: A literature review

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**Abstract:** To provide relevant and effective support for the dementia caregiver, it is important to understand caregiver perspectives of the care-recipient receiving a diagnosis of dementia in earlier stages as compared with later stages of dementia.

A literature search of four computerised databases of published literature was systematically conducted. Two researchers independently assessed abstracts and full text articles for eligibility. 4335 articles were found. Removal of duplicates and applying inclusion and exclusion criteria to titles and abstracts left 152 articles. Full text assessment of eligibility left 25 articles (reporting on 22 studies). Qualitative and quantitative studies were eligible. Quality criteria were applied.

Five primary issues at diagnosis relevant to the care-giving experience were identified: 1. dealing with the immediate and subsequent emotional impact of the diagnosis; 2. dealing with grief, loss and the uncertain future course of the dementia; 3. coping on an on-going basis with care-giving responsibilities; 4. the importance of acceptance of the diagnosis to assist adaptation and adjustments in the caregiving role; 5. the need for post-disclosure follow-up with practical information, guidance and advice relevant to their situation and expectations rather than generic information. Caregivers expect person-centred advice, guidance and information that are relevant to their needs and expectations at diagnosis and at follow-up. No study was identified that explored the differential needs of earlier stage dementia caregivers compared with later stage caregivers at diagnosis. In addition to the usual concerns of providing a diagnosis and explaining dementia, health practitioners need to be mindful to address caregiving needs after diagnosis as there are suggestions that this may positively influence caregiver wellbeing with consequences for the person with dementia. Research is required to identify whether there are differences in the caregiving experience and needs of the carer of the person diagnosed at different stages of dementia severity.

## Dementia diagnosis, its timing and help-seeking by the dementia caregiver

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**Abstract:** The benefits of timely diagnosis of dementia are widely proposed with little empirical clinical research evidence to support the position. We aim to identify themes regarding the timing of diagnosis considered important to informal caregivers of people with dementia as they usually instigate diagnosis-seeking.

An ethics approved consumer-modified semi-structured guide of open-ended questions was used in interviews and focus groups. A convenience sample of all 554 caregivers who attended two memory(metropolitan)/geriatric(regional) clinics over 3 years were screened. 76 qualified on inclusion and exclusion criteria (including being present at disclosure). 23 consented to participate.

Thematic results (in capitals) revealed caregivers preferred earlier diagnosis to offer Certainty and permit Dementia-Directed Decisions and Planning. Concerns were expressed of Premature Loss of Status from stigma and potential for Contention due to subtle and unconvincing symptoms if diagnosis was too early. Caregivers strived to maintain Stability and Familiarity in daily routines and sought assurances in the face of uncertainty and progressive losses. The timing of diagnosis required Buy-In from the caregiver (Realising and Acknowledging and acting on concerns), the person with dementia (degree of Insight, Resistance and Denial) and the health-practitioner (to Believe The Concerns, and formally test cognition). The caregivers preferred their help-seeking to occur On Their Terms and in Their Own Time. Caregivers exhibited a spectrum of proactivity to passivity and avoidance in their Attitude To Resource And Service Use and Responsiveness To Advice. Caregivers exhibited a strong sense of Self-Reliance, and Reliance On Informal Sources of support and assistance. Many caregivers preferred to maintain Status-Quo until circumstances forced changes.

This study has provided insights to help develop meaningful engagement of caregivers to meet their needs and understand their responses to offers of support and assistance. This is required to understand and overcome the low degree of timely up-take of services currently experienced.

## Residential care isn't the best place to have a fracture

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**Abstract:**

**Aims:** To determine if the environment can have an influence on the type and severity of a minimal trauma fracture in the elderly.

**Methods:** The Joondalup Health Campus (JHC) trauma registry data was retrospectively analysed.

**Findings:** Between January 2015 and July 2016, 720 elderly  $\geq 65$  years of age presented to JHC with a fracture post fall from standing. In general, injury severity scores (ISS) were the same whether the fracture occurred at home ( $n=445$ ,  $6.7\pm 3.0$ ) or not ( $n=275$ ,  $6.7\pm 2.7$ ). However, length of in-patient stay (LOS) was longer if the fracture occurred at home ( $7.9\pm 8.6$ ) than if it did not ( $6.4\pm 6.0$ ),  $t(718)=2.5$ ,  $p=0.01$ . When matched for age, those whose fracture occurred at home ( $n=182$ ,  $age=87.8\pm 4.1$ ,  $ISS=7.0\pm 3.1$ ,  $LOS=9.0\pm 9.2$ ) had significantly lower ISS ( $t(323)=2.1$ ,  $p=0.03$ ), not higher LOS ( $t(323)=1.6$ ,  $p=0.12$ ) compared to those whose fracture occurred in residential care ( $n=143$ ,  $age=87.8\pm 6.3$ ,  $ISS=7.7\pm 2.7$ ,  $LOS=7.6\pm 6.3$ ). Fractures were either more likely in the femur ( $76/67$  vs  $146/299$ ,  $\chi^2=19.0$ ,  $p<0.0001$ ) when it occurred in residential care, or more likely in other bones when it occurred away from the usual residence ( $105/27$  vs  $299/146$ ,  $\chi^2=7.4$ ,  $p<0.01$ ), as compared to fractures that occurred at home.

**Conclusions:**

1. Staying at home may not increase the severity of elderly osteoporotic fractures.
2. Residential care may be a risk factor for having the fracture in the femur.
3. These findings appear to favour the least restrictive approach towards patient disposition in elderly with increased falls and fracture risks.
4. Further studies can verify these observations which have health economic implications.

## Do people with early stage dementia experience Prescribed Disengagement®?

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**Co-author/s:** Kate Swaffer, University of Wollongong; Kate Swaffer, University of Wollongong, New South Wales, Australia; Margaret McGrath, Faculty of Health Sciences, University of Sydney, New South Wales, Australia; Henry Brodaty, Dementia Collaborative Research Centre and Centre for Healthy Brain Ageing, University of New South Wales, New South Wales, Australia

**Abstract:**

Introduction

Prescribed disengagement® is the description of the post-diagnostic advice given to people after a diagnosis of dementia, that explicitly or implicitly suggests that the person should be slowing down or pulling back from activities. This results in isolation, loss of hope, self-esteem and self-identity, and threatens social health. This study aims to review whether prescribed disengagement® can be identified in the literature on subjective experiences of people living with early dementia.

**Methods:** A systematic search was performed. Inclusion criteria were original empirical qualitative studies published in English that addressed the subjective experiences of living with a diagnosis of objectively defined early dementia. Thematic synthesis was undertaken.

**Results:** Thirty-five papers involving 373 participants were included. Following a diagnosis, people with dementia struggled with self-identity, independence, control and status, activities, stigma, and how to view the future. Reactions in these areas ranged from active and positive to negative and passive. Many studies reported participants' dissatisfaction with the way the diagnosis was communicated. There was insufficient information provided about dementia and limited treatments and support offered. The diagnostic process and post-diagnostic support may have contributed to disempowerment of the person with dementia, made it more difficult to accept the diagnosis, and exacerbated negative views and self-stigma around dementia.

**Conclusions:** These results confirm dissatisfaction with the diagnostic process but do not provide evidence for Prescribed Disengagement®, this may be because none of the included studies included questions specifically around this issue. Disengagement may have been implied during the diagnostic process and subsequent post-diagnostic support. Original research is needed to investigate whether Prescribed Disengagement® occurs, as well as on how to improve the communication of the diagnosis of dementia and support people to live well post-diagnosis.

## Engaging community-dwelling older people in developing falls risk awareness messages

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**Co-author/s:** Anne-Marie Hill, School of Physiotherapy and Exercise Science, Curtin University, Bentley / Perth, Western Australia, Australia; Chris Wortham, The School of Arts and Sciences, Notre Dame University, Fremantle, Western Australia, Australia

**Abstract:**

**Introduction:** Annually one in three people aged 65 or above fall over. Despite the physical and social problems caused by these falls, many older people don't believe that they are at risk of falling. Additionally, many older adults possess low levels of knowledge about falls prevention and have low motivation to engage in falls prevention strategies. These findings suggest that further health promotion efforts are required to warn older people of their falls risk and encourage participation in preventive strategies.

Engagement of community members in the development of falls prevention messages could potentially create solutions based on their understanding of what would work best in their own community.[1] We aimed to translate falls prevention evidence into practice by developing falls risk awareness messages in cooperation with community-dwelling older people.

**Method:** We set out to convene a community reference panel and to engage with them in developing falls risk awareness messages.

**Results:** Two researchers advertised for a community reference panel of older people (≥60 years). Nine people responded, of whom two men and five women participated at two face-to-face meetings. First, panel members agreed on the overall agenda and terms of reference. Subsequently, they discussed ideas about persuasive falls prevention messages and how these should be presented to their peers. Panel members suggested several key messages and recommended they should be presented using short (advertisement-like) videos. A filmmaker translated the ideas of the panel members into three video storyboards. Panel members reviewed these and decided all three should be made. Videos were subsequently filmed with some panel members posing as background actors. The reference panel is ongoing in a translational research project using these videos.

Reference

[1] Khong L, et al. How older adults would like falls prevention information delivered: fresh insights from a World Café forum. *Ageing and Society*. 2016;1–18.

## Residential medication reviews: Does the model still suit the residents?

**Author/s:** Ms Nicole, Faculty of health, Discipline of Pharmacy, University of Canberra, Australian Capital Territory, Australia

**Abstract:** Prescribing in the older population is highly complex compared with younger adult populations. Medication related problems are associated with worsening cognitive impairment, frailty, disability, falls, unplanned hospital admissions and mortality. Persons with dementia are at even higher risk of medication-related problems than the general older population due to an exaggeration of age-related pathophysiological changes as well as deficits in language and cognition, and involvement of multiple health care professionals.

In recognition of the need to establish a medication review service to prevent medication related problems, the Australian Government commissioned Commonwealth-funded remuneration for residential medication management review (RMMR) providers in 1997. Pharmacists are experts in pharmacotherapy, and should be well positioned in clinical teams to assist in managing the complex multi-drug regimens often seen in the older population. However, there are access restrictions in place limiting the frequency of RMMRs that a resident is eligible to receive, and the current RMMR service is not designed as a regular review service, thus precluding pharmacists from routinely participating or developing established and effective collaborative relationships in patient care.

This presentation will report on qualitative findings from an investigation into the efficacy of the current RMMR service in reducing medication related problems in residents with dementia; and the practical issues with this service which impact resident access and outcomes as perceived by current stakeholders. This presentation will also introduce an ongoing pilot study into a new model of aged care pharmacy practice, which facilitates collaboration and pharmacist integration into the residential aged care setting to overcome some of the practical issues reported by current service providers.

## Moving forward: Barriers and enablers to mobility in sub-acute wards

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**Abstract:**

**Introduction:** Studies measuring mobility levels of older patients in sub-acute settings have described low levels of mobility outside of scheduled therapy time but few have explored the barriers and enablers to mobility in this setting. The aims of this study were to: 1) measure mobility levels in patients aged 65 and older in 2 sub-acute wards of a purpose built-rehabilitation facility; 2) identify barriers and enablers to mobilisation from staff and patient perspectives.

**Method:** This prospective observational study conducted at Brighton Health Campus, Brisbane, between February and November 2016. It used mixed methods to identify current inpatient mobility levels and patient and staff perceptions of barriers and enablers to mobility. Mobility levels were measured using activity mapping across two wards (a rehabilitation and restorative care ward). Barriers and enablers were identified by a validated staff survey (n=85; 52 nursing, 29 allied health professionals, 4 other) and semi-structured patient interviews (n=24).

**Results:** On average, patients spent less than 10% of day time upright and mobile; spent less than one third of day-time out of their bedrooms and even less on the week-end. Staff agreed that mobilisation benefitted patients, had leadership support, and agreed they had knowledge and skills to mobilise the patients. Barriers included workload concerns; unclear responsibility between disciplines; team communication; fear of personal injury; and patient resistance. Patients reported mobility was important for their recovery; and having permission; assistance; equipment and meaningful activities enabled mobility. Barriers included lack of assistance; physical symptoms and their emotional state.

**Conclusion:** We found that mobility levels of older patients were low in this rehabilitation facility, consistent with previously reported studies. The reasons for this appear to be complex. Understanding the barriers and enablers to mobility will inform strategies to enhance mobility levels in this vulnerable patient group.

## Disparity in Chronic Disease Prevalence and Treatment in Older People

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**Co-author/s:** Emma J. Glasson, Telethon Kids Institute, Perth, Western Australia, Australia; Stuart Wark, School of Rural Medicine, University of New England, Armidale, New South Wales, Australia; Matthew P. Janicki, University of Illinois at Chicago (RRTC/DDH), Illinois, USA; Trevor Parmenter, Centre for Disability Studies, University of Sydney, Sydney, New South Wales, Australia; Marie Knox, Centre for Disability Studies, University of Sydney, Sydney, New South Wales, Australia

**Abstract:** Introduction: Chronic diseases constitute the largest burden of disease in older people. These include cardio- and cerebro-vascular, respiratory, musculoskeletal, and mental health disorders. This report concerns the prevalence and treatment patterns of chronic diseases in community-dwelling adults aged 60-years and older.

**Methods:** The findings are based on a survey across metropolitan and rural regions in Queensland and New South Wales. The analysis sample comprises 872 respondents. The survey contained detailed demographic and socioeconomic questions, quality-of-life measures, chronic health conditions and treatment, and access to various health service providers.

**Results:** The mean age of respondents was 73.1 years (SD 8.2) and two-thirds (67.0%) were females. In relation to chronic health conditions, 52.1% reported having arthritis. Other major physical & mental health issues included cardiovascular (20.1%), thyroid (12.9%), diabetes (12.4%), asthma (10.4%), anxiety (17.0%) and depression (16.0%). Sensory impairments included vision (20.1%) and hearing deficit (27.2%). Only 2.7% of respondents did not have a regular GP. We then examined the disparity between prevalence and treatment for the listed conditions. Nearly-half (52.8%) of those with arthritis, 40.3% with anxiety and 48.1% with depression reported receiving treatment. Multivariate regression for each of these three conditions showed significantly lower odds ratios of treatment for older patients but sex, financial hardship and access to health services were not significant covariates.

**Conclusion:** The prevalence of chronic conditions is comparable to figures reported by national surveys. The prevalence of arthritis increases with age but often only older respondents with ongoing pain and/or functional impairment tend to self-report in population-based surveys. Depression in the elderly continues to be under-diagnosed and under-treated. Adequate management in primary care for both physical and mental health disorders is important and has bearing within the context of Australian government's emphasis on reducing the burden of chronic diseases.

## Reducing restraint with education in residential care

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**Co-author/s:** Tamra Macleod, Goodwin Aged Care, Goodwin, Australian Capital Territory, Australia

**Abstract:**

**Background:** Despite the strict legal implications of using physical restraints in the care of those who have limited cognitive ability the actual frequency is relatively high. The aim of this study was to review the prevalence and types of physical restraints in care facilities within the single not-for profit provider. An action research framework was adopted with a view to reducing restraint use with education.

**Methods:** We conducted a multicentre cross-sectional study with 3 care facilities, with 225 beds. Organisational data were collected by questionnaires addressing nursing managers. Descriptive statistics and reasons for use were collected with detailed education to both the care providers and families followed by review of the overall use of the restraints.

**Results:** The prevalence of residents with at least one physical restraint was 15.5%. Bedrails were most frequently used. Length of residence, degrees of care dependency and mobility limitation were significantly positively associated with the use of physical restraint. There was a reduction to 0.89% after education and detailed review.

**Conclusion:**

Carer and family education has been useful in aiming at restraint-free nursing care. Education should be considered in sustaining this type of care which is likely to improve quality of life at this stage.

## Digital understanding, safety and engagement of older Tasmanians

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**Abstract:** Australia is embracing the digital age and its opportunities, but many older Australians are being left behind. Offline older people suffer greater disadvantage than those online (1) as digital technologies provide access to social interaction, information and services, and support ageing in place, life control, financial savings, employment opportunities, free speech and equality. Despite digital inclusion benefits, digital literacy of people over 65 years is the lowest of any demographic (2).

COTA Tasmania conducted state-wide consultations identifying what older people enjoy and find challenging about growing older. 841 Tasmanians responded through online surveys (OS), hard copy surveys (HCS), focus groups, multilingual postcards, stories and special interest discussions.

Digital literacy was raised as a barrier and opportunity in many aspects of life, including health, low literacy, cost of living and intergenerational relationships. Though most participants noted the importance of digital engagement, many see little use for it.

Tasmanians over 75 years were twice as likely to respond through HCS or focus groups rather than OS. 27.1% of HCS respondents had poor understanding of modern technology, compared to 3.9% of OS. 3.5 times more HCS respondents felt unsafe or very unsafe while online than OS respondents. 27.6% of HCS respondents left this question unanswered, many citing no use of modern technology (OS: 2.6%).

Digital inclusion of older people benefits the whole community, but poor understanding of technology or feeling unsafe online disengages many people over 75 years. A program that successfully engages this cohort requires co-design that acknowledges older person diversity.

1. Digital Lives of Older Australians (2016) Australian Communications and Media Authority. Roy Morgan Single Source data (2015)

2. Thomas, J., Barraket, J., Ewing, S., MacDonald, T., Mundell, M. & Tucker, J. (2016) Measuring Australia's digital divide: The Australian Digital Inclusion Index 2016, Swinburne University of Technology, Melbourne, for Telstra

## Neighborhood cohesion, health behaviors and well-being in older Chinese people

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**Abstract:**

**Introduction:** The study examined the associations of neighborhood social cohesion with health behaviors and subjective well-being among community-dwelling older people in Hong Kong, taking into account personal and perceived environmental characteristics.

**Methods:** This cross-sectional study included 222 individuals aged 60 years and older. Neighborhood social cohesion was measured using the 18-item Neighborhood Cohesion Instrument (NCI). Subjective well-being including life satisfaction, happiness, sense of purpose and meaning in life were measured with three single items on scales from 0 to 10. Loneliness was measured using the 6-item version of the De Jong Gierveld Loneliness Scale.

**Results:** The mean age of the study population was  $72.8 \pm 8.0$  (range, 60-95 years), 64.0% were women, and 64.4% were married. The mean score of NCI was  $3.8 \pm 0.5$  (range, 2.2-4.9). Findings demonstrated that individuals with higher NCI scores had higher levels of physical activity. In addition, neighborhood social cohesion was positively associated with life satisfaction, happiness, sense of purpose and meaning in life, and inversely associated with emotional and social loneliness. These associations persisted after controlling for personal (age, gender, education, marital status, and income) and perceived environmental characteristics (perceived availability of broad pavements, accessibility to buildings, availability and accessibility of public transport). Sub-group analyses revealed that the association between neighborhood social cohesion and subjective well-being was stronger in the young-old (age 60-69 years) than in the middle- and old-old (age 70 years and older), and in men than in women, with the exception of sense of purpose and meaning in life, which was more strongly associated with neighborhood social cohesion in women.

**Conclusion:** Our preliminary results demonstrated the importance of neighborhood social cohesion for health behaviors and subjective well-being in community-dwelling older people. Interventions focusing on neighborhood social cohesion may result in improved health and well-being in older people, particularly among the young-old and men.

## Examination of a partnership model to create health system change

**Author/s:** [Mrs Sally Grosvenor \(1\) \(2\)](#), 1.NHMRC Cognitive Decline Partnership Centre, New South Wales, Australia; 2. University of Sydney, Sydney, NSW, Australia

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**Abstract:** The National Health and Medical Research Council (NHMRC) Partnerships for Better Health Initiative recognised that bringing together clinicians, consumers, researchers and decision makers to work on developing the research questions is essential to translate research into health and health system improvement.

The Partnership Centre: Dealing with Dementia and Related Functional Decline in Older People (Cognitive Decline Partnership Centre or CDPC) is a working example of this model in practice.

Improving the lives of people living with dementia and associated functional decline and their carers requires co-creation and dissemination of knowledge that changes policy, systems and practice. During this presentation the audience learn how the CDPC was developed, the funding partner role in this development, the process of consumer engagement within the Partnership model, as well as internal evaluation results that examine how the CDPC is progressing in its aim of building effective partnerships to bring about change.

Increased partnerships enhance translation into best practice care for people living with dementia in Australia. Two case studies; the development of the Clinical Practice Guidelines and Principles of Care for People with Dementia, and new online resources for Advance Care Planning and how this needs to be different for people with dementia, will illustrate how this funding model is impacting the care of people with dementia.

## Online intervention program to reduce dementia-related stigma: DESeRvE project

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**Co-author/s:** Kaarin J. Anstey, Centre for Research on Ageing, Health, and Wellbeing, Australian National University, Canberra, Australian Capital Territory, Australia; Perla Werner, Department of Community Mental Health, University of Haifa, Haifa, Israel; Alice Richardson, National Centre for Epidemiology & Population Health, Australian National University, Canberra, Australian Capital Territory, Australia

**Abstract:** Dementia is a highly stigmatised condition leading to significant negative effects on the health and well-being of people with dementia, and their carers. Stigma can also prevent people from seeking help. This results in people missing out on timely diagnosis and the utilisation of health and social services. It is therefore vital to develop programs to reduce the stigma of dementia.

Despite the success of interventions for reducing the stigma of mental illnesses, research investigating strategies to tackle dementia-related stigma is lacking. This talk will report on a project to fill this significant gap in knowledge through the design, implementation and evaluation of an online intervention programme (DESeRvE) to reduce dementia-related stigma. DESeRvE project entails three parts as below:

- 1) Conduct focus groups with both the general public on what they would like to learn from people with dementia, and with consumers (people with dementia and their carers) on what they would like the general public to know about them and about living with dementia
- 2) Develop an online intervention programme aimed at the general public to reduce dementia-related stigma by evidence-based approaches (education and contact) successfully applied to other stigmatising conditions. For the education component, we will adapt the dementia literacy module from the Body Brain Life project (Anstey, et al., 2013). For the contact component, we will create a series of short video clips featuring people with dementia and carers answering frequently asked questions identified from the focus groups.
- 3) Evaluate the short term efficacy of the intervention programme in stigma reduction for dementia using a randomised controlled trial with approximately 500 Australian adults aged 40 and older.

An overview of the study design and outcomes from the focus groups will be presented.

## An integrative review on falls efficacy among older persons

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**Abstract:**

**Aims:** To synthesise published research on psychosocial factors related to falls efficacy among community-dwelling older persons and explore the relationship between caregivers' and older persons' falls efficacy.

**Background:** Falls efficacy is an important psychological factor associated with older persons' risk of falling and their commitment to an active lifestyle. Understanding the relationship between falls efficacy and psychosocial factors could inform interventions to prevent falls and other falls-related psychological issues.

**Design:** Integrative review.

**Data Sources:** CINAHL, Embase, Medline, Psycinfo, Science Direct, Scopus and Web of Science were searched for peer-reviewed studies published up to November 2016.

**Review methods:** Evidence was synthesised using a five-stage integrative review method which included problem identification, literature search, data evaluation, data analysis and presentation. The methodological quality of the studies reviewed was appraised using Joanna Briggs Critical Appraisal tools. Results: 23 studies were included, of which 21 were quantitative and 2 were qualitative research studies. The majority of the studies were conducted in Western countries (n=12). Findings were synthesized to the following themes: self-health concept, quality of life (QOL), psychological wellbeing, social support and social participation. Anxiety and overall QOL were found to have the strongest association with fall efficacy. Other factors including the self-health concept, fear of falling, individual QOL domain, psychological wellbeing, depression, social support and participation yielded mixed results. No study explored the influence of caregivers on falls efficacy.

**Conclusion:** The potential influence of caregivers and qualitative views of the older persons' falls efficacy have not been adequately reported at the time of this integrative review. Understanding associations between caregivers and falls efficacy could provide alternative approaches for healthcare professionals in promoting fall prevention among older persons in the community. The multiple factors associated with falls efficacy require a multidisciplinary team working together to provide an individualised care plan for the older person.

## Connecting Care: Visiting geriatrician service for Aboriginal Australians in NSW

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**Abstract:** Life expectancy for Aboriginal Australians is 10-12 years less than for non-Aboriginal people. Approximately 80% of this gap is attributed to chronic diseases (AIHW 2011). Other diseases of ageing also affect Aboriginal populations disproportionately. Dementia prevalence rates are 3 times that of the general Australian population aged 60 years and older (Koori Growing Old Well Study-KGOWS).

Aboriginal people may experience reduced access to health services, due to a combination of factors including poor proximity, lack of transport or inappropriateness of services. Affordability and poor health literacy may play a role, as well as a lack of trust in mainstream services.

Through the Aboriginal Health and Ageing Group, we have established working relationships with Aboriginal communities on the NSW Mid-North Coast and over the past 4 years, have built up a comprehensive and collaborative care model.

Our service consists of a Geriatrician and Advanced Trainee visiting fortnightly (Coffs Harbour) or monthly (Kempsey). In Coffs Harbour we visit Galambila Aboriginal Health Service and in Kempsey, Durri Aboriginal Corporation Medical Service and Booroongen Djugun Aged Care Facility. We view these bases as a 'medical home', or a hub of care where we work closely with primary care providers, Aboriginal Health Workers and other members of the multidisciplinary team to provide care that is both appropriate and respectful.

The core service elements are those outlined in the Chronic Disease Management Program (CDMP) Operational Model: targeted enrolment; comprehensive assessment; shared care planning; case coordination; self-management support; and ongoing client monitoring and review. Our collaborative approach also fosters ongoing ethnographic research, to gain a better understanding of Aboriginal health and ageing priorities.

## Student led service and community development

**Author/s:** Mr Tim Walsh, Domiciliary Care, Dept Communities & Social Inclusion, SA Government, South Australia, Australia & Member, Australian Association of Social Workers

**Abstract:** Harnessing the assets of older people, staff and Social Work students to extend the range of opportunities for older people in our communities.

The Active Minds and Wellbeing Program at Domiciliary Care was redeveloped from a Respite Program to a Social Support service to provide more targeted and individualized assistance to clients, enabling them to more effectively participate in group activities and sustain relationships and valued social roles within their communities.

The service redevelopment and intensity of individualized support has been assisted through partnerships with Universities and field education placements with Occupational Therapy and Social Work students over the past 4 years.

Each student group developed service options with program managers, staff and current clients. Initially Cognitive Stimulation Therapy was successfully introduced and later, music, dance, cooking and gardening. Students have extended the capacity of staff and volunteers and increased program diversity, leading to improved client engagement and satisfaction.

The approach included adoption of

- Appreciative Inquiry methods promoted by the Statewide training body known as the Better Practice Project ,
- an Assets Based Community Development [ABCD] approach which sought to recognise the assets / gifts by all participants – clients, staff, students, community members, and
- Student Led models for Service Delivery & Organisational Development ,

This presentation will capture lessons learnt from all participants.

References: Better Practice Project (2011) Imagining a Better Life for Older People Co-ordinator's Handbook. Aged and Community Services SA/NT. Adelaide

Assets Based Community Development [ABCD]

<http://pilotlight.iriss.org.uk/category/tags/asset-based>

Frakes et al. (2011). The Capricornia Project: Developing and implementing an interprofessional student-assisted allied health clinic. Queensland Health

Waugh et al (2013) Authentic Assessment in Practice Settings: A Participatory Design Approach  
<http://www.socialworkfieldassessment.net>

## Respite needs: Older carers and those caring for the elderly

**Author/s:** Dr Timothy Broady, Carers NSW, New South Wales, Australia

**Co-author/s:** Tom Hinton & Sarah Judd-Lam, Carers NSW, Sydney, New South Wales, Australia

**Abstract:** Caring for a family member or friend who has a disability, mental illness, drug and/or alcohol dependency, chronic condition, terminal illness, or who is frail can result in a range of detrimental outcomes for carers. In order for carers to maintain their important roles, their own wellbeing must be supported. The ability to take a break from caring responsibilities has been advocated as one mechanism by which carers' ongoing wellbeing can be sustained.

This presentation will explore these issues by drawing on findings from a national survey of carers' respite needs. Focusing on older carers and those caring for elderly family members, carers' use of respite, reasons for using it, and satisfaction levels will be explored. Broadly speaking, survey results highlight the importance of respite for carers, and also indicate how carers' respite needs vary across caring contexts. The specific respite needs of older carers and those caring for the elderly will be discussed, along with policy implications in light of the contention surrounding respite in national aged care and disability reforms.

## EDDIE introduces high-fidelity simulation into aged care

**Author/s:** A/Prof Trudy Dwyer, School of Nursing, Midwifery & Social Sciences, Central Queensland University, Queensland, Australia

**Co-author/s:** Kerry A. Reid-Searl, Barbara J. O'Neill & Lynne Parkinson, School of Nursing, Midwifery & Social Sciences, Central Queensland University, Rockhampton, Queensland

**Abstract:**

**Introduction:** High-fidelity simulation has the potential to increase residential aged care (RAC) staff knowledge and change staff behavior when detecting deterioration in the elderly. When PresCare, a RAC provider, introduced a hospital avoidance program (HA) named EDDIE (Early Detection of Deterioration in the Elderly) they incorporated Mask-Ed (KRS simulation) into the program. Mask-Ed is a realistic simulation method where the educator wears realistic props, including masks, hands and body torsos to portray an authentic character, who then facilitates learning and engagement. The character was a resident named Mr Edwards Perkins (AKA Eddie). This case study reports on the development and impact the Mask-Ed character when implementing the EDDIE program.

**Method:** RAC staff were involved in the 'birth' of the Eddie character, this included the development of a genome outlining his personal, social, and medical history. Eddie was central to multiple engagement activities involved in the 'roll out' and sustainability of the EDDIE program both within and external to the facility. Activities such as the development and delivery of staff teaching resources, face-to-face education sessions, video vignettes and case studies. Patient/family brochures and staff newsletters also featured Eddie.

**Results:** Eddie was a key success factor in the implementation and engagement of staff, internal and external to the facility, in the HA program. The authenticity of the character became a focal point for staff, family and residents referencing the program and the hospital avoidance efforts. The novelty of Eddie brought attention to the program and made a human connection to the program's aims.

**Conclusions:** Novel and meaningful approaches engage staff, residents and families when introducing a HA program. The site-specific Mask-Ed character facilitated nursing staff learning and engagement and became a focal point for the overall implementation of the program. Simulation should be used more readily in aged care training and education.

## Aged care nurse practitioner: Health service evaluation

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**Abstract:** Aged care nurse practitioners (NP) can reduce avoidable hospitalisation of residential aged care (RAC) residents. This study evaluated the NP model of care within a hospital avoidance (HA) service in regional Australia.

**Method:** Components of the Donabedian framework of Structure, Process and Outcome informed the evaluation of the RAC NP model of care. A convergent mixed-methods approach using validated AUSPRAC data collection tools guided interview schedules, with other health professions (OHP)(n=9), residents/families (n=4) and NPs (n=2), a OHP survey (n=30) and a 30 day occasion of service audit being collected. Recorded and transcribed interviews were analysed using content analysis and quantitative data entered into SPSS and presented as descriptive statistics.

**Results:** During the 30 audit the two NPs saw 121 residents, predominantly for behavioural (28.9%) issues. The structure of the HA service, distance, NP legislative regulations and RAC models of care were identified as barriers and these influenced the referral process, the NPs response and interactions with other professionals. NPs take time to connect, instigate collaborative care plans, are accepted by OHPs and residents/families. They educate and support RAC staff with decision making, function as intra and interprofessional boundary spanners. Quality outcomes were about timely intervention, HA, return to RAC, partnering with residents/family (knowing what they want) and resident and OHP satisfaction.

**Conclusions:** The NP, because they can respond in a timely manner, prescribe, and provide advanced clinical and communication skills are well positioned to enable RAC nurses to deliver quality care in regional areas, impacting staff satisfaction and quality outcomes for residents.

## Acceptance of the Nurse Practitioner role by Australians over 65 years

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**Abstract:**

**Introduction:**

National and international evidence supports consumer satisfaction and acceptance of the Nurse Practitioner(NP) role, for chronic illness and minor injury, as an alternative model of service delivery where they would have traditionally only consulted the medical doctor. Given Australians the aging population and access to doctors, particularly in regional and rural settings, it is import clarify the publics 'willingness' seen by an NP. The aversion or willingness of people to an unfamiliar model of health care is a complex and important notion that should be explored. This research will assist in contributing to new knowledge in this area in the Australian context.

**Method:** This Australia-wide cross-sectional population-based survey used Computer Assisted Telephone Interviewing (CATI) to explore the general public's (n=1318) acceptance and willingness to be seen by an NP. All Australian states and territories were represented. The final survey consisted of a general introduction, NP opinion questions and demographic, sociocultural and health-related questions. Responses were analysed using R statistical program to conduct exploratory logistic regression.

**Results:** Two thirds were married (66.5%), Australian born (75%), and a mean age of 52.6 years (SD 17.96; range 18-101 years). Half (53%) had heard of the NP, and willing receive care in the community (91.6%), emergency department (88%) or to manage chronic conditions (84.9%). People over 65years, when compared to other age groups were more likely to have heard of NPs and prefer to wait for a Doctor even if it takes longer. They were more likely to always consider the NP.

**Conclusions:**

This is important information for those implementing alternative models of health care. While there may be general acceptance of the NP role in community and emergency department settings, the level of acceptance varied across age groups and may influence service uptake.

## 'Ageing' seen through a cultural lens

Author/s: Ms Vicki Kanakaris, Multicultural Aged Care, South Australia, Australia

**Abstract:** What is 'Ageing'? Various understandings and approaches to the concept of 'ageing' will be discussed from two perspectives:

- 1) cultural intelligence theory, combined with
- 2) practical experience, case studies and examples gained during working in the aged care industry.

Shaping a new effective response to care for aged care consumers in Australia we need to know and understand who our clients are, and, what they need, value and expect. To address the concept of 'ageing well' we need to understand what 'ageing' is for different people and what determines 'well'. How, who and what defines 'ageing' and what are possible implications. Ageing continues to be a cultural and social concept and construct. The meanings given to ageing will continue to differ across and within cultural groups and the meanings attributed by the individual will be influenced by these cultural and social associations and therefore the approaches to ageing will continue to be different. Learning about the different approaches to ageing and applying the cultural lens will contribute to our shared knowledge about the psychology of ageing and inform our inclusive method and best practice.

As the South Australian PICAC (Partners in Culturally Appropriate Care), and over 15 years of expertise, PICACs have extensive and well established partnerships with CALD community organisations, aged care providers and related sectors' peak bodies, providing ongoing development and implementation of ageing and aged care government policies and initiatives at both state and federal levels so that older people from CALD backgrounds have increased access to targeted aged and community care services. The PICAC Programme brings together experts in the field of CALD diversity, ageing' policy development, training, resource development and consultancy. PICAC expertise has informed government policy, industry/sector reviews, conferences, communication strategies and many other initiatives.

## Baseline BMI and physical activity predicts 2-year progression in sarcopenia

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**Abstract:**

**Background:** Sarcopenia refers to the age-related loss of skeletal muscle mass and strength. Longitudinal studies that comprehensively assess risk factors to predict progression of sarcopenia are lacking. This prospective cohort study sought to elucidate potentially modifiable clinical, functional, nutritional and blood biomarkers that predict sarcopenia progression at 2 years among community-dwelling Asian older adults aged  $\geq 50$  years.

**Methods:** We assessed demographic information, comorbidity, Chinese Mini-Mental State Examination; Activities of Daily Living; Frenchay Activity Index (FAI); and physical performance. Nutritional biomarkers included body mass index (BMI), Mini-Nutritional Assessment, vitamin D and albumin. We measured blood biomarkers of inflammation, anabolic hormone and myostatin. Sarcopenia was defined using the Asian Working Group criteria. Subjects not fulfilling criteria for sarcopenia were further classified as either: (i) pre-sarcopenia or (ii) non-sarcopenia. We classified subjects as progressors if they had a diagnosis of sarcopenia at 2-years or progressed from non- to pre-sarcopenia. We performed binary logistic regression to ascertain baseline predictors of 2-year progression.

**Results:** Among 115 (57.5%) subjects who completed baseline and 2-year DXA, there were 43 (37.4%) progressors. In univariate analysis, there was a significant difference between progressors and non-progressors in baseline BMI and FAI score. Among blood biomarkers, only tumour necrosis factor- $\alpha$  receptor 1 protein (TNFR1) showed a trend ( $p=0.09$ ). In logistic regression, only baseline BMI [OR= 0.82 (0.72-0.93),  $p=0.002$ ] and FAI score [OR= 0.90 (0.82-0.99),  $p=0.028$ ] were independent predictors for progressors at 2-years. Posthoc logistic regression analysis using validated factor scores for FAI revealed that “outdoor work” factor predicted 2-year progressors.

**Conclusion:**

Early decline in BMI and outdoor work activities such as gardening/heavy housework were predictive of sarcopenia progression, whereas baseline function, physical performance, and blood biomarkers were not. Our findings, if corroborated, may facilitate early detection of at-risk older adults to guide targeted interventions to counteract sarcopenia and maintain functional performance.

## Nutrition's causative and curative roles in neurodegeneration – an overview

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**Abstract:** Neurodegeneration occurs when there is sustained oxidative stress such that all the available vitamin C in the cells is consumed, resulting in no available vitamin C to support neuronal function and metabolism. Oxidative stress results from an imbalance between the levels of Reactive Substances (previously Reactive Oxygen Species [ROS]) and endogenous antioxidant mechanisms resulting in structural and functional impairment of cells and ultimately cell death. Antioxidants neutralize or quench the action of reactive substances and include vitamins C, E, A, riboflavin, pyridoxine, zinc, selenium, melatonin, CoQ10.

Evidence now indicates nutrition is important in many of the basic neurological functions such as neuronal function and repair (cholesterol, biotin, vitamin C), oligodendrocytic function (biotin, vitamin K), astrocytic function (thiamine, vitamin C), myelin sheath production and maintenance (vitamins C, B12), myelination (vitamins C, K), remyelination (vitamins C, E, D, K, biotin), and modification of the inflammatory response (vitamin B12, omega-3 fatty acids).

Astrocytes are among the first cells to be affected by thiamine deficiency in advance of neuronal cell death – there is now evidence of similarities between thiamine deficiency and neurodegenerative disorders such as Alzheimers dementia, Parkinsons disease and Neuromyelitis Optica.

The body stores about 2-3 weeks supply of thiamine and depletion of body reserves occur due to inadequate intake, and increased losses due to the effects of some prescribed drugs such as diuretics, chronic inflammatory states, diabetes, acute and/or chronic alcohol consumption, dialysis (haemo and peritoneal). Thiamine availability is diminished if there is a magnesium deficiency.

Underlying nutritional assumptions that require investigation include whether people do eat adequately to meet nutritional requirements in the presence of neurodegenerative disorders, and the level of impact of prescribed drugs on nutritional health.