2018 AAG Conference Rapid Fire Presentations - Abstracts

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A matter of principles: palliative care in residential aged care

Mr Tim Van Ierschot[1]

[1]*Palliative Care Australia*

The Australian population is rapidly ageing and as a result the number of people who die each year is anticipated to double over the next 25 years. As this figure increases, so too will the demand for palliative and end-of-life care across all care settings and will have a particular impact on residential aged care.

In 2010–11, 75% of those aged at least 65 years who died in Australia had used aged care services in the 12 months before death. For most people entering a residential aged care facility it will be their last home, making palliative care and end-of-life care an important part of planning their care needs.

Palliative care should be seen as core business in aged care. Under the Aged Care Act 1997, it is the approved residential aged care provider who is responsible for providing access to a qualified practitioner from a palliative care team and establishing the palliative care program.

So, what should a palliative care program within a residential aged care setting aspire to? This presentation will explore the principles that palliative care and end-of-life care should be delivered in accordance with, to help older Australians in residential aged care to have the best death possible, and to live the remainder of their lives to the fullest with dignity and in comfort.

ACAT in remote NT: a unique service delivery model

Miss Rebecca McGrath[1]

[1]*Top End Rural And Remote ACAT*

The Katherine Office of Disability's key contact service delivery model has facilitated change in the professional skills of the allied health team, and improvement in the quality of aged care service delivery for remote communities in the Katherine region. The key contact approach involves transdisciplinary upskilling and ongoing support of allied health professionals to provide a single point of contact for a community. This model encourages each allied health discipline to think outside the traditional boundaries of their profession and consider a more holistic approach to delivering health services in the remote context where resources are limited.

In particular this has been a huge transition for the physiotherapists on the allied health team, who previously worked in specialised areas of physiotherapy and now work in general practice across the lifespan, with the additional role as ACAT assessors. In the past, all Top End Remote key contacts were trained as ACAT assessors. Recently, Katherine region received funding for an ACAT position to be based locally. To make best use of available resources in Katherine, the ACAT position became 2 part-time roles, filled by the physiotherapists, to cover the whole Katherine region. This model addressed the difficulties in recruitment and retention to Katherine, and improved the quality of ACAT assessments completed, through upskilling of remote allied health staff and aged care providers. As a result the physiotherapists have acquired increased knowledge, and a broader skill set that includes aspects of occupational therapy and social worker roles, that are traditionally outside our scope of practice.

Additionally this service delivery model has enabled the development of stronger relationships between the health service provider and the remote communities, through provision of culturally appropriate aged care service delivery, leading to increased client engagement, community empowerment, and generally improved outcomes for the remote aging population.

Additional Saturday allied health services for geriatric evaluation and management

Ms Katherine Lawler[1], Professor Nicholas Taylor[1,2], Professor Pēteris Dārziņš[1,3], Professor Nora Shields[2], Mr Grant Scroggie[1]

[1]Eastern Health, [2]La Trobe University, [3]Monash University

Objective: To investigate whether providing additional allied health services on a Saturday on a Geriatric Evaluation and Management (GEM) ward could reduce length of stay without affecting discharge outcomes.
Design: A prospective controlled before-and-after trial. Pre-intervention and intervention data were collected for six months in two consecutive years.

Participants: All patients admitted and discharged from two GEM wards at Eastern Health in Melbourne, pre-intervention (n=331) and intervention (n=462).

Intervention: Occupational therapy, physiotherapy and social work and an on-call service for other disciplines were provided on a Saturday on the intervention ward in addition to the usual Monday to Friday staffing. On the comparison ward, no Saturday allied health services were provided.

Results: Length of stay did not reduce at the intervention ward (MD -0.6 days, 95%CI -4.3 to 3.0) but reduced in the comparison ward (MD -4.6 days, 95%CI -7.9 to -1.3). FIM discharge score did not change in the intervention ward (MD -2.7 points, 95%CI -7.6 to 2.2) but reduced in the comparison ward (MD -8.4 points, 95%CI -13.5 to -3.4). In the intervention ward number of days admitted in the 30 days after discharge was reduced (MD -3.7 days, 95%CI -6.8 to -0.5) but did not change in the comparison ward (MD -2.4 days, 95%CI -6.2 to 1.4). There was a 44% reduction in readmission rate in the intervention ward compared to the comparison ward (IRR 0.56, 95%CI 0.31 to 1.01).

Conclusions: In an unexpected finding, greater changes were observed in the comparison ward than the intervention ward. Additional Saturday allied health services did not reduce length of stay but may have been associated with reduced readmissions. In the comparison ward reductions in length of stay appeared to be achieved by discharging patients at a lower functional level, which may have been associated with increased readmissions.

Addressing social isolation: an 'engagement with life' (EWL) approach

Dr Edoardo Rosso[1]

[1]ECH Inc.

Interventions to reduce social isolation (SI) among older people are widely advocated, however there is a need to refine theoretical understandings of how interventions successfully mitigate SI. This presentation draws on literature on SI, loneliness, successful ageing, social exclusion/inclusion, social connectedness and social capital, and it proposes that it is not enough for interventions to promote social connectedness and/or participation. While a community engagement approach is a valuable foundation, it is important to better understand how personal experiences of 'being alone' may be mediated. This implies considering those personal and/or solitary dimensions of engagement which are positively associated with psychosocial benefits, such as reading or listening to music. To this extent, the concept of 'engagement with life' (EWL) – a key aspect of successful ageing (Rowe & Kahn 2015) – presents the opportunity to look at SI in a more conceptually inclusive way, encompassing the whole sense of wellbeing that people can derive from 'being engaged', be it with others or with meaningful solitary activities. This has both theoretical and practical implications, and it can be useful to inform the design of interventions. For example, an EWL approach can assist organisations designing/delivering SI interventions to 'use' solitary engagement as a step towards the more traditional social connectedness/participation paradigm for particularly vulnerable people (e.g. helping people to 'connect' with an interest first and then building on it to foster social connections with other people). A strategy based on the EWL approach described here and involving an integrated response of informal connections (e.g. peer support), service enrichment activities and participatory, locally-driven, community engagement programs is currently under development in South Australia.

Rowe, JW and Kahn, RL (2015). Successful ageing 2.0: conceptual expansions for the 21st Century. Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 70(4), 593-596.

Alcohol consumption and older adults

Dr Caroline Vafeas[1], Dr Gideon de Jong[1]
[1]*Edith Cowan University*

Introduction: Health expositions provide opportunities for screening and can give useful information on patterns of lifestyle factors such as alcohol consumption. More importantly, such activities provide openings for screening for people living in rural and remote areas, who may have limited occasions to participate in screening programs.

Aim: This study aimed to demonstrate that health expositions as a screening opportunity, can provide an overall impression of alcohol consumption among seniors living in rural areas.

Methods: This study included a series of cross-sectional studies, completed over a four-year period (2011; 2012; 2013; and 2014), in the same geographical location. An alcohol screening audit survey was used to collect data on consumption of alcohol among participants aged 65 years and over. Data were classified based on the consumption risk (low risk, risky and high risk).

Results: The results showed there was a statistically significant difference in the levels of alcohol consumption across the four years ($p=0.001$). Overall there was a notable trend on increasing levels of alcohol consumption over the four years. Tests showed risk was significantly higher in 2011 compared to 2012 and higher in 2013 compared to 2012. Similarly, the risk of alcohol consumption was significantly higher in 2014 compared to 2012 and compared to 2011. Although the risk increased over time, the majority of the participants presented a low risk category in each individual year.

Conclusions: This study provides a useful insight into the importance of using health expos for screening for lifestyle factors such as alcohol consumption. Screening during health expos can be used to advise health promotion programs of a particular target group or geographical location.

Key Words: alcohol consumption, older adults, screening, health promotion

Are retirement villages promoting active ageing?

Dr Annie Holt[1], Assoc Professor Jonine Jancey[2], Professor Andy Lee[2], Professor Deborah Kerr[2], Emeritus Professor Peter Howat[2]
[1]CQUniversity, [2]Curtin University

Introduction: It is well known that physical activity facilities can increase physical activity (PA) levels. Retirement villages (RV) are becoming a popular residential choice for adults aged 60 and over. Older adults living in RV's are typically sedentary, similar to community-dwelling older adults. The built environment of the RV both within and outside of the village can impact upon PA behaviour in RV residents. Physical activity facilities of retirement villages and the neighbourhood environment were assessed in RV's located in Perth, Western Australia.

Methods: Observational and self-report data were collected from 50 RVs containing 30+ independent living units (ILUs). The Audit of Physical Activity Resources for Seniors (APARS) was used to determine facilities and programs provided (Kerr et al., 2011). Brief telephone interviews with the RV residents (n=200) were conducted to identify neighbourhood barriers to walking.

Results: RV residents (n=200) were aged 43-101y with a mean age of 79 years (SD 67-91y). The larger RVs (101+ ILUs) offered 57 different facilities that supported PA, while smaller RVs (<100 ILUs) offered less (n=26). 'Outside exercise facilities' rated highly in larger RVs with a mean score of 6.67 compared to 1.0 in smaller RVs and 'inside exercise facilities' rated highly with a mean score of 7.5 compared to 1.9 in smaller RVs. Neighbourhood barriers to walking were reported as being a 'significant barrier' by one-third (n= 68) of those surveyed.

Conclusions: Larger sized RV's provided more PA facilities and programs. The age range of residents (43-101y) may indicate the challenges RVs face when trying to provide facilities and programs for residents. Other factors that may have influence on the APARS results are age of the village, geographical location, entry price/cost of ILU.

Recommendations: More research is required to better understand barriers and enablers to better support the PA levels of RV residents.

Associations between medications or prescribing patterns and hospitalisations in RACFs

Miss Kate Wang[1], Prof J Simon Bell[1,2,3], Ms Esa Chen[1,2], Dr Julia Gilmartin-Thomas[3], Dr Jenni Ilomäki[1,3]

[1]Centre for Medicine Use and Safety, Monash University, [2]NHMRC Cognitive Decline Partnership Centre, Hornsby Ku-ring-gai Hospital, [3]Department of Epidemiology and Preventive Medicine, Monash University

Aim: To systematically review the association between medications and prescribing patterns with hospitalisations from residential aged care facilities (RACFs).

Methods: MEDLINE, EMBASE, Cumulative Index to Nursing and Allied Health literature (CINAHL) and International Pharmaceutical Abstracts (IPA) were comprehensively searched to identify published, peer-reviewed, original research articles in English using a combination of key terms related to hospitalisations, RACFs and medications. Two independent investigators completed the study selection, data extraction and quality assessment using the Joanna Briggs Institute Critical Appraisal Tools.

Results: Three randomized controlled trials (RCTs), 22 cohort studies, five case-control studies, one case-time-control study and one case-crossover study, investigating 13 different medication classes and two prescribing patterns were included. Four studies suggested polypharmacy and potentially inappropriate medications (PIMs) increased all-cause hospitalisation. However, associations between polypharmacy (two studies) or PIMs (one study) and fall-related hospitalisations were inconsistent. Inconsistent associations were found between psychotropic medications with all-cause and cause-specific hospitalisations (11 studies). One RCT demonstrated high-dose influenza vaccination reduced all-cause hospitalisation compared with standard-dose vaccination (RR=0.93; 95%CI 0.88-0.98). Two cohort studies also demonstrated influenza vaccination reduced hospitalisations. Another RCT found no difference in hospitalisation rates between oseltamivir as influenza treatment and oseltamivir as treatment plus prophylaxis (treatment=4.7%, treatment and prophylaxis=3.5%; p=0.7). The third RCT reported no difference between multivitamin/mineral supplementation and hospitalisation (OR=0.94; 95%CI 0.74-1.20). Warfarin, nonsteroidal anti-inflammatory drugs, pantoprazole and vinpocetine but not long-term aspirin, statins, trimetazidine, digoxin or β-blockers were associated with all-cause or cause-specific hospitalisations in single studies of specific resident populations. Most cohort studies assessed prevalent rather than incident medication exposure, and no studies considered time-varying medication use.

Conclusion: High-quality evidence suggests influenza vaccination reduces hospitalisation. Polypharmacy and PIMs are consistently associated with increased all-cause hospitalisation. Further studies are required to better understand the relationship between other classes of medications and hospitalisation risk in RACFs.

Body mass index at a population level: evidence to action

Ms Megan A. Clifford[1], Ms Loretta M. Vaughan[1], Dr Imran Haider[1]
[1]*Department of Health and Human Services*

Introduction: The Victorian Public Health and Wellbeing plan 2015-2019 recognises that health and wellbeing needs change. Age-appropriate data to guide intervention is vital.

The World Health Organisation (WHO) classifies the healthy Body Mass Index (BMI) range as 18.5-24.9 (kg/m²) for adults ≥18years. Research exploring BMI and all-cause mortality in older adults proposes a healthy BMI range is 23.0-30.0.[1] A BMI <23.0 was associated with increased mortality risk from frailty and malnutrition, a BMI >30.0 was associated with increased mortality risk from chronic disease.

A cross-sectional study investigated the relationship between a modified BMI classification and multiple variables in older adults.

Method: A random sample of 14,756 adults ≥65 years from the 2014 Victorian Population was used to determine BMI. Modified BMI classification were underweight (<23.0); healthy weight (23.0-30.0); overweight (>30.0).

Results: Approximately 17% were underweight, 52% were healthy weight and 21% were overweight. One quarter of adults ≥85years were underweight.

Older adults who did not complete high school, had incomes <$40,000, had high or very high psychological distress, were ex-smokers, reported fair or poor health status, doctor-diagnosed hypertension and ≥2 chronic conditions were significantly more likely to be overweight.

Older adults with healthy body weight were more likely to meet physical activity guidelines and had excellent/very good self-reported health.

Conclusion: Interventions to improve population health status predominately focus on obesity prevention. These data show a similar proportion of older adults at increased mortality risk from being underweight, as overweight. Future interventions should consider this.
We will further examine the relationship between modified BMI classifications and health status, compared to the WHO classifications. Opportunities to develop a tailored, ageing profile at the population level will be explored. Appropriate interventions and target groups should be developed.

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[1]J. E. Winter, R. J. MacInnis, N. Wattanapenpaiboon and C. A. Nowson, AJCN, 2014, 875-90.

Delirium is present before it started: logic gone mad?

Dr Paul Regal[1]

[1]*University of Newcastle to 2015*

Aim: Determine frequency of cognitive domain deficits of delirium in memory clinic free of delirium, sub-syndromal delirium (SSD) or acute illness.

Methods: Audited cognitive domain battery scores for attention, executive function, language, memory and visual intelligence in 339 memory clinic subjects after excluding delirium with DSM-V and SSD by Delirium index (DI) 8-10.

Results: Mean age 80. On average 52% were impaired in each domain. Comparing 14 SSD-subjects with 339 DI 0-7, SSD group was older, more often in nursing homes and had higher frequencies ($P<0.0001$) of all cognitive domain impairments.

Comparing 54 with normal cognition (NC) to 285 with mild cognitive impairment (MCI) or dementia, NC group was 5 years younger and higher MMSE, MoCA and cognitive domain scores. I selected 81 SSD-free subjects by cognitive domain scores all below versus all above the cut-offs. Comparing 39 with all domains below cut-offs to 42 with all domains above cut-offs, the multi-impaired group was 10 years older, much less likely to live in the community and had much lower function (IADL 44% lower).
Aesop's fable of the informant who cried "acute." A man reporting 3 months continuous chest pain is unlikely to gain hospital admission. If he falsifies the history to 2 hours chest pain he is more likely to be admitted. A woman with BPSD for months will be rejected by ED and referred for community management. If symptoms are contracted to "4 hours acute confusion" the informant wins the "Get into hospital" card for delirium.

Conclusion: Major deficits in attention, executive function, memory and visual function are frequent in a memory clinic in the absence of delirium or SSD.
Clinical implications: False delirium diagnosis is easy when someone mis-labels cognitive deficits acute or when LB fluctuations are counted as delirium. DRG's further reward over-diagnosis.

Explanatory note: For more than 30 years, tremendous effort has been channelled into detecting delirium. In contrast, almost no effort has been spent preventing over-diagnosis of delirium in BPSD, Lewy body dementia, malignant catatonia and psychotic depression. This presentation demonstrates that in "cold" clinic patients (no acute illness), cognitive domain cut-offs derived from normal cognition group in a memory clinic showed high rates of cognitive domain deficits in 285 memory clinic subjects with MCI or dementia. All that is required to convert these deficits into "acute confusion" is a GP trying to gain admission by labelling confusion "acute" or another informant crying "acute" like the boy in Aesop's fable. A review of 405 articles on delirium in 789,709 medical patients found that only 11 studies (2.7%) reported the mean or median acuity of subjects (Clinical Interventions in Aging 201717:377-380). This is the ultimate trump card – "Trust me!"

Dietary intake of nutrients and tooth decay: the CHAMP study

Ms Kate Milledge[1,2,3], Professor Robert G Cumming[2,3,4], Professor Frederick Wright[2], Professor Fiona Blyth[2], Dr Vasant Hirani[1,2,3]

[1]University of Sydney, School of Life and Environmental Sciences, the Charles Perkins Centre, [2]Centre for Education and Research on Ageing, University of Sydney, Concord Hospital , [3]The ARC Centre of Excellence in Population Ageing Research (CEPAR), University of New South Wales , [4]University of Sydney, School of Public Health

The relationship between tooth decay and diet has been well established in children and adults, however research amongst older adults research is limited. The aim of this study was to examine the association between dietary intake of nutrients and tooth decay in older men.

Preliminary analysis of 520 men (mean age: 84 years) who completed a standardised validated dietary assessment and comprehensive oral health examination of decay in the Concord Health and Ageing Men Project (CHAMP). The presence of active crown decay was defined as having at least one or more surface areas on the crown of any tooth with active decay present. Similarly the presence of active root decay was defined as having at least one or more surface area on the root of any tooth affected. Nutrients were categorised according to whether they met the Australian Nutrient Reference Value (NRV) recommendations. Participants who were above the Acceptable Macronutrient Distribution Range (AMDR) for percentage of energy from fat (35%), and below the AMDR for percentage of energy from carbohydrates (45%) were categorised as a lower carbohydrate/higher fat diet.

The prevalence of active crown decay was 34.2% (n=178), and of active root decay was 27.1% (n=141). After adjusted analysis participants within the AMDR for total fat and meeting energy requirements were significantly more likely to have active crown decay (OR 1.56(95%CI:1.03 – 2.36) and 1.66(1.07 – 2.56) respectively). Meeting fibre recommendations was associated with being less likely to have active root decay, 0.58(0.34 – 0.99). Those on a lower carb diet/higher fat diet, were significantly less likely to have crown decay, 0.59(0.39 – 0.90), however no association was found between a lower carbohydrate/ higher fat diet and root decay.

These preliminary results highlight an association between macronutrients and dental decay in older men. Further analysis examining these associations is warranted.

Dietary risk factors for cardiovascular diseases among older Australians

Dr Xiaoyue (luna) Xu[1], **Prof. Deborah Parker[1]**
[1]University of Technology Sydney

Introduction: Healthy eating is important for healthy ageing. Fewer studies examined the association between dietary intake and chronic diseases for older people in Australia. Therefore, the aim of this present study is to evaluate dietary risk factors, in particular breakfast cereals and CVDs for older Australians.

Method: We used Australia New South Wales 45 and Up Study 2006-2009 baseline data (N=266,885) to address our research aim. Dietary consumption was assessed by validated short questions. CVDs were self-reported including diagnosed hypertension and heart diseases.

Results: Our preliminary data showed that more than two thirds of people don't have adequate vegetable intake, and approximately one third of people don't have adequate fruit intake; 39% of people were overweight, and 22% of people were obese. People aged 65 years and above have significantly higher cereal consumption than people aged between 45 and 65 years ($p<0.001$). Univariate logistic regression showed higher cereals consumption was significantly associated with low prevalence of hypertension among people aged between 45 and 80 years ($p<0.001$), but no association was found between cereal consumption and hypertension among people aged 80 and above (Odds Ratio: 0.99; 95% CI: 0.98; 1.00). No association was found between cereals consumption and heart diseases among people aged between 45 and 65 years, but interestingly, the positive association was found among people aged 65 years and over (OR: 1.04, 95% CI: 1.04; 1.05), which indicated higher cereal consumption was associated with higher risk of heart diseases. The association between different type of cereals (such as bran- oat- cereals) and CVDs will be further explored.

Conclusion: Diet the key factor for CVDs among older Australians. The association between breakfast cereals and CVDs may differ by different age groups. The study suggests the age-specific dietary guideline for older people need to be further developed.

Gold Coast response to elder abuse: a grassroots approach

Ms Deidre Venz[1], Ms Deanne Lawrie[2]

[1]Queensland Health, Gold Coast Hospital and Health Service, [2]Elder Abuse Prevention Unit

The Gold Coast Elder Abuse Project set out to bring local stakeholders and broader government entities together to discuss and understand the current role of their organisation in responding to and advocating against elder abuse. The project sought to develop strategic partnerships with the goal of identifying ways for services to work effectively and collaboratively, enhancing outcomes for older people experiencing elder abuse. The concept of the project evolved from challenges faced in a community social work practice that identified systems that are not always equipped for effective interventions and issues specific to an older person experiencing elder abuse. A pivotal elder abuse case was the catalyst which brought various stakeholders together to address the gravity of this person's situation also highlighting the broader systemic gaps in accessing the necessary action required to provide adequate safety and security for older people.

The project has evolved with input and support from the Elder Abuse Prevention Unit over the last two years to now include a Gold Coast Elder Abuse Reference Group and Elder Abuse Response Panel for collaborative, specialist input with complex elder abuse cases. Stakeholders involved continue to grow for both the reference group and response panel. The response panel meets monthly to hear new and ongoing complex cases and is an innovative concept that involves core representatives from key organisations as well as other relevant stakeholders who when requested can contribute offering additional specialist input. This presentation will provide de-identified cases which demonstrate efficacy of the response panel as an innovative and collaborative means towards responding to and guiding intervention for complex elder abuse cases. The presentation also seeks to outline future goals including supporting other communities to establish reference groups and response panels in their area with the project currently working on a framework to guide this.

Impact of the current aged care reforms: a case study

Ms Cathy Monro[1], Associate Professor Lee-Fay Low, Associate Professor Kate O'Loughlin
[1]*The University Of Sydney*

It has been five years since the Gillard Labor Government introduced Living Longer Living Better, a $3.7 billion, ten-year, aged care reform package. The mid-point of the reform agenda provides an opportunity to review the roll out of the package and to assess the impact on the providers and consumers of aged care services.

This study is a cross-sectional, organisational case study of an aged care service provider and their clients and families as they navigate through the reforms. It aims at evaluating the impact of the reforms at an organisational governance, management, frontline staff and consumer level.

Using qualitative research methods, this study presents preliminary findings from thematic analysis of semi-structured interview data and relevant organisational documentations to illustrate the impact of the reforms on providers and consumers of aged care services.

This case study is a part of a PhD project examining the impact of the current aged care reforms on providers and consumers of aged care services in the areas of residential and home care.

Improving clinical communication between older people and health professionals

A/Prof Rosie Crone[1,2], Dr Sarah Hosking[2], Professor Julie Pasco[2,3,4]

[1]Barwon Health McKellar Centre, [2] School of Medicine, Deakin University , [3]Department of Medicine - Western Health, Melbourne Medical School, The University of Melbourne., [4]Department of Epidemiology and Preventive Medicine, School of Public Health and Preventive Medicine, Monash University

Background

Previous research has shown that health literacy (HL) declines with ageing, studies of HL in Australia to date have classified the over 65yo as a homogenous group. The study aim was to determine if differences existed within older age groups.

Methods

Data were collected from women participating in the Geelong Osteoporosis Study (GOS), a randomly selected population-based cohort in south-eastern Australia, from Dec 2014 – Mar 2016. HL was ascertained using the HLQ, a 44-item multi-dimensional tool that generates scores across nine distinct scales. Number of health conditions were self-reported. Age was categorised as <65yo, 65-74yo, 75-84yo, ≥85yo.

One-way ANOVA were utilised to investigate differences in mean HL score across the age groups. Participants aged <65yo were held as referent. Ordinal regression analysis was used to assess differences in number of self-reported conditions by age category.

Results

A total of 715 participants (age-range 29.8-94.4yo) completed the HLQ. Women aged 75-84yo and ≥85yo demonstrated lower scores in HLQ scales 'Ability to find good health information' ($p< 0.001$ and $p<0.01$, respectively) and 'Understanding health information well enough to know what to do.' ($p < 0.002$ and $p< 0.02$, respectively). Women in the 75-85 yo age groups performed worse in these categories than women aged ≥85yo. Women aged 75-84yo also experience greater difficulty with 'Appraisal of health information' ($p <0.02$) than the over 85yo women ($p =0.88$). Women over 85yo had a non-significant ($p=0.28$) trend towards lower scores for the scale 'Social support for health'.

Conclusion

These data suggest that HL needs differ across age groups in women over 65yo, a finding that has implications for clinical practice. Health practitioners need to be aware of their specific needs for support in finding, appraising and understanding health information.

Medication omissions and New Zealand care homes: a descriptive analysis

Miss Stephanie M Garratt[1], Dr Ngaire Kerse[1], Dr Kathryn Peri[2], Dr Monique Jonas[1]
[1]School of Population Health, FMHS, University of Auckland, [2]School of Nursing, FMHS, University of Auckland

Background: Medication omissions are a common yet poorly understood aspect of medication administration, occurring when a dose of medication is not administered to a resident before the next dose time (Allan Flynn & Barker, 2007). Omissions can potentially result in harm; equally they can reflect resident choice and pragmatic clinical decision-making. There are no annual estimates for omissions, how to best record these events, or how to quantify the proportion of concerning versus justified omissions. The introduction of e-records has led to faster reporting around medication administration, but the rates and reasons behind omissions remains unclear.

Purpose: The purpose of this study was to investigate the prevalence, influences, and reasons behind medication omissions within care homes in New Zealand. It fits within a wider project that also investigates clinical decision-making around residents with fluctuating competency and refusal of medication.

Methods: A retrospective sample of de-identified administrative records for those who resided within a care home using Medi-Map electronic records from Dec 1st, 2016 to Dec 31st 2017 was obtained. Resident, staff, and facility-level data was analyzed using SPSS.

Results: Of the 11,015 residents across 374 care homes, 8,468 resided within a care home using Medi-Map for the entire timeframe. 68% were female, with Registered Nurses responsible for 61% of medication omissions. The average number of dispenses for those present over the year was 3769 per resident, with 110 dose omissions. 48% of all omissions had no corresponding reason, although an action (e.g. 'refused') was recorded. The most common omission was Paracetamol, and common reasons for omissions included: asleep, 'refused', 'said no', and 'spat' out.

Conclusions: Omissions occur across care homes in New Zealand, but there is significant variation in how they are recorded. Further study is required to ascertain the rationales behind care staff decision-making in relation to medication omissions.

New mental health first aid course to help older persons

Ms Leonie Marks[1]

[1]*Mental Health First Aid Australia*

Introduction: Good mental health is an important factor in facilitating senior Australians to live full, active and healthy lives. In older age, mental illnesses can particularly occur in association with physical illnesses, loss of independence, bereavement and brain changes that occur with ageing1.

The new 12-hour Older Person Mental Health First Aid (OPMHFA) Course is suitable for people who live or work with people aged 65 and over. Launched in November 2017, the curriculum is based on expert consensus guidelines using both professional and lived experience experts from English speaking developed countries, e.g. Mental Health First Aid Guidelines for Helping the Confused Older Person2.

Aims: The aim of this paper is to describe the OPMHFA course and present the results of the pre-course and post-course surveys uncontrolled trial for 100 home and community care workers in Victoria.

Methods: Surveys are being administered immediately before and after the course, and at six-month follow up, to 100 home care workers in Victoria. The surveys measure any changes in intentions to assist an older person with mental health problems, mental health literacy and stigmatising attitudes. Data about course satisfaction and relevance is also being collected. We are also gathering six-month follow-up data. However, these surveys have not been collected yet and will not be presented.

Results: Early data analysis indicates that participants show improvements in intentions to assist older people with depression or confusion, and in their confidence in providing help. Stigmatising attitudes were also found to be reduced. The course was found to be highly acceptable to the participants.

Conclusion: The Older Person Mental Health First Aid course is an effective public health intervention to reduce stigma about mental health problems in older people and increase appropriate helping behaviours in people who work within the aged care industry.

Online course engages ageing Australians in open discussions about dying

Dr Lauren Miller-Lewis[1], Professor Jennifer Tieman[1], Ms Deb Rawlings[1], **Professor Deborah Parker[2]**, Dr Christine Sanderson[3]

[1]Flinders University, [2]University of Technology Sydney, [3]University of Technology Sydney and Calvary Health Care Kogarah

Background/Aims: Massive-Open-Online-Courses (MOOCs) have changed the way in which the general community can engage with each other and learn together. MOOCs are freely available short online courses that make use of the digital environment to deliver educational content and create socially-constructed learning and exchange. CareSearch, an evidence based palliative care website, offered the Dying2Learn MOOC to the general public, which aimed to build community awareness and acceptance of death as a natural part of life.

Methods: The free five-week course provided the opportunity to actively discuss and collaboratively learn about issues around living, dying and palliative care. The platform enabled evaluation of participant engagement, learning gains, and pre-post attitudinal change. Data was examined usingParker
Results: 1156 people joined the online course in 2016, and 1960 joined in 2017. This demonstrated a need for online forums offering the chance to explore death and dying from social perspectives. In 2017, most MOOC participants resided in Australia. Participants ranged in age from 17 through to 82 years (mean= 47 years), with 17% of participants aged over 60. Older participants completed a greater percentage of the course content and were more likely to fully complete the course. Course completion was highest in the 60+ age group. Course participants in all age groups reported becoming more comfortable with talking about death and reported high levels of satisfaction with the experience.

Conclusions: The Dying2Learn MOOC was well-utilized by participants varying widely in age, including active participation by people aged over 60. This highlights the potential of these innovative online digital platforms for fostering community conversations about life, dying and death, and for increasing community awareness of palliative care and death preparedness. Age was not a barrier to participation, with the interactive and social design of the course appealing to older and younger participants alike.
Biography:
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Planning for the future in dementia: finding meaning and value

Miss Michelle Lai[1], Professor Yun-Hee Jeon[1], Associate Professor Heather McKenzie[1]
[1]*Faculty of Medicine and Health, University of Sydney*

The beliefs people with dementia, their families and carers, and their healthcare professionals (stakeholders hereafter) have about the meaning and value of planning for the future (e.g., care, treatment and service utilisation) can have a considerable impact on their engagement with decision-making about the future.

This presentation will draw on the findings of a systematic review conducted by the authors on the key factors for engagement of these three stakeholders in planning for the future. Stakeholder views about informal and formal processes that enable future planning will be explored, as well as the barriers they face and how they can be addressed in light of the contextual complexities faced by stakeholders.

Existing research, policy, and initiatives heavily emphasise formal future planning processes, particularly advance care planning (ACP).

Our review shows that there has been little focus on informal processes, despite the fact people with dementia and their families and carers are reluctant to engage with ACP when planning for the future. Many healthcare professionals face challenges due to the time-consuming nature of planning for the future and engaging people with dementia and their families and carers in such discussions. Furthermore, some do not perceive it to be part of their responsibility.

Recent studies have shown that by the time people with dementia are in residential care, many do not have an ACP in place. With the current emphasis on the importance of ACP, this is particularly concerning, given that most people with dementia enter residential care at an advanced stage when they have lost their decision-making capacity.

This review shows that key stakeholders need to feel comfortable with formal future planning processes before they can confidently engage with them. They need to have a sense of ownership of the processes, and also perceive them to be meaningful and valuable.

Seated exercise for older adults: a systematic review and meta-analysis

Ms Bernadette Sexton[1], Professor Nicholas Taylor[2,3]

[1]Eastern Health, Transition Care Program, [2]Eastern Health, Allied Health Clinical Research Office, [3]La Trobe University, School of Allied Health

Introduction: The burden of physical inactivity increases with age: functional decline, decreased independence and reduced participation levels are associated with decreased quality of life, increased depression and stress, and a further reduction in physical activity. Seated exercise programs provide an opportunity for older adults with impaired mobility or balance to engage safely in a structured form of physical activity. A significant amount of time and resources are invested into seated exercise programs conducted in a range of settings including home, residential care facilities, day centres and hospitals, yet their effectiveness is unclear.

Objective: This systematic review aimed to determine the effect of seated exercise on impairment, activity and participation levels of older adults living with a health condition or impairment.
Methods: A systematic search of the electronic databases MEDLINE, PsycINFO, CINAHL, EMBASE and AMED combined concepts of seated exercise and controlled trials. Selected trials were appraised for quality and results synthesised by calculating Standardised Mean Differences (SMD) and meta-analyses where appropriate.

Results: Fourteen randomised controlled trials met inclusion criteria. Compared to usual care or social activities, seated exercise had a large positive effect on cognition (SMD 1.20, 95% confidence interval 0.25, 2.16). There were smaller effects on strength, spinal flexion, activity, depression and quality of life, but not balance and mobility. There was little or no effect when seated exercise was compared to alternate exercise programs including weight-bearing and functional exercises.

Conclusion: Seated exercise is of benefit for older adults in protecting or improving cognition or for those who are unable to exercise in other positions. Where it is safe to do so, weight-bearing and functional exercises should be incorporated into programs.

Social and productive activities and health among partnered older adults

Dr Jack Lam[1], Dr Danilo Bolano[2]
[1]*University of Queensland,* [2]*University of Lausanne*

Objectives. We theorize and test the health of older adults as a result of their activity engagement, as well as a product of their spouse's engagement.

Method. We draw on 15 waves of couple-level data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey. Using responses of time engaged in nine different activities, we estimate Latent Class Models to describe activity profiles of partnered older adults. Given potential health selections into activity engagement, we lag older adults' activity engagement by one wave to examine its association with subsequent health. We then investigate associations between the lag of
the spouse's activities with respondents' health, controlling for their own activity engagement at the previous wave.

Result. We find four activity profiles for men, and three for women. Respondents who were predominantly engaged in community activities
generally report better subsequent health. Beyond their own activity engagement, for both older men and women, having a partner who was also community engaged associate with better subsequent health, though for older women, there were little differences between having a husband who was community engaged or inactive.

Discussion. Our findings highlight the value of considering activities of partnered older adults at the couple level.

The ideal and non-ideal client: risk in OT

A/Prof Mandy Stanley[1], Ms Deborah Forsythe[2], Professor Debbie Laliberte Rudman[3]
[1]Edith Cowan University, [2]University of South Australia, [3]Western University

Background: In the Western world there is a growing aversion to risk and a concurrent increase in policies and procedures to manage exposure to risk. Provision of services including occupational therapy (OT) to older people living in a rural and remote community context has not escaped the increased attention to risk aversion however the intensification of focus on risk for occupational therapy practice in this context has not been critically examined.

Method: Four occupational therapists working with older people in a rural context participated in semi-structured interviews. Two risk-related documents designed to guide their practice and identification of risk were also obtained. A critical discourse analysis approach was taken to analyse both sets of data to illuminate how risk was conceptualised and consider how this impacted therapists' ways of working with older clients.

Results: Organisational documents predominantly conveyed a techno-scientific focus on risk as objective, measurable, and able to be proactively managed. Although therapists discussed risk as complex, dynamic and having subjective elements, many of their ideas about the ideal client closely followed the dominant organisational discourse. Therapist's mixed views of risk produced difficulties with balancing client choice with risk minimisation or elimination.

Conclusion: The differing conceptualisations of risk created tensions in practice and impacted therapists' attitudes and behaviour towards older clients. This may limit therapists' abilities to practice in client-centred ways, thereby decreasing the autonomy of the older client. There is a need for those working with older people at individual and collective levels to actively contribute to reformulating how risk is conceptualised and addressed to enable practice that acknowledges the rights of clients to make autonomous choices and engage in everyday life which is inherently risky.

Therapy based dementia strategies - beyond the clinical

Ms Jane Meldrum[1], Ms Kylie Jacques[1]
[2]*Anglican Care*

The presentation will report on the development and implementation of a service for residential homes and consumers living in the community, offering non-pharmacological interventions for people living with dementia, with the goal of reducing behavioural and psychological symptoms of dementia (BPSD). The Direct-Action Response Team (DART) program was introduced in 2017 to address this identified need. The program has been developed to augment existing management strategies by:

• Creating a system for internal referrals to the DART team
• Enabling multi-disciplinary discussions amongst staff to discuss current interventions for BPSD with the DART team
• Allowing the gathering of information from a person's family to develop a person-centred approach to management that focuses on the person's previous interests
• Developing person centred plan of care including tailored, non-pharmacological interventions
• Enabling referral to the organisations Clinical Practice Unit and external support services as required.

Overall objectives of the DART program are to:
• Reduce BPSD from a non-pharmacological perspective
• Enhance individualised programs for residents and consumers
• Enhance communication with family carers
• Increase cross unit communication
• Expand the services offered by Anglican Care.

The individualised therapy-based strategies developed by the DART team include, but are not limited to, a combination of exercise, music, reminiscence, multi-sensory and pet therapy. Resource packs are prepared for each participant of the program utilising a range of items that can be used in tailored activities. These resources often come from another program unique to Anglican Care, our Lifestyle Resource Van. The DART team communicate with staff about how to use the contents of the resource pack with participants of the program.

Findings from an independent evaluation of the establishment of the program by Dr Jane Sims will be presented together with case studies of several participants of the program.