

8th National Conference of Emerging Researchers in Ageing

**A new era for ageing research: What's in
your toolkit?**

Friday 23 October 2009

(Half day pre-conference workshop - 22 October 2009)

ABSTRACTS & PROCEEDINGS

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Welcome



It is with great pleasure that we welcome you to the 8th National Conference of Emerging Researchers in Ageing. This conference builds upon the very successful previous ERA conferences hosted around Australia and for the first time is taking place in Melbourne, Victoria. Located in Carlton, Rydges on Swanston is on the fringe of Melbourne's CBD, making this an ideal conference location, surrounded by a bustling cosmopolitan centre boasting a diverse range of outstanding restaurants, shops, cultural activities and night spots.

ERA 2009 brings together student researchers, practitioners and policy contributors to showcase the latest ageing-related research from a range of disciplines. This year's conference reflects the breadth of student's research, with students participating from over 25 universities across Australia and overseas this exciting conference.

The programme's major theme: "A new era for ageing research: What's In Your Toolkit?", focuses on the importance of methodological issues in ageing research. With the inclusion of 69 oral presentations and 12 poster presentations in this year's ERA conference, the programme offers you considerable opportunity for interstate dialogue, networking with other postgraduates and the opportunity to learn more about the broader policy context of ageing. Once again, it is a privilege to convene the conference in Melbourne and to extend this warm welcome to you.

Professor Colette Browning
Conference Convenor
Healthy Ageing Research Unit
School of Primary Health Care
Faculty of Medicine, Nursing and Health Sciences
Monash University

SPEAKER PROFILE



Professor Paul Higgs is Professor of the Sociology of Ageing in the School of Life and Medical Sciences at University College London where he has made a significant impact in designing and implementing both undergraduate and postgraduate programs and has published widely in both social gerontology and medical sociology. His research interests in ageing include the Third Age; embodiment; identity; generations, cohorts and ageing; consumption and later life; and influences of quality of life in early old age and retirement. Longitudinal research contributions include carers of people with dementia and as a collaborator in the English Longitudinal Study of Ageing. He has enhanced the discipline internationally via his involvement in a number of committees, editorial roles, as a regular reviewer for key journals in ageing, and as a popular international speaker. He is currently co-authoring a book on the embodiment of ageing due to be published in 2010.

KEYNOTE ADDRESS

Researching the new contingencies of later life

The 21st century has brought to many researchers the realisation that the study of later life is much more complicated than it was in the preceding 50 years. The impact of greater longevity and improved health has gone hand in hand with improvements in the social circumstances of the retired population. The issues that confront ageing research have also begun to change particularly in connection to the growing significance of culture and generation in the lives of older people. The emergence of a third age culture and its connection to the growing demographic importance of the baby-boomer cohorts foregrounds new challenges and opportunities for gerontologists. These challenges and opportunities are not just limited to issues of health and well-being as they have been traditionally understood, but go much wider to encompass topics such as leisure and popular culture.

In this presentation Professor Higgs will look at how different methodologies can help those involved in research to examine the idea of generation and the new contingencies of later life. In particular he will focus on ideas about how we need to think about the changing interrelationship between age, period and cohort in describing post-working life. Professor Higgs will argue that it is only thinking through the changed nature of these relationships that allows an understanding about how a different century requires us to research old age in different ways.

PROGRAM

Thursday 22 October - Pre-conference Grant Writing Workshop

12.30 - 1.00pm:	Registration
1.00 - 1.10pm:	Welcome
1.10 - 3.00pm:	Workshop Session 1
<i>3.00 - 3.30pm:</i>	<i>Afternoon Tea</i>
3.30 - 4.50pm:	Workshop Session 2
4.50 - 5.00pm:	Overview and close

Thursday 22 October – Welcome Event

6:00 - 6:30pm:	Drinks, appetisers and networking
6.30pm:	Informal Conference Opening and Introduction to Performance Dr Susan Feldman
6.30 - 7.30pm:	Performance and forum: From thesis to theatre
7.30 - 8.00pm:	Drinks, appetisers and networking

Friday 23 October – ERA Conference

7.45 - 9.00am:	Registration
9.00 - 9.10am:	Welcome to ERA 2009 and Acknowledgment of Traditional Land Owners Prof Helen Bartlett, Pro-Vice Chancellor, Monash University Gippsland Campus
9.10 - 9.15am	Student speaker Sasha Stumpers
9.15 - 9.25am:	8th ERA Conference Official Launch Prof Ed Byrne, Vice Chancellor, Monash University
9.25 - 9.35am:	Welcome on behalf of research in ageing at Monash University Prof Colette Browning, Director Healthy Ageing Research Unit
9.35 - 10.30am:	Keynote Speaker and questions Prof Paul Higgs, Professor of the Sociology of Ageing, UCL, UK
<i>10.30 - 11.00am:</i>	<i>Morning Tea (and posters)</i>
11.00 - 12.45pm:	Sessions 1-5 (Paper presentations)
<i>12.45 - 1.30pm:</i>	<i>Buffet Lunch (and posters)</i>
1.30 - 3.15pm:	Sessions 6-10 (Paper presentations)
<i>3.15 - 3.45pm:</i>	<i>Afternoon Tea (and posters)</i>
3:45 - 4.30pm:	Panel and Questions: What's in your toolkit? Facilitated by Prof Leon Piterman AM, Head of School PHC, Monash University
4.30 - 4.40pm:	Translation of research into primary care practice Prof Leon Piterman AM, Head of School PHC, Monash University
4.40 - 5.00pm:	Overview, prizes and close Prof Helen Bartlett, Pro-Vice Chancellor, Monash University Gippsland Campus

PRESENTERS PROGRAM

Morning Session 11:00am-12:45pm

Session 1 Working on the Ground		Session 2 Mind Matters		Session 3 Working Life & Life After Work		Session 4 Health & Functioning		Session 5 Engaging with the Community	
Room 5 Chair: Dennis Lowther		Room 1 Chair: Claudia Meyer		Room 2 Chair: Sonia Allen		Room 4 Chair: Jing Yang		Room 3 Chair: Tess Tsindos	
1A Peta McVey A Palliative Approach for People with Declining Health Living in Hostel Accommodation: Age Care Staff Experiences		2A Fiona Millard Raising Community Awareness of Dementia and Its Risk Factors		3A Megan Tones Stability of the Learning and Development Survey: Findings for Mature Age Local Government and Private Healthcare Organisations		4A Nicola Fairhall Measurement of Participation Restriction in Older People		5A Carollee Garnham The Relationship Between Psychological Strengths and Health of People over 65 Years Living in the Community with Minimal Community Support Services	
1B Gael Walsh Older People's Perspectives on the Management of Their Assets In Aged Care Facilities		2B Nichole Saunders Attention and Working Memory Deficits in Mild Cognitive Impairment		3B Jennifer Buckley Ageing in the 21 st Century – Are Baby Boomers Prepared?		4B Carolina Weller CONSORT: A Valuable Tool to Improve Research in the Aged with Venous Leg Ulcers		5B Tess Tsindos Why Friends Matter to Health – The Manningham Study of Chinese and Anglo Australian Experience	
1C Lynsey Brown The 'Nuts and Bolts' of Caregiver Wellbeing: A Longitudinal Study		2C Amanda Scicluna Socioemotional Functioning in Older Adults with Alzheimer's Disease		3C Anthony Brown Tools From the Shed – Building a Toolkit For Retirement		4C Lora Vanis Comparative Effects of Two Carbohydrates, Glucose and Xylose, on Blood Pressure and Gastric Emptying in Healthy Elderly		5C Joan Stewart How Are You Today? – The Shop and Its Significance for the Well-being of Older People	
1D Lyn Phillipson Factors Influencing the Non-use of Respite Services by Caregivers of people with Dementia differ According to Respite Product and by Caregiver and Care Recipient Need		2D Nicola Gates Mind Your Language: Defining Cognitive Training in MCI and AD		3D Jodi Oakman Are Organisations Able to Influence Their Employees' Retirement Intentions?		4D Dianne Goeman Improving the Style and Content of General Practitioner Consultations for Older People With Asthma: A Mixed Methods Approach		5D Rowena MacKean An Under-Rated Community Resource? How Community Organisations Run by Peers Help Older People Maintain Their Wellbeing and Independence	
1E Esther Munyisia How Carers Spend Their Time in a Nursing Home		2E Kathryn Nicholson The Experience of Caring for a Person with Dementia with Lewy Bodies: Presenting Research Findings as an Educational Resource		3E John Van Holsteyn Does Retirement Call for Another Identity?		4E Kim Kiely Variable Harmonisation in the DYNOPTA Project: Establishing a Common Ground for Combining Sensory Functioning Data Across 9 Australian Longitudinal Studies of Ageing		5E Sue Malta Qualitative Interviewing of Older Adults: Offline versus Online Methods	
1F Ellen Meissner Where is all this going? – Middle Managers' Perspectives on Current Challenges Within the Non-profit Aged Care Industry		2F Rachelle Arkles Dis(cover)ing Experience and Meaning in 'Dementia': Aboriginal Elders in Urban Australia		3F Martin Snoke Are Baby Boomers Seeking Retirement Advice?		4F Lisa-Jane Moody Hearing Access in Healthy Ageing		5F Pam Coutts Locating A Diverse Population of Older Users and Non Users of the Internet for a Statistically Significant Sample Survey by Telephone Interview – A Micro Data Analysis Approach	
1G Kieren Diment Positive and Negative Unintended Consequences of Electronic Nursing Documentation in Aged Care Facilities		2G Julia Poole The Challenges of Employing Action Research Methods to Facilitate Sustainable Practice Improvement When Caring for Confused Older Patients		3G Edmund Ramon Talob Predictions of Graceful Ageing in Senior Australians		4G Susan Hunt Modelling Successful Ageing, Ageing Transitions and Lifestyle Behaviour Patterns		5G Nikos Thomacos Reconceptualising Social Support Across the Lifespan	

Afternoon Session: 1:30-3:15 pm

Session 6 Connecting Past, Present & Future		Session 7 Let's Get Physical		Session 8 The Quality of Care		Session 9 Allied Health & Nutrition		Session 10 Emotional Health & Wellbeing	
Room 4 Chair: Jing Yang	Room 1 Chair: Niki Fairhall	Room 5 Chair: Sonia Allen	Room 2 Chair: Claudia Meyer	Room 3 Chair: Tess Tsindos					
6A Bridget Garnham Using Foucault's Toolbox in Ageing Research	7A Mei Guo Examination of Social Demographic Status, Disease Status, Health Behaviours and Quality of Life in Older Australians Using the Theory of Planned Behaviour Model	8A Lois Hazelton The Toolbox Experience: Evaluating 2 Research Tools to Facilitate Enhanced Innovation in the Aged Care Industry	9A Julie Luker Age-Related Differences in the Quality of Care: How Well are We Using Our 'Tool Kits' for Older Stroke Patients	10A Fatimah Zailly Ahmad Ramli Reflections on Interviewing, Transcribing and Translating Process: An Experience with the Malays Caregivers of Older People with Mental Health Problems					
6B Margaret Simmons A Toolkit for Stories of Women Who were Child Evacuees in WWII Britain, and Also Postwar British Immigrants to Australia	7B Elisabeth Lord Qualitative Prospective Study of Men at Risk and Walking	8B Dolly Hsiao-Yun Huang Factors Associated with Aged Care Utilisation Among the Chinese-Speaking Elderly in Australia	9B Ann Rahmann Aquatic Physiotherapy after joint replacement Surgery : Reflections on Completing a Clinical RCT	10B Karen Burnell Developing a Model of Narrative Analysis to Investigate the Role of Social Support in Coping with Traumatic War Memories					
6C Theresa Mason Finding a Voice	7C Thorlene Egerton The Immediate Effect of Moderate Physical Activity on the Balance of Older People	8C Maria O'Reilly Building the Toolkit of Quality Monitoring: Clinical Outcomes as a Means of Assessing Quality in Residential Care	9C Yan Yu Life-Course Patterns in the Relationship Between Body-Weight and Mortality: An Age- and Cohort-Specific Analysis	10C Miriam Anna Mosing Potential sex differences in the genetic architecture of the covariation between optimism and health in aged Australian and Swedish twins.					
6D Glenna Lear Learning From Natural Disasters: Unexpected Explorations During a PhD Project	7D Georgia Birch How Does Physical Activity and Motherhood Influence Activity Levels in Later Life for Older Ethnic Women?	8D Joan Ostaszkievicz Ethical Challenges Associated with Research on the Management of Incontinence in Residential Aged Care Settings	9D Paul Jeffery The Influence of Food Processing on the Ability of Older Australians to Meet the Nutrient Reference Standards	10D Jessica Swain The Depression-Dementia Dilemma for Primary Care: Relationships Between Cognitive Impairment and Mental Illness in Community-Dwelling Elderly Australians					
6E Jane Palmer Do No Harm: Ethical and Methodological Dilemmas in Interviewing Older People In Aceh	7E Rina Kusumaratna Factors Influencing Frailty Among Community-Dwelling Elderly in Manggarai Sub-district, South Jakarta	8E Joanne Rowley Sharing Knowledge: An Action Research Study	9E Jane Kellett What is an Appropriate BMI for Individuals over the Age of 70 Years?	10E Jenny Patterson Developing Evidence-Based Methodology to Evaluate the Effects of Music and Animal-Assisted Activities on Depression in Cognitively Intact Elderly Individuals					
6F Allyson Thomson A Lifetime of Parenting: When Your Child Has an Intellectual Disability of Genetic Origin	7F Anne-Marie Hill The Effect of Patient Education For the Prevention of In-hospital Falls in Older Patients – A Randomised Controlled Trial	8F Juanita Westbury The 'RedUse' Project: Reducing the Use of Sedatives in Residential Aged Care	9F Sandra Ullrich The Essential Palette of Action Research	10F Christina Aggar Informal Carers of Community-Dwelling Frail Older People: Aspects of the Caregiving Experience Predict Depression					
	7G Satyan Chari What Makes a Fall a "Fracture" Fall?: Analysis of Over 14000 Patient Falls Incidents in Queensland	8G Cik Yin Lee Risk of Medication Misadventure Among Residents of Retirement Villages (RV) in Victoria: A Cross-sectional Survey	9G Julie Woods Malnutrition on the Menu: Nutritional Status of Institutionalised Elderly Australians in Low-Level Care	10G Celia Wilkinson The Pouring Practices of Older Drinkers: Implications					

Prizes Awarded at the 8th National Emerging Researchers in Ageing Conference - ERA 2009

Helen Bartlett Prize for Innovation in Ageing Research

The Helen Bartlett Prize for Innovation will be awarded to the student whose research is considered by the judging panel to be the most original and creative. The prize recognises the outstanding contribution made by Professor Helen Bartlett, ProVice Chancellor Monash Gippsland campus, to the field of ageing research in Australia, particularly as the founder of the ERA initiative. In 2009, the prize will be sponsored by the ARC/NHMRC Research Network in Ageing Well. This cash prize is valued at \$500

Royal College of Nursing Australia Prize – Nursing students only

This prize is sponsored by the Royal College of Nursing Australia and will be awarded to the best paper presentation by a Nursing student as considered by the judging panel. The prize is a 12 month membership to the RCNA, valued at \$386.

AAG-Victoria Prize – Victorian students only

The AAG is Australia's largest multidisciplinary professional association of people who work in, or have an interest in, ageing. The Victorian Division of AAG plays an active role in supporting the development of student and early career researchers. The AAG-Victoria prize will be awarded to the best paper presentation by a Victorian student as considered by the judging panel. A cheque to the value of \$250 will be awarded to the winning student.

Best Paper Presentation by a Doctoral student

This prize will be awarded to the Doctoral student who presents the best overall paper presentation at ERA 2009 as considered by the judging panel. This cash prize is valued at \$250

Best Paper Presentation by a Masters student

This prize will be awarded to the Masters student who presents the best overall paper presentation at ERA 2009 as considered by the judging panel. This cash prize is valued at \$250

Best Poster Presentation on ageing by a research student

This prize will be awarded to the postgraduate student who presents the best poster presentation as considered by the judging panel at ERA 2009. This cash prize is valued at \$250

Healthy Ageing Research Unit (HARU) Encouragement Prize

The HARU Encouragement Prize recognises the future research potential demonstrated by a student in the early stages of their research degree. The prize is a book voucher to the value of \$150

ABSTRACTS

Session 1 - Working on the Ground

1A

A palliative approach for people with declining health living in hostel accommodation: Age care staff experiences

Ms Peta McVey

The University of Sydney

Authors: McVey, P., McKenzie, H., & White, K.

Presenter Profile

Peta McVey has worked in the field of palliative care / oncology in Sydney for over 25 years and for the past 10 years has been working in the position of the Clinical Nurse Consultant / Coordinator of the community Palliative Care Outreach Service at Neringah Hospital, Hope Healthcare in Sydney. Peta is currently a Doctoral candidate enrolled at the University of Sydney. Peta is a recipient of a 2007 National Health and Medical Research Palliative Care Scholarship to undertake this research and a recipient of the RCNA 2008 NSW Nurses Research Grant

Abstract

In Australia, residential aged care facilities are increasingly becoming the place of care and site of death for people with complex chronic illnesses (Cooper et al, 2004). A palliative approach is an approach to care that is linked to the principles and philosophy of palliative care with the intention this approach be used by primary care services and general practitioners (Palliative Care Australia, 2005). Most research to date has focused on end-of-life care in high-level care nursing home settings (Clarke & Ross 2006). Little is known about the use of a palliative approach in caring for elderly people with complex needs living in hostels in Australia.

This study was conducted in eight hostels in two residential aged care facilities in NSW (one rural and one metropolitan). A descriptive instrumental case study methodology was used drawing on multiple data sources, both quantitative and qualitative. Three validated tools were used to determine the resident's health status, wellbeing, and functional ability and assess current symptoms. A medical record audit tool was developed to collect demographic data, and organisational and managerial data tools were developed to collect information of policies, education and staffing levels. Semi-structured interviews were conducted with 30 aged care staff, 21 guardians and 72 high-level care residents. Data collection was conducted over a nine month period. This paper discusses the study's preliminary findings and the implications of these for the delivery of effective care to high level care people living in hostel facilities.

1B

Older people's perspectives on the management of their assets in aged care facilities

Mrs Gael Walsh
University of Queensland

Presenter Profile

With a professional background as a social worker my main aim while working with older people was to ensure older people's voices were heard and that their rights and interests were protected. As a hospital social worker and as a senior legal guardian in the Office of the Adult Guardian in Queensland, I have extensive practice experience working closely with older people in a hospital setting and for those with impaired decision-making capacity. My practice framework consists of providing ongoing support for families and older people, counselling and strong advocacy, to ensure the best possible outcome for vulnerable older people where their wishes are respected. This practice experience has provided me with extensive knowledge of substitute decision-making legislation, processes and practices.

Abstract

The aim of this research is to better understand the current practices and preferences in asset management from the perspectives of older people with cognitive capacity living in aged care facilities (ACFs). The intention of the research is to build knowledge and inform policy and practice in an area that is not well understood.

The Australian Aged care Standards encourage older people living in aged care facilities to have independence and control in asset management but to date it is unknown how this concept is operationalised in residential aged care settings. As residents in ACFs have high levels of disability they require daily support and care by families, friends and aged care staff to meet their daily care needs. However, ongoing assistance can potentially create dependency which may increase the resident's vulnerability.

With an ageing population there are increasing dilemmas for policy makers around how best provide care that respects older people's wishes. As aged care policy is moving along a continuum that promotes older people's rights to independence, yet their voices have not been heard about what they wish to happen in asset management. Understanding older people's views will ensure their wishes are respected.

This is a small scale qualitative study. Recruitment includes up to 18 residents from a mix of both high and low care and "extra-services" ACFs in the Brisbane metropolitan area. Data was collected through in-depth semi-structured interviews. Analysis of preliminary findings will be presented.

The ‘nuts and bolts’ of caregiver wellbeing: A longitudinal study

Miss Lynsey Brown
Flinders University

Authors: Brown, L. J., & Bond, M. J.

Presenter Profile

Lynsey Brown is a PhD student and a SA Department of Health Research Award recipient (2008 – 2010). Her project entails a longitudinal assessment of the physical and mental health of spouse caregivers of dementia patients. This research addresses three major themes: the plausibility of a mechanism linking stress and disease (allostatic load); the likelihood of gender differences in caregiver outcomes; and the impact of relinquishment on the caregiving journey. Previous work in the health psychology field includes Lynsey's Honours project entitled 'Predictors of Men's Health Behaviour' which resulted in a publication in the International Journal of Men's Health.

Abstract

One in fifteen Australians aged over 65 are likely to experience dementia, and are commonly supported by family members such as spouses, who provide assistance as primary caregivers. Research has consistently reported negative outcomes in terms of caregivers' wellbeing, though it is often cross-sectional methods that are used to establish such findings. Yet for dementia caregivers the role entails a dynamic long-term journey. Therefore the ideal method for tracking caregiver outcomes and advancing the field is to engage in a study of longitudinal design. The current study involved six home visits (spanning seven years) during which participants were assisted in completing a questionnaire that included measures of wellbeing and dementia severity. Visits were initially conducted with 200 individuals who nominated themselves as primary caregivers to a co-resident spouse diagnosed with dementia, and 60 community members (age and sex matched to caregiver sample). Over time caregivers who transitioned out of their role due to nursing home placement or death of their spouse, were retained in the study as 'relinquished caregivers'. Longitudinal studies are frequently affected by attrition though in the current study there were 16 continuing caregivers, 105 relinquished caregivers and 27 community members remaining at the completion of data collection (N = 148). By presenting between-group and within-group differences for the 148 participants and examining changes in psychological and physical health, results from this study will demonstrate the decline in health of caregivers, the improved health of relinquished caregivers and the benefits of longitudinal studies in documenting the caregiving journey.

1D

Factors influencing the non-use of respite services by caregivers of people with dementia differ according to respite product and by caregiver and care recipient need

Ms Lyn Phillipson

Centre for Health Initiatives, University of Wollongong

Authors: Phillipson, L., & Jones, S. C.

Presenter Profile

Lyn Phillipson initially trained as a physiotherapist and also has a Masters in Public Health. She has worked in clinical practice as a physiotherapist, as a health educator, and as a research associate in a population health research centre. She is currently undertaking her doctoral study investigating the factors that influence the non-use of respite services by carers of people with dementia.

Abstract

This paper utilizes Anderson's behavioural model of service use to discuss the various factors associated with the non-use of respite services by carers of people living with dementia, many of whom themselves are aged. The physical and psychological burden of providing care for someone with dementia is well established. Formal services can assist carers to support people with dementia to live at home for longer by providing a break or 'respite' from their responsibilities. Such an outcome is consistent with both community and government preference for older people to remain living in their own homes for as long as possible. However, despite dementia caregivers indicating a need for respite services, their use of such services is often low, and little is known about factors that may be associated with non-use of different types of respite services. In this paper, the results of a critical literature review (inclusive of both qualitative and quantitative papers), reveal that the predisposing, enabling (or disabling) and need factors associated with respite non-use differ according to respite product (i.e. day care or in-home respite services) and are not just the inverse of those factors that have been associated with respite use. Results highlight the need for the evaluation of approaches to supporting respite service use that consider what actions may be required to overcome the specific barriers to the use of particular respite services for both the caregiver and those living with dementia themselves.

1E

How carers spend their time in a nursing home

Ms Esther Munyisia
University of Wollongong

Authors: Munyisia, E., Yu, P., & Hailey, D.

Presenter Profile

Esther is a Postgraduate student at the University of Wollongong in the faculty of informatics. She is pursuing a Doctoral degree in the field of electronic health. Esther also holds a degree in Health Sciences and a Masters degree in Health Informatics. She has over 10 years work experience in public health, especially in managing health information. Esther believes that information technology is a great opportunity in the provision of quality nursing care to the elderly. Her ambition is to contribute towards enhanced health care services through effective use of technology in aged care settings.

Abstract

OBJECTIVES: This paper describes how carers utilize their time on activities in a residential aged care home (RACH).

BACKGROUND: The introduction of electronic information systems in RACHs in Australia is on the increase. To understand the effects of the systems in nursing care, baseline information against which to measure change is important.

METHODS: An observational work sampling study was undertaken with 13 Registered Nurses, 4 Endorsed Enrolled Nurses, 52 Personal Carers and 6 Recreation Activity Officers using a data collection tool with 7 classifications of nursing activities. The study lasted 5 days.

RESULTS: 6,538 observations were recorded. Overall, carers spent 39.7% of their time communicating, 30.2% in direct care and 11.8% documenting. They spend equal time in transit and indirect care activities (6.4% each). Personal errands consumed 5.1% of their time and 0.4% was spent on other nursing tasks. A significant difference was found in time spent on activities in low and high care units. Carers in the low care unit spent less time in both direct care (23.2% vs 36.0%, $p < 0.01$) and personal activities (4.9% vs 5.2% $p < 0.01$), and more time in transit (8.7% vs 4.5%, $p < 0.01$). Carers in both units spent equal time in communication, documentation, indirect care and other nursing tasks.

CONCLUSION: Communication activities consumed much of the carers' time suggesting the need for a computerized system to support them in performing these tasks. Cares required less time to provide direct care to residents in the low care unit since most of them are physically able.

1F

Where is all this going? – Middle managers' perspectives on current challenges within the non-profit aged care industry

Ellen Meissner
University of Queensland

Presenter Profile

Ellen Meissner is a registered psychologist in Queensland. She has worked as organisational psychologist in the UK, Germany and Australia focusing on evaluation processes, change management, leadership and the measurement of training outcomes. She has been involved in project concerning health and the elderly and is an active member of the College of Organisational Psychology as well as the student representative of the AAG QLD. Her PhD focuses on middle managers within the non-profit aged care industry and is funded by RSL Care in conjunction with The University of Queensland.

Abstract

Increased competition for funding, complex accreditation requirements, shortages of skilled personnel, changing client needs and the necessity for innovative service delivery models are drivers for change within the aged care industry. Additionally, a new pro-business zeitgeist impacts dramatically on non-profit organisations. They have reorganised, restructured and implemented new management approaches and strategies while aligning their operations for a more corporate approach. Tensions arise from the interaction of demands for adjustment in both service delivery models and management styles.

This paper reports the findings of the qualitative phase of a mixed method study in one large non-profit provider of community and residential aged care. A mixed method design allows collecting in-depth knowledge of participants as well as noting trends and generalisations. In the first phase of this research study, a purposive sample of 30 middle managers from different areas of operation was interviewed using a semi-structured interview guide. The data provides an in-depth understanding of how working more 'business-like' matters in non-profit human services, what challenges middle managers are facing and how they respond to them. It also provides information on how participants adapt to change while dealing with the tensions constantly presented to them. Conceptually, the research adds to the understanding of organisational factors and individual characteristics that are important in assisting managers to adjust to continuous change. At an applied level, the research provides guidelines for enhancing the performance of middle managers in the not-for-profit sector while increasing job satisfaction and well-being.

1G

Positive and negative unintended consequences of electronic nursing documentation in aged care facilities

Mr Kieren Diment
University of Wollongong

Authors: Diment, K., & Yu, P.

Presenter Profile

Kieren Diment is a PhD Student in the School of Information Systems at the University of Wollongong. Prior to this he has conducted research in Management Studies, molecular biology and clinical neuropsychology.

Abstract

Existing literature on introduction of electronic health records have usually focused on unintended negative consequences. However, unintended positive consequences are often as important as they are drivers of system adoption. Aged care facilities are complex environments with different workplace and organisational cultures across different sites, and different management groups. To this end a colleague and I have interviewed 59 interviews with the full range of care staff and management in five different facilities under the same management group. When we began interviewing, three of our study sites were 1 to 1.5 years into (the incomplete) deployment of the electronic system, one was three weeks into implementation, and one was three weeks prior. This provides us with rich data for the longitudinal component of our study. While the implementation's intended consequences are relatively easy to assess, I am developing methods to assess the unintended consequences. Unintended consequences are a class of emergent property, which in turn are addressed in the theoretical framework of complex adaptive systems. To uncover these, we are using qualitative analysis, informed by grounded theory and symbolic interactionism. Preliminary analysis suggests that important factors that influence consequences are initial conditions (e.g training setup, regulatory framework, site age and location), proximity of management with floor staff, and the demographic and educational profile of the staff at each site. The aim of our research is to identify particularly sensitive factors that influence deployment, and to provide a holistic view of how these factors should be managed.

Session 2 - Mind Matters

2A

Raising community awareness of dementia and its risk factors

Dr Fiona Millard
James Cook University

Authors: Millard, F. B., & Baune, B. T.

Presenter Profile

Dr Millard is a general practitioner (GP) and adjunct senior lecturer in aged care at James Cook University, Townsville, undertaking research to improve GP dementia services supported by an Alzheimer's Australia Scholarship. In her role as the medical advisor for the Mackay Division of General Practice, she liaises with GPs, the community and the media to improve GP services, networking with GPs throughout Australia to share models of care. She presents widely and was awarded a travel scholarship to present at the International Conference on Alzheimer's Disease (ICAD) in Vienna 2009.

Abstract

INTRODUCTION: Increased community awareness of dementia and its risk factors may encourage lifestyles that reduce risk factors, increase patient presentation earlier in the disease and improve opportunities for support and management.

METHODS: Patients aged 30 years and over attending their GP were invited to complete a questionnaire about dementia and its risk factors. The Alzheimer's Australia 'Mind Your Mind' dementia risk factor summary was provided randomly either before (intervention group) or after (control group) completion of the questionnaire. Responses were analyzed using SPSS software.

RESULTS: 45% of patients had learned about dementia from an acquaintance and only 15% from their doctor including 5% of patients aged over 80 years. 20% of the intervention group described dementia as a brain disease, compared with 10 % of controls. 57% of patients responded they would undertake a memory test if asked with no difference between groups, but only 14% of patients over 70 years answered that they had been offered one. Patients were asked if they thought dementia risk factors could be reduced and 59% of the intervention group responded positively compared with 49% of controls. 38% of the intervention group suggested more than one way of reducing dementia risk factors compared with 23% of controls. Only 11% of the combined groups did not wish to learn more about dementia risk reduction with no difference between groups $\chi^2 4.553, p=.871$.

CONCLUSIONS: The readily available Alzheimer's Australia 'Mind Your Mind' risk reduction summary improved awareness of dementia risk factors compared with the control group.

2B

Attention and working memory deficits in mild cognitive impairment

Ms Nicole Saunders
University of Tasmania

Authors: Saunders, N. L., & Summers, M. J.

Presenter Profile

Nichole Saunders is a PhD candidate at the University of Tasmania's School of Psychology. She is in the third year of her candidacy and will submit her thesis in November 2009.

Abstract

Mild cognitive impairment (MCI) has emerged as a classification for a prodromal phase of cognitive decline that may precede the emergence of Alzheimer's disease (AD). Recent research suggests that attention and working memory deficits may appear much earlier in the progression of AD than traditionally conceptualised, and may be more consistently associated with the later development of AD than memory processing deficits. This study examines memory as well as working memory and attentional processing capacities in both amnesic and non-amnesic variants of MCI and assesses the stability and evolution of visual and verbal episodic memory, attention, semantic language, and working memory deficits in individuals with different subtypes of MCI. A total of 131 participants; 60 with amnesic-MCI (a-MCI), 32 with nonamnesic-MCI (na-MCI), 14 with mild AD, and 25 age-matched controls undertook longitudinal neuropsychological assessment of visual and verbal memory, attentional processing, working memory capacity, and semantic language. The results of the present study raise questions regarding the specificity of existing criteria for the subtypes of MCI, with our results indicating a high degree of instability in classification over time. In addition, the results highlight the need for future research to investigate the risk for cognitive decline in aging adults with non-amnesic variants of MCI. Furthermore, the results suggest that, in contrast to the traditional view that AD follows a linear sequential trajectory, that there may in fact be multiple trajectories with multi-domain MCI potentially being the most reliable precursor stage to development of AD.

2C

Socioemotional functioning in older adults with Alzheimer's Disease

Ms Amanda Scicluna

Australian Catholic University

Authors: Scicluna, A., Rendell, P., & Henry, J.

Presenter Profile

I have successfully graduated with a Bachelor of Social Science and a Bachelor of Psychological Science (Honours). I am currently completing a combined Master of Psychology (Education and Developmental)/PhD at Australian Catholic University. My PhD is investigating age related differences in short term memory and a cognitive process called Redintegration. I am examining whether differences in redintegration can be attributed to cognitive impairments from neurodegenerative diseases such as Alzheimer's disease. I have a keen research interest in ageing, particularly older adults with Alzheimer's disease and work as a research assistant at the Parenting Research Centre.

Abstract

Although abundant research has focused on the cognitive changes associated with Alzheimer's disease, limited research has investigated how Alzheimer's disease affects the nature of emotional functioning, specifically emotion regulation. In other populations, such as schizophrenia, emotion regulation has shown to be related to mental health and social functioning, thus it represents an important area of inquiry. This is the first published study to empirically test how the presence of Alzheimer's disease influences the capacity to regulate emotions through two well recognised strategies, suppression and amplification. This study also examined how this regulatory capacity related to other aspects of socioemotional functioning, emotion recognition and theory of mind. Twenty older adults diagnosed with Alzheimer's disease and twenty demographically matched older adults were instructed to naturally watch, suppress, and amplify their behavioural expressions of amusement while watching humorous video clips. These clips were identified as eliciting high levels of amusement during earlier piloting. Participants were also asked to complete standardised measures of facial affect recognition and theory of mind. Results indicated that participants with Alzheimer's disease retained the ability to suppress their amusement but were similar to controls in experiencing difficulty amplifying their amusement. This study supports a model of socioemotional functioning in Alzheimer's disease that is characterised by both stability and losses. Given the importance of expressing emotion as a means of communication, these findings may be relevant for caregivers who use emotion expressive behaviour as an indicator of how a person with Alzheimer's disease is feeling.

2D

Mind your language: Defining cognitive training in MCI and AD

Ms Nicola Gates

UNSW School of Psychiatry

Authors: Gates, N., Sachdev, P., Singh, M. F., & Valenzuela, M.

Presenter Profile

Nicola Gates graduated from Melbourne University with a MA in Neuropsychology and has worked in rehabilitation of acquired brain injury for the past fourteen years. Her focus has recently changed towards prevention and she is conducting a longitudinal RCT of cognitive training in at risk elderly.

Abstract

Development of preventative strategies to combat Alzheimer's dementia is an international priority and the concept of neuroplasticity has become widely accepted with mental activity being found to induce a number of protective and adaptive changes. Meta-analyses has shown that individuals with higher levels of mental activity almost halve the risk for developing dementia and cognitive training in the elderly has increased ADL functioning. Cognitive training (CT) is a very specific type of complex mental activity that is attracting increasing public, commercial and scientific interest. Unfortunately, in the field of ageing and dementia, research has been burdened by a number of methodological issues including multiple terms used interchangeably, making the identification of research trials and comparative studies difficult, and obscuring important differences in concept and application. In addition traditional forms of intervention are being eclipsed by technology, and research is lagging behind the proliferation of commercial products. The purpose of this paper is to present a systematic review of the current literature of CT in MCI and AD, and to provide an operational definition of CT and the different types of cognitive intervention. The potential of new technologies and computer-based CT will be discussed with a critical review of several commercial programs, prior to recommendations for future research being presented.

2E

The experience of caring for a person with dementia with Lewy Bodies: Presenting research findings as an educational source

**Ms Kathryn Nicholson
The University of Melbourne**

Authors: Nicholson, K.

Presenter Profile

Kathryn has a background in physiotherapy and adult education. She holds a Masters in Assessment and Evaluation in which she developed and validated a standards referenced assessment system for skills training in manual handling injury prevention. Her personal experience of caring for a family member with dementia and subsequent association with Alzheimer's Australia, Victoria, as a volunteer and sessional educator, led her to explore the experience of caring in the presence of dementia with Lewy bodies. Nearing the completion of her PhD, Kathryn's aim is to raise the profile of this dementia

Abstract

This paper discusses a novel presentation of the research findings associated with caring for a person with dementia with Lewy bodies. This dementia is poorly understood yet it is the second most prevalent dementia in the ageing population. Initially, it is often diagnosed as mild cognitive impairment, Alzheimer's disease or Parkinson's disease. The experience of caring for a person with dementia with Lewy bodies was explored in a qualitative study using heuristic methodology. Thirteen carers responded to a questionnaire which provided demographic information, an overview of the assessment processes and an indication of the early signs of decline that carers noticed in their spouses. The carers then participated in in-depth unstructured interviews which focussed on their caring experiences. Seven also participated in a focus group. Results were presented as vignettes and thematically analysed. Heuristic methodology also requires the researcher to draw the findings into a creative synthesis. This paper focuses on that synthesis; an audio-visual presentation portraying the researcher as a carer sharing experiences with family and friends. Through this medium the unique challenges faced by these carers are explored including dementia without memory loss, knowing, maintaining continence in the presence of physical and visuospatial impediments and issues of ongoing management and care. The implications of presenting research findings in this way are discussed. It has the potential to translate research into practice and quickly reach target audiences, family and professional carers, as an accessible educational resource.

2F

Dis(cover)ing experience and meaning in ‘Dementia’: Aboriginal elders in urban Australia

Ms Rachelle Arkles

University of New South Wales

Authors: Arkles, R.

Presenter Profile

Rachelle has been working for a number of years with the Muru Marri Indigenous Health Unit in the School of Public Health and Community Medicine, and the Prince of Wales Medical Research Institute, at the University of New South Wales. Rachelle’s current and recent research interests include Indigenous health, ageing and cognition across the life cycle, qualitative methodologies in health and social research and human resources for health. In March 2009, Rachelle enrolled for a PhD in the School of Public Health at UNSW and received a scholarship from the Australian Institute of Population Ageing Research for full-time study

Abstract

Dementia is a global phenomenon, although predominantly described in Western diagnostic terms. In remote-living Indigenous communities in Australia, dementia is almost five times as prevalent and presents at an earlier age than in the non-Indigenous population. There is no data on dementia prevalence in non-remote Aboriginal communities, and empirical research is lacking into the dementia experience in Indigenous populations.

This study will investigate the lived experience of ‘dementia’ amongst Indigenous people in an urban setting. How is dementia configured and imagined? The research aims to examine the experiences and meanings of dementia in families with a dementia sufferer, its perception in the broader community, as well as, the social and cultural context in which formal (government and community) and informal (family) care giving and care seeking are experienced. Its starting point is how ‘dementia’ is lived and acted in concrete situations, and as such, a phenomenological orientation and methodology has evolved. Carers of Indigenous people with dementia will be interviewed over time to map an experience trajectory and enable participants to reflect on the meaning of their accounts. Through a process of reflection and ‘meaning making’, by both study participants and the researcher (myself), the data will be (re) interpreted in relation to, “culturally derived and historically situated interpretations of the social life-world” (Crotty, 1998). Interviews with Elders groups will uncover community narratives of dementia.

This presentation will address the impetus behind my choice of research methodology, including, the evolution of the study’s research questions, purpose, approach and potential application.

2G

The challenge of employing action research methods to facilitate sustainable practice improvement when caring for confused older patients

Ms Julia Poole

University of Technology, Sydney

Authors: Poole, J. L., McKinley, S., Chenoweth, L., & Hilmer, S.

Presenter Profile

Julia is a PhD candidate approaching the final stages of thesis completion. The care of older people exhibiting symptoms of confusion has been the focus of many years of study and publications including the 'Poole's algorithm: nursing management of disturbed behaviour in older people' lecture notes series. Julia hopes to encourage more informed and equitable care for older patients, their families and their nurses.

Abstract

This presentation discusses the challenges and achievements of employing Person-Centred Care in an acute aged care ward to improve care for confused older patients, enhance family satisfaction and decrease nursing stress. The study was prompted by the lengthy hospitalisations occurring for growing numbers of older patients with cognitive impairment, complicated by symptoms of confusion. Confusion in older patients is mostly caused by delirium and/or dementia. It is not well understood, generally poorly managed and causes stress for nurses. Poor outcomes can be avoided by early assessment of confusion risk factors, diagnosis and implementation of prevention and management strategies. The setting was a 25-bed acute aged care ward in a large metropolitan tertiary hospital. A triangulated theoretical framework was employed to guide a before and after-intervention design. The study interventions were informed by the participating nurses' insights following non-participant observations of care delivery for confused older patients using the Quality of Interaction Schedule. Constant staff churn throughout the Area Health Service during the study created challenges despite staff support and encouragement. Nevertheless, results showed in significant improvements in analgesic use, family satisfaction and a trend towards improvements in nurse/patient social interactions. These were supported by the development of a number of care prompt tools including the Communication and Care Cues form and the Delirium Risk Assessment Tool sticker. Ongoing practice development and uptake of the tools has ensued in other units within the health service.

Session 3 - Working Life and Life After Work

3A

Stability of the learning and development survey: Findings for mature age local government and private healthcare organisations

Mrs Megan Tones
Queensland University of Technology

Authors: Tones, M., Pillay, H., & Kelly, K.

Presenter Profile

Mrs Megan Tones is a research assistant and postgraduate student in the School of Learning and Professional Studies in the Faculty of Education at Queensland University of Technology. Her research and interests include lifespan developmental psychology, adult learning, engagement, industry-based training, worker wellbeing, and learning and cognition. Her PhD project involves the construction of a survey to measure engagement and disengagement in learning and development goals within an organisational setting. She has presented at conferences both nationally and internationally.

Abstract

This article investigates work related learning and development amongst mature aged workers from a lifespan developmental psychology perspective. The current study follows on from research regarding the construction and revision of the Learning and Development Survey (LDS; Tones & Pillay, 2008). Designed to measure adaptive development for work related learning, the LDS encompasses goal selection, engagement and disengagement from individual and organisational perspectives. Previous findings suggest that mature aged workers are less likely to report engagement in learning and development goals than younger workers, which is partly due to insufficient opportunities at work. In the current paper, exploratory factor analysis was used to investigate responses to the LDS amongst two groups of mature aged workers from a local government and private healthcare organisation to determine the stability of the LDS. Organisational constraints to development accounted for almost a quarter of the variance in LDS scores for both samples, whereas organisational opportunities for development emerged as the most powerful factor in Tones and Pillay (2008). Remaining factors emerged in different orders for each data set. Organisational opportunities for development explained about 17% of the variance in LDS scores in the local government sample, while the individual goal disengagement contributed a comparable proportion of variance to LDS scores for the private healthcare sample. Findings from the current study indicate that opportunities for learning and development at work may be age structured and biased towards younger workers. Implications for professional practice are discussed and focus on improving the engagement of mature aged workers.

3B

Ageing in the 21st century – Are baby boomers prepared?

Ms Jennifer Buckley
University of Adelaide

Authors: Buckley, J., & Hugo, G.

Presenter Profile

Jennifer Buckley is a full-time PhD candidate and part of the Nutrition, Obesity and Lifestyle (NOBLE) project funded by the Australian Research Council. Her research is on baby boomers, obesity, social change and preparation for later life. Previously, Jennifer has worked in both government and non-government settings in a variety of areas including suicide prevention, urban planning, curriculum development, and ageing.

Abstract

Baby boomers are a transitional generation. They have broken “the mould of the modern life-course” and are now at the centre of a fundamental shift in how later life will be experienced. This, plus the issues associated with structural ageing, means that the construction and management of later life has become a matter of significance to both individuals and governments. How baby boomers age in the future is influenced by their current status in relation to factors such as health, finances, and social networks. Of equal importance are government policies and the capacity of public institutions to support independence in old age. To date, there is little empirical research which has provided an in-depth or holistic analysis of baby boomers and the extent to which they are prepared for later life. Such an analysis is important for overall policy development and for the identification of sub-groups that may be at risk. This presentation discusses the extent to which different sub-groups of baby boomers (1946-1965) strategically position themselves for later life. It reports findings from an analysis of a representative sample of baby boomers (n=1272) drawn from the North West Adelaide Health (Cohort) Study. The conceptual framework for this analysis is structured around three domains: public protection; self insurance; and self protection. This presentation focuses on self protection and examines baby boomers’ preparations in relation to health, social participation, and living arrangements. Preliminary results suggest baby boomers need to increase self protection if popular assumptions about their future health and wellbeing are to be realised.

3C

Tools from the shed – Building a toolkit for retirement

Mr Anthony Brown

University of Western Sydney

Authors: Brown, A.

Presenter Profile

Anthony Brown is the Project Officer at the Men's Health Information and Resource Centre at the University of Western Sydney, which focuses on the social determinants of men's health. Anthony has almost 20 year experience in the community sector, and has worked extensively with older people in both residential and community contexts. Anthony hopes to one day to develop a hobby or own a dog.

Abstract

This paper will explore the ways in which men construct and reconstruct a positive and productive sense of identity in retirement. There is much evidence that leaving paid work represents a crisis of identity for men. Despite this many men appear to have happy, healthy and productive retirements. There is scant research exploring this positive adaption to retirement and even less focusing on the actual experience of being retired. This paper will present the findings of current PhD research examining men's adaption to life after paid work. Using a narrative analysis methodology, the research is investigating the stories men tell about being retired to gain insight into their experiences and sense of identity. The study shows that the men interviewed are constructing a positive dynamic identity, in which they are constantly positioning themselves within a matrix of relationships, historical contexts, and wider social narratives. The men site themselves firmly within a narrative of 'productive retirement', as opposed to the prevalent ageist societal narrative of retirement as a time of decline, withdrawal and morbidity. These findings give some insight into what is needed for men to have a positive transition to retirement. This includes the need for social engagement and implications for current social support services; together with a cultural shift in attitudes to retirement. Current ageist narratives of retirement need to be resisted and replaced with more realistic narratives, which give men positive models which adhere to their real life experiences, instead of negative ones that they constantly fight against.

3D

Are organisations able to influence their employees' retirement intentions?

Ms Jodi Oakman
La Trobe University

Authors: Oakman, J., & Wells, Y.

Presenter Profile

Jodi Oakman is a senior lecturer at the Centre for Ergonomics and Human Factors, La Trobe University. Previous to this she has worked extensively in industry as a consultant Ergonomist in a diverse range of roles which have included product design and risk management. Her key areas of interest are in the psychosocial aspects of work, work design and the ageing workforce. She is currently a PhD candidate in the area of the ageing workforce.

Abstract

Labour shortfalls as a result of population ageing are now being experienced across western nations, and to counter this, employers will need to encourage people to postpone retirement. At the same time, with extensions to the lifespan, individuals will need to remain in paid employment for longer to fund their retirement years.

This study examines the retirement intentions of employees of a large public sector organisation. The main aim of the study was to gain an understanding of employees' retirement intentions and of potential influences on changing these intentions.

Quantitative and qualitative methodologies were utilised in the study. A survey tool was developed and administered to the mature age workers in the organisation (n=332). The survey included several well established measures: the General Health Questionnaire (GHQ12), the Copenhagen Psychosocial Questionnaire (COPSOQ), and a measure of work capacity derived from the workability index (WAI). Multivariate regression analyses were used to identify the most important predictors of intention to retire. The results of the analyses reflect the complexity of retirement decisions. Age, length of service, and workability, were strong independent predictors of both outcome measures. Family situation (having a partner and dependents), job demands, and mental health predicted only the continuous measure, but job satisfaction was important in identifying people who intended to retire within the next five years. Theories of retirement intentions need to take into account the complexity of retirement decisions and recognise that the importance of predictors may shift depending on how intentions are operationalised.

3E

Does retirement call for another identity?

Mr John Van Hosteyn

La Trobe University/Lincoln Centre for Research on Ageing

Authors: Van Holsteyn, J., Wells, Y., & Merkes, M.

Presenter Profile

During the last years of his career as a procurement manager, the author completed a degree in psychology. After graduation he was invited to apply for an APAI scholarship within the Ageing Baby Boomers in Australia research project to study the psychosocial aspects of baby boomers entering retirement. He intends to complete his PhD in 2011 as a first step in his new career as an academic.

He lives with his wife in the foothills of the Dandenongs. They enjoy very regular contacts with their five grandchildren.

Abstract

Retirement is changing through an extended retirement transition, and people's intention to work more years. It is problematic for social research (Luborsky & LeBlanc, 2003) and has an unclear impact on the retiree's identity.

Cote and Levine (1987) defined identity as the sense of self, supported by the recognition from the social environment. An extensive literature describes the formation of identity in adolescence and emerging adulthood, where the progress of the identity formation can be ascertained through status measures (Marcia, 2002). Kroger (2002) lamented that there is hardly any current research on identity re-formation in later adulthood, despite similarities between adolescence and late-adulthood, such as an increased independence, transition into and out of work, and changes in social contacts. Marcia (1980) measured the process of the identity formation against the dimensions of exploration and commitment. These dimensions remain valid to identity formation in retirement, albeit somewhat incomplete. Can other relevant dimensions be identified to describe how the retiree identity model is different from the original identity formation model? To answer this, an in-depth qualitative

analysis is being undertaken of the transcripts of the Ageing Baby Boomers in Australia (ABBA) focus groups and subsequent interviews, focusing on all references to a changing identity in retirement, thereby providing the rationale for this study: to describe the changing construct of retirement within the parameters of an adjusted model of Marcia's identity formation.

3F

Are baby boomers seeking retirement advice?

Mr Martin Snoke
University of Sydney

Authors: Snoke, M., Kendig, H., & O'Loughlin, K.

Presenter Profile

Martin is a PhD student in the Faculty of Health Science at the University of Sydney. Having worked at the Department of Health and Ageing, he is completing his studies within the ARC Linkage funded project "Ageing Baby Boomers in Australia (ABBA): Informing Action for Better Retirement".

Abstract

The economic downturn and policy changes are leading many Australian baby boomers to reassess their financial security and needs in retirement. Good information is crucial in making sound decisions and minimising risk in the midst of continuing debates and uncertainties about complex and volatile superannuation and taxation arrangements. This preliminary study aims to identify which baby boomers are seeking financial advice prior to retirement. It analyses data on people who were aged 45 to 62 years in 2007 (n=2731) from Wave 7 of the national Household Income and Labour Dynamics in Australia survey. The survey was conducted just after the 2006 'New Super' policy changes and before the Global Financial Crisis of late 2008. Only 40 percent of boomers were found to have sought advice for retirement planning. Logistic regression showed that the chances of seeking retirement advice were greater among those who had completed a bachelor/diploma degree or higher, those who were employed in a clerical or sales position, those who had thought about their expected retirement income, and those who were relatively older. Gender was not significant nor was income (except those on the highest incomes were less likely to have sought advice). The low and variable use of retirement advice requires further examination. Do older workers perceive a need for professional advice in retirement planning? What are the barriers to accessing it? Whether or not boomers access financial advice is important in understanding their capacities to achieve positive leisure, family and work outcomes in retirement.

3G

Predictors of graceful ageing in senior Australians

Mr Edmund Ramon Talob

The University of Sydney, Faculty of Health Sciences

Authors: Talob, E. D., Matthews, L., & Russell, C.

Presenter Profile

Edmund Ramon Talob is a PhD candidate at the Faculty of Health Sciences of The University of Sydney and an accredited Rehabilitation Counsellor. He completed a Master of Rehabilitation Counselling degree from The University of Sydney and a Bachelor of Science degree in Psychology from The University of the Philippines. He has worked extensively in aged care and disability services and in vocational rehabilitation for mature-aged jobseekers and people with disabilities.

Abstract

While living in urban communities has challenges and functional losses emerge in old age, this research supports the notion that ageing is a positive experience. Using a multi-stage mixed-methods design, this study investigated variables associated with the graceful ageing experience. Stage 1 involved a survey of 152 Australians who volunteered to complete a questionnaire consisting of an ageing gracefully scale (0=not at all, 6=very much), the ComQoL yielding objective well-being and life satisfaction scores, and the MLQ measuring meaning in life. Respondents had a mean age of 68.75 (SD=7.72), comprised 46.7% males, and were 52% Anglo-Celtic. Twenty-five percent rated ageing gracefully 'quite a lot' or 'very much' while 17% 'not at all' or 'not much'. Females rated higher than males ($t[150]=-2.66, p<.01$). A post hoc Bonferroni analysis showed significant mean differences in Anglo-Celtic, Arabic, Asian and Greek respondents ($F[3,148]=5.51, p<.05$). Correlations revealed strong relationships between graceful ageing and productivity, intimacy, safety, community participation, and emotional well-being. Regression analysis suggested that objective well-being and life satisfaction contributed to variances on ratings on the ageing gracefully scale and were found to be predictors of graceful ageing in this sample. In conclusion, senior Australians living in Sydney's eastern suburbs are ageing gracefully despite cultural and gender differences. These findings reaffirm Australia's ageing well policy and have implications for policymakers in their responsibility to build better sustainable cities for older people. To further validate these findings, semi-structured interviews and cross-cultural analysis will be completed in stages in collaboration with the Institute of Philippine Culture.

Session 4 - Health and Functioning

4A

Measurement of participation restriction in older people

Mrs Nicola Fairhall

The George Institute for International Health, The University of Sydney

Authors: Fairhall, M., Sherrington, C., Cameron, I. D., & Clemson, L.

Presenter Profile

Nicola Fairhall is a PhD candidate at The George Institute for International Health, The University of Sydney. She is in the first year of her candidature, with her PhD focusing on participation restriction in older people. Nicola is an APA Neurological Physiotherapist and holds a Masters of Health Science (Neurological Physiotherapy). She is a casual academic at the Discipline of Physiotherapy, The University of Sydney.

Abstract

Participation restriction, as defined by the International Classification of Functioning, Disability and Health (ICF), reflects the societal consequences of health conditions. Despite being a key component of disability, measurement of participation restriction in ageing research remains inconsistent. Poor evaluation of participation outcomes is due to the recent development of the concept and a lack of accepted measurement tools. Available measures are limited to tools designed to measure similar constructs and recently created instruments. The objective of this paper was to identify the essential characteristics of an instrument that measures participation restriction. Development of the criteria was a necessary precursor to a systematic review of the quality of instruments measuring participation restriction in older people. Literature searches were undertaken, addressing both the construct of participation restriction and available measurement instruments. It is proposed that an instrument measures participation restriction if it meets five criteria: measures participation restriction (i.e. problems experienced in involvement in life situations) in at least 75% of items; uses the perspective of the individual; captures the person's own perceptions of their participation in life roles; includes a minimum of three domains of the ICF framework and demonstrates adequate psychometric properties. The development of these criteria will enable identification and evaluation of the tools that measure participation restriction in older people. The recognition of valid measures of participation restriction is an essential step in the understanding and management of disability in ageing research.

4B

CONSORT: A valuable tool to improve research in the aged with venous leg ulcers

Ms Carolina Wller
Monash University

Author: Weller, C., McNiel, J., Evans, S., & Reid, C.

Presenter Profile
Bachelor of Nursing (RMIT)
Master of Education by Research (RMIT)
Graduate Certificate in Higher Education (MONASH)
PhD candidate Monash University

Carolina's background is in clinical practice, research, health policy and education. Her clinical expertise is primarily in wound care with a focus on evidence based practice and randomised controlled trials.

Carolina is currently a doctoral scholar at the NHMRC Centre for Research Excellence in Patient Safety in the Department of Epidemiology and Preventative Medicine at the Monash University Alfred campus

Abstract

Currently up to 20 per 1000 Australians over the age of 80 have an active leg ulcer, greatly affecting quality of life. Among younger affected persons venous ulcerations also result in days off work. The management of venous ulcers causes considerable strain on the health system and is likely to worsen in future. Analysis performed ten years ago in Australia estimated that venous ulcers were responsible for \$400 million annually in health costs. Strategies to improve management of this condition are essential.

The multi-layer high compression system is described as the current gold standard for treating venous ulcers. To date, despite advances in venous ulcer compression bandaging therapy, no convincing low cost, easy to apply compression therapy study has been conducted that may improve wound healing and compliance. A recent meta-analysis of bandaging systems found that multilayer compression bandages appeared to be superior to single-layer bandages in promoting venous ulcer healing. However, it was noted that many of the studies had small sample sizes and the quality of research in the area was poor.

There is a need for well designed studies based on the CONSORT statement. Clinicians need to be able to discern high quality studies from ones of poorer quality. This paper discusses how CONSORT was used as a template to design and implement a multicentre randomised controlled trial to evaluate the efficacy and safety of two compression bandaging systems in patients with chronic venous ulceration.

4C

Comparative effects of two carbohydrates, glucose and xylose, on blood pressure and gastric emptying in healthy elderly

Ms Lora Vanis
University of Adelaide

Authors: Vanis, L., Hausken, T., Gentilcore, D., Ridga, R. S., Rayner, C. K., Feinle-Bisset, C., Horowitz, M., & Jones, K. L.

Presenter Profile

I am currently in my third year of my PhD at the University of Adelaide, Discipline of Medicine. Studies in my PhD are focused on the role of gastric and small intestinal mechanisms in postprandial hypotension. My clinical research is performed in healthy elderly volunteers, and the techniques used in these studies are intraduodenal nutrient infusions, gastric emptying, 2D and 3D ultrasound, blood pressure and heart rate measurements and blood sampling. My undergraduate degree was a Bachelor of Medical and Pharmaceutical Biotechnology with Honours at the University of South Australia.

Abstract

Postprandial hypotension (PPH), is defined as a fall in systolic blood pressure (BP) of ≥ 20 mmHg, sustained for at least 30 min, occurring within 2 hours of meal ingestion. PPH occurs frequently (in ~40% of elderly nursing home residents) and is an important, yet under recognised condition, leading to faints and falls, and, in more severe cases, stroke and angina. PPH is also associated with increased mortality. The fall in BP is related to the rate of gastric emptying (GE) and occurs, particularly after meals containing carbohydrates, specifically glucose. There is little information about the effects of other carbohydrates. This paper reports the effects of two carbohydrate drinks, (glucose and xylose), on the magnitude of the fall in BP and rate of GE in 7 healthy elderly subjects (age 66-76 yr). Each subject had simultaneous measurements of BP (DINAMAP) at 3-minute intervals and GE (3D ultrasound) at 15-minute intervals for 2 hours, on 3 separate occasions, in double blind, randomised order. On each day, subjects consumed a 300 ml drink of either water, or isocaloric (187 kcal) glucose or xylose. The fall in BP was reduced following xylose compared to glucose ($P < 0.05$), with no difference between water and xylose. GE was faster following water compared to glucose and xylose ($P < 0.001$), with no difference between glucose and xylose. We conclude that xylose may be considered as an alternative sweetener to glucose, as an approach to the management of PPH.

4D

Improving the style and content of general practitioner consultations for older people with asthma: A mixed methods approach

Ms Dianne Goeman
Monash University

Authors: Goeman D., O’Hehir R., Sanci L., Scharf S., Jenkins C., & Douglass J.

Presenter Profile

Dianne is a Research Officer for the Co-operative Research Centre for Asthma and Airways. She is also currently writing up her PhD thesis on “Asthma in older people”.

Abstract

Recent figures released by Australian Bureau of Statistics confirm that people aged over 55 years are those most at risk from asthma death. Patient-centred health care has been acknowledged as important in the delivery of care to people with chronic conditions by improving patient outcomes, we developed and evaluated an intervention to improve the style and content of general practice consultations for older people with asthma. An initial exploratory investigation using in-depth interviews revealed problems with both the self-management strategies and the provision of asthma care to older people. These findings informed the design of a multi-faceted educational intervention using best practice models to change physician behaviour. The success of our intervention was measured by patient and GP outcomes. Video-taped consultations of GPs and simulated patients (SPs) using scenarios extrapolated from the patient interview data, were used to measure the content and style of the consultations and also as a feedback tool for GPs. Patient outcomes were evaluated by a cluster randomised controlled trial and GPs satisfaction with the program and change to their practice were measured by self-report. This presentation demonstrates how mixed methods and mixed methodologies were successfully utilised to translate knowledge and achieve a change in physicians practice when delivering asthma care to older adults.

4E

Variable harmonisation in the DYNOPTA project: Establishing a common ground for combining sensory functioning data across 9 Australian longitudinal studies of ageing

Mr Kim Kiely

CMHR, The Australian National University

Authors: Kiely, K., Anstey, K., & DYNOPTA Investigators

Presenter Profile

Kim is a PhD student in the Ageing Research Unit, at the Centre for Mental Health Research, ANU. He is working on the Dynamic Analysis to Optimise Ageing (DYNOPTA) Project. His PhD research program seeks to demonstrate the utility of harmonised longitudinal data in testing theories of cognitive ageing and investigate the dynamic inter-relationships between cognition and sensory functioning during the years preceding death.

Abstract

Within ageing research disciplines there is a current movement towards greater integration and optimal use of existing data. One strategy to achieve these aims is variable harmonisation and data pooling. Variable harmonisation methodologies rescale functionally equivalent measurement instruments onto a common metric. The benefits of harmonisation include increased sample size, greater representation and the capacity for immediate cross-population comparisons. Limitations include the introduction of study design effects, censoring, information loss, and dataset complexity. The Dynamic Analyses to Optimise (DYNOPTA) Project has harmonised and pooled nine Australian Longitudinal Studies of Ageing. Based on the experiences of DYNOPTA, this paper will describe the harmonisation process and explain the criteria of functional equivalence for reliable harmonisation. This will be illustrated by providing examples of the harmonisation process for objective and subjective sensory functioning variables. Sensory functioning is an important factor to consider when investigating the health and wellbeing of older Australians. Vision and hearing impairments are leading causes for Commonwealth funded disability services for men and women aged over 65 and have consequences for mobility, social participation, quality of life and mental health. Within DYNOPTA, vision and hearing variables were harmonised using the by-fiat method, which required identification of mutually exclusive categories that were common to all contributing studies.

By allowing for the combination and direct comparison of independent datasets, harmonisation techniques present an excellent opportunity to capitalise on Australia's investment in longitudinal ageing research and are a great addition to the methodological toolkit of integrative researchers.

4F

Hearing access in healthy ageing

Ms Lisa-Jane Moody

Deakin University/Barwon Health

Authors: Moody, L.-J.

Presenter Profile

Lisa-Jane Moody is an Audiologist with 19 years clinical experience in public health settings and an academic background in Linguistics. As Manager, Audiology at Barwon Health in Geelong Lisa-Jane drove the development of a number of innovative hearing care programs in the acute, inpatient rehabilitation and aged care sectors. Lisa-Jane commenced her PhD through Deakin University in March 2009 and is delighted and excited about this new phase of learning. Lisa-Jane enjoys travel and cooking, and is mother to beautiful 8 year old Claudia. Her 86 year old Dad gives ageing well all the meaning it needs.

Abstract

Hearing loss is an invisible and isolating disability approaching 80% prevalence in the over 70 age group, yet our toolkit currently lacks an affordable and reliable method to identify and support the needs of the ageing hearing impaired, especially in relation to healthcare. Hearing loss is significantly associated with a range of negative outcomes including depression, delirium, diminished functional status, social isolation and a poorer quality of life, and is an important public health issue. The costs to the individual are also significant: hearing loss affects one's ability to understand speech, even loud speech, accurately. This limits access to the precious words of a grandchild through to the questions of a doctor, and threatens their right to both understand and consent to medical treatment. The individual with hearing loss has particular communication support needs in order to gain access to spoken language, just as the physically disabled might need a ramp to gain access to a building. While the need for a wheelchair might be self evident, many hearing impaired are unaware of their hearing loss. Evidence suggests hearing loss is under-detected and under-managed and our support of communicative access in healthcare is limited. It is proposed that strategies to support healthy ageing could be enhanced if the deleterious effect of hearing loss on the individual's capacity to be involved and active in their own care was better managed. The author will describe evidence informing this view and preliminary attempts to identify hearing loss and communication access needs in healthcare.

Modelling Successful Ageing, Ageing Transitions and Lifestyle Behaviour Patterns

Ms Susan Hunt
Monash University

Authors: Hunt, S., Browning, C., Sims, J., & Wang, W.

Presenter Profile

Sue completed her honours in psychology in 2005, which involved investigating the promotion of conflict resolution skills. Sue worked at the Murdoch Institute, assisting research into the wellbeing of adolescents. Sue was then employed by the National Ageing Research Institute (NARI). Her project activity at NARI included developing the Dementia Resource Guide and the national recommendations for physical activity for older people for the Department of Health and Ageing. Sue has worked with residential care facilities organising action research groups to implement falls prevention activities. She has also been involved in research into health benefits associated with volunteering.

Abstract

Successful ageing is a process most of us would like to be involved in. However there is no generally accepted functional definition of successful ageing or its predictors. In addition, much of the research on ageing has focussed on preventing chronic illness and disability. The lack of a definition of successful ageing creates difficulty in designing and measuring practical health promotion activities that target the components of successful ageing. The aim of the current paper is to present the methodology employed to generate and test an appropriate multi-dimensional model of successful ageing that incorporates physical and mental health constructs. The Dynamic Analyses to Optimise Ageing dataset will be used. 'Healthy ageing' and 'unhealthy ageing' outcome variables will be defined. The distribution of healthy and unhealthy ageing will be examined by age and gender. Transitions between healthy and unhealthy states will be investigated to define potential predictors. Lifestyle behaviour patterns will also be examined to document predictors of behavioural changes that promote healthy ageing. A model of successful ageing and its predictors will enable a functional definition to inform policy and practice and create interventions designed to optimise the ageing experience.

Session 5 - Engaging with the Community

5A

The relationship between psychological strengths and health of people over 65 years living in the community with minimal community support services

Ms Coralie Graham

University of Southern Queensland

Author: Graham, C.

Presenter Profile

Coralie is a Registered Nurse with many years experience as a domiciliary nurse with an interest in aged care. She is also Registered Psychologist, and her PhD combines two passions: health and positive Psychology. Her interest in the psychological strengths of older adults was sparked by responses provided to questions regarding subjective health status during community clinical health assessments. Coralie currently works as a lecturer at the University of Southern Queensland where she teaches Community Rehabilitation and Community Clinical Nursing.

Abstract

The potential for spiraling health care costs of the ageing baby boomer cohort has provided impetus for research into all aspects of this group. Previous studies from other countries have shown a positive association between a number of psychological strengths and health; however limited Australian research exists in this area. This triangulated 2 Phase study investigates the psychological strengths that older adults use in maintaining their health and quality of life. This methodology was chosen to provide a deeper insight into the concepts and cross validation of results. The qualitative analysis of the interviews of 10 older adults in Phase 1 found that a adaptability, a positive outlook, social connectedness, and spirituality, in addition to receipt of support services are important factors to maintaining health, quality of life and the ability for those over 65 to remain independent in their own home in the community. The quantitative Phase 2 of this study investigated of the degree of the relationship between resilience, optimism and health and surveyed 620 older adults by mail. Preliminary data analysis using multiple regression has found a strong positive relationship between optimism and resilience, and self-reported health which is consistent with previous studies. Previous research also indicates that a number of these strengths are able to be enhanced with minimal intervention, and their positive relationship with health status, the potential for flow on financial savings in the promotion of health and satisfaction is huge.

5B

Why friends matter to health – The Manningham study of Chinese and Anglo Australian experience

Ms Tess Tsindos
Monash University

Author: Tsindos, T.

Presenter Profile

Tess is a Research Fellow and PhD student at Monash University in the Department of Health Social Science. With more than 20 years experience as a practitioner in the aged and community care field, Tess now focuses her research on the relationship between loneliness and health in Chinese and Anglo Australian seniors.

Abstract

There is a growing evidence base that family and friends are critical to reducing loneliness and that there is a relationship between loneliness and health. Loneliness is linked to poorer health outcomes so understanding what factors reduce loneliness could improve the lives of many older people. This paper presents the findings of mixed-methods sequential explanatory design research in loneliness and health in Anglo Australian and Chinese seniors in the City of Manningham. During the quantitative phase, computer assisted telephone interviews (CATI) were utilised to identify factors that contributed to loneliness and health. During the qualitative phase, semi-structured face-to-face interviews were undertaken to explore perceptions of health, loneliness and socialisation patterns to understand factors that contributed to loneliness among participants and to explore more deeply, the information participants provided in the CATI surveys.

There were significant differences in health and socialisation patterns between the Chinese and Anglo-Australian seniors. Chinese seniors reported poorer health and socialised much more with their families while Anglo Australian seniors reported better health and socialised more with friends. Themes of self reliance, positive attitudes and feeling connected to loved ones, supported reduced loneliness. The results of the Manningham Study identified a relationship between living alone, lower rates of socialising with friends and poorer self assessed health, with higher loneliness. Of significance was that 20% of the sample reported high/very high loneliness and 30% reported poor/fair health, which indicates that policies and programs to alleviate loneliness among older people should be a priority.

5C

How are you today? – The shop and its significance for the well-being of older people

Ms Joan Stewart
Monash HARU

Author: Stewart, J.

Presenter Profile

Master Gerontology, Post Grad Dip Health Education (Promotion), Cert Social Gerontology

Joan has been employed in aged care for over 20 years, initially in lifestyle programs and specialised in programs for dementia sufferers and their families.

Later Joan became involved in quality management and was employed as an aged care assessor, a residential aged care manager and as a lecturer.

She now manages the quality systems for the Monash Division of General Practice while completing her PhD.

Joan's Masters research was a qualitative study which explored the social meaning for the families of younger nursing home residents.

Abstract

This study will explore the relationship between the well-being of older people and regular, ongoing visits they make to shops. The researcher puts forward that some older people seek, either consciously or subconsciously, regular, ongoing contact with one or more stores such as a coffee shop, hairdresser, hardware supplier, newsagent, or general store because there are benefits that go beyond the ritual of purchase. These benefits may include: social interaction; sometimes physical contact; a boost to self-esteem; information exchange; and enhanced sense of connectedness. Additionally, it is suggested that these interchanges which involve little burden of responsibility, are important to well-being and irrespective of other closer social tie activities such as contact with a spouse or other family. Key questions that this research may answer include: What is the social meaning of visits to shops for older people? What are shop keeper's perceptions of the role they play in the relationship with the older people and in the community generally? What recommendations can be made with a view to encouraging and continuing a similar experience for other older people? eg Urban planning. In addition to answering these questions, the researcher considers that the study may: give a better insight into healthy ageing; encourage the social gerontology endeavour which should strive to promote autonomy and well-being of older people; and raise awareness among those who inform, guide and fund urban planning.

5D

An under-rated community resource? How community organisations run by peers help older people maintain their wellbeing and independence

Ms Rowena MacKean
University of Tasmania

Author: MacKean, R.

Presenter Profile

My academic qualifications are: MA (Oxon), Dip. Ed. (Tasmania). I am now at the final stage of an M.Ed (Research) at the University of Tasmania, studying older people's experiences of community-based learning. I am actively involved in older people's learning activities as a group member, organiser and tutor, and as coordinator of an advocacy and promotional group for Third Age Learning. I also serve as a community member on several state and local committees promoting Positive Ageing. In 2007, I was awarded the Order of Australia Medal for services to Adult and Community Education.

Abstract

It is now generally accepted that participation in mental, physical and social activities helps older people maintain their health and wellbeing. However, there is continuing debate on the best ways of encouraging participation, especially in the context of older people's leisure pursuits. This presentation examines ways in which belonging to a community group which is run by older people for their peers promotes such leisure activities and active social engagement.

Using a phenomenological approach, this study explores 25 older people's lived experience of their involvement in community-based peer-group organisations. Methods used were interviews, observation and interviewer self-reflection. Through semi-structured interviews conducted by a researcher of similar age and experience, participants were able to voice their opinions freely without the constraint of ageism. Data were coded and analysed using thematic analysis.

The study suggests that peer-group organisations have particular characteristics that help older people maintain their wellbeing, independence, identity and self-esteem, by providing community, structure and meaning. They give older people opportunities to use their knowledge and experience, to act reciprocally, and to continue learning in an informal, supportive setting. Implications for policy and practice are discussed, with suggestions of ways in which authorities could encourage peer-group organisations as valuable community resource.

Qualitative interviewing of older adults: Offline versus online methods**Ms Susan Malta****Swinburne University of Technology****Author: Malta, S.****Presenter Profile**

Sue Malta is a PhD candidate in the Faculty of Life and Social Sciences at Swinburne University of Technology in Melbourne, Australia. She is also Managing Editor of the online journal, the International Journal of Emerging Technologies and Society (iJETS). Sue's research interests include older adults, sexuality and, slightly tangentially, social connectedness and social isolation. She is particularly interested in the idea that older adults are not sexual beings. She recently completed a community development project with the DHS and Eastern Access Community Health, looking at social participation of older adults in long-term care.

Abstract

This paper is based on a qualitative study of 45 Australian participants (aged 60 years and over) and their online and offline romantic relationships. Four different interview methods were employed in this study: (1) face-to-face and (2) telephone interviews and (3) email and (4) instant messaging interviews. A description of each of these methods is given in turn and a comparison between the different modes is provided. It is argued that older adults are often dismissed as a suitable online research population due, in part, to stereotypical norms that label them as technophobic. The results from this study indicate that online interviewing of older adults – by both email and instant messaging – is easily achievable and cost effective and has unique benefits for researchers in ageing. Not only does online interviewing provide access to often difficult-to-reach populations, it also allows for the discussion of topics which at times may be embarrassing or confrontational in face-to-face interviews.

5F

Locating a diverse population of older users and non users of the internet for a statistically significant sample survey by telephone interview – A micro data analysis approach

Ms Pam Coutts
University of Adelaide

Author: Coutts, P.

Presenter profile

Pam has conducted research in various research centres attached to the university of Adelaide into Information and Communications Technology use in disadvantaged populations over the past ten years .The culmination of her work is the Australian Research Council Linkages Postgraduate Research Project that she is currently doing in which she is working towards to publish as a doctoral thesis

Abstract

Policy makers tend to assume that older populations are homogeneous in nature. This is no less so in the assumptions made about older people and Internet use. The challenge of this research therefore was to identify the diversity within older populations .This paper outlines an approach used to spatially locate and identify structurally different older population cohorts of users and non users of the internet in a low adopting and therefore hidden population for the purposes of conducting a statistically representative sample survey. The second challenge was to locate the population in a way that would make them accessible. Older populations have low internet usage levels and therefore the use of online surveys, a method used in other population groups, is not viable. The older population cohort are however are easily accessible by telephone. This paper describes how census data was analysed at the smallest unit level - that of Census Collection District (CCD), each of which represents 200 households. The internet use, age profile and socio economic data of each CCD in a local government area was analysed to locate a diverse sample of the older population and this linked to a telephone data base for the purposes of conducting a telephone survey of patterns of Internet use and non use to a statistically representative sample of individuals. The results will inform strategic policy making that reflects the range of barriers and enablers that older people experience that are more than just being associated with being old.

5G

Reconceptualising social support across the lifespan

Mr Nikos Thomacos

Department of Health Social Science, Monash University

Authors: Thomacos, N., & McMurray, N.

Presenter Profile

Dr Nikos Thomacos is a Senior Lecturer within the Department of Health Social Science at Monash University, having come to academia after extensive experience in industry, government and non-government organisations, holding senior and key positions within industry, human services and health. His research interests include social support, health literacy and maintenance, and the health and well-being of minority populations.

Abstract

According to the literature, social support plays an important role in the maintenance of health and well-being (e.g. Cohen & Wills, 1985; Tiikkainen & Heikkinen, 2005). What is not as well studied, however, is the impact of the negative effects of social support on health and well-being. Furthermore, few studies have operationalised the positive and negative effects of supportive relationships concurrently. To address this gap in the literature the study presented operationalised both these constructs in a consistent manner, and in doing so investigated how each, as well as their interaction, impacted on individuals' health and well-being across the lifespan. Using a cohort aged between 18 and 82 years ($N = 626$), the findings confirm those of many previous studies but also suggest that the effects of both the negative and positive effects of supportive relationships differ, and that the interaction between the two is salient in understanding how social support is able to promote health and well-being. Lincoln (2000), in her seminal review of the relationship between social support and the negative effects of supportive relationships, identified three models that she hypothesises can explain this relationship. Key findings together with an exploration of how the current study's findings can be explained by theorists such as Lincoln (2000) will be presented. Additionally, the policy implications arising from this study will also be presented; as a better understanding of the social support needs of people as they age is critical in the development and implementation of successful interventions and programs.

Session 6 - Connecting Past, Present and Future

6A

Using Foucault's toolbox in ageing research

Ms Bridget Garnham

University of South Australia

Author: Garnham, B.

Presenter Profile

Bridget Garnham is a full time PhD candidate and scholarship holder in the Centre for Aged Care Studies, School of Health Sciences at the University of South Australia. Her doctoral research is concerned with how people aged 65-75, the "young old", both understand themselves and are understood in relation to altering their bodies using cosmetic surgery.

Abstract

Social and cultural changes in the context of population aging are generating the need for "a significant and radical rethink" (Gilleard & Higgs, 2000:9) of traditional understandings of "older people". New demographic categories such as the "young old" accompanied by proliferating discourses around 'active', 'positive' and 'successful' aging are challenging what it means to be older in Australian culture and society. In response, the Australian government has made research that contributes to understanding major shifts in cultural expectations and attitudes about ageing a national priority. In this new era for aging research, methodological tools are needed to address social and cultural dimensions of aging, and help inform the politics of aging. One approach able to contribute to this agenda draws inspiration from the critical work of Michel Foucault (1926-1984). Foucault contends that researchers can consider his works a 'toolbox' from which to select tools suited to their inquiries. In my PhD I am using theoretical tools from Foucault's work to critically analyse some of the contemporary ways in which people aged 65-75 years who have undergone cosmetic surgery understand themselves and are understood by others, to demonstrate how these understandings are shaped by some of the social, political and cultural contexts in which older people live. This presentation will explore what these tools have enabled me to do in my analysis and demonstrate the potential that such an approach offers for research that aims to contribute critically to major shifts in cultural expectations and attitudes about older people.

6B

A toolkit for stories of women who were child evacuees in WWII Britain, and also postwar British immigrants to Australia

Ms Margaret Simmons
Monash University

Author: Simmons, M.

Presenter Profile

I am currently completing my PhD on the topic of women's stories of evacuation and migration. I am the daughter of an evacuee and a migrant and I grew up hearing Mum's stories. I wanted to find out if other women shared her stories, hence the genesis of my study. In my spare time I lecture in sociology at Gippsland and tutor at the Gippsland Medical school. I am presenting a paper at the University of Reading in the UK in September about Children in War. I love chocolate, reading and champagne.

Abstract

The paper addresses my PhD research which explores the stories of 16 women living in Gippsland, Australia; women in their 70s, who are both former British WWII child evacuees and postwar British immigrants. Framed by a post-realist narrative approach and informed by feminist sociological theory, I transform the women's stories into poetic representations to illustrate how particular cultural narratives work to construct the women's experiences. I argue that reconstructing the women's narratives in this way contributes to our knowledge of evacuation and migration. Furthermore, this process of knowing enables a sociological analysis of not only how that knowledge is produced, but also how it is opposed, disrupted, accommodated or embraced by the women. Traditional cultural narratives of evacuees and migrants have portrayed them stereotypically or one-dimensionally, such as powerless evacuee victim or unwanted immigrant. This way of positioning women is reductive and unreflective of the more nuanced and empowering stories the women tell. The women not only tell individual stories, they also share stories; collective narratives of marriage, motherhood and femininity and stories of leaving home which intersect with themes of identity, class and gender. In the analysis of the women's stories, notions of 'becoming' both evacuees and migrants are signalled, as are the ways in which memories are reconstructed and embodied. Importantly, while the study explores the contradictory narratives which often constrain women's lives, it also highlights the interesting and enabling ways in which the women's stories can be read and from which their multiple selves are constructed.

Finding a voice

Ms Theresa Mason

Southern Cross University

Author: Mason, T.

Presenter Profile

Theresa C Mason, BA(Hons), ADA(Writing), PhD Candidate, School of Arts & Social Sciences, Southern Cross University, Lismore, Australia. Theresa has worked in various media including newspapers, community publications and radio, as well as the anthologies *Coastlines 4* and *Re-Placement*. Her two year editorship of *The Village Journal* led to an interest in the stories of older local residents, and a return to study saw her focus in this area. Following on from her Honours research, Theresa is researching the nexus between reminiscence as storytelling and therapy in an ageing Australia with a focus on the Northern Rivers area of NSW.

Abstract

Influenced by postmodernism and feminism, research, particularly within the social sciences, enables the validation of subjective narrative modes of individual, local and particular forms of knowledge. These approaches embrace the subjective and facilitate new relational models of qualitative research focussing on in-depth understanding, framed by active, dialogic and reflexive research relationships. This paper will draw upon the author's research into reminiscence as therapy among ageing rural Australians. It will focus on a phenomenological approach using an oral history methodology, and discuss methods, including time-use diaries, questionnaires, collaborative interview techniques, and levels of transcription, that better reflect and respect the uniqueness of participants' individual voice. The issue of voice is paramount, both as a way of validating and negotiating a lifetime of experiences, and in presenting intimate narratives that are personal and contextual. The focus on older participants within the North Coast of NSW helps map the landscape both historically and culturally, demonstrating the multi-storied nature of lives and localities, and exploring the intrinsic link between identity and place. Australia's population is ageing, and with this comes a need to extend research in ways which dignify, celebrate and honour the lives of ageing Australians. Reminiscence is both an enabling form for narrative, and a means for exploring participants' feelings of wellbeing, with the focus on individual local histories. The author's research reveals multiple benefits of reminiscence for participants, including improved health and wellbeing, recognition of value to self and others, and producing a narrative of their life achievements.

6D

Learning from natural disasters: Unexpected explorations during a PhD project

Mrs Glenna Lear
University of South Australia

Author: Lear, G. C.

Presenter Profile

I am in the final stages of my PhD at the University of South Australia, where I am exploring the experiences of my fellow Third Age rural women living on the Lower Eyre Peninsula. My thesis, 'There's got to be More! The Third Age life of rural women of action', features our autobiographical narratives of learning, personal growth, and personal fulfilment in the Third Age.

Abstract

Early in my PhD research of the Third Age learning of Lower Eyre Peninsula women, we had an extreme bushfire event, which devastated the region. Initially, I wanted to exclude it; like everyone in the region, I knew some of the people who died, and extended family members and former neighbours lost property. But three of my research participants were more directly involved with it and the subsequent recovery phase, which provided openings for new learning, leadership, and personal growth for Third Age women. My research methodology gave them the opportunity to reflect on their autobiographies and the more recent experience of the fire, as co-researchers, during our two informal conversations about their learning. The underlying meanings of important human experiences, expressed in descriptive narratives during a process of self-inquiry provided opportunities for critical self-reflection, more objective interpretations, new insights, and understandings as they spoke about their experiences. This reflects the methodological stance of, heuristic inquiry, which requires that the researcher has a passionate interest in the phenomena under investigation, and in this case includes my tacit knowledge as a Third Age learner and long term resident of the region. This paper discusses some of the individual and community learning identified as a result, as well as the communities' experiences of remote centralised management and the professionalisation of disaster services, which ignored their local knowledge, and marginalised and disempowered local community interests. Our experiences on the Lower Eyre Peninsula may be relevant to other rural communities devastated by sudden natural disasters.

6E

Do not harm: Ethical and methodological dilemmas in interviewing older people in Aceh

Ms Jane Palmer

Institute for Sustainable Futures, UTS

Author: Palmer, J.

Presenter Profile

Jane Palmer is a PhD candidate at the Institute for Sustainable Futures, University of Technology, Sydney. A former architect and student of philosophy, Jane is working on a transdisciplinary approach to the confluence of an ageing population and environmental change, including an examination of experience in Indonesia and Australia.

Abstract

During interviews with older people in Aceh, Indonesia, the extent of suffering endured over whole lifetimes by the older people interviewed, and cultural factors such as self-effacement, hospitality and courtesy, forced ethical and methodological decisions during the course of interviews which influenced both format and content.

Older people in Aceh have endured the Dutch occupation, the Japanese occupation during World War II, the Darul Islam and Tjumbok rebellions, communist purges, and the 30 year conflict between the Free Aceh Movement (GAM) and the Indonesian military, which formally ended in 2005. Older people were subject to arbitrary violence and to theft of food supplies, and thus protracted periods of fear and malnutrition.

In four out of the five villages where interviews were conducted, older people had also lost family and homes in the 2004 tsunami.

To interview these older people about their life story and their relationship with their land and village can cause great distress, and the manifestation of clear symptoms of post-traumatic stress. The interviewer can either persist with questions to extract 'the full life story' for the purpose of the research project, or redirect the conversation to areas such as work or interests, when people visibly relax and start to enjoy the interview.

This has implications for interview format, the 'data' thus collected, the type of analysis to be performed, and indeed the entire purpose of the research project.

6F

A lifetime of parenting: When your child has an intellectual disability of genetic origin

**Ms Allyson Thomson
Edith Cowan University**

Author: Thomson, A.

Abstract

People with intellectual disability (ID) are living longer, with serious implications for their ageing parent-carers who face difficulties in making suitable provision for the care and support of their adult offspring. As part of a research study, parents were interviewed about the stresses and coping mechanisms associated with caring for an individual with ID over the life course. Seven parents aged over 50 years of six people with Angelman or Prader-Willi syndrome participated in the wider study. The mean stress rating from the Family Stress and Coping Interview was 51.8, range 40-64 (maximum possible score 96). Comments relating to anger, frustration, and funding were common, while time pressures and paperwork/bureaucracy were also problematic. Major stressors for carers were dealing with service organisations/government agencies, the initial diagnosis, and meeting their own personal needs. Participants expressed a variety of coping strategies, with a majority being problem-focused. The most common was active coping (doing what has to be done, concentrating efforts), followed by instrumental support (getting help from professionals, speaking to other parents, increasing knowledge). There also were substantial numbers of emotion-focused approaches, such as adjusting goals to reflect reality. One mother had limited influence on the daily life of her offspring, although she, like all other participants, expressed considerable disquiet about the effects on their child of their own demise or incapacity. Indeed two parents hoped their offspring would die before them. Information from this study can direct the provision of appropriate supports for the ageing carers of people with ID.

Session 7 - Let's Get Physical

7A

Examination of social demographic status, disease status, health behaviours and quality of life in older Australians using the theory of planned behavioural model

Ms Mei Guo

Queensland University of Technology

Authors: Guo, M., Courtney, M., & Anderson, D.

Abstract

The increase of life expectancy worldwide during the last three decades has increased age-related disability leading to the risk of loss of quality of life. How to improve quality of life including physical health and mental health for older people and optimize their life potential has become an important health issue. This study using the Theory of Planned Behaviour Model will examine factors influencing health behaviours, and relationship with quality of life. A cross-sectional mailed survey of 1300 Australians over 50 years was conducted at the beginning of 2009, with 730 completed questionnaires returned (response rate 63%).

Preliminary analysis reveals the mean and median age of the respondents is 65 years (age range 52-80). Over 80 percent of the respondents (81.3% of 727) reported having one or more chronic diseases. Arthritis or other rheumatic disease (42.8%) and hypertension (32.4%) were the most common disease in these respondents. Also over 65 percent of participants had a BMI over 25. The health related quality of life of respondents shows generally lower than average score in physical health compared to the Australia norm for general people. Attitude, perceived behaviour control and intention are strongly correlated with actual behaviour (physical activity, eating healthy food and medication adherence). Perceived behaviour control of physical activity, depression and chronic disease self efficacy scores were strongly correlated with physical health summary score of quality of life. The results reveal that attitude and perceived behaviour control toward health behaviours, depression and self-efficacy toward the diseases are strong modifiable factors that influence older people's quality of life.

7B

Qualitative prospective study of men at risk and walking

Mrs Elisabeth Lord
University of Queensland

Author: Lord, E.

Presenter Profile

My current role, as Research Officer, Healthy Communities Research Centre, University of Queensland. Academic studies have included: Bachelor of Education (Physical Education), Graduate Diploma in Health Science, and the Masters of Arts in Leisure Management (Honours). I am currently undertaking Doctorate Studies. Throughout my professional career, I have worked in a range of settings across a range of discipline areas, health and physical education, special education, social inclusion, volunteerism, active leisure and health.

Abstract

This research paper discusses a one year longitudinal study of three groups of older men as they engaged, or otherwise, in a walking program in three of their local areas in South East Queensland. As the study evolved the data showed that the men began to fall naturally into full engagement with the program, partial engagement and no engagement. The focus of this qualitative prospective study is to explore the meaning that older men make of their walking experiences and to begin to understand why some men have little desire to become engaged in exercise of this kind. Many quantitative studies exist on how many men engage in exercise and their motives, however, there is a dearth of literature that explores the meaning older men make of a walking program and the reasons why some might value such a program and others not. The study seeks to fill this gap by exploring the motivations that older men may have to engage in exercise and the sense that they make of such engagement.

The difficulties encountered in designing and organising complex qualitative longitudinal research of this kind will be detailed, as will preliminary results from the study. Five distinct data sets were collected (1) background information on n= 132 men who were offered the program, (2) in-depth interviews from men who participated in the program (3) focus group data on men in Hervey Bay, Toowoomba and the Redlands (4) diaries of men who engaged in the program and (5) in-depth interviews with men who completed the walking program. The rationale behind the choice of five methods and the difficulties encountered with the collection and application will be discussed.

The value of using a complex set of qualitative methods to reach a group of men at risk will be explored. The presentation will identify the methods that have worked well when reaching men at risk and the lessons learnt from a study of this kind. Further, a discussion outlining the study time line and the value adding made possible through working in a study area over an extended period of time will be provided. Recommendations will be made for engaging men in physical exercise programs.

The immediate effect of moderate physical activity on the balance of older people

Ms Thorlene Egerton

The University of Queensland

Authors: Egerton, T., Brauer, S., & Cresswell, A.

Presenter Profile

Thorlene Egerton is completing her PhD candidature in Physiotherapy at the School of Health and Rehabilitation Sciences, The University of Queensland. She has an interest in postural and gait research and has previously completed a Masters of Philosophy in Bioengineering and a Post-graduate Diploma of Biomechanics.

Abstract

Older people are increasingly being encouraged to be more physically active. This investigation aimed to determine whether balance is detrimentally affected immediately after everyday levels of physical activity. Balance before and after physical activity was compared by using three different tools for measuring postural stability; i) centre of pressure displacement during quiet standing, ii) step and muscle activity timing during a rapid forward step-up task, and iii) step response strategies to an unexpected lateral postural disturbance at waist level. The physical activity involved a series of mobility tasks carried out for 14 minutes, self-paced at moderate intensity. In quiet standing, older people demonstrated larger amplitude of centre of pressure motion after the physical activity. For the step-up task, there were no signs of decreased balance performance following the physical activity. Finally, when they were pulled laterally off balance, the older participants had increased frequency of using cross-over steps, a less optimal response than single outward steps, after the activity, but they could perform single outward steps as rapidly as before. Collectively the studies demonstrated that older people are capable of maintaining or regaining balance after performing moderate-intensity physical activity. However, small changes were observed in some variables that we propose could be explained by the impact of subjective feelings of tiredness on attentional resources required for balance. These changes may indicate increased risk of falling. Testing balance with a range of methodological tools enabled a better understanding of the mechanisms responsible for the findings than one tool alone.

7D

How does physical activity and motherhood influence activity levels in later life for older ethnic women?

Mrs Georgia Birch
Deakin University

Author: Birch, G.

Profile

Lecturer in Health promotion at the Australian Catholic University.

Abstract

The purpose of this PhD is to undertake a qualitative analysis of how previous physical activity and the role of motherhood influence activity levels in later life for women over 65 years of age from the Horn of Africa. Using interviews and focus groups, it is my intention to establish themes and outcomes that can be used to implement culturally appropriate physical activity interventions for this group.

Factors influencing frailty among community-dwelling elderly in Manggarai sub-district, South Jakarta

Dr Rina Kusumaratna
University of Indonesia

Author: Kusumaratna, R.

Presenter Profile

Community Medicine, Trisakti University, Jakarta

Post-graduate student, Community Nutrition, University of Indonesia, Jakarta

Abstract

INTRODUCTION: Frailty among the elderly could be viewed as an indicator of increased morbidity and mortality. Frailty may be defined as the condition that decreases the ability to conduct activities of daily living and social activities, and is commonly found among women and the elderly living in urban areas throughout the world. However, in Indonesia, especially in Jakarta, the prevalence of frailty among the elderly has not been determined previously.

The objectives: To assess the prevalence of frailty among community-dwelling elderly in a Jakarta urban area and to determine the factors influencing frailty.

METHODS: An observational cross-sectional study was conducted on community-dwelling elderly aged 60 years and above in Manggarai sub-district, South Jakarta. A total of 183 community-dwelling elderly were interviewed on demography, life-style and chronic diseases as independent variables and frailty as dependent variable. A chi-square test was used to test the correlation between the variables.

RESULTS: The study showed that the majority of the subjects consisted of women, aged 60 – 69 years, with low educational and poor socio-economic status. The prevalence of severe frailty in the elderly was 23%. It was also shown that demographic factors, namely education ($p=0.014$) and socio-economic status ($p=0.002$) and physical activity ($p=0.005$) significantly affected frailty.

CONCLUSION: It is recommended that in order to reduce the proportion of severe frailty in community-dwelling elderly, particularly women, they should be encouraged to join senior clubs in their community.

Key words: frailty, elderly, community, South-Jakarta

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7F

The effect of patient education for the prevention of in-hospital falls in older patients – A randomised controlled trial

Ms Anne-Marie Hill

The University of Queensland

Authors: Hill, A. M., Hill, K., Brauer, S., Oliver, D., Hoffmann, T., Beer, C., McPhail, S., & Haines, T. P.

Presenter Profile

Anne-Marie Hill is a titled APA Gerontological Physiotherapist with over 20 years clinical experience who has completed a Masters degree in Physiotherapy in the area of aged care. At present she is a full time PhD candidate investigating the effectiveness of patient education on prevention of in-hospital falls in older people. She holds a Menzies Scholarship in Allied Health Sciences for 2009/2010. She is a senior lecturer in the Physiotherapy programme at University of Notre Dame Australia and has completed a Graduate Certificate in University Teaching

Abstract

Accidental falls in older hospital patients are a serious problem. Trials to date aiming to prevent older people falling whilst inpatients have produced conflicting results.

The aim of this trial was to investigate the effect of providing individual patient education in addition to usual care on the rate of falls and falls related injuries in older hospital patients compared to the effect of providing usual care alone. A randomised controlled trial (n=1206) was conducted at two hospitals in Australia. Inclusion criteria were that participants were over 60 years of age and they, or their family or guardian, gave written consent. Participants were randomised into three groups. The control group continued to receive usual care. Both intervention groups received a specifically designed patient education intervention on minimising falls in addition to usual care. The education was delivered by Digital Video Disc (DVD) and written workbook. One of the intervention groups also received follow up education training visits by a health professional. The primary outcome measure was falls by participants in hospital. Secondary outcome measures included falls at home after discharge, knowledge of falls prevention strategies and motivation to engage in falls prevention activities after discharge. The interim analyses conducted with data from (n=500) participants indicated a trend towards a lower rate of falls and proportion of participants who became fallers in one of the three groups (investigators were blinded to group allocation in interim analyses). Data collection for this component of the study is anticipated to be complete by May 2009.

7G

What makes a fall a “fracture” fall?: Analysis of over 14000 patient falls incidents in Queensland

Mr Satyan Chari

Queensland Health/Monash University

Authors: Chari, S., Haines, T., Varghese, P., & Ferrar, K.

Presenter Profile

Satyan is an occupational therapist with over 7 years of experience gained across clinical rehabilitation, and hospital injury prevention settings. Satyan currently coordinates the RBWH falls injury prevention and is concurrently pursuing an M Phil through Monash University on the role of the environment of patient falls in hospital.

Abstract

Falls-related injuries are among the highest reported causes of preventable harm to older patients in Australia, constituting a major health system burden. A greater understanding of the relationship between falls-related injury and spatio-temporal and activity factors would allow for targeted application of increasingly finite resources towards the prevention of falls mostly likely to result in significant injury. Falls incident records from January 2007 to April 2008 was extracted from the Queensland Health clinical incident database. 14,863 falls-incident records were statistically analysed using univariate logistic regression against ‘injury’ and ‘fracture’ end points. 5321 injurious incidents were contained in the dataset, of which 142 were incidents which resulted in fractures. Results indicated that males who fell had higher odds of sustaining injury than females, however females had significantly higher odds of sustaining fractures. Patients over 85 were more likely to sustain injuries and fractures than younger patients. Falls while grooming/dressing were associated with increased odds of sustaining a fracture than other activities of daily living. Falls while transferring from bed were associated with reduced fracture odds while falls during sitting were associated with reduced odds of sustaining injury. Falls while toileting were associated with higher odds of injury as were falls that occurred in the bathroom. The results of this study suggest increased fracture risk for certain activities associated with upright postures as opposed to a general injury risk for other activities performed in seated position or while lying down. These results support current biomechanical models of falls-related fracture mechanisms.

Session 8 - The Quality of Care

8A

The toolbox experience: Evaluating 2 research tools to facilitate enhanced innovation in the aged care industry

Ms Lois Hazelton

AGSE Swinburne University of Technology

Author: Hazelton, L.

Presenter Profile

Lois Hazelton is enrolled in a PhD program examining governance, stewardship and innovation in aged care. Her career has included time as a director of care of an aged care facility, nursing academic and representing the profession on various committees. She also co-wrote and edited the book 'The Practicing Nurse'.

Abstract

The residential aged care sector is under significant stress. It is currently dependent on an outdated regulatory and pricing system at a time of unprecedented demand and projected growth. There is a strong need to overhaul the system to offer quality, equitable, efficient and sustainable care. This paper seeks to evaluate two research tools that can be used to measure the effectiveness of innovation initiatives within aged care facilities. If innovation is considered a primary theme for achieving a value added environment for aged care then what research tools are available to measure it? Using case study research in selected aged care facilities two methodological tools were used: screening surveys to measure innovation intensity and aspects of innovation culture; and content analysis of staff and board interviews using the latest version of NVivo 8. The survey tool acts as a determinate of climate indicator and provides a profile of management support; work discretion; rewards reinforcement; time availability; and organization boundaries. Use of NVivo 8 identifies the innovation nodes in the culture of the organization. Specifically the tool will allow the subtle patterns or themes of content analysis to be uncovered thereby helping build a rich picture of the practice context where you can take action to evaluate the issues and propose solutions. Results from these research tools can be applied to enhancing the knowledge we are seeking about aged care needs and service delivery and to contribute to an overall enhancement of the context of aged care.

8B

Factors associated with aged care utilisation among the Chinese speaking elderly in Australia

Ms Dolly Hsiao-Yun Huang
The University of Melbourne

Author: Huang, D. H.-S.

Presenter Profile

I graduated from the Kaohsiung Medical University in Taiwan with a Bachelor of social work. I came to Australia in 2003 to pursue higher education and further my career experience. I completed a one-year Masters in social work at Monash University and went on to undertake my research Masters at the University of Melbourne, comparing aged care policy in Taiwan and Australia. I commenced my PhD in 2008, investigating the topic of aged care utilization among the Chinese-speaking elderly in Australia. My primary research interests are aged care policy and cross-cultural practice.

Abstract

Background: The proportion of the aged population from culturally and linguistically diverse (CALD) backgrounds is growing significantly over the years, however many studies have reported health inequality and under-utilisation of aged care services among this population. **Objectives:** This paper, in preparation for a larger study, aims to explore issues which may influence aged care use among the Chinese elderly by undertaking a review of literature and three case studies of older Melbournians of Chinese-speaking backgrounds. **Results:** The review found that use of aged care services is determined by health need, as well as demographic, social structural, psychological, familial, community and organisational factors. While age and health status are common factors that were identified to influence the utilization of aged care services regardless of ethnicity, other factors such as language, migration circumstances, filial piety, and care source preference were socially and culturally related factors that affected utilisation of aged care among Chinese elderly. Additionally, the case studies of the Chinese elderly in Melbourne also demonstrated that the aged Chinese population is an internally diversified group demonstrating considerable variation in attitudes toward aged care use. **Conclusion:** Based on this review, a modified Andersen behavioural model is developed as the framework to guide the future study which will adopt the mixed methods research design, consisting of survey and in-depth interviews.

Building the toolkit of quality monitoring: Clinical outcomes as a means of assessing quality in residential care

Ms Maria O'Reilly
Queensland University of Technology

Authors: O'Reilly, M., Courtney, M., Edwards, H., & Hassall, S.

Presenter Profile

Maria is a PhD Candidate in the Institute of Health & Biomedical Innovation (IHBI) at the Queensland University of Technology (QUT) in Brisbane. She has been actively involved in the field of aged care since graduating as an occupational therapist over 20 years ago, having had experience in clinical, education and research fields. For the past 8 years she has been at QUT working on a research project focusing on quality of care and quality of life for residents in aged care facilities. A component of this project is now the subject of her PhD studies.

Abstract

Residential aged care in Australia does not have a system of quality assessment related to clinical outcomes, creating a significant gap in quality monitoring. Clinical outcomes represent the results of all inputs into care, thus providing an indication of the success of those inputs. To fill this gap, an assessment tool based on resident outcomes (the ResCareQA) was developed and evaluated in collaboration with residential care providers. A useful output of the ResCareQA is a profile of resident clinical status, and this paper will use such outputs to present a snapshot of nine residential facilities. Such comprehensive data has not yet been available within Australia, so this will provide an important insight; if available, benchmarking results will also be presented. Registered Nurses from participating facilities completed ResCareQA assessments for all residents (N=498) and returned the data in de-identified form. For each facility, numerator–denominator data were calculated to assess the degree of potential clinical problems (e.g. prevalence of pressure ulcers, taking nine or more medications). Results varied across clinical areas and across facilities. Within the presentation, rank-ordered facility results for selected clinical areas will be reviewed and discussed.

Use of the ResCareQA to generate clinical outcome data provides a concrete means of monitoring care quality within residential facilities; benchmarks will enable facilities to compare their results with markers of high and low quality, and thus determine the need to analyse or change care practices. Regular use of the ResCareQA could thus contribute to improved care outcomes within residential aged care.

8D

Ethical challenges associated with research on the management of incontinence in residential aged care settings

Ms Joan Ostaszkiewicz
Deakin University

Authors: Ostaszkiewicz, J., O'Connell, B., & Dunning, T.

Presenter Profile

Joan is a registered nurse with an extensive clinical and academic background in aged care. Her research expertise and interests are in quality, safety and risk management for older people, evidence based healthcare and in systematic review methodology. She is currently enrolled as a PhD student and her research is on continence care in residential aged care settings.

Abstract

More than 50% of individuals living in residential aged care settings in Australia experience urinary incontinence and between 10% and 30% experience faecal incontinence (Pearson et al., 2002). Moreover, 86% are dependent on another person for support with bladder management, 77% require support with bowel management, and 78% require assistance in toileting (DoHA, 2003). Despite the magnitude of the problem of incontinence and care-dependence in residential aged care settings, little attention has been directed toward developing an in-depth understanding of current practices about how continence care is delivered. Using Grounded Theory method, the current study will to explore and describe how continence care is determined, delivered and communicated in residential aged care settings.

Data will be derived from interviews with carers, field observations of practice and documentation audits. This paper will discuss some of the ethical dilemmas posed by the study design and proposed data collection methods. It will discuss issues related to obtaining consent in vulnerable populations; researching topics that are private and sensitive as well as the challenges meeting ethics application requirements.

Sharing knowledge: An action research study

Mrs Joanne Rowley
Southern Cross University

Author: Rowley, J.

Presenter Profile

Registered Nurse

Southern Cross University PhD Student

Awarded an Aged Services Learning and Research Collaborative (ASLaRC) post graduate scholarship to conduct this study.

Abstract

One of the core business functions of the residential aged care industry is meeting the end of life care needs of dying residents. The number of frail, older Australians dying of chronic progressive non-malignant illnesses in residential aged care facilities is increasing therefore the demand for compassionate quality end of life care is growing in importance. The purpose of this paper will be to discuss the appropriateness of action research as a methodology for exploring end of life care delivery with aged care nurses. Action research aims to engage participants to influence practice or facilitate change. The process requires participants to identify issues that are relevant to their practice and develop solutions or strategies to change practice or improve situations. Action research has been criticised as being a 'soft' research methodology, a style of research and the poor second cousin of 'true' research. Accusations of vague findings, unrefined themes and controversial data analysis have surrounded the methodology for decades. This paper will report how action research was used in two, rural residential aged care facilities to explore issues surrounding end of life care and how the aged care nurses examined practice issues including the constraints to practice. Recommendations are made, aimed at closing the theory-practice gap in aged care and acknowledging the importance of improving the support for those who deliver end of life care.

8F

The 'RedUse' project: Reducing the use of sedatives in residential aged care

Mrs Juanita Westbury
University of Tasmania

Authors: Westbury, J., Shane, J., & Peterson, G.

Presenter Profile

Juanita's background is as a community pharmacist. Ten years ago, Juanita became accredited to perform medication reviews in aged care homes in South Australia. From 2001, Juanita worked as a NHS pharmacist in England where she provided pharmaceutical advice to GPs and developed policy and programs promoting optimum medication use for older persons. Whilst in England she completed a Master of Science degree investigating medication adherence in older people. In 2007, Juanita was awarded a scholarship to complete a PhD at the University of Tasmania. Her thesis is entitled: "Roles for pharmacists in improving the quality use of psychotropic medicines in residential care facilities."

Abstract

Objective: To evaluate a multi-faceted, interdisciplinary intervention to promote appropriate usage of antipsychotics and benzodiazepines in aged care homes: the RedUse (Reducing Use of Sedatives) project.

Methods: The RedUse project was a controlled trial conducted in 25 aged care homes in Tasmania, with 13 intervention and 12 control homes. A series of pharmacist-led strategies were provided to intervention homes including two medication audit cycles, staff education, and a interdisciplinary sedative review. Data on psychotropic drug use at each home was collected utilising a computerised program at baseline, 12 weeks and 26 weeks.

Results: An average of 1591 residents was audited for each RedUse measurement. Over the six month trial, there was a significant reduction in the percentage of intervention home residents taking benzodiazepines (31.8% to 26.9%, $p < 0.005$) and antipsychotics (20.3% to 18.6%, $p = 0.047$), whereas control home sedative use did not alter. For residents taking benzodiazepines and antipsychotics at baseline, there were significantly more dose reductions/cessations in intervention than in control homes (benzodiazepines: 39.6% vs 17.6%, $p < 0.0001$; antipsychotics: 36.9% vs 20.9%, $p = 0.006$). Pharmacist and nursing staff participants reported a high degree of satisfaction with the project.

Conclusion: 'RedUse' led to a significant reduction in the proportion of residents taking benzodiazepines and antipsychotics, and a significant increase in the number of dose reductions/cessations. Our findings suggest that QUM strategies coordinated through community pharmacies, and incorporating the dissemination of local data on medication use, offer an effective approach to reduce psychotropic use in aged care homes.

8G

Risk of medication misadventure among residents of retirement villages (RV) in Victoria: A cross-sectional survey

Miss Cik Yin Lee

Department of Pharmacy Practice, Monash University

Authors: Lee, C. Y., George, J., Elliott, R., & Stewart, K.

Presenter Profile

I am a PhD candidate currently doing a research with Dr Johnson George, Associate Professor Kay Stewart and Mr Rohan Elliott at the Monash University, Department of Pharmacy Practice. I am supported by a National Health and Medical Research (NHMRC) Postgraduate Research Scholarship. My research aims to study medication use issues among the older people living in retirement villages and supported residential services (SRSs), and to investigate ways to improve the safe and effective use of medications in these groups.

Abstract

This paper explores issues associated with medication use among RV residents. Scant information exists on medication use in this group. However, as an older segment of the community they are likely to use multiple medications and hence be at risk of medication misadventure. Further research is needed to confirm this and to inform prevention strategies. We used a postal questionnaire to survey a convenience sample of RV residents who were members of the Residents of Retirement Villages of Victoria (RRVV). The 4-page questionnaire included validated items on health-related measures, medication risk assessment, medication use and access of home medicines review (HMR) service. Our survey was endorsed by RRVV and the Council on the Ageing Victoria (COTA Vic), and had a very good response rate (2116 of 2995 surveys, 70.7%). The survey found that the use of prescribed medications (94.8%), multiple regular medications ≥ 5 (46.7%), and medications(s) associated with increased risk of adverse events or drug-related hospitalisations in older people (89.0%) were highly prevalent. There were also high levels of medication-related risk factors (90.7%) reported. Unplanned hospitalisations (20.5%), adverse drug reactions (9.7%), and medication nonadherence (23.6%) were also self-reported. Despite the high rates of medication use issues, only 3.8% of respondents had received a HMR. Screening at-risk residents and recommending the GP to make a referral in those meeting the criteria for a HMR, a service recommended and funded by government, might minimise medication-related problems. Interventions for improving medication use and the uptake of HMRs in this group are warranted.

Session 9 - Allied Health and Nutrition

9A

Age-related differences in the quality of care: How well are we using our ‘tool kits’ for older stroke patients?

Ms Julie Luker

University of South Australia

Authors: Luker, J., & Grimmer-Somers, K.

Presenter Profile

Julie Luker is a physiotherapist with particular interests and expertise is in the fields of stroke management, the rehabilitation of older adults and inter-disciplinary models of team based care. Julie completed a Master of Physiotherapy in 2008 in which she investigated the implementation of acute stroke clinical guidelines by allied health staff, and is now exploring this topic further as a PhD candidate. Julie is actively involved in stroke service planning, guideline development and implementation at national and state levels, whilst maintaining a role as an allied health team leader within an acute stroke unit in Adelaide.

Abstract

BACKGROUND: Despite strong evidence to guide best-practice care for stroke patients of all ages, international studies indicate that older stroke patients are less likely to receive optimal evidenced-based care than younger patients and thus have a greater risk of poor outcomes.

METHODOLOGY: A two part study was conducted to investigate inequity of care: Firstly, a retrospective audit was conducted of 50 systematically sampled medical records in a tertiary hospital in SA to explore the quality of care provided by allied health professionals. The recorded care was benchmarked against 38 evidence-based recommendations in the Australian Clinical Guidelines for Acute Stroke Management (www.strokefoundation.com.au/clinical-guidelines). Secondly, a systematic review of the international literature was conducted to explore age-inequities in allied health care for acute stroke patients.

RESULTS: The audit identified variable quality of allied health care provided to acute stroke patients. Patients' age was one of a number of factors which explained differences between actual care and benchmark care. Older stroke survivors received less guideline-compliant care from allied health staff than younger stroke patients. Lower quality of care was not related to functional ability scores on admission or discharge, nor to functional improvements made by older patients. The systematic review provided further evidence of age-related differences in the quality of acute stroke care.

CONCLUSIONS: Understanding why age exerts an effect on the care decisions of acute stroke professionals is essential, given the ageing population and the increasing proportion of old acute stroke sufferers.

9B

Aquatic physiotherapy after joint replacement surgery: Reflections on completing a clinical RCT

Ms Ann Rahmann

University of Queensland

Authors: Rahmann, A., Brauer, S., & Nitz, J.

Presenter Profile

Ann graduated from the University of Queensland, has a Graduate Certificate in Gerontology and is currently completing her PhD through the Physiotherapy Department of the University of Queensland. She works as a clinical educator in the Neurology, Aging and Balance Clinic at the University of Queensland with final year physiotherapy students and she also works in a private domiciliary aged care practice. Her research interest was sparked while working in aquatic physiotherapy for over ten years at The Wesley Hydrotherapy Clinic in Brisbane until its closure in 2007. Her clinical and research interests include aquatic physiotherapy for older people as well as balance and vestibular rehabilitation.

Abstract

Randomised controlled trials are the gold standard in clinical research, but undertaking such a study is not an easy task. As a clinical physiotherapist, I was interested in the benefits of early post-operative aquatic physiotherapy in older people but could find no previous research evidence. This paper presents the final results of my clinical RCT, designed to evaluate the effect of inpatient aquatic physiotherapy in addition to usual ward physiotherapy on the recovery of strength, function and gait speed after total hip or knee replacement surgery. Reflections on the difficulties and positives of answering a clinical question with an RCT will be included throughout. The study was a pragmatic RCT with blinded 6-month follow-up and Day 14 was the primary end-point of interest. Sixty-five people undergoing primary hip or knee arthroplasty were recruited (average age 69.6+-8.2years, 30 men) and were randomly assigned to receive supplementary inpatient physiotherapy, aquatic physiotherapy, general water exercise or additional ward physiotherapy, beginning on Day 4 after surgery. Results at Day 14 showed hip abductor strength was significantly greater after aquatic physiotherapy intervention than additional ward treatment ($p = 0.001$) or water exercise ($p = 0.011$). No other outcome measures were significantly different at any time point in the trial but relative differences favoured the aquatic physiotherapy intervention at Day 14. A specific inpatient aquatic physiotherapy program was shown to have a positive effect on early recovery of hip strength after joint replacement surgery and can be safely undertaken in this older age group.

9C

Life-course patterns in the relationship between body-weight and mortality: An age- and cohort-specific analysis

Dr Yan Yu

University of Wisconsin-Madison

Author: Yu, Y.

Presenter Profile

Yan Yu finished her Ph.D. in sociology and master degree in statistics from the University of Wisconsin-Madison in December 2008. Her research interests include health and mortality, demography of ageing, family, and research methods. Her doctoral thesis examined the relationship between obesity and adult mortality. She is currently working on the Dynamic Analyses to Optimise Ageing (DYNOPTA) project at the Australian National University.

Abstract

Excess mortality due to overweight or obesity was found to decline over cross-sectional age groups, which has been interpreted as a declining age effect in the public health literature and contributed to the widespread myth that an extra amount of fat is protective in old age. This finding is susceptible to cohort distortions because the age groups belong to different birth cohorts. Additionally, prior research used time since baseline as analysis time, making it impossible to evaluate age-specific mortality. The current study conducts an age- and cohort-specific analysis of mortality differentials by weight for five cohorts of men and women born in the first half of the twentieth century, using U.S. data from three National Health and Nutrition Examination Surveys. The long-term mortality consequences of excess weight do not decline over age but change across cohorts. Ignoring cohort differences leads to a distorted age pattern or biased estimates.

9D

The influence of food processing on the ability of older Australians to meet the nutrient reference standards

Mr Paul Jeffrey
Deakin University

Authors: Jeffrey, P., & Lawrence, M.

Presenter Profile

Paul has obtained a Master of Health Science (Human Nutrition) with Deakin University. He has an interest in dietary modelling and how health is affected by food processing. He is currently employed with the National Ageing Research Institute in the Preventive and Public Health Division.

Abstract

Consuming a nutritionally adequate diet is a health priority for older Australians. This paper presents the findings of a dietary modelling research project designed to assess the impact of food processing on the ability of older Australians to consume a diet consistent with nutrient recommendations. The findings of the different dietary modelling scenarios were compared with the 2006 Nutrient Reference Values that had been recommended for Older Australians. The analysis revealed that older Australian's diets are at particular risk of inadequate intake for the nutrients calcium, folate, zinc, potassium, magnesium, riboflavin, fibre and vitamin A. The findings also indicate how sensitive inadequate nutrient intake is to physical activity level and food processing. Results have been obtained from dietary modelling with a software application developed for this project and utilising data from Australian food composition and consumption databases. The recommendations from this paper have implications for food policy and the dietary behaviour of older Australians including the importance of selecting food for quality and freshness.

What is an appropriate BMI for individuals over the age of 70 years?

Miss Jane Kellett
University of Sydney

Authors: Kellett, J., Brock, K., Clemson, L., & Cant, R.

Presenter Profile

Jane Kellett is a lecturer in Nutrition and Dietetics in the Faculty of Health at the University of Canberra. She is currently completing her PhD at the University of Sydney under the supervision of Kaye Brock, Lindy Clemson and Rosemary Cant. She is investigating Malnutrition in the community-dwelling elderly.

Abstract

The elderly are at risk of malnutrition and the associated nutrition-related complications. Early detection of at-risk individuals with poor nutritional status is essential. It is important to use screening methods that identify those who are malnourished or are at risk of developing malnutrition. One anthropometric measure used is the Body Mass Index (BMI) which assesses nutritional status and identifies people at risk of malnutrition. The World Health Organisation (1995) currently has the following reference ranges for BMI: underweight $<18.5\text{kg/m}^2$; normal range $18.50\text{--}24.99\text{kg/m}^2$; overweight $\geq 25.00\text{kg/m}^2$, obese $\geq 30.00\text{kg/m}^2$. A review of the literature indicates that the optimal range of BMI for elderly people is changing, and that different cut-off values may be more appropriate in individuals over the age of 70 years. The majority of studies on older people have been on hospitalised and nursing home patients. In these settings, it has been suggested that a BMI of less than 24kg/m^2 be used to identify the patient at-risk of undernutrition. In the community-dwelling elderly findings have suggested that a BMI of less than 22kg/m^2 is associated with increased mortality and other risks. From our data, we suggest that the current BMI for overweight in the elderly is not associated with chronic diseases and conditions. Further research is needed to determine the appropriate BMI range for individuals over the age of 70 years.

9F

The essential palette of action research

Ms Sandra Ullrich

University of South Australia

Authors: Ullrich, S., McCutcheon, H., & Parker, B.

Presenter Profile

Ms Sandra Ullrich is currently in her third year of her PhD in nursing. Prior to entering nursing she worked in the hospitality industry. Her research interests in ageing include nutritional care, systems thinking and organisational change. Sandra is a member of the Action Learning and Action Research Association and is PhD representative for the University of South Australia's School Research Management Group.

Abstract

Despite being preventable and treatable inadequate nutrition remains a problem for many older people within residential aged and acute care settings. Nevertheless, many of these organisations are uniquely positioned to implement solutions that will lead to better care. This action research study explores the connections between organisational systems and group processes across two health care settings in relation to the changes that were made to nursing practice in nutritional care. This presentation is about the repertoire of skills essential for action research and how they featured in creating change within a residential aged care facility. Non participant observation and focus groups were the primary data collection methods and data were analysed using thematic analysis. Implementing action research has been described as a work of art which requires an understanding of the nature of the participatory world view. Its five dynamic principles are the researcher's palette to be creatively used for a living and evolving process of coming to know rooted in everyday experience. Action research and its participative and democratic principles draw on and express the many diverse ways of knowing as it seeks to bring together action and reflection, theory and practice. This strongly value orientated approach also seeks to address issues of significance that concern people in the every day conduct of their lives. As this work of art emerges over time it not only leads to practical knowledge, but to new abilities to create knowledge. This enhanced understanding further empowers people and allows for the opening up of new communicative spaces.

Malnutrition on the menu: Nutritional status of institutionalised elderly Australians in low-level care

Ms Julie Woods
Monash University

Authors: Woods, J1., Walker, K. Z2., Iuliano-Burns, S3., & Strauss, B. J1.

1 Nutrition and Dietetics Department, Monash University, Melbourne, 2 Preventative Health Unit, BakerIDI Heart and Diabetes Research Institute, Melbourne, 3 Endocrine Centre of Excellence, Department of Medicine, Austin Health, University of Melbourne, Melbourne, Australia.

Presenter Profile

Currently a lecturer in Nutrition and Dietetics at Monash University, with 25 years experience in the field. Undertaking a PhD investigating nutritional status and immune function in elderly requiring low level care as part of a broader study investigating effects of a nutrition intervention on falls and fractures.

Abstract

BACKGROUND: Many elderly are at increased risk of poor nutritional intake due to a complex range of social, psychological and medical factors. Most studies investigating nutritional status in the elderly focus on those in nursing homes or those still living in the community. Few studies have examined the many elderly living in low-level care.

OBJECTIVE: To investigate the food supply and nutritional status of elderly in low-level care facilities. **DESIGN:** A cross sectional study design in low-level aged care facilities in Melbourne. **Participants:** Convenience sample of 103 ambulatory elderly (86 ± 6.6 years, 76% female) able to self feed. **Measurements:** A comprehensive mix of assessments including: three-day weighed food records, haematological and biochemical markers and body composition by dual energy X-ray absorptiometry.

RESULTS: Food served did not supply the estimated average requirements (EAR) for 5 of the 14 nutrients analysed for. Thirty four percent of participants were protein malnourished and 62% had energy deficits. Intakes of calcium, magnesium, folate, zinc (for men) and dietary fibre were low. Vitamin D deficiency (serum 25OHD $<50\text{nmol/L}$) was present in 58% of residents. More men than women had haematological indicators of undernutrition. Men also had greater prevalence of sarcopenia (43% vs 21% in women, $P<0.001$). Only 12% showed no sign of undernutrition using seven different nutritional indicators. Around 65% had two or more indicators of undernutrition.

CONCLUSION: These findings highlight the need for the supply of more, better quality, nutrient dense food to residents and better detection of undernutrition in aged care facilities.

Session 10 - Emotional Health and Wellbeing

10A

Reflections on interviewing, transcribing and translating process: An experience with the Malays caregivers of older people with mental health problems

Miss Fatima Zailly Ahmad Ramli
University of Queensland

Author: Ahmad Ramli, F. Z.

Presenter Profile

PhD student from Malaysia and working on the topic of Informal caregivers of older people with mental health problems: an exploratory study in Kelantan, Malaysia. My interest is on topic of older people, caregivers and mental health problems in Malaysia; the relationship of social welfare and the policy for their well being.

Abstract

Qualitative studies are often focused on the richness of the data from the interviews conducted by the researcher. For the researcher working across cultures and language, qualitative research presents particular challenges of capturing the meaning intended by the respondent in appropriately structuring the interview, analysing data when two languages are involved and presenting a trustworthy final report. Whilst, transcribing the recorded interviews also contribute to the learning process to understand the whole pictures of the themes under study.

This paper aims to contribute to an understanding of the research process by reflecting on the experiences of the researcher while conducted a study about the Malay caregivers of the older people with mental health problems in Kelantan, Malaysia. The strengths and difficulties are identified and some suggestions are offered to researchers working across language groups based on the researcher's experiences.

10B

Developing a model of narrative analysis to investigate the role of social support in coping with traumatic war memories

Dr Karen Burnell
University College London

Authors: Burnell, K., Coleman, P., & Hunt, N.

Presenter Profile

I read Psychology at the University of Southampton from 2000-2003. In 2003, I achieved my BSc and, at the same time, successfully applied for the Economic and Social Research Council 1+3 Postgraduate Award to fund a full time MSc in Research Methods in Psychology and a PhD. I completed my MSc 2004 and my PhD in 2007 entitled 'The Reconciliation of Traumatic War Memories throughout the Adult Lifespan: The Relationship between Narrative Coherence and Social Support'.

I am currently a Research Associate at University College London working on the SHIELD: Support at Home – Enhancing Life in Dementia research programme.

Abstract

Within clinical and health psychology, narrative is used to understand how people make meaning of events that challenge one's beliefs about the self and the world e.g. the diagnosis of an illness or the experience of a traumatic event. This paper introduces a model of narrative analysis that can provide insight into the ways in which people make meaning of traumatic events and the types of resources that aid or hinder this process throughout the life course. The model, an adaptation of grounded narrative analysis (Murray, 2003), was applied at two levels (narrative form and narrative content) to the narratives of 30 British male veterans of World War II (WWII) and post WWII veterans up to and including the Iraq war (2003-). Narrative form concerned the coherence of the narrative, which was defined as an oriented, structured, affectively consistent, and integrated narrative, indicative of the reconciliation. Narrative content focused on the social support experiences of the veterans. Through this two level analysis, it was possible to make theoretical links between the types of social support that aid the meaning making process and help veterans to reconcile their experiences. This paper will present the model of narrative analysis along with the findings from the study, highlighting implications concerning the role of social support in the search for meaning throughout the life course and the possibility for reconciliation in earlier life whilst personal and social resources are still available.

Potential sex differences in the genetic architecture of the covariation between optimism and health in aged Australian and Swedish twins

Ms Miriam Anna Mosing
University of Queensland

Authors: Mosing, M. A., Wright, M. J., & Martin, N. G.

Presenter Profile

Miriam Mosing is a second year PhD student at the Queensland Institute of Medical Research, Genetic Epidemiology Unit. Her PhD topic is “Genetic influences on the variation of traits and covariation between traits related to quality of life (e.g. personality and health variables) throughout life time and in the aged”. She has done a Bachelor in Bio-psychology and a Masters in Neuropsychology, both at the University of Maastricht in the Netherlands. During her Bachelor she did a 6 months exchange at Bond University, Gold Coast, Australia. To finalize her Masters degree, Miriam did a 6 months research internship at UQ conducting head injury research at the emergency room of the Royal Brisbane Hospital, QLD.

Abstract

Optimism has a positive influence on mental and somatic health throughout lifetime and into old age. It has been shown that the frequently reported association between optimism and health is mainly due to shared genetic influences. There has been some indication of sex-differences in the heritability of these traits in the literature. Here we explore potential sex-differences in the genetic architecture of optimism, mental and self-rated overall health and their covariation. Optimism, mental, and self-rated health are measured in 3053 Australian twin individuals (501 identical female, 153 identical male, 274 non-identical female, 77 non-identical male, and 242 non-identical opposite-sex twin pairs and 561 single twins; mean age 60.97 ± 8.76), as well as in 812 Swedish twin individuals (71 MZ female, 53 MZ males, 93 DZ females and 67 DZ male twin pairs and 244 single twins; mean age 60 ± 14.3) using the Life Orientation Test (LOT), the General Health Questionnaire (GHQ) and a single-item self-rating of overall health, respectively. Genetic modelling of the twin data was conducted. Results, possible explanations and implications will be discussed.

10D

The depression-dementia dilemma for primary care: Relationships between cognitive impairment and mental illness in community-dwelling elderly Australians

Ms Jessica Swain

Authors: Swain, J., & Pond, D.

Presenter Profile

Jessica Swain is a PhD (Clinical Psychology) candidate at The University of Newcastle. She completed a Master of Psychology (Work and Organisational) at The University of South Australia and has a Bachelor of Psychology (Hons) from The University of Newcastle. Jessica has worked as a Project Manager on a large multi-centre research trial in general practice examining dementia in elderly people. This experience led to the development of Jessica's PhD research, which is investigating the depression-dementia relationship in older community-dwelling Australians and exploring the implications of GP detection and management of these conditions on patients and their families.

Abstract

Australian statistics indicate that depression and dementia are the top two contributors to disability burden in Australia. The depression-dementia relationship is complex. A number of symptoms are the same for both conditions and depression coexists in up to 57% of dementia sufferers. GPs play a key role in their detection and management as more than 80% of older people attend their GP regularly. There is evidence for a need to improve GPs' ability to detect depression and dementia, as GPs fail to identify ~50% of cases. Diagnostic accuracy is important as misdiagnosis has substantial implications for patients and carers.

A multi-centre randomised controlled trial is currently being undertaken across five Australian cities. 190 GPs and 1930 of their 75+ patients have been recruited. At Month 1 GPs audited patients for dementia. GPs were allocated to intervention or control group. Intervention GPs received dementia-specific detection and management training including information on comorbid conditions and differential diagnoses. Patients completed a battery of assessments including the CAMCOG and GDS-15. At Month 12 GPs reaudit their patients for dementia and depression. Baseline measures are repeated.

Currently 12-month data is being collected. Preliminary results produced depression and dementia prevalence of 6.9% and 8.8%, respectively. GPs accurately detected dementia in 63/154 patients. Quality of life outcomes were significantly poorer for those with dementia than without. This presentation will explore the depression-dementia relationship in older people and the role of GP detection on patient quality of life outcomes.

10E

Developing evidenced-based methodology to evaluate the effects of music and animal-assisted activities on depression in cognitively intact elderly individuals

Ms Jenny Patterson

Authors: Patterson, J., Toukhsati, S., Barber, B., & O'Connor, D.

Abstract

Music Therapy (MT) and Animal-Assisted Activities (AAA) are commonly used in conjunction with conventional medicines in a number of clinical populations, with the therapies claimed to be effective in treating a range of mental illnesses including depression, anxiety and schizophrenia. Evidence-based research to support the utility of MT and AAA as treatments for depression in the elderly is, however, limited and much of the evidence to support their use is derived from case studies or research employing music listening protocols as opposed to structured MT interventions. Although these studies offer support for the claim that MT and AAA are effective in treating depression, methodological limitations (such as a lack of appropriate control conditions and randomisation procedures), means that care must be taken against the over-interpretation of findings. Accordingly, further empirical justification for the use of MT and AAA as interventions for depression is needed. To this end, the implementation of an evidenced-based methodology to evaluate the efficacy of MT and AAA to reduce depressive symptomatology in cognitively intact elderly individuals will be discussed. In addition, the advantages and disadvantages of employing both subjective and objective measures to enable exploration of the possible physiological mechanisms that underpin any observed effects of the therapeutic interventions on depressive symptomatology will be examined. In establishing the need for evidenced-based research, it is hoped that the use of more rigorous research methodology to explore the effects of alternative therapies will provide valid and reliable evidence which may inform the future implementation of MT and AAT for elderly individuals experiencing depression.

10F

Carers of community dwelling frail older people: aspects of the caregiving experience predict depression

Mrs Christina Aggar

Faculty of Nursing & Midwifery, University of Sydney

Authors: Aggar, C., Ronaldson, S., & Cameron, I. D.

Presenter Profile

Christina Aggar is a registered nurse with over 20 years experience. She is a PhD candidate and Research Assistant at the Faculty of Nursing & Midwifery, University of Sydney. Her research focuses on the caregiving experience of frail older community dwelling people.

Abstract

Carers are an important source of support to frail older persons and often play a direct role in their quality of life and ability to maintain independence in the community. Both the impact of providing care and depression have been demonstrated to affect a carer's ability to continue in their caregiving role. This paper examines the relationship between caregiving experiences and depressive symptoms in carers of frail older people. The study involved carers of community dwelling people (>70years) who were participants of a randomised controlled trial aimed at investigating treatment of frailty. The caregiving experience was evaluated using the Caregiver Reaction Assessment (CRA)¹ and levels of anxiety and depression were measured using the Hospital Anxiety and Depression Scale (HADS)². The association of caregiving experiences with depressive symptoms was investigated. A main finding was 19% of informal carers reported borderline depressive symptoms and 11% abnormal depressive symptoms. Regression analysis indicated that impact on schedule ($\beta = 1.416$, $p = 0.01$) and health ($\beta = 1.695$, $p = 0.028$) as a result of caregiving predicted 42% of variance in the depressive symptoms of the carers ($p = 0.000$). This research confirms that specific aspects of caregiving predict depression in carers. Interventions targeting specific aspects of the caregiving experience have the potential to improve the emotional health of carers of frail older people, enabling them to continue in their caring role.

10G

The pouring practices of older drinkers: implications

Dr Celia Wilkinson
Edith Cowan University

Authors: Wilkinson, C., Allsop, S., & Chikritzhs., T.

Presenter Profile

Celia completed her PhD in 2008 at the National Drug Research Institute, Curtin University and is currently employed as a Senior Lecturer in Addiction Studies at Edith Cowan University, WA.

Abstract

This research involved three studies. Study 1 entailed telephone interviews with 32 key informants from across Australia to investigate alcohol guidelines for older Australians. Study 2 involved face to face interviews with 844 men and women aged 65 to 74 years of age in Perth, WA. Participants were required to “pour” their “usual” amount of alcohol and were interviewed about their alcohol consumption. Study 3 involved secondary analysis of the 2004 NDSHS. This paper will report on the results from the above completed research and discuss some of the strategies employed to recruit older subjects.

Poster Presentations

A preliminary investigation of the effects Ropren vs Placebo on cognitive function, biochemical blood indices, mood and stress in healthy 60 to 80 year old participants

Ms Vanessa Bilog
Swinburne University of Technology

Authors: Ms Vanessa Bilog, Ms Christina Kure, Ms Elizabeth Harris, Dr Andrew Pipingas, Prof Kevin Croft, Prof Con Stough

Abstract:

Ropren is a preparation isolated from green pine and spruce needles which contains the biologically active compound dolichol. In humans dolichols are naturally distributed in the lipid bilayer of cellular membranes, and as we age dolichol levels accumulate in the brain; where accumulation is particularly more pronounced in pathological conditions such as Alzheimer's disease. Previous studies suggest that dolichol in neurons may act as a carrier of proteins essential for the synthesis of acetylcholine, and thus may exert a considerable influence on efficient synaptic transmission for mediating memory functions. This double-blind, randomised, placebo-controlled exploratory study investigated the possible cognitive effects of chronic 12-week administration of Ropren (100mg) in healthy participants on cognitive performance, mood and stress. Cognitive performance was assessed using the Swinburne University Computerized Cognitive Assessment Battery and a standardized battery of neuropsychological tests. Profile of Mood States and the State-Trait Anxiety Inventory were included as a measure of mood and stress. Repeated measures ANOVA indicates improvement of several complex cognitive variables, whilst blood indices revealed an improvement in several measures; particularly in the reduction of Low Density Lipoproteins. No significant changes were observed for any of the antioxidant measures. Together, these results suggest that administration of Ropren has the capability to improve aspects of cognition and important health related measures. A separate related study also demonstrated the capability of Ropren to improve electrical activity during complex tasks using EEG. Implications for future studies should consider employing a larger sample size and inclusion of clinical patients demonstrating cognitive decline.

Transitions In Later Life: The impact of residential relocation on wellbeing.

Ms Dimity Crisp
Australian National University

Authors: D.A. Crisp, K.J. Anstey, P. Butterworth, T.D. Windsor

Abstract:

In view of Australia's ageing population, issues surrounding housing and the psychosocial resources that promote successful adaptation to significant later-life transitions, such as residential relocation, represent important areas for research. It is expected that the transition from living within the community to a retirement village may have important consequences for the mental health, well-being and social relationships of individuals in later life. While previous studies have retrospectively investigated outcomes following residential relocation, the present study utilises a more comprehensive prospective longitudinal design to examine both immediate and longer-term consequences associated with the transition. The present study comprises prospective residents of a new retirement complex established in 2009 by Illawarra Retirement Trust (IRT). Participants will be assessed on four occasions over a period of 15-18 months, completing written assessments at Baseline (prior to moving), 1-month post-relocation, 8-months post-relocation, and 15-months post-relocation. Characteristics examined include the physical living environment, personality, coping style, social networks, health and wellbeing (including physical activity, psychological distress and life satisfaction) and cognitive function (assessed via telephone interview). Participants' personal experience of the move is also reported allowing for an extensive investigation of factors associated with the transition. A group of community dwelling residents will be assessed for comparison. As this project is currently ongoing, preliminary results will be presented at the conference. Applications for this research reside in its capacity to assist aged care providers to identify key factors contributing to an individual's positive relocation experience and overall wellbeing.

What is in the qualitative toolkit for researching a multilingual ageing population?

Ms Caroline Fryer
University of South Australia

Authors: Ms. Caroline Fryer, Dr. Shylie Mackintosh, Dr. Mandy Stanley, Dr. Jonathan Crichton

Abstract:

This presentation reviews which research methods are used to conduct qualitative health research with multilingual populations of older people, how each method is described in the research literature and how trustworthiness is determined. Australia is one of the most culturally and linguistically diverse countries in the world with an increasingly multicultural ageing population. Qualitative research enables health care providers to understand how older people experience health and illness and can guide clinical practice. However, people who do not speak English well are often excluded from research or participation is limited to a single language group. Such strategies restrict the relevance and potential benefit of research findings for the health care of culturally and linguistically diverse older Australians. The electronic databases Medline, Web of Science, Embase, CINAHL, Ageline, PsycInfo, Social Sciences Citation Index and Sociological Abstract will be systematically searched using relevant search terms including 'migrant', 'limited English proficiency', 'cultural diversity' and 'qualitative'. Hand searching of reference lists will also be undertaken. All qualitative health research studies that include more than one language group and are written in English will be included in the review. The Matrix Method will be used for analysis. Findings from this systematic literature review will increase the awareness and knowledge of researchers in ageing to the tools available for conducting qualitative health research with linguistically diverse populations. This will hopefully encourage researchers to give all older people the opportunity to participate in qualitative research and benefit from its results.

Variable Harmonisation in the DYNOPTA Project: Harmonising Education Variables Across 9 Australian Longitudinal Studies of Ageing and Estimating Study Censored Data

Mr Kim Kiely
The Australian National University

Authors: Kim Kiely, Kaarin Anstey, the DYNOPTA Investigators

Abstract:

Recently, there has been a push in ageing research disciplines towards greater integration and optimal use of existing data. Variable harmonisation methodologies rescale functionally equivalent measurement instruments onto a common metric and present one strategy to achieve these aims. The benefits of harmonisation include increased sample size, greater representation and the capacity for immediate cross-population comparisons. Limitations include the introduction of study design effects, censoring, information loss, and dataset complexity.

The Dynamic Analyses to Optimise (DYNOPTA) Project has harmonised and pooled nine Australian Longitudinal Studies of Ageing. This poster will describe the harmonisation process for education variables. Education is an important factor to consider when conducting ageing research as it captures early life-course processes, has been found to be predictive of a range of health related outcomes and is directly relevant to policy. Education variables were harmonised using the by-fiat method, which required identification of mutually exclusive categories that were common to all contributing studies. One of the contributing studies did not obtain age left school data for the entire sample, or qualification level for low education achievers. Thus, level of education was study censored for a sub-population of DYNOPTA. Logistic regression and cold deck imputation methods were used to estimate education for this sub-population. By allowing for the combination and direct comparison of independent datasets, harmonisation techniques present an excellent opportunity to capitalise on Australia's investment in longitudinal ageing research and are a great addition to the methodological toolkit of integrative researchers.

Healthy Ageing and the survival of Older Marriages

Prof Dennis Lowther
Monash University

Authors: Dennis Lowther, Dr Susan Feldman, Professor Colette Browning

Abstract:

This study is concerned with the role of long-term marriage on healthy ageing. The uniqueness of this study relates to the predicted increase in couples married for over forty years, as a consequence of the ageing of populations in developed countries. For example in Switzerland at retirement age 75% of women and 80% of men are still married and expected to live fifteen or more years with their partners (Martin and Wight 2008). Late-life husband and wife relationships are increasingly recognised as important for the promotion of the well being of spouses in terms of their health, social, emotional and practical needs (Walker and Luszcz 2009). This study will use qualitative and quantitative methods to examine the perceptions of individuals and couples about aspects of spousal relationships that help maintain long term marriages and contribute to healthy ageing in Australia.

The research questions will include key aspects such as; mutual liking, trust, and easy communication which help in marital relationships and dispute resolution (Lauer, Lauer & Kerr 1990), interrelationship skills, sex and intimacy, which may aid in the prevention of social and emotional loneliness (Giervald et al 2009).

Other aspects covered in this study and particularly relevant to ageing within marriage will include, the improvement of cognition and problem solving in daily living by active co-operation between the marriage partners, (Meegan and Berg, 2002) and the role of 'concordance' in sharing and strengthening emotional resilience, very important for coping with health or behaviour problems and unintended marital separation (Meyler, Stimpson, and Peek 2007).

Testing the “Overinvestment” Hypothesis of Attention in Young and Older Adults

**Ms Sharon Male
Monash University**

Authors: Sharon J Male, Dianne M Sheppard

Abstract:

Aging has been shown to have a negative impact on the frontal lobe – particularly the prefrontal cortex. As such, control of fast and efficient attention-related processing in novel or unfamiliar tasks as well as in dual-task situations have been shown to be affected by the aging process.

The Attentional Blink (AB) refers to a reduced capacity to fully process a second target (T2) when it appears temporally close to a first target (T1) in a rapid serial visual presentation (RSVP) stream. This effect is robust, even occurring in normal healthy young participants when the second target occurs within 100 to 500ms of the first. Despite this general robustness, researchers have recently found that some manipulations can attenuate, or even eliminate, the AB effect. Recently it has been suggested that the amount of attention or resources being allocated to each of the targets in the task is important in determining the AB. Olivers and Nieuwenhuis (2006) found, somewhat counterintuitively, that the introduction of a concurrent memory task into the AB paradigm, thereby drawing attention away from the primary task, resulted in a significant improvement in T2 identification during the classic “blink” period. Interestingly, this improvement in identification of T2 did not occur at the expense of T1 identification, which in fact was even slightly improved.

The current research aimed to further test this “overinvestment” hypothesis in both young (18-30 years) and older adults (65 years and over), to see whether older adults in particular were able to benefit from diffusion of their attentional state or whether they would, in fact, be further disadvantaged.

Using vignettes in web based delirium education for nurses: Development, validation and pilot testing

Ms Judith McCrow
Queensland University of Technology

Authors: McCrow J, Beattie E, Sullivan K, Park J

Abstract:

Delirium is a serious issue associated with high morbidity and mortality in hospitalised elders. Research shows accurate nurse recognition of delirium is poor. Thus responsive education is required to improve recognition rates, a strategy acknowledged by previous research. Vignettes provide convenient and flexible training tools which, incorporated in a web-based delivery system, offer an effective interactive educational tool. The purpose of this presentation is to report the methodology for the development, validation and pilot testing of the vignette-enhanced web delivered training program. Initially ten vignettes were developed using literature review and study team experience. Following an extensive editing and refinement vignettes were reviewed by an expert panel (N=15 Australian and US academics, clinical nurses, medical doctors). Panellists were asked to independently assess validity and reliability. Final vignettes will be video-taped and included in an interactive web based delivery package. User personas critical to end user requirements have been created to inform development of this package. A pilot test using registered nurses working in a regional acute care facility is planned to determine usability of the completed web based educational package. This extensive validation and testing will generate valuable psychometric data on vignettes and web design. Further it provides the vehicle for an intervention study designed to test the efficiency of the package in improving nurse recognition of delirium. Study outcomes have the potential to improve both delirium recognition rates and patient outcomes for this vulnerable group.

The Recommended Dietary Intake (RDI) for protein and indicators of sarcopenia in community-dwelling older adults

Mr David Scott
Menzies Research Institute

Authors: David Scott, James Fell, Leigh Blizzard, Graeme Jones

Abstract:

Sarcopenia describes the age-related loss of muscle mass resulting in functional decline in older adults. Increased dietary protein intake may ameliorate sarcopenia however the current Recommended Dietary Intake (RDI) for older adults is based on limited evidence. We examined N = 979 community-dwelling older adults aged 51-80 years (mean age 62.3 ± 7.4 years; 51.3% female) randomly selected from electoral rolls in southern Tasmania. The Anti-Cancer Council of Victoria's self-administered Food Frequency Questionnaire was used to assess protein intake (g/day) and energy intake (KJ/day). Dual-Energy X-ray Absorptiometry assessed body fat and percentage appendicular lean mass (%ALM). Leg strength was measured using an isometric exercise, and leg muscle quality (LMQ) was calculated as kg leg strength per kg leg lean mass. Physical activity was assessed by 7-day pedometer records. Participants were stratified as either meeting ($>$ RDI) or failing to meet ($<$ RDI) protein intake recommendations. The $<$ RDI group was significantly older, had greater body fat percentage and lower physical activity and energy intake levels than the $>$ RDI group (all $P < 0.001$). Multivariable regression analyses adjusting for age, gender, physical activity and energy intake revealed the $<$ RDI group had significantly lower %ALM (-0.02% ; $P < 0.001$) and LMQ (-0.47kg/kg ; $P = 0.005$), compared to the $>$ RDI group. A dietary intake of protein which meets or exceeds the current RDI for protein may reduce muscle mass and functional declines associated with aging. These findings have implications for policy makers and health professionals, as well as for community-dwelling older adults themselves.

Which interventions do nurses in small rural hospitals find effective when caring for patients who have dementia?

Ms Kay Shannon
University of Canberra

Abstract:

Rural residents with dementia have limited access to services including respite services. Frequently respite for carers is provided by the local hospital. Long waiting times for specialist medical assessment can result in extended hospital stays for people with dementia. In small rural hospitals patients with a range of diverse medical diagnosis are often nursed on the same general ward. This can make caring for the unique needs of patients diagnosed with dementia particularly challenging. This presentation will report on the development of a research project designed to find out the most effective nursing interventions for in-patients with dementia in rural hospitals. This is a poorly-researched area. It is envisioned that both qualitative and quantitative data will be required to investigate this problem. The results of this project will help rural nurses to use evidence-based practice in their care of patients with dementia.

This project is being undertaken in conjunction with “the impact of hospital-based aged care and dementia services on outcomes for people with dementia admitted to hospital – a regional analysis” project funded through an NH&MRC Dementia Research Grant. Chief investigators are Diane Gibson and Brian Draper.

Age related differences in foot and ankle muscle strength using hand held dynamometry

**Mr Martin Spink
La Trobe University**

Authors: Martin J. Spink, Dr Reza Fotoohabadi, A/Professor Hylton

Abstract:

Background: Muscle strength has been reported to decline with age with average decreases in the order of 20–40%. Objective assessment of muscle strength can be obtained using a portable hand held dynamometer. The aim of this study was to quantify the difference in muscle strength between young and older people as well as determine the reliability of hand held dynamometry to measure foot and ankle strength.

Methods: Foot and ankle muscle strength was recorded from 36 older (aged 67 to 89 years) and 36 younger (aged 19 to 35 years) healthy community-dwelling participants. Strength was recorded by two separate examiners using a Citec hand held dynamometer. The mean of three recordings of each muscle action was used. Test-retest reliability was assessed on 2 separate occasions separated by a week interval.

Results: Older participants were significantly weaker than the younger group for all foot and ankle muscle groups tested ($p < 0.001$). Percentage differences in strength were in the range 24 to 37% depending on the muscle group involved. Intra-tester reliability was good for the group as a whole with intraclass correlation coefficients (ICCs) in the range 0.78 to 0.93 depending on the muscle group and tester involved. Inter-tester reliability was also good with ICC'S in the range 0.77 to 0.88.

Conclusion: Ageing is associated with significant reductions in the strength of foot and ankle muscles. Hand-held dynamometry is a reliable and objective instrument to measure muscle strength in both young and older people.

Efficacy of a multifaceted podiatry intervention to improve balance and prevent falls in older people: study protocol for a randomised controlled trial

Mr Martin Spink
La Trobe University

Authors: Martin J Spink, Hylton B Menz, Stephen R Lord

Abstract:

Aim: There is increasing evidence that foot problems and inappropriate footwear increase the risk of falls. This is the design of a randomised trial to evaluate the efficacy of a multifaceted podiatry intervention to reduce foot pain, improve balance, and reduce falls in older people.

Method: Three hundred community-dwelling men and women aged 65+ years with current foot pain and an increased risk of falling will be randomly allocated to a control or intervention group. The control group will receive routine podiatry (i.e. nail care and callus debridement). The intervention group will receive routine podiatry plus a multifaceted podiatry intervention consisting of: (i) prefabricated insoles customised to accommodate plantar lesions; (ii) footwear advice and assistance with the purchase of new footwear if current footwear is inadequate; (iii) a home-based exercise program to strengthen foot and ankle muscles, and; (iv) a falls prevention education booklet. Primary outcome measures will be the number of fallers, number of multiple fallers and the falls rate recorded by a falls diary over a 12 month period. Secondary outcome measures assessed six months after baseline will include the SF-12, the Manchester Foot Pain and Disability Index, the Falls Efficacy Scale International, and a series of balance and functional tests.

Conclusion: This study is the first randomised trial to evaluate the efficacy of podiatry in improving balance and preventing falls. The intervention has been pragmatically designed to ensure that the study findings can be implemented into clinical practice if found to be an effective falls prevention strategy.

How to Measure the Quality of Nursing Documentation in Aged Care Homes

Ms Ning Wang

The University of Wollongong

Authors: Ning Wang, Ping Yu, David Hailey, Deborah Oxlade

Abstract:

Quality of care depends on access to high quality information. Electronic nursing documentation systems are anticipated to improve the quality of nursing documentation and quality of care through better communication. Evaluation of nursing documentation calls for valid audit instrument with comprehensive and universal criteria. This paper describes the development of a nursing documentation audit instrument for a research project aimed at evaluating the quality of electronic versus paper-based nursing documentation in residential aged care homes in Australia. Three sources of information have been reviewed to identify approaches of measuring the quality of nursing documentation: a comprehensive literature review, relevant government legislations and professional standards, and organisational documentation practice. The audit approaches explored focus on nursing process, completeness and comprehensiveness of information and quality of recording. Review of nursing process is to examine how nursing care has been delivered in conformance with the five phases of nursing process. Completeness refers to the extent to which items in a nursing document are filled in and comprehensiveness refers the scope of care the nursing records have covered. Quality of recording focuses on the compliance of the record format with the relevant legal requirements. A preliminary nursing documentation audit instrument has been constructed with a list of questions against the quality criteria set up for the instrument. An initial consultation with eight nursing experts has been undertaken. The instrument will be further tested for its feasibility, reliability, and validity through a pilot study and consultation with more nurses.

FULL PAPERS

REFLECTIONS ON INTERVIEWING, TRANSCRIBING AND TRANSLATING PROCESS: AN EXPERIENCE WITH THE MALAY CAREGIVERS OF OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS

Fatimah Zailly Ahmad Ramli

School of Social Work and Human Services, University of Queensland

Abstract

Qualitative studies often focus on the richness of the data from interviews conducted by the researcher. For researchers working across cultures and languages, qualitative research presents particular challenges. Capturing the meaning intended by the respondent by appropriately structuring the interview, transcribing and analysing data when two languages are involved, and presenting a “trustworthy” final report, are all made more complex by cultural and language differences. This paper aims to contribute an understanding of the research process or in such circumstances by reflecting on the experiences of the researcher whilst conducted a study with Malay caregivers of the older people with mental health problems in Kelantan, Malaysia. Strengths and difficulties are identified and some suggestions are offered to researchers working across language groups based on the researcher’s experiences of interviewing in Malay, but writing a thesis in English.

Research Question

My study was exploratory and intended to identify Malay caregivers’ perspectives on their experiences of providing care for older people with mental health problems in Kelantan, Malaysia. The focus was on the dynamic experience of caregiving within the family system and its relationship with health and other formal services as well as informal services. The process and issue of investigating these questions across different languages and cultures are explored in this paper. The research questions were:

- i. How did Malay caregivers experience caregiving in the context of caring for older people with mental health problems in Kelantan, Malaysia?
- ii. How did they experience the interaction of the family system with the health care system and other system of formal and informal support?
- iii. What were the perceptions of caregivers regarding the responsibilities of the family, community and the state to provide support for caregivers and the person they cared for?

Methods

A purposive sample of fourteen Malay caregivers of older people with mental health problems was recruited. The criteria for selection of caregivers were family members (adult children or spouses or siblings) who are currently caring for an older person with mental health problems and living with or nearby to the person receiving care. In this study, older people with mental health problems refers to men and women aged sixty years and above who are diagnosed with depression, schizophrenia, anxiety or bipolar disorders using DSM-IV criteria through a local government hospital. The Patient Registration Record for Adult Cases at the hospital was used to identify potential participants.

Primary data collection was completed using one-to-one in-depth semi-structured interviews with family caregivers. An interview guide was used to gather information from these caregivers regarding their views and experiences. Close ended questions were use to understand participants’ demographic backgrounds, exploring age, gender, periods of being a caregiver, relationships with people under their care and types of mental health problems. Open-ended questions explored the meanings given, and perspectives employed, in caring for older people with mental health problems, participation with health providers as well as networking within the contexts of both formal and informal support. Their opinions on the role of family, community and the state were also included. The in-depth interview topic guide was used flexibly; as a guideline and subject to change, in line with information gained from the participant’s response during the interview. The guided interview questions, based on the research questions, were prepared in the English language for the convenience of the ethics review process and my PhD supervisors. The guide was then translated into the Malay language. In-depth interviews were conducted in Malay since it is the native language of the participants. It is also the first language of the researcher. All interviews were tape recorded. These taped interviews were transcribed in Malay and then translated into English, the language to be used in presenting the thesis.

Reflections

The experience of recruiting

The design of the study can appear sound in theory, but practice raised further issues for consideration and decision-making while doing the study. Doing all the preliminary writing in English, then translating this to the Malay language required persistence to make sure the way questions were phrased and the order in which they were presented would be appropriate for these participants in my home country. This process involved moving from an English language approach to appropriate cultural and language terms for Kelantan. Issues also arise because Kelantan is a 'unique' state with a distinct subculture including the language spoken (Leete, 2007). The negotiation to obtain approval and ethical clearance from the gatekeepers was essential particularly dealing with different level of ministry/agencies. The procedure of recruitment was slightly changed from what had been proposed because of practical considerations. It was too time consuming for participants and not workable for the hospital staff who acted as gatekeepers. They had their own restrictions on accessing people in the hospital. As a result, adjustment was made to suit the working environments at the hospital and the problems of workloads of the nursing staff. From November 2008 until February 2009, I approached twenty three caregivers via the psychiatric clinic in one of the government's hospitals in Kelantan, Malaysia. Fourteen of them agreed to participate in the study. Hospitals attract a range of research efforts. This setting is a university hospital, and I experienced competition from other researchers, including medical students, who also wished to approach caregivers. Although, the selection of participants was different for my study, the presence of a group of students and researchers can disturb both family members and patients. I did not expect to have to compete for research participants.

I learnt that, despite sharing a common culture and language, establishing trust from the prospective participants was not an easy task. My strategy changed from introducing myself simply as a PhD student to a lecturer completing a PhD. The status of the researcher seemed to facilitate a more welcoming approach from family caregivers. Another demand is on the family caregiver's time; the initial and quick conversation focused on an introduction to the study, asking simple questions about their backgrounds and asking whether they would like to be involved in the study. Since time was precious, I needed to be sensitive to the fact that caregivers came to the clinic with another purpose and that they needed to accompany the older person to the psychiatrist's room for the consultation and treatment.

Recruiting appropriate participants was an exciting experience. Not everyone agreed to participate to the study. There were cases when caregivers were undecided about sharing their experiences and some did not respond after I gave my contact number. Some caregivers cancelled the appointment for interviewing without reason and informed me via a short messaging system. Caregivers who were reluctant to share their experiences were mostly those caring for an older person with schizophrenia. Among the reasons given were: they were afraid of others knowing their problems they had; nothing to share; and they were unavailable for the interviews. Those caring for an older person with depression were the most likely agree to be involved in the study. Since I was on my own conducting all the processes, there were times when I missed three other potential caregivers while I was talking with or approaching with another caregiver at the psychiatric clinic.

The experience of interviewing

The interview process itself was challenging and exhausting. Although the interviewing was within my own culture and language, the participants were not from my local community. It is important to become familiar with the geography and location of the study, particularly when the researcher needs to travel to rural areas, as sometimes I became lost whilst trying to find a participant's house. Nonetheless, the participants welcomed me and some participants started to tell their stories immediately and I did not have the chance to switch on my audio recorder. I would switch on the recorder immediately and told them the taping had started and followed by relevant questions. Some interviews took only 35 to 45 minutes, but there were also interviews that lasted more than one hour. During the interview process, it was sometimes really difficult to encourage participants to expand on their story although I tried to rephrase the questions. Sometimes it seemed they were only answering my questions without further details. Participants became emotional whilst sharing their experiences. Therefore, a researcher would need to be prepared to manage such a scenario. The principal skill a researcher, needs is empathy rather than sympathy. Fieldwork in a rural area in an overseas country can mean distance from the advisory team and usual supports. Peer support, as suggested by Padgett (2008), is significant in dealing with this issue as soon as possible. Sharing problems with my PhD colleagues is the main step I have taken while far away from the supervision advisory team. Telephone and email contact with the advisory team

was also important. It seemed that roles of the interviewer-researcher need to be prepared to deal with changing conditions during the process (Minichiello, Aroni, & Hays, 2008).

Flexibility regarding the site for interviews is also crucial when doing the fieldwork. Although most interviews took place in the participant's home, four interviews were done elsewhere (two in the hospital and another two in a restaurant) because caregivers refused to have researchers coming to their house. The reason they gave was they did not want their neighbours to know about my presence. It seems that stigma still exists for these family caregivers. As a researcher, we need to avoid being 'too ambitious' by conducting the interview process in a short period. For example, I only managed to conduct two interviews in a day and needed to travel for quite a distance from one location to another. It also took time to schedule appointments with family caregivers; it depended on their availability. Even during public holidays, we still needed to conduct interviews. We need to be pragmatic when facing participants from different backgrounds. Although the list of questions was drafted earlier, each interview was quite different. When entering into other people's lives, we are actually entering secret and past history of their families.

Issues of ethics are often raised during fieldwork. The presence of other family members who were interested to listen and sit together during the interviews, including patients themselves put the researcher and interviewees in a difficult position. The need for privacy during interviews is sometimes 'impossible' to achieve, especially if the interview was conducted at the participant's home and the older person is staying with them. Another challenge arose when a son agreed to be interviewed about caring for his mother, but then organised for me to talk to his sister. She agreed. However, the son subsequently wished to know what had been discussed. It really put me in a dilemma. I just told him, it was an informal sharing experience. This is because, confidentiality of information gained from the interview process is part of the ethics including the consent given earlier. The basic principle that researcher should adopt is not to interfere in their family matters, although I was concerned what would happen after I left the house. Interruption during the interview, for example, participants entertaining their children or answering phone calls and sometimes noises from the surroundings affected the quality of the audio recording.

The experience of transcribing and translating process

Transcribing the recorded interviews also contributed to the learning process in understanding the whole picture of the themes under study. The transcribing and translating process is based on my preliminary work with three interviews. In order to preserve meaning, the raw data from the interview process was transcribed individually into the Malay language before being translated into English. Transcribing the interview is not a single task but needs to be repeated two to three times to make sure it is correct. Despite using modern technology such as a PC transcription kit and foot switch, listening again to the audiotapes is still required. But as Wellard and McKenna (2001) remarked this process ensured that the researcher "become more involved in the interpretation of content, with in-depth memorisation of the interview" (p. 182). The researcher needs to create systematic transcriptions throughout the process to indicate meaning and content (Powers, 2005). Therefore, for the purposes of analysing the data using computer program, specifically NVivo (Bazeley, 2007), I used wide margin in the left hand side for making notes.

Translating a full transcript from Malay to English is a challenging task. The meaning-based style of translations suggested by Esposito (2001) was followed so that the meaning of translation was equivalent to the original language (Sechrest, Fay, & Hafeez, Zaidi, 1972). Uncertainty during the translation process often occurred when choosing the most accurate words to reflect the intended meaning. Choosing suitable words is not simply a matter of 'word by word' translation, but capturing the essence of combinations of nouns and adjectives where the translated term is often different to that achieved by simply adding the meaning of individual words. It is the meaning that needs to be translated and hence the interpretive process in qualitative analysis goes through an additional phase compared to when no translation is needed. When doing the translation, I tried to retain some the terms and words in Malay language as I find it will make the text more rich and meaningful. I will be providing a glossary to explain terms kept in the Malay language. As suggested by Lapadat and Lindsay (1999), the researcher has choices about "whether to transcribe, what to transcribe, and how to represent the record in text" (p. 66).

'Twice translation' was required for some interviews. Some of the participants used Kelantanese Malay dialect, which has a different pronunciation and way of speaking the language from the standard Malay language. I needed to transcribe to standard Malay language from the Kelantanese words and then translate it again to English language. These was particularly challenging for an international student where the process required a double task and require more time to complete the process.

Summary

In conclusion, the process of interviewing, transcribing and translating is a unique personal journey in qualitative research. The journey itself is made more complex when working across language and culture as qualitative research generally focuses on language and meaning. In my view, a reflective approach is central and the whole process as positions the researcher to explore and engage with the new perspectives.

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MEASUREMENT OF PARTICIPATION RESTRICTION IN OLDER PEOPLE

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Abstract

Participation restriction, as defined by the International Classification of Functioning, Disability and Health (ICF), reflects the societal consequences of health conditions. Despite being a key component of disability, measurement of participation restriction in ageing research remains inconsistent. Poor evaluation of participation outcomes is due to the recent development of the concept and a lack of accepted measurement tools. Available measures are limited to tools designed to measure similar constructs and recently created instruments. The objective of this project was to identify the essential characteristics of an instrument that measures participation restriction. Development of the criteria was a necessary precursor to a systematic review of the quality of instruments measuring participation restriction in older people. Literature searches were undertaken, addressing both the construct of participation restriction and available measurement instruments. It is proposed that an instrument measures participation restriction if it meets five criteria: measures participation restriction (i.e. problems experienced in involvement in life situations) in at least 75% of items; uses the perspective of the individual; captures the person's own perceptions of their participation in life roles; includes a minimum of three domains of the ICF framework and demonstrates adequate psychometric properties. These criteria will enable identification and evaluation of tools that measure participation restriction in older people. The recognition of valid measures of participation restriction is an essential step in the understanding and measurement of disability in ageing research.

Background

Participation restriction is defined in the World Health Organisation's International Classification of Function, Disability and Health (ICF) as 'problems an individual may experience in life situations' (World Health Organisation [WHO], 2001). Within the ICF framework, participation is the personal and societal consequence of the interaction between multiple dimensions: health conditions, body structures and functions, activities and contextual factors (Figure 1). Participation, "involvement in life situations", is a key component of function and has been linked with both health related quality of life and survival in older adults (Dahan-Oliel, Gelinas & Mazer, 2008).

The ICF concept of participation is meaningful and relevant to the daily life and ongoing needs of the individual (Cott et al., 2005). Despite this, health outcomes are infrequently evaluated in terms of participation. In research and clinical settings, outcomes are traditionally conceptualised at the ICF levels of body function and activity - the ability to execute an action or task (WHO, 2001), or using broader concepts such as quality of life.

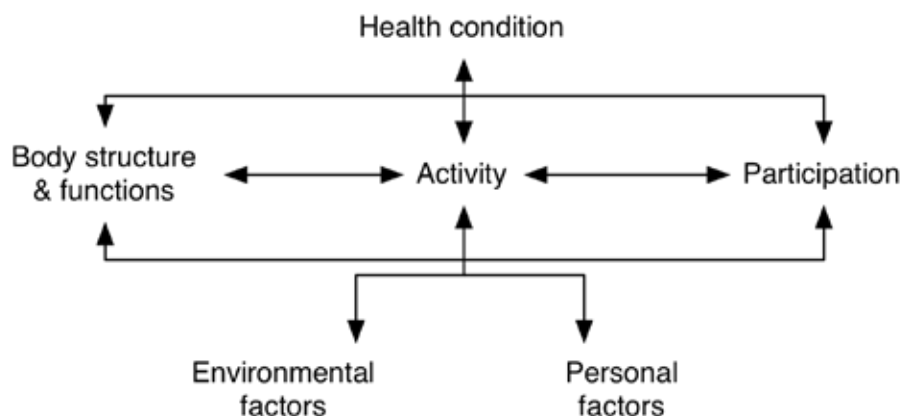


Figure 1. The relationship between participation and other dimensions in the ICF (WHO, 2001).

There are a number of possible explanations for the inconsistent evaluation of participation outcomes in ageing research. The ICF is a relatively new framework. In the WHO model that preceded the ICF, dysfunction was described in terms of impairment, disability and handicap. The ICF articulates a broader biopsychosocial model of health, in which participation has evolved from the concept of handicap. Since the ICF was published in 2001, the construct of participation has undergone continued development, with substantial literature

addressing ambiguities in the original ICF document and aiming to enhance the practical application of the participation concept (Hammel et al, 2008). The lack of an agreed framework for empirically distinguishing the constructs of participation and activity has also hindered separate evaluation of participation.

Attempts to measure participation are limited by a paucity of specific, validated measurement instruments. Although measurement tools targeting the concept of handicap have been employed, few of these explicitly measure participation (Perenboom & Chorus, 2003). The suitability of applying instruments that measure related constructs, such as occupational performance and community integration, is uncertain (Cott et al, 2005). The recent development of several instruments based specifically on the ICF concept of participation is promising (Gandek, Sinclair, Jette & Ware, 2006; Wilkie et al, 2005), and review of their psychometric properties is warranted.

This study aimed to propose a set of necessary criteria for an instrument to be classified as measuring participation restriction in older people. This was an essential precursor to a systematic review of psychometric properties of instruments measuring participation restriction in older people.

Methods

Two systematic literature searches were undertaken using MEDLINE, CINAHL, Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews. The initial search combined the search term “participation” with “ICF” or “International Classification of Functioning Disability and Health”, to explore the construct of participation, yielding 295 results. The second search combined search terms for participation and outcome measurement instruments, in order to identify instruments potentially measuring participation.

Findings

Considerable research has appraised the definition, conceptualization and measurement of participation, via qualitative (Hammel et al, 2008) and quantitative studies (Jette, Haley & Kooyoomjian, 2003), as well as critiques of participation according to the ICF (Cardol, DeJong & Ward, 2002; Cott et al, 2005; Perenboom & Chorus, 2003; Wilkie, Peat, Thomas, Hooper & Croft, 2006). A critique of literature that addressed the concept of participation and existing measurement instruments enabled the development of a set of criteria which could be used to assess whether an individual instrument is a measure of participation. The five items are outlined below and summarised in Table 1.

Table 1. Proposed characteristics of an instrument measuring participation

1	Participation, defined as “involvement in life situations”, is distinguished from other dimensions of the ICF by its definition. Participation is measured in at least 75% of items.
2	The perspective of the individual is considered, as opposed to the service provider, health professional or other party.
3	The individual’s own perceptions of their participation in life roles are captured, as distinct from assessment against accepted normative standards.
4	At least three of the ICF participation domains are included.
5	Adequate psychometric properties are demonstrated.

There is no consensus regarding how outcome measures should be classified in the ICF. The framework has also been widely criticised for not directing how to empirically distinguish participation and activity. Options include discrimination by definition, by relationship within the ICF model of function (see Figure 1) or application of ICF domains or codes. The framework provides single lists of domains and codes to which participation and/or activity may be designated, however it does not standardise how this categorisation should occur (Magasi, Heinemann & Whiteneck, 2008).

Several methods for separating the dimensions of the ICF have been employed by authors whilst reviewing outcome measures. The framework has been considered a continuum, from body structure and function through activity to participation, with the instruments’ authors asked to identify the component most appropriate to the measurement tool (Slater et al, 2005). Rules have been developed to standardise linking of items on outcome instruments to ICF codes (Cieza et al, 2002), however due to the single list of codes for activity and participation, the linking rules do not differentiate the two concepts. Perhaps the most useful approach was the mapping of each item of the instrument to the ICF definitions of activity and participation (Sakzewski, Boyd & Ziviani, 2007). The latter method was employed in the first criterion of the current model, with behavioural and environmental complexity considered if categorisation of an item remained ambiguous (Cott et al, 2005).

The consensus in recent literature is that participation is best described from the viewpoint of the individual, rather than being assessed against a predetermined normative standard as advocated in the initial ICF document (Hammel et al, 2008). The range of factors influencing participation, coupled with the variety of personal goals and societal roles, make the experience of participation unique to the individual. Participation therefore includes not only actual performance, but also the perceived engagement in life situations and satisfaction resulting from this involvement (Cott et al, 2005; Perenboom & Chorus, 2008). The second and third criteria align with this interpretation of participation, by ensuring the individual's own perceptions of their involvement in life roles are captured.

Similarities exist between participation and other theoretical models describing individuals' functioning in society (Cott et al, 2005). Instruments that evaluate such constructs are included only if they align to participation within the ICF framework. The ICF considers participation in nine domains of life, including personal care, communication, mobility, domestic life, education, social relationships, work and economic life, plus community, social and civic life. The fourth criterion ensures the instruments have sufficient breadth to measure participation.

The fifth criterion reflects the need to evaluate not only the content of measurement instruments, but also their psychometric properties. The Quality Criteria for Psychometric Properties of Health Status Questionnaires (Terwee et al, 2007) will be used to assess both the results of psychometric testing and the methodological quality of research on the development and appraisal of instruments that measure participation.

Implications for practice

The proposed set of criteria was developed to guide inclusion of outcome measures in a systematic review of instruments evaluating participation in older people. These criteria may also have broader application, as identification of valid measures of participation has important implications in both research and clinical settings. We anticipate that this integration of current critiques of participation will contribute to the understanding of the concept of participation. It is also hoped that the capacity to effectively evaluate participation will contribute to enhanced management of disability in older people.

Conclusion

A review of the literature critiquing the concept of participation according to the ICF generated a model that classifies an instrument as measuring participation. Development of the five criteria was one step in the evaluation of participation outcome measures, with the ultimate aim of contributing to older persons' participation in the life roles that are important to them.

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EXAMINATION OF SOCIAL DEMOGRAPHIC STATUS, DISEASE STATUS, HEALTH BEHAVIOURS AND QUALITY OF LIFE IN OLDER AUSTRALIANS USING THE THEORY OF PLANNED BEHAVIOUR MODEL

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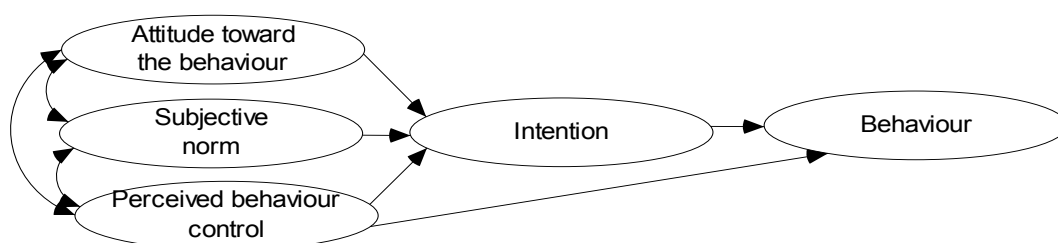
Abstract

The increase of life expectancy worldwide during the last three decades has increased age-related disability leading to the risk of loss of quality of life. How to improve quality of life including physical health and mental health for older people and optimize their life potential has become an important health issue. This study used the Theory of Planned Behaviour Model to examine factors influencing health behaviours, and the relationship with quality of life. A cross-sectional mailed survey of 1300 Australians over 50 years was conducted at the beginning of 2009, with 730 completed questionnaires returned (response rate 63%). Preliminary analysis reveals that physiological changes of old age, especially increasing waist circumference and co morbidity was closely related to health status, especially worse physical health summary score. Physical activity was the least adherent behaviour among the respondents compared to eating healthy food and taking medication regularly as prescribed. Increasing number of older people living alone with co morbidity of disease may be the barriers that influence their attitude and self control toward physical activity. A multidisciplinary and integrated approach including hospital and non hospital care is required to provide appropriate services and facilities toward older people.

Research Question

Increasing age is related to long term health conditions and higher rates of chronic diseases, which can lead to severe disability, diminished quality of life and greatly increased health care costs. Some studies show disability can be postponed through healthier lifestyles (Dangour, Grundy, & Fletcher, 2007; Hubert, Bloch, Oehlert, & Fries, 2002; Lorig, Stewart, Ritter, Gonzalez, & Laurent, 1996). Theory of Planned Behaviour (TPB) Model (Figure1) has been recognized as a good model for understanding the process of health behaviour change and has been found to be applicable to diverse health behaviours (Ajzen, 1988; Armitage & Conner, 2001; Hwu & Chin-Ching, 2006). According to TPB, perceived behaviour control together with behaviour intention toward an interested behaviour, can be used directly to predict the behavioural achievement. Three conceptually independent determinants of intention include attitude toward the behaviour (positive or negative), subjective norm (social pressure to perform or not perform) and the degree of perceived behaviour control (perceived ease or difficulty). In general, the more favourable the attitude and subjective norm with respect to a behaviour, and the greater the perceived behaviour control, the stronger individual's intention should be to perform the behaviour under consideration (Ajzen, 1991).

Figure 1, Theory of Planned Behaviour Model (Icek Adjen, 1988)



This study aims to investigate factors that influence health behaviours, such as physical activity, healthy eating and medication adherence, and the relationship with quality of life using the Theory of Planned Behaviour Model.

Methods

A cross-sectional mailed survey of 1300 Australians over 50 years was conducted at the beginning of 2009 with totally 730 respondents completing the questionnaire. The total response rate was 63%. The survey included the areas of Theory of Planned Behaviour Model (Ajzen, 2002) including attitude (4 items), social support (3 items), perceived behaviour control (3 items), intention (4 items) and last week's behaviour (1 item) (undertaking physical activities for 30-40 min per day; eating low fat, low sugar, and high fibre food each meal and taking medication regularly as prescribed every day; Quality of Life (MOS SF-36, 36 items) (Ware, Snow, Kosinski, & Gandek, 1993, 2000); The Centre for Epidemiologic Studies Depression (CES-D) Scales (20 items) (Radloff, 1977); Chronic Disease Self-Efficacy Scales (33 items) (Lorig et al., 1996) and social demographic

factors (age, gender, income, education, disease status, weight, height, waist circumference, living status). The two component summary scores from the SF-36 scales were the dependent variables including physical health component summary score (PCS) and mental health component summary score (MCS).

Analysis included descriptive statistics of respondents by three age groups and two component summary scores from the SF-36 scales by age groups, gender, waist circumference and disease co morbidity.

Results

A total of 730 cases aged from 52 to 80 years (mean \approx median, 65 years) responded validly and this data was analysed. There were more females (55.4%) than male respondents. The percentages of respondents in age groups were: <65 years (48.8%), 65-74 years (41.4%) and \geq 75 years (9.8%) (Table1). Only 16 percent of the respondents had not completed secondary education and 33.3 percent had tertiary qualifications. Over thirty two percent of respondents had average incomes of less than \$30,000. The majority were married (62.2%) and living with spouse or partner. Nearly 28 percent of total respondents lived alone and 38 percent of those living alone were aged over 75 years. Less than 20% of respondents reported having no medical conditions and over 48 percent had at least two diseases. Nearly fifty six percent of the oldest group had more than one disease. Over 70 percent of the respondents had a BMI over 25. Arthritis and hypertension were the most common diseases among the three age groups (Table 2).

Table 1. *Characteristics of the Respondents*

Variable	Total No. (%) (N=725)	50-64.9 (n=354)	65-75 (n=300)	75-80 (n=71)
Gender (female)	402 (55.4)	207 (58.5)	160 (53.3)	34 (47.9)
BMI \geq 25	482 (70.4%)	243 (73.2)	190 (66.7)	49 (72.1)
Waist circumference (overweight + obese)	574 (79.6%)	278 (79.2)	236 (78.7%)	60 (85.7%)
Disease comorbidity (more than one disease)	347 (48.1)	157 (44.6)	151 (50.3)	39 (55.7)
Education, \leq 12y	116 (16.0)	62 (18.5)	40 (13.3)	14 (19.7)
Income, \leq \$ 30,000	223 (32.2)	79 (23.3)	115 (40.2)	29 (42.6)
Living alone (yes)	202 (27.9)	79 (22.3)	96 (32.1)	27 (38.0)

Table 2. *Prevalence of Health Conditions among Respondents*

Variable	Total (N=722)	Age Groups		
		50-64.9 (n=352)	65-74.9 (n=300)	75+ (n=70)
Diabetes	80 (11.1)	30	37	13
Heart disease	114 (15.8)	46	53	15
Hypertension	234 (32.4)	101	106	27
Arthritis	309 (42.8)	136	131	42
Asthma	95 (13.2)	51	36	8
Cancer	104 (14.4)	48	44	12
Others	210 (29.1)	112	75	23

Table 3 shows the Physical Health Summary Score (PCS) and Mental Health Summary Score (MCS) across respondents with varying age, BMI, waist circumference status, and number of health problems. There was a wide variation in the physical health summary score, which was clearly related to age, BMI, waist circumference, and number of health problems. With increasing age, number of health problems, BMI and waist circumference, physical functional status was poorer.

Respondents aged over 75 years had relatively worse PCS than the younger groups. There was a statistically significant difference between respondents aged over 75 and those less than 65 years ($p<0.05$). The obese group of people according to criteria of BMI or waist circumference has worse PCS than the overweight and normal weight people. Respondents with normal waist circumference had relatively higher PCS than overweight or obese people with statistically significant difference ($p<0.05$). Respondents with no disease had significantly higher PCS than those with one disease or \geq two kinds of health problems ($p<0.01$). For mental health, the respondents aged between 65 and 75 years old had better MCS than the oldest group and the youngest group. Those without disease had better MCS than those with two or more diseases. There was no statistically significant difference in PCS and MCS for males and females.

Table 3. Age, Gender, Disease co morbidity, Waist Circumference and Quality of life

		N	PCS	MCS
Observed cases		668	668	668
Mean Score		668	44.8	52.1
Standard deviation		668	9.9	9.9
Age group (years)	50-64.9	326	45.8 (10.1)	50.9 (10.3)
	65-74.9	278	44.4 (9.3)	53.7 (9.0)
	75+	60	40.9 (10.2)	51.5 (10.8)
Gender	Male	302	45.0 (9.3)	51.8 (9.9)
	Female	362	44.6 (10.3)	52.3 (9.9)
Number of Health Problem	None	126	51.7 (6.8)	54.4 (8.0)
	One	218	46.5 (8.7)	52.8 (9.4)
	Two or more	321	40.7 (9.8)	50.9 (10.5)
Waist Circumference	Normal	131	49.0 (8.7)	52.1 (9.6)
	Overweight	183	45.7 (9.5)	53.2 (8.7)
	Obese	347	42.8 (9.9)	51.6 (10.6)

For the three behaviours, 42.2% of the respondents did regular physical activities for 30-40 min/day for five days or over during last week and nearly 75 percent did three days or over during last week. For healthy eating behaviour, there were 59.6% of respondents who ate low fat, low sugar and high fibre food five days or more during last week. For taking medication regularly as prescribed, 81.7 percent of respondents took 7 days medication as prescribed. Thus the large majority of respondents took medication as prescribed everyday.

Discussion and Conclusion

Outcomes of the analysis indicated physiological changes of old age, especially increasing waist circumference and co morbidity, are closely related to health status, especially worse physical health component score. These were consistent with other researcher's findings (Han, Tijhuis, Lean, & Seidell, 1998; Mond & Baune, 2009). Also the number of participants who lived alone with a household income of less than \$30,000 increased with age. The number of respondents who have arthritis (mainly osteoarthritis), cardiovascular diseases, diabetes and cancer increased with age. Arthritis and hypertension are the most common diseases, these were consistent with report from Australian and American (AIHW, 1993,2005; CDC, 2002)

Compared to eating low fat, low sugar and high fiber food each meal and taking medication regularly as prescribed, doing regular physical activities for 30-40 min/day was the least adherent behaviour. According to TPB, factors influencing attitude, social support and perceived behaviour control toward physical activity will indirectly influence intention towards actual behaviour. Increasing number of older people living alone with co morbidity of diseases may be the barriers that influence their attitude, social support and self control toward physical activity. Older people should be informed and encouraged that regular physical activity is appropriate and desirable in old age. A multidisciplinary and integrated approach including hospital and non hospital care is required to provide appropriate services and facilities toward older people.

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THE INFLUENCE OF FOOD PROCESSING ON THE ABILITY OF OLDER AUSTRALIANS TO MEET THE NUTRIENT REFERENCE STANDARDS

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Abstract

Consuming a nutritionally adequate diet is a health priority for older Australians. This paper presents the findings of a dietary modelling research project designed to assess the impact of food processing on the ability of older Australians (specifically those aged over 70) to consume a diet consistent with nutrient recommendations. The findings of the different dietary modelling scenarios were compared with the 2006 Nutrient Reference Values that has been recommended for older Australians. The analysis revealed that when following healthy eating guidelines older Australians' diets are at particular risk of inadequate intake for folate, calcium, potassium, riboflavin, magnesium, fibre, zinc and vitamin A. The findings also indicate the strong influence of physical activity level and food processing in achieving adequate nutrient intake. Results have been obtained from dietary modelling with a software application developed for this project and utilising data from Australian food composition and consumption databases. The recommendations from this paper have implications for food policy and the dietary behaviour of older Australians including the importance of selecting food for quality and freshness.

Research question

The Australian Guide to Healthy Eating (Commonwealth Department of Health and Family Services, 1998) is the key guide to help Australians choose the amounts and kinds of food that a person needs to eat each day to get enough of the nutrients essential for good health and to reduce the risk of diseases such as heart disease, cancer, diabetes and obesity. It is a practical guide showing people how to follow dietary guidelines, with recommended servings for five main food groups; grains, vegetables/legumes, fruit, dairy and meat/protein. It also outlines guidelines for the intake of Extra Foods (i.e. 'junk' foods).

Nutrient Reference Values (Commonwealth of Australia, 2006) outline the amount of essential nutrients considered to be adequate to meet the known nutritional needs of practically all healthy people for prevention of deficiency states. The nutrients with Nutrient Reference Values include macronutrients (e.g. protein, fibre), vitamins, minerals and trace elements. The Nutrient Reference Values superseded the previous Recommended Dietary Intakes published in 1991, due to expanded scientific knowledge, resulting in increased requirements for many nutrients.

Ideally older Australians would be able to meet average nutrient targets for their population group (as outlined in Nutrient Reference Values) whilst following healthy diet guidelines, such as the Australian Guide to Healthy Eating. This project tested this scenario using dietary modelling. This project also tests the impact of food processing on the ability to obtain nutrients. Evidence shows that the nutrient density of food is intimately linked to the freshness and quality of the food. Table 1 lists typical losses in micronutrients with various methods of processing. The nutrient density of processed food decreases because micronutrients are either converted to breakdown products or lost, whereas the energy value of the food remains relatively constant or increases, particularly with added sugars or fats.

Table 1 – Typical micronutrient losses with processing: (Belitz et al., 2004)

Nutrient	Food	Method of Processing	% Losses
Thiamin	Fruit	Production of juices / dried fruit with added sulfite	Up to 100%
Vitamin A	Green beans	Canning (including blanching)	52%
Vitamin C	Vegetables	Storage from winter through late spring	Up to 70%
	Peas	Storage at 4°C for 21 days	40%
Riboflavin	Wheat flour	Extraction rate of 80%	50%
	Milk	Exposure to bright sunlight in glass bottle for 2 hrs	Up to 50%
Zinc / Iron	Wheat	Processing from wholegrain to flour	76%
Zinc	Rice	Polished rice	75%
Iron	Pearl millet	Modern extruded millet relative to roasted millet	39%
Phosphorus	Wheat	Processing from wholegrain to flour	66%

The need for food processing to be made more prominent in public health policy has been stated by Monteiro (2009). The Australian Guide to Healthy Eating permits a range of processed foods such as white bread, canned vegetables, dried fruit, cheese and processed meats. This project tests the impact on nutrient intake for an older person with different levels of processed foods in their diet whilst still adhering to healthy eating guidelines. Other factors tested in this project include the influence of physical activity and variations in permitted food group proportions.

Methods

FoodWorks™ Professional Edition food composition software was used, which sourced nutrient data from the AUSNUT database and, for brand foods, the AUSFOODS database. The advantage of using these Australian food composition databases is that it is more likely to reflect the true nutrient composition of locally grown foods.

The following nutrients were modelled; protein, fibre, vitamin A, thiamin, riboflavin, niacin, vitamin C, folate, sodium, potassium, magnesium, calcium, phosphorus, iron, and zinc. Another 14 nutrients were excluded due to incomplete data in food databases. Both varieties of eating plans recommended by The Australian Guide to Healthy Eating were modelled, called Example A and Example B. The Example A diet is higher in the grain food group and the Example B diet is higher in the remaining food groups. Additionally Diets were modelled with and without the permitted limit of Extra Foods.

Three diets with different quantities of processed foods were modelled, these being identified as minimally processed, 50% and 100% processed. The foods I used to make up each serving in the minimally processed diet are identical and in the same proportion to those used in The Core Food Groups (Cashel & Jeffreson, 1992), from which The Australian Guide to Healthy Eating was derived. The reason for this was to ensure the modelling reflected typical foods consumed in the Australian diet and also to provide consistency between the present modelling results and the modelling used to derive The Australian Guide to Healthy Eating. I selected a wide variety of processing techniques to eliminate undue influence from any one food processing method. No foods were fortified. Some examples are shown in Table 2.

Table 2 – Examples of processed foods for modelling

“Unprocessed”	“Processed”
Lamb, leg, baked/roast, fat trimmed	Sausage, lamb, fried
Pork	Salami
Fish, baked/grilled	Fish, canned
Orange, navel, raw	Juice, orange, commercial, unsweetened
Banana, raw	Banana, dried
Potato, boiled, without added salt, with skin	Potato, canned
Beans, cooked from raw	Bean, green, pickled
Tomato, raw	Tomato, canned, in tomato juice
Milk, whole	Cheese, cheddar, reduced salt
Bread, wholemeal, homemade	Bread, white
Rice, wild, boiled	Rice, white, boiled, with added salt

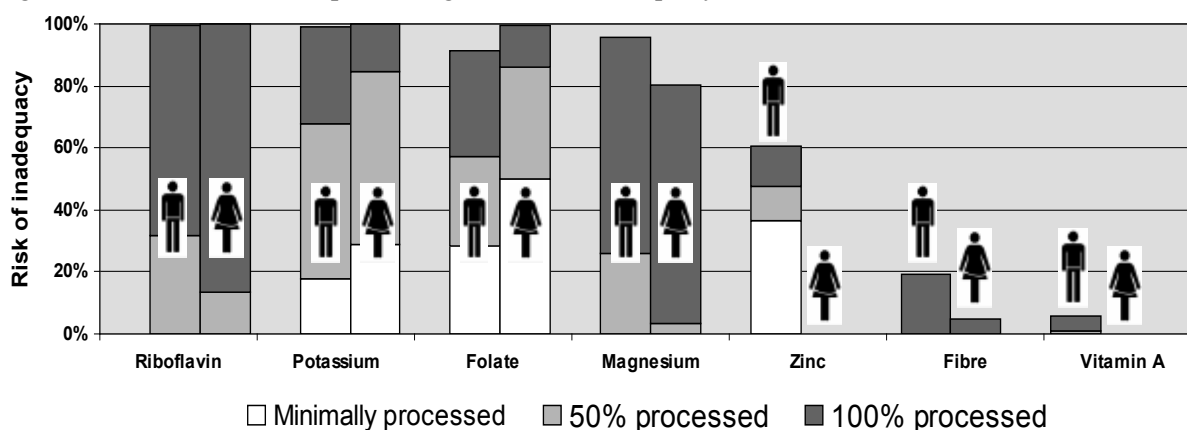
In calculating the risk of inadequacy for nutrients I used the same assumptions used by the Nutrient Reference Values working party. This includes assuming that the population requirements for a given nutrient follow a normal distribution and each nutrient has a distinct Coefficient of Variation that determines the shape of the normal distribution curve. I calculated the risk of inadequacy as equivalent to the area under a normally distributed curve, which is also known as the ‘EAR Cut Point Method’, where EAR is the Estimated Average Requirement. The complexity of modelling soon becomes apparent with the compounding effect of the variables of serving proportions, gender, nutrient, level of processing and physical activity level. This totals almost 10000 individual scenarios. To automate these calculations I developed a program in Microsoft Excel™ using the Visual Basic for Applications (VBA) programming language. This required rigorous software testing to ensure results were correct.

Results

Influence of food processing:

Figure 1 shows the nutrients with the highest risk of inadequacy with increased food processing. These results are modelled with moderate physical activity.

Figure 1 – Influence of food processing on risk of inadequacy



Summary

Older Australians are at highest risk of inadequacy for folate, calcium, potassium, riboflavin, magnesium and fibre. Older men have an additional higher risk for zinc and vitamin A. This risk can be reduced for men and women by emphasising foods from the fruit, vegetable and dairy groups. Men could benefit by also emphasising the meat group.

The old assumption that a person can easily obtain all the nutrients they require from a healthy varied diet may not necessarily be true. Older Australians need to be aware that following healthy eating guidelines does not guarantee they are getting enough of all nutrients. This modelling project demonstrates that multiple strategies are optimal to obtain enough nutrients, including at least a moderate physical activity level, consumption of mostly minimally processed and nutrient dense foods, and reduction or elimination of Extra Foods.

Whilst older Australians may have good awareness of the importance of physical activity and reduction of junk foods, they may not be aware that selection of fresh, high quality, nutrient dense and minimally processed foods may be just as important in obtaining required nutrients. Choosing too much of the more processed versions within a healthy eating menu will compromise nutrient intake.

The importance of minimally processed foods becomes even greater for older Australians who are limited in their physical activity, either through disease or fear of falling. However, incorporating minimally processed foods could be difficult for older Australians due to longer travel distances to source food and the requirement for independence and mobility in planning, preparation and cooking. Additionally, those in residential care or dependent on carers for their food preparation may have limited choice for minimally processed foods.

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FACTORS INFLUENCING FRAILTY AMONG COMMUNITY-DWELLING ELDERLY IN MANGGARAI SUB-DISTRICT, SOUTH JAKARTA

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Abstract

Frailty is defined as the condition that decreases the ability to conduct activities of daily living and social activities, and is commonly found among women and the aged living in urban areas throughout the world. However, in Indonesia, especially in Jakarta, the prevalence of frailty among the elderly has not been determined previously. The objectives of this study were to assess the prevalence of frailty among community-dwelling aged in a Jakarta urban area and to determine the factors influencing frailty. An observational cross-sectional study was conducted on community-dwelling aged in the 60+ age group in Manggarai sub-district, South Jakarta. A total of 183 community-dwelling aged were interviewed on demography, life-style and chronic diseases as independent variables and frailty as dependent variable. A chi-square test was performed to determine differences, while linear regression used to determine influencing variance. The study showed that the majority of the subjects consisted of women, aged 60 – 69 years, with low educational and poor socio-economic status; 23% of the subjects were in the most frail category. Gender ($p=0.011$), age ($p=0.000$), education ($p=0.014$), economic status ($p=0.002$), physical activity ($p=0.005$), social activity ($p=0.001$) and living arrangement ($p=0.013$) significantly affected frailty. After multivariate analysis, gender and age were influencing factors on the model. It is recommended that for reducing the prevalence of the most frail in community-dwelling aged, particularly women, they should be encouraged to join senior clubs.

Key words: frailty, aged, community-dwelling, South-Jakarta

Introduction

Frailty is very common among older persons, who are at increased risk and have associated poor health outcomes. Frailty is described as 'a state of increased vulnerability to stressors that results from decreased physiological reserves and multi-system dysregulation, with limited capacity to maintain homeostasis and to respond to internal and external stresses (Fried et al., 2004). Frailty is an aggregate expression of risk resulting from age- or disease-associated physiologic accumulation of subthreshold decrements affecting multiple physiologic systems resulting in adverse health outcomes (Topinkova, 2008).

Frailty is also associated with social factors, such as low income and education, small family size, or not having active social relationships (Woo et al. 2005). In addition, other factors, such as low physical activity, anorexia, diabetes mellitus, depression and delirium could also increase frailty (Topinkova., 2008; Woo et al. 2005). Rockwood et al. (2004) reported that fitness could contribute to survival of the elderly. Good management of depression, delirium, osteoporosis and hypertension, together with social support and cognitive therapy could prevent frailty among the aged (Morley et al., 2002).

In district public health centres in Indonesia there is a programme for community-dwelling elderly, called *posyandu lansia* (senior club activities), but overall only 8% of the elderly join the activities. The club activities are conducted on a monthly basis and is under supervision of the district health centre. The activities mostly consist of primary medical check-ups, health promotion, health gyms and social gatherings. Most senior club members in South Jakarta districts are women (Kusumaratna, 2009). Little is known about the prevalence of frailty and its influencing factors among community-dwelling elderly in urban areas in Indonesia, such as Jakarta. The aim of this study is to assess the prevalence of frailty among the elderly and the factors influencing this condition.

Methods

Study design and participants

An observational cross-sectional study was performed from May to July 2008. 183 participants were randomly selected from 6 hamlets in Manggarai sub-district and only households having older persons aged 60 years and above were approached. All study subjects participated on a voluntary basis and had signed a written consent. The study was approved by the Trisakti University Medical Faculty research and ethics committee. Data collection was done through personal interviews using a structured questionnaire, aimed at obtaining frailty-related information on lifestyle, socio-economic profile, and health status.

Socio-economic factors, lifestyle, and health status

Variables relating to socio-economic factors were gender, age group, education and economic status, lifestyle, and chronic diseases (hypertension, diabetes mellitus) as independent factors, and frailty as an outcome.

Frailty

Frailty is defined as deficits based on self-reported symptoms using the Edmonton Frailty Scale (Rolfson et al., 2000), in cognition, general health status, functional independence, social support, use of medication, nutrition, mood, continence and functional performance. Each variable was given a score of 0 if there was no deficit, and 1 if a deficit was present; the scores used were 0-3 (not frail), 4-5 (least frail), 6-8 (moderately frail) and 9-17 (most frail).

Statistical analysis

Descriptive analysis and chi-square tests were performed on categorical variables to determine differences between factors and frailty index. Further analysis with linear regression was performed to determine the influencing variances on outcomes. $P < 0.05$ was regarded as statistically significant. Statistical analyses were done using SPSS for Windows version 15.0.

Results

The study sample consisted of 132 (72%) women and 51 (38%) men, with a mean age of 67 ± 3.5 years. Eighty three percent of the participants had only a primary education or less (≤ 6 years of formal schooling), 16% had secondary education (6 to 9 years) and 0.5% had tertiary education (9 to 12 years). Most of the aged (96%) had a poor economic status, based on the minimum regional income of Jakarta province, and had regular sources of income, such as pensions, contributions from their children, and informal economic activities.

Around 56% of the aged habitually performed light physical activity, namely morning walks 3 times a week for approximately 20-30 minutes; 43.2% were in the moderate category of more than 5 times a week, with a combination of morning walks and cycling for 30 minutes. The majority (91.3%) of the aged had less than the recommended total energy intake from daily consumption, including total protein and calcium-rich food. Eighty percent of the aged participated in social activities, such as group recital of the Holy Qur'an (*pengajian*), voluntary work in the community, or small-scale economic activities (having a kiosk at home or the local market, or taking boarders). Ninety-three percent of the aged were living with their extended family. Around 24% of the aged had hypertension, and 11% had hypertension and diabetes mellitus. Only 10.4% of the aged were not frail; 90.6% could be categorized as frail, where the most frail category accounted for 23% of the aged subjects.

Table 1. Characteristics of participants by level of frailty

Variables	Frailty index					<i>p</i>
	Total	Not frail	Least frail	Moderately frail	Most frail	
Gender						
Men	51	11	14	18	8	0.011
Women	132	8	31	59	34	
Age (yr)						
60-69	115	15	33	52	15	0.000
70-79	45	4	10	20	11	
≥ 80	23	0	2	5	16	
Education						
Low	152	12	34	68	38	0.014
Moderate	31	7	11	9	4	
Economic status						
Poor	177	16	42	77	42	0.002
Moderate	6	3	3	0	0	
Physical activity						
Light	103	4	28	41	30	0.005
Moderate	80	15	17	36	12	
Total Energy consumption						
< RDA	167	18	41	68	40	0.581
= RDA	16	1	4	9	2	
Social activity						
Yes	147	16	37	69	25	0.001
No	36	3	8	8	17	
Living arrangement						
Co-residence	170	19	45	71	35	0.013
Alone	13	0	0	6	7	
Chronic disease						
Yes	44	3	9	22	10	0.577
No	139	16	36	55	32	

Each variable in socio-economic factors contributed significantly to frailty among the aged subjects. The mean frailty index for women was higher than for men ($p < 0.05$). Older women with low education and poor economic status were more frail compared to younger aged. Doing habitual physical activity and having social relationships had a better influence compared to none. Persons living alone were also more vulnerable compared to those living with family members. However, the health status in this study had no significant influence on frailty (Table 1).

Table 2 presents the results from the linear regression analyses for the association between the level of frailty index and influencing factors. A model was run to determine whether socio-economic (factors, lifestyle, health status, or co-residence as independent variables) explained any of the variances with frailty index as dependent effect. Multivariate analysis indicated that all independent variables, except education and physical activity had significant influence on susceptibility to frailty ($p < 0.05$).

Table 2. Model predicting influence of various factors on frailty

Variables	Frailty index		
	B	95%, CI	beta
Gender	0.371	0.081 – 0.661	0.182
Age	0.441	0.263 – 0.619	0.341
Education	-0.226	-0.601 -0.069	-0.115
Economic status	-0.652	-0.91 – (-0.39)	-0.347
Physical activity	-0.02	-0.08 – 0.04	-0.053
Social relationship	-0.355	-0.69 – (-0.01)	-0.154
Co-residence	-0.86	-1.37 – -0.35	-0.24

Discussion

The distribution of socio-economic vulnerability showed that it increased with age, male gender, poor education, and poor economic status. These results are similar with those of Rockwood et al. (2004) who found that frailty increased with age and gender, which was especially true for the female aged who live relatively longer and may be more vulnerable to socio-economic factors. On the other hand, older men are more resistant, because if widowed, they may remarry to help them get on with their life, compared to older women. Most of the female aged occasionally also take responsibility in financial matters, if the children are also of low economic status, which is mostly the case in rural areas. In these areas, older women must help in the field, and they do not just take care of the grandchildren but also conduct economic activities. In a developing country like Indonesia, these conditions are also frequently encountered in suburban areas. Labour force participant rates are lower for older women than for older men, as most of the women work in the informal sector and are underpaid.

Overall, the gender differences in labour participation or economic activities could be interpreted as influencing frailty. Older women are dependent and vulnerable to financial insecurity and economic dependence, therefore may become more frail (Mujahid, 2006). The present study also indicates that in suburban areas, the care of the elderly, including financial support, lies with the young families, which may only be possible if these families have adequate incomes to share.

Among lifestyle factors, namely habitual (moderate) physical activity and social relationship, but not total energy consumption, were significantly associated with the frailty index. Increasing the physical activity level of a frail aged is likely to be an important preventive strategy, resulting in improvement of strength, flexibility, exercise tolerance and nutritional intake (appetite). Less frequent physical activity could have an independent association with difficulty to perform daily activities. The results of the present study differ from those of previous studies, because the total energy consumption was not an influencing factor of frailty in the aged subjects. In several studies, nutrition has been recognized as an important component of healthy ageing. Vellas et al. (2006) has identified risk of malnutrition as a good single marker of frailty, while malnutrition is correlated with weight loss, poor appetite, and functional and cognitive decline.

Social relationship refers to active engagement of the aged to fulfill their entire life after retirement. In this study, social relationship in the form of community participation was measured by the opportunity of the aged to do informal work in their community. Participation at community level among the aged may typically be different among men and women. Female aged preferred to perform group recital of the Holy Qur'an once weekly or to participate as health cadres in their communities, whereas men preferred to participate in funeral activities or voluntary work at the community level or in their mosque. Some of them, especially the women, conducted small-scale economic activities, such as selling household necessities in a small kiosk at home, or selling vegetables at the local market. However, 19.7% among of them did not participate in any social relationships in their community. The majority the aged were participating within the family, in terms of housekeeping and caring for grandchildren. This participation occurred at the time of co-residence with their children. Providing suitable activities for the aged, such as joining senior clubs, could reduce the numbers of frail aged and contribute to a sense of self-esteem and fulfillment among the elderly. Elderly joining senior clubs would be stimulated to engaged in social relationship.

Aged persons living alone are at risk for becoming frail as they have do not have caregivers. In most Asian countries the aged usually co-reside with and are taken care of by the family members. In most cases it is the responsibility of the daughters for taking care of parents in their old age. However, globalization has led to a change especially in urban areas, where the younger family members may prefer to live independently and the older people also preferred to live in their own house, as shown by several studies (Mujahid, 2006; Kusumaratna, 2009). The present study has revealed that co-residence with family members reduces vulnerability, and can be considered as one of the factors favourably affecting frailty. Living together between the aged and their children might allow for mutual financial support or domestic services. In many conditions, relatives, especially the children of the aged, are the potential caregivers for their parent(s) in health care services, yet co-residence might also have disadvantages for both of them.

Conclusions and Recommendations

The results of the study could be used to implement effective prevention strategies of frailty among older persons. The present study indicates that gender and age affected the level of frailty. Use of an indicator of frailty does assist in the identification of the most frail in planning for prevention strategies at the community level. In the current study, most factors have a significant influence on the frailty index, and have contributed to vulnerability, which could be prevented with several strategies at the community level, integrated with the existing senior club activities (*posyandu lansia*) at the health centre. The activities of the aged should be tailored to gender- and age-specific levels of frailty that have been indicated to influence one's susceptibility, to prevent them from becoming most frail.

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LEARNING FROM NATURAL DISASTERS: UNEXPECTED DISCOVERIES WHILE EXPLORING THIRD AGE LEARNING

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Abstract

Early in my PhD research of the Third Age learning of Lower Eyre Peninsula women, we had an extreme bushfire event, which devastated the region. Initially, I wanted to exclude it; I knew some of the people who died, and extended family members and former neighbours lost property. But three of my research participants were more directly involved with it and the subsequent recovery phase, which provided openings for new learning, leadership, and personal growth for Third Age women. My research methodology gave them the opportunity as co-researchers, to reflect on their autobiographies and the more recent experience of the fire, during our two informal conversations about their learning. The underlying meanings of important human experiences, expressed in descriptive narratives during a process of self-inquiry provided opportunities for critical self-reflection, more objective interpretations, new insights, and understandings as they spoke about their experiences. This reflects the methodological stance of heuristic inquiry, which requires that the researcher has a passionate interest in the phenomena under investigation, and in this case includes my tacit knowledge as a Third Age learner and long term resident of the region. This paper discusses some of the individual and community learning identified as a result, as well as the communities' experiences of remote centralised management and the professionalisation of disaster services, which largely ignored their local situated knowledge, and marginalised and disempowered local community interests. Our experiences on the Lower Eyre Peninsula may well be relevant to other rural communities devastated by sudden natural disasters.

Introduction

The Third Age for rural women often begins in their late 40s or 50s, about the time their children become independent and they have the time and freedom to develop new interests and a new identity, independent of their family. Until the 1980s, when feminist researchers began to focus on Australian rural women, their lives, their experiences, and their contributions to the family farm and rural communities, they were largely invisible from the quantitative data and qualitative literature on rural life (Alston, 1998; Rickson, 1997; Rickson & Daniels, 1999).

More recently, Third Age women have become leaders and have transformed their rural communities into vibrant 'can do' societies better able to cope with the economic, environmental, and social changes of the last two decades. My interest is in the personal learning and self-development of these women with the aim of providing an insider's view of how they experience and attribute meaning to their Third Age learning activities.

The bushfire started near the small community of Wangary about noon on Monday 4th January, in the shadow of the Marble Range, which dominates the horizon of the western side of the Lower Eyre Peninsula. It was a remote rural corner of the state with a low population. Even the Adelaide ABC news mispronounced Wangary. By Tuesday afternoon, nine people were dead. However, it became an important learning opportunity for local communities, for individuals, and for the government.

Initially, I wanted to exclude the bushfire, as it was only a few kilometres from where we had lived for many years, and former neighbours lost property. We all knew some of the people who died and their stories. Like the women I interviewed, I needed time to understand and to put things into perspective.

Method

My study is on seven rural women, who all live on the Lower Eyre Peninsula. In their Third Age, they wanted more from life and became community leaders, role models, and change agents, who transformed themselves and their communities. The collaborative research methodology gave them the opportunity to reflect on their autobiographies as co-researchers during two informal conversations about their learning. This process of self inquiry and critical self-reflection, via their descriptive narratives provided opportunities to develop more objective interpretations, new insights and fresh understandings of the underlying meanings of important

human experiences. Researching the underlying meanings of the lived experience reflects the methodological stance of heuristic inquiry, which requires that the researcher has a passionate interest in the phenomena under investigation and therefore it includes my tacit knowledge as a Third Age learner and a long term resident of the region.

The first research interviews occurred in July 2005, seven months after the devastating bushfire. As the informal conversations were loosely structured around a series of questions about their learning, and changes in the rural community it was natural to discuss the fire; we were all traumatised by its speed, ferocity, and intensity. However, it was only in the second round of interviews, over two years later, that the three women with direct experience through their families and the recovery processes felt able to discuss their personal experiences and deeper learning which increased their self-understanding and aided their recovery and personal growth. Although my research focuses on their Third Age learning, this paper considers the individual, community, and government learning from the disaster.

Discussion

The local farmers, who lived in the area for 50 or more years, responded quickly as they knew that a strong northerly was expected on Tuesday and they understood high fuel loads after harvest, the weather patterns, and the extreme conditions that develop unnoticed in the Great Australian Bight. The fire appeared contained overnight and a few inexperienced officers remained as nightwatchmen. However, nearby land owners worked desperately through the night making the fire breaks they knew they needed, but which the authorities would not permit if they had been present.

Preparations began in Cummins about 25 km away early Tuesday morning when an elderly woman looked at the weather, drove to the Bowling Clubrooms and turned on the urns knowing that people would gather there at the end of the day. All the traditional emergency activities swung into action. After preparing their own properties, the able men and women from Lower Eyre Peninsula went to fight the fire with their local units, and the remaining women gathered in local halls to prepare food, which others delivered to the fire site.

Today, fighting bush fires is centrally organised, professionalised, and managed from a site in an air-conditioned office in the city. They rely on ideal conditions and good communications for decision making, which provide many opportunities for local resistance. However, by ignoring local situated knowledge (de Carteret, 2008; Indian, 2008) about the weather, effectiveness of communications, available water resources and equipment they had a limited understanding of the situation.

Government contracts to supply services and confidentiality agreements mean that the local resources are under-utilised or marginalised, thus undermining the traditional self-reliance of country people. Once contractors to supply food to the emergency services, became operational, the women were told their refreshments were not required. As someone commented 'no-one ever died from eating CWA scones'. The Cummins community was incensed by this marginalisation of local support services and they decided to form a Disaster Committee to plan for future natural catastrophes in the region. As Martha, a co-researcher said, 'we've had a real wake-up call, suddenly some things became a reality, and one of it was danger and death.'

The local aerial spraying company wanted to provide water bombers or aerial observations but was grounded although no official service was available as a fire in the Adelaide foothills took precedence. Eventually, after receiving a desperate plea for help, they defied official instructions and used their planes to drop water on a friend's burning home, probably saving three lives and earning them considerable community goodwill. Other broke through the road blocks, and in near total darkness, got them to safety. There are other stories of similar rescues by individuals prepared to resist authorities and take risks to look for survivors. The official fire-fighters obey orders and are fully aware of the legal liabilities (Parkin, 2008); their priority seemed to be to protect themselves and their vehicles; but they were probably traumatised too. As one man was told when he pleaded for help to rescue his daughter, 'she's just one person.'

As I'm sure many Victorians know, it is impossible to find out anything during a major fire. People only realised how close it was when it came over the hill, minutes before it was on their doorstep. The media emergency bulletins created more stress without providing any useful information to those in the fire zone.

Afterwards, people came from everywhere to encourage and assist a stunned and bewildered community and this year locals went to Victoria to reciprocate. We had never experienced anything like the speed, the ferocity, and the intensity of the fire. We learned others cared, and it brought people and communities together; we again began to wave to passing vehicles on the roads. We realised that we need each other, we are not alone but interdependent. It changed us all. We learned to stop and listen if someone wanted to tell the story of their experiences.

However, the community is enormously grateful for the government's immediate response and the public support, which flowed in after the disaster (Government of South Australia, 2005). The government established two committees to coordinate the recovery process, one in Pt Lincoln, and the other in Adelaide. The emphasis was on locals helping locals and the process became a template for managing other natural disasters in the state (Government of South Australia, 2005).

Following a visit by a breakfast TV program, the Third Age women of Cummins established a grass roots community recovery organisation, staffed entirely by volunteers. They distributed truck loads of donated goods, clothing, plants, and fruit trees for over 1 year. Although many people were content to help out, few were willing to take on managerial responsibility and leadership roles and some found close contact with survivors difficult.

Cummins became more than a distribution centre. During the early days, Jude, the organiser took clients to the doctor. Professional counselors were available but, over time, she was preferred although she had no formal qualification or professional experience. She attributed it to being motherly, an older woman and was happy to sit with them over a cup of tea and listen without probing whenever required. Many clients became regulars, sharing important milestones, like the arrival of a new house, with her. One morning a couple turned up with a cake and said 'We just want to say thank you because we wouldn't have got through the last few months if it hadn't been for you people, just being there to talk.' Those times were her reward.

People preferred the volunteers in Cummins rather than dealing with the Port Lincoln Recovery Centre managed by a contracted Not for Profit Organisation, which was caught between community perceptions of it as a relief organisation and its role as a member of the crisis response team (Government of South Australia, 2005). They bore the brunt of some recipients' frustration with faulty or worthless donated household goods and personal items.

Jude later described the experience as a stepping stone to other positions. She learned that she could do things that she had never suspected, like counselling, managing and caring for large numbers of volunteers and clients in very difficult conditions. She learned how government organisations work and about public servant mentality and it gave her the confidence and self esteem to nominate for state and national executive positions in an International Women's organisation. She says although she doesn't have any great academic qualifications she gained a vast amount of practical experience managing people which she continues to use.

Conclusions

Learning is lifelong and a major event like a bushfire leaves its mark on everyone associated with it. The government used the recovery process as a template for successfully managing other natural disasters. At the local level, most of the learning was spontaneous, informal, practical, and experiential (Illeris, 2004), embodied in the community and individual store of knowledge (Varela, Thompson, & Rosch, 1993). We do not realise quite what and how much we know, nor do we value it; however, we know more than we can tell and it contributes to our growing wisdom as we age (Jarvis, 2001). As Polanyi (1969) argues, 'all knowledge is *either tacit or rooted in tacit knowledge*.' It guides us to speak or to remain silent at appropriate times; others used it when they made the decision to resist authority by making firebreaks and breaking through road blocks. The tacit knowledge embedded in the community is a valuable resource; local situated knowledge of people, networks, the environment, and resources were important in saving lives and rebuilding the devastated communities.

Heuristics inquiry offers a flexible framework for self-directed, self-motivated research into the meanings, essences, quality, and the underlying meanings experiences of human reality. Like the research questions, which arise out of the researcher's intense interest, direct personal encounter and autobiographical connections, heuristic methodology flows out of the researcher's inner awareness, and self-discovery (Moustakas, 1990).

Tacit knowledge guides them in unseen directions by challenging them to accept thoughts, feelings, and intuitions as authentic and valid (Moustakas, 1990). Positioning the informants as co-researchers collaboratively exploring their biographies, enhanced the verification, comprehensiveness, and accuracy of interpretations and minimised the ethical issues of trust, confidentiality, and privacy (Moustakas, 1990).

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QUALITATIVE PROSPECTIVE STUDY OF OLDER MEN'S INVOLVEMENT IN A PHYSICAL EXERCISE PROGRAM

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Abstract

This research paper discusses a one year longitudinal study of three groups of older men as they engaged in a walking program in three local areas of South East Queensland. As the study evolved the data showed that the men began to fall naturally into full engagement with the program, partial engagement or no engagement. The difficulties encountered in designing and organising complex qualitative longitudinal research of this kind will be detailed. Five distinct data sets were collected (1) background information on men who were offered the program, (2) in-depth interviews from men who participated in the program (3) focus group data on men in the three areas Hervey Bay, Toowoomba and the Redlands (4) diaries of men who engaged in the program and (5) in-depth interviews with men who completed the walking program. The rationale behind the choice of five methods and the difficulties encountered with the collection and application will be discussed. The presentation will identify the methods that have worked well when reaching men at risk and the lessons learnt from a study of this kind. Further, a discussion outlining the study time line and why working in a study area over an extended period of time was beneficial will be provided. Recommendations will be made for engaging men in future physical exercise programs.

Research Question

This research was an exploration of the meaning that a group of older men at risk derive from their involvement in a walking program. Exercise has continually been shown to be beneficial for all ages, especially for those suffering depression and at risk of negative health outcomes (Dunn, 2004; Saxena, Ommeren, Tang, & Armstrong, 2004). To achieve the study aim, the following three research objectives were developed:

1. To explore men's life experiences of being active. Such exploration will identify the experiences that contribute to or guide men's motivation to start an exercise walking program.
2. To explore the experiences of men who successfully complete a 24 week walking program.
3. To explore the factors and experiences that hinder men's engagement and lead to men dropping out of the physical activity program in order to foster greater understandings of the barriers and constraints to physical activity engagement and provide insights explaining why adherence may be difficult.

Methods

Data was collected on three different groups of men at various stages of the one year study. A sample of men were accessed in three geographical areas, Hervey Bay, Toowoomba and the Redlands, currently involved in the Queensland Government Department of Communities Older Men's Well-being groups. The three study groups consisted of participants who volunteered to be involved in a 24 week walking intervention program at the three locations:

- a. Toowoomba Older Men's group (TOMNET),
- b. Redlands Men's Well-being group (ROMWG), and
- c. Hervey Bay Older Men's Unlimited group (OMU).

Methodology

Understanding men's experiences and listening to their concerns requires a qualitative approach. The choices of methods required sensitivity given that the men in this study have been identified 'at risk' as a result of experiencing one or more negative impacts or indicators of suicide risk, these include: 1) social isolation or loneliness; 2) poor physical health; 3) poor mental health; and 4) experience of a life changing event (Department of Families, 2001, p.3). These ethical dilemmas called for a qualitative approach to engage with the men throughout all research activities within a supportive environment (Patton, 2002). Social constructionism provided the focus to understand collectively men's experiences that may hinder or enhance physical activity engagement. Crotty (1998) explains that meanings are constructed by human beings as they engage with the world they are interpreting. The context of the situation, the time, social environment, an individual's experience and perceptions, and the interaction between the researcher and individual involved in the research (Grbich, 1999) were important in the construction of meaning for this study.

Research Methods

A combination of qualitative approaches were used to reach men at risk, utilising a mix of field based (interviewing) and action-based (intervention and documentation) methods (Grbich, 1999; Patton, 2002) to explore men's motivations to engage in walking, their capacity to stay engaged over time and motivations to leave or not become involved at all. This approach aims to understand men's meaning from the consumer perspective and uncover aspects that were specific to older men at risk. The focus on three distinct groups of men:

1. Participants who started (starters) and completed the intervention (stayers)
2. Participants who exited early from the intervention (stoppers)
3. Participants who were involved in the men's well-being groups but did not volunteer to be involved in the walking group (non-starters).

Five distinct data sets were collected over a period of 12 months (1) background information on men who were offered the program, (2) in-depth interviews from men who participated in the program (3) focus group data on men in Hervey Bay, Toowoomba and the Redlands (4) diaries of men who engaged in the program and (5) in-depth interviews with men who completed the walking program. The rationale behind the choice of five methods and the difficulties encountered with the collection and application will be outlined.

Reaching the sample

The researcher was invited as a guest speaker to the regular meeting of each group, visiting Toowoomba in August 2007, Redlands in December, 2007, and Hervey Bay in early March 2008. The guest presentation provided the groups with the general aim and purpose of the research and an outline of the planned research activities. This introduction to the study enabled greater insights concerning the groups of men and their at risk behaviour. With this information, the researcher reconsidered the way the walking intervention would be delivered. One of the main reasons men had been identified as at risk and attended the three groups was as a result of experiencing social isolation and loneliness. It was proposed to conduct the walking intervention as an extension to the older men's regular activities.

Pilot Test

To test for question accuracy and understanding, all questions were pilot tested with 10 interview participants, during February and March, 2008.

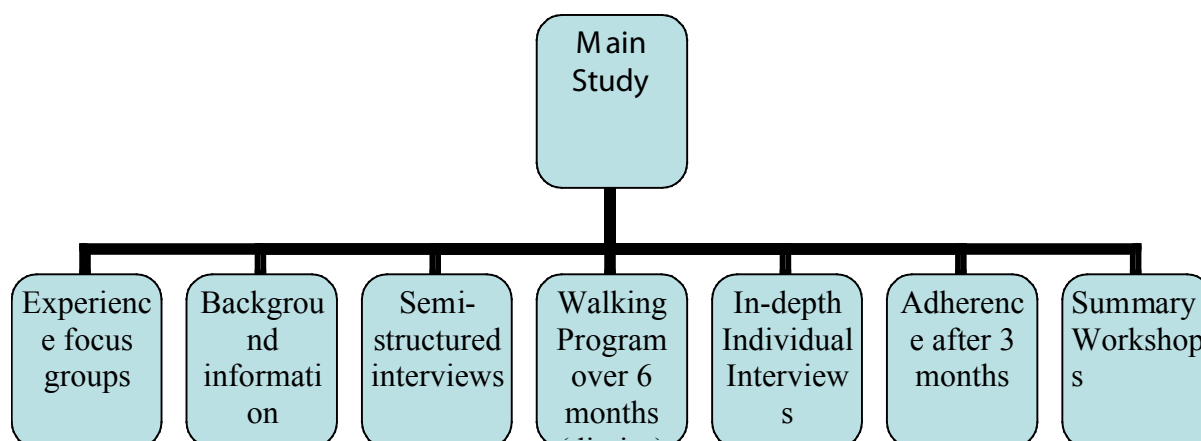
Expert Focus Group Interviews

These were held with the Men's well-being groups at Toowoomba, Hervey Bay and the Redlands in March, 2008. The small focus group interview was held with the administrators of the men's well-being groups to affirm the proposed methodology and to check for sensitivities in terms of the sample of men to be interviewed.

Main Study

The main study steps are summarised in Figure 1.

Figure 1: Main steps of qualitative prospective study with men 'at risk'



Experience Focus Group

Focus group interviews were conducted to understand men's health and physical activity experiences and why it was important to them. Focus groups were used as the method of choice to collect background information about men at risk, and to help guide the structure of the qualitative interviews to be conducted in Phase 2. Insightful comments were also obtained through this technique to guide the researcher with the intervention in Phase 3 (Grbich 1999).

Background Data Collection

Structured questionnaires were handed out to men at the three locations during late May and early June, 2008. The questionnaire was administered at the regular older men's well-being group meetings. A large membership of men attend the group meetings with up to 60 members involved in the Hervey Bay group, up to 90 members involved in the Toowoomba group, and up to 30 members of the Redlands group. The membership at each meeting location, included men who were 40 years and older, and who were considered at risk. A total of 150 men filled out the base-line questionnaire. Many men found the task of filling out a questionnaire difficult and the researcher ensured that support was provided to individuals. All members of the three men's well-being groups were invited to take part in the walking program.

Semi-structured Interviews

Qualitative face to face interviews were conducted with men who volunteered to take part in the six month walking program in the three study areas. The semi-structured qualitative interview schedule was devised and implemented at the commencement of the 24 week walking intervention. By chatting one on one with men about their experiences, the researcher was privileged to listen to the men's stories and appreciate why some men are starters, non-starters or become stoppers.

The Walking Program

The exercise program was designed to provide a healthy activity that has known benefits for health outcomes. Prior to the commencement of the study each research participant agreed to participate in the six-month walking program. Participants were encouraged to record their weekly physical activity participation in an exercise log. Although voluntary, most participants took up the opportunity to record their physical activity experience as the log provided a motivational tool and a record of their efforts and improvements throughout the journey. The walk participants fell into those who engaged in the walking program, those who dropped out part way and those who preferred not to enter the program.

In-depth Individual Interviews

This interview phase was designed to examine the stayers, the stoppers and the non-starters. We do not know how to make exercise programs valuable to all men. Scientific studies have met with mixed results in engaging men. Although not considered a pure action research, this study method is action based, as the men were engaged in walking over a 24 week period. All men involved in the groups were given the opportunity to get involved in the walking.

Adherence after 3 months

Men involved in the walking program were contacted three months after the official 6 months walking program had finished to check for enduring benefits derived from their participation in the walking program.

Summary Workshops

Summary workshops were held at each study location with:

- Participants who completed the intervention (starters and stayers)
- Participants who exited early from the intervention (starters and stoppers)
- Participants who were involved in the men's wellbeing groups for social activity and were not involved in the intervention (non-starters).

Recommendations

As men 'at risk', the detailed quantitative questionnaire put many of the men involved in the study in an uncomfortable personal space. To engage men 'at risk' more positive outcomes were achieved by setting up the research groups and interview settings in familiar surrounds. Important aspects to consider included:

- *Interview location* the regular meeting places of the three older mens' well being groups provided the most familiar environment for the men to be interviewed. The focus group was held after the regular meetings, so participants did not incur travel or accommodation expenses.
- *Male champion in each of the three locations:* were identified and the researcher discussed their role as a walk group coordinator. Male leaders were identified in the Redlands and Hervey Bay. Each walk coordinator was provided with a walk leader training manual to support them in their role. The researcher took the coordinator through the guide. The researcher called the Hervey Bay walk leader every Wednesday prior to the walk on Thursday. The researcher walked weekly with the Redlands and Toowoomba group.
- *Time:* the study duration became an asset to the study. Over time, the researcher visited the three groups several times before the intervention began, weekly during the intervention, and several times after the intervention was completed. As time progressed through the study, the information gained and the stories told become significantly richer.
- *Trust:* take time to build relationships in the study location. Building trust and integrity was the real core criteria for success.

Using a mixed set of qualitative methods to reach a group of men at risk helped the researcher to get under the radar and explore men's experiences of physical activity. The qualitative methods worked well to relate to men 'at risk'. The long study duration allowed time for the research participants to feel more relaxed with the researcher.

Thank you to the Smart State PhD Scholarship Program, which funded my travel to the three locations and supported the research costs. Thank you to the Department of Communities, Office of Seniors for their support of the research and to my three supervisors, Associate Professor Margaret Shapiro, Associate Professor Fran Boyle, and Professor Robert Bush, thank you.

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AN UNDERRATED COMMUNITY RESOURCE? HOW COMMUNITY ORGANISATIONS RUN BY PEERS HELP OLDER PEOPLE MAINTAIN THEIR WELLBEING AND INDEPENDENCE

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Abstract

It is now generally accepted that participation in mental, physical and social activities helps older people maintain their health and wellbeing, but there has been little research on the best ways to encourage such activities. This study suggests that organisations run by older people for their peers have particular characteristics that help older people maintain their wellbeing, independence, identity and self-esteem, by providing community, structure and meaning. They provide older people with opportunities to use their knowledge and experience, to act reciprocally, and to continue learning in an informal, supportive setting.

Using a phenomenological approach, this study explores 25 older people's lived experience of their involvement in community-based peer-group organisations. Methods used were interviews, observation and interviewer self-reflection. Through semi-structured interviews conducted by a researcher of similar age and experience, participants were able to voice their opinions without the constraint of ageism. Data were coded and analysed using thematic analysis.

Implications for policy and practice are discussed, with suggestions of ways in which authorities could encourage peer-group organisations as a valuable community resource.

Research question

My study sought the answers to two questions: what characteristics of community-based organisations do older people see as encouraging or deterring their participation? and how does participation affect their self-assessed quality of life?

The increase in the number and proportion of older Australians has aroused fears that the economy will suffer a 'health burden', because older people are prone to the chronic diseases which already account for 70% of the national cost of health. Since it is now generally accepted that participation in mental, physical and social activities can prevent or postpone the onset, and ameliorate the course, of chronic disease, this research aims to discover the best ways to encourage older people to participate in activities, by asking them to talk about their own experiences as members of community-based groups.

Methods

A phenomenological approach was used to explore older people's lived experience of their involvement in community-based peer-group organisations. Methods used were semi-structured in-depth qualitative interviews with individuals, observation and self-reflection. Interviews were digitally recorded, and transcribed with at least two checks for accuracy. Data were coded and analysed using thematic analysis (Strauss & Corbin, 1990). 25 volunteers aged 65 and over (14 men and 11 women) were recruited from seven community-based organisations offering a variety of activities. Interviews were conducted in the participant's home or the group's usual meeting place. Participants were keen to share their views with an interviewer of similar age and experience. A final open-ended question invited participants to give voice to their lived experience, and brought a wide range of responses on matters they saw as important.

The phenomenological approach helped uncover the finding that groups run by older people for their peers have characteristics that make them particularly appealing.

Results

Participation in activities

The 25 interviewees took part in a total of 106 activities. Ninety two per cent of the groups were run by their members, though some received infrastructure support (eg. low-rent premises).

State of health was a more important determinant of participation than chronological age. All but one interviewee suffered from one or more chronic diseases, but all regarded themselves as ageing successfully, supporting Bennett's (2005) finding that social engagement is a predictor of self-assessed health.

Motivations for joining a group were: opportunities for social interaction, personal wellbeing, and the activities offered – all ‘leisure activities’ such as hobbies, crafts, physical activities, organized learning and volunteering. Leisure is an important resource in coping with stress and with negative life-events such as physical disability, chronic disease or bereavement – all likely events for older people (Janke, Davey & Kleiber, 2008).

An important finding that emerged from deeper analysis was that peer group organisations – those run by and for their members – are uniquely capable of providing the satisfactions older people are seeking. Alvin Toffler’s (1981) ‘three basic requirements of any individual: the needs for community, structure and meaning ... to create a fulfilling emotional life’ (p.377) provided a conceptual framework within which to explore further the interviewees’ perception of the groups.

The role of peer group organisations

Community: All the interviewees expressed the satisfaction they derived from their feelings of belonging, and of acceptance by the group: *‘Oh, yes, it’s the companionship, ... at our stage of life’* (M 75+). The group was a place to make new friends: *‘friends I wouldn’t have made otherwise’* (F65-74), and to renew old acquaintances. Many interviewees chose a group as much for the social contact as for the activity: *‘I’m as good as the tutor; I just go for the companionship’* (M 65-74).

Although some interviewees belonged to mixed-age organisations, they saw a special value in groups of their peers, with whom they shared interests and life experience. There was a fellow-feeling: *‘we’re a very caring group. Because, you know, a lot of us in turn have something wrong with us, and we, um, allow for that’* (F 65-74). They could feel part of the group even when they were unable – permanently or temporarily – to take part in the activities: *‘Even if you’re not feeling well, you come, and just sit and talk’* (F 75+).

Belonging to a peer group was specially important for those who had experienced personal losses; the friendship, support and understanding they found was a help to the thirteen who had lost a spouse, and to those living alone: *‘The social side has become more important, because I had family before’* (F65-74). Groups arranged to send cards or visit members in hospital; one craft group made provision in its tiny budget so that *‘if anyone gets sick we can buy them flowers’* (F 75+).

A major benefit of belonging to a peer-group organisation is the opportunity for reciprocity. This is an important ingredient of independence and consequently of self-esteem (Wahrendorf et al., 2006), but it is often unavailable to older people, who are more likely to receive services than give them. Eleven of the 25 interviewees were actively involved in running their group, as organisers or tutors. Others helped by giving lifts to members who were no longer driving, or by baking a cake for morning tea, or by bringing vegetables from their garden to give away or to sell to raise group funds. An 80 year old widower, who was the life and soul of his group, explained:

‘I go because I feel – I’m putting a bit back in... I do as much as I can. There’s lots of things you can’t do, lots of things in the garden I can’t do... So I enjoy it. Return for the good things I ... I’m happy. I go out. I laugh...’

Another advantage of belonging to the peer group is the chance for relaxation and enjoyment without the fear of being thought old and silly: *‘We all enjoy it, all friendly and helpful. We laugh together, joke together’* (M 75+). Among peers and in familiar surroundings, older people maintain their personal identity.

Structure: Participation in activities provides the structure of time, place and energy that is often lost on retirement; *‘It gives me a reason for getting out of bed in the morning’* (M 65-74). Older people’s groups offer their participants opportunities to do things for which they had not had time before, or to spend more time on activities they already enjoy. Interviewees appreciated having a choice of a variety of activities suited to different levels of ability.

Participation in mental and physical activities offers a challenge and an opportunity to learn, but the learning in the peer group is informal and cooperative rather than competitive, building confidence and making allowances for others’ difficulties. Community-based groups have more in common with Communities of Practice in the workplace (Wenger, 1998) than with formal learning institutions. There is no Them and Us, no hierarchy of teachers and taught; teachers are also learners, and learning is through participation in activities (Sfard, 2008). The tutors and organisers are volunteers, fellow learners and members of the peer group; they are rewarded with the appreciation and thanks they receive: *‘That’s a lovely feeling, you know, that I’m helping to do something that they find useful’* (F 65-74).

Volunteering helps to keep the cost of participation within the reach of pensioners and those on fixed incomes, so no one need feel uncomfortable or excluded. A morning at a craft group '*costs you three dollars and you get morning tea as well. Can't complain!*' (M 65-74).

Meaning: Participation is a way to maintain a sense of meaning and purpose, the single attitude most strongly associated with life satisfaction (Headley & Wearing, 1992), and one that can be lost under the impact of declining health, restricted income, and ageist attitudes in the wider community. Membership of a peer group organisation empowers older people to retain their life-role as responsible adults, to use their knowledge and skills and exercise their freedom of choice.

Membership of the peer group is also an opportunity to observe and practice strategies to cope with the difficulties that can accompany old age - loneliness, poor health, social exclusion, a loss of purpose and self-worth - and to offer and receive support and friendship from people of similar age and life-experience. This appears to confirm Nimrod's (2007) finding on the benefits of participation in activities: essentiality, growth, challenge and companionship as contributing significantly to life satisfaction.

Implications for policy and practice

As the number of older people increases, there will be greater demand for the preventive health activities that community-based groups can and do provide. Community-based self-help peer groups can provide an effective preventive health measure at very little cost to participants or to the community, but these groups have infrastructure needs which they are generally unable to fill, such as accessible, affordable and suitably equipped venues (MacKean, 2003).

Older people's experience of group participation is an under-researched topic; a recent search of databases (Lund & Englesrud, 2008) identified no recent studies. Government authorities have yet to recognize and support the solution suggested here. Cooperation between Health and Education authorities, consultation with the Third Sector, and most importantly, with older people themselves, could provide a low-cost solution to the 'problem' of an ageing population that satisfies older people's need for community, structure and meaning.

Summary

The special characteristics of community-based groups, especially those run by and for older people, make them an important community resource that can help older people maintain their wellbeing and independence.

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QUALITATIVE INTERVIEWING OF OLDER ADULTS: OFFLINE VERSUS ONLINE METHODS

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Abstract

The current paper is based on a study of 45 Australian older adults (aged 60 – 92 years) and their offline and online romantic relationships. It discusses the four different interview methods that were used to collect the data: (i) face-to-face, (ii) telephone, (iii) instant messaging and (iv) email. It is argued that with increasing numbers of older adults making use of the Internet, online interviewing provides researchers in ageing a further means of access to segments of this population. Online interviewing has many benefits, not least of which are that it is both cost effective and efficient. Furthermore, if the nature of the research topic is of a potentially sensitive nature, as in the project reported here (love, sex and intimacy), the use of online interviewing can help alleviate potentially embarrassing and confrontational moments which can occur for both researcher and participants with more traditional face-to-face and telephone interviewing methods.

Introduction

Late-life romance, both on- and offline, is a much neglected area of research, primarily because of ageist views and stereotypes that portray older adults as both asexual (Schlesinger 1996) and technologically incompetent (Philbeck 1997). The research which this paper is based on looked at older adults and their romantic relationships, those that began through F2F means and those that were mediated by technology, that is, via the Internet. Two groups of older adults were interviewed and were differentiated by their mode of relationship initiation: the F2F Romance group, who met in person (13 interviews: 8 females, 5 males, 63 – 92 years, mean age 72 years) and the Online Romance group, who met online (32 interviews: 16 females, 16 males, 60 – 76 years, mean age 66 years). The results presented herein pertain to the interview methods employed; therefore discussion of the study itself is limited to details relevant only to the methodology (see Malta 2008 for a fuller discussion of the project).

Qualitative interviews

Four different semi-structured qualitative interview methods were used in obtaining the data: (i) face-to-face, (ii) telephone, and online via (iii) synchronous computer-mediated-communication (variously known as instant messaging, IM or private ‘chat’) and (iv) by asynchronous electronic mail (email) correspondence. It is acknowledged that F2F interviewing is usually the preferred method of interviewing older adults in qualitative studies (Shuy 2001: 552). This paper compares the different types of interviews, arguing that online interviews can be effective for research with older adults.

Allowing participants to decide the interview medium they prefer can increase retention rates and rapport (Kazmer & Xie 2008: 273), and this was precisely why participants were asked to select their preferred mode of interview. Consequently, the interview mode that participants chose did not always reflect which relationship group they belonged to. Table 1 shows a breakdown of the interview modes and how they correspond to the two different relationship groups.

Table 1. Interview Method by Relationship Group (n)

Interview Method	Online Romance Group	F2F Romance Group	Totals N (%)
Face to Face	1	9	10 (22%)
Telephone	5		5 (11%)
Online : IM	23	3	26 (58%)
Online : Email	3	1	4 (9%)
Totals	32	13	45 (100%)

Each of the interview methods had their own advantages and disadvantages, but it is argued that the online interviews (both IM and email) were the easiest to set up and use, were the most cost effective and enabled access to a population of older adults that would have been hard to reach under normal circumstances. Some researchers have argued that online interviewing negatively affects the quality of the data produced, but this was not found in the current study. Each of these methods will be discussed in turn in the following sections.

Face-to-Face interviews

The interview approach taken was characteristic of the recursive interviewing model described by Minichiello and Aroni (1995: 80-81; 88-92), which allows for interviews to follow a conversational format. This method was chosen because of its informal nature, which was seen to be the best way to help put older adults 'at ease'. The quality of the data obtained by this method was rich and informative and visual cues (such as body language) allowed the researcher to interpret nuances that may have been lacking in other non-F2F methods. The F2F interviews did have their problems however, as they were hard to schedule and involved much time and effort, as well as financial costs, to both participants and researcher, particularly in terms of travel. Sometimes it could be difficult for the researcher to establish rapport with the participant as the nature of the questions asked involved embarrassing or, at times, confrontational topics – such as love, sex, intimacy and infidelity – making for awkward and uncomfortable moments for both the interviewer and interviewee. Nevertheless, all respondents said they welcomed the opportunity to speak about late-life romance.

Transcribing the interviews was extremely time-consuming and could also be costly, but allowed the researcher to become re-engaged with the data, especially if there had been a gap in time between the interview itself and the transcription period.

Telephone interviews

Telephone interviews were recorded via a device attached to the telephone, which saved the interviews as voice files onto a digital recorder. These files were later downloaded to a computer and transcribed.

In qualitative research, telephone interviews have historically been seen as an inappropriate technique for semi-structured and in-depth interviews (for discussion see Sturges & Hanrahan 2004: 108). The literature comparing F2F and telephone interviewing showed differing results in the quality of data obtained from these two modes, suggesting that telephone interviews were less than ideal (Sturges & Hanrahan 2004: 110). Other studies, however, concluded that there were no significant differences in responses between the two different techniques, with Miller concluding that telephone interviews could not be classed as either "better or worse" than F2F interviews (1995: 37). Furthermore, some researchers argue that telephone interviews have important advantages over F2F interviews; in particular, allowing access to participants who may be geographically distant, being able to cover sensitive topics with more perceived anonymity, cost savings in terms of time and travel and interviewer safety (Stephens 2007: 209; Sturges & Hanrahan 2004: 109).

In the current study, similar difficulties to those of the F2F interviews were encountered, such as problems with scheduling and sometimes building connection between parties. The absence of visual and bodily cues did mean, on occasion, that extra clarification was required on both the part of the researcher and the participants, and some questions needed to be repeated. Although the literature states that sensitive topics are more easily covered over the telephone, it was found that they were sometimes difficult to broach in this medium but, once rapport was established, initial embarrassment was overcome. Certainly participants who were interstate were more easily accessed using this interviewing mode.

Online interviews

When this research project was first mooted, sceptics argued that older adults would be difficult to reach online. This initial scepticism was proved unfounded, however, and respondents were easily found via dating websites and senior-specific websites. Countering the stereotype that older adults are technophobic, a total of 30 older adults (67%) chose to be interviewed online, either by IM or email, indicating a high degree of familiarity and trust in the technology.

Instant messaging interviews

Hamman (1997: 3) suggests that interviewing respondents online allows researchers to observe people in their own environment; whilst Hammersley and Atkinson (1995: 150) argue that it "is the best strategy"

because participants are comfortable and relaxed in their own familiar surroundings. Couch and Liamputtong recommend interviewing online daters by IM because it is in common usage amongst online daters and, therefore, offers a “mode of communication [which is both] relevant and appropriate” (2008: 270).

IM interviews were conducted using standard, open-source, proprietary software, such as *Yahoo®* or *Hotmail®* Chat. Of those who chose this method, four were unfamiliar with the technology but asked for some guidance in setting it up. All four participants were pleased to have learnt a new skill and three commented that they would now be able to chat online with their grandchildren.

The benefits of online interviewing are many: geographical flexibility (researchers and respondents can be located anywhere); automatically-generated transcripts (less time-consuming and costly for the researcher; see Herbert 2001); respondents may feel less inhibited by the relative anonymity of the online environment (which may enable greater disclosure and participants may be less affected by social desirability factors, see Couch & Liamputtong 2008 and Tatano Beck 2005); and furthermore, an absence of interviewer/interviewee effects, such as power dynamics inherent in traditional research methods, which may allow the researched to feel on a more equal footing with the researcher (see Fox, Morris & Rumsey 2007:544-545; Meho 2006: 1292). These benefits were evident in this project.

Online interviewing is not without its detractors, however. There are two major problems associated with conducting online interviews. Firstly, it is often difficult to categorize the demographics of the sample, as it is possible that respondents lie about this information. However, this is an issue relevant to all non F2F questionnaires or surveys, whether they are online or by pen and paper. Besides, the alert researcher can check for discrepancies whilst the interview is in progress, or later via follow-up emails. Secondly, questions (and, for that matter, answers) can be open to misinterpretation and, therefore, misunderstanding, due to the absence of F2F cues. According to Herbert, “body language and visually/verbally expressed nuance of face-to-face interaction associated with conventional qualitative research is lost online” (2001: 3). However, Suler argues that, in reality, people do not misconstrue one another online all that often, despite the lack of visual and auditory cues (1997: 4). The current project found that those who regularly communicated online appreciated that this might happen and were always willing to reiterate and restate what was said in an effort to facilitate understanding.

The IM interviews in the present study were relatively easy to set up and administer and, compared to the F2F and telephone modes, were less constrained by time. Participants were located throughout Australia, however, geographical distance was not an issue when using this method, although time differences between States needed to be accounted for. As each IM interview progressed the Chats were copied and pasted into a Word document, providing instant transcripts with no additional transcribing necessary apart from some tidying up and formatting.

In terms of broaching sensitive subjects, this mode was relatively stress-free and less awkward for both the researcher and participants than that experienced in the F2F and telephone interviewing modes, perhaps due to the anonymity of the online environment. Many participants commented on the ease with which the interviews were conducted, and said they were comfortable being interviewed in their own homes, although a small number were located at business premises.

Email interviews

The participants who chose to be interviewed by email did not wish to be interviewed by IM, F2F or telephone, or were prevented from doing so by reasons of illness or geographical location. Interviewing by email is achieved asynchronously and is therefore not subjected to the vagaries of scheduling that can accompany other methods (Meho 2006: 1292). Curasi (2001) has cautioned, however, that email interviewing can be more susceptible to participant attrition than F2F interviewing because of the time lag between participant acceptance and receipt of interview questions. The current study supports these findings and highlights that this attrition needs to be factored in at the beginning of study.

Initially there appeared to be a difference between interviews conducted by IM and those conducted by email. Answers received during the IM interviews tended to be in-depth and rich in qualifications, whereas primary responses to the email interviews were much shorter and succinct. It is argued that this difference is due to the interactive nature of the IM contact – contact that mirrors a real-life telephone or F2F conversation, albeit

in text – whereas the asynchronous nature of email interviews allowed the conversational ebb and flow to be lost. However, Meho contends that email interviews allow participants the time to be more reflective of their replies and provide the opportunity for editing of responses, making for more focused answers (2006: 1291). This project found that, although email interviews were relatively shorter than their IM counterparts, the data obtained was just as rich and valuable as IM interviews.

Discussion and Conclusion

The perception that older adults are technophobic has often precluded their inclusion in studies of Internet-based research. It is clear from the current study that many older adults are familiar with and have trust in the technology, as evidenced by their willingness to be interviewed via online methods such as email and IM. Online interviewing has many benefits for researchers in ageing: it provides an effective means to access older adult populations, it is easily achievable and is both time- and cost-effective, and it also allows for the discussion of topics which at times may be embarrassing or confrontational in F2F and telephone interviews. A potential downside to online interviews is that the group of older adults who are online are not necessarily representative of older adults in general. Nevertheless, online interviews provide an important tool for ageing researchers, particularly those studying potentially sensitive topics such as sexuality.

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FINDING A VOICE

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Abstract

Influenced by postmodernism and feminism, research, particularly within the social sciences, enables the validation of subjective narrative modes of individual, local and particular forms of knowledge. These approaches embrace the subjective and facilitate new relational models of qualitative research focussing on in-depth understanding, framed by active, dialogic and reflexive research relationships. This paper will draw upon the author's research into reminiscence as therapy among ageing rural Australians. It will focus on a phenomenological approach using an oral history methodology, and discuss methods, including time-use diaries, questionnaires, collaborative interview techniques, and levels of transcription, that better reflect and respect the uniqueness of participants' individual voice. The issue of voice is paramount, both as a way of validating and negotiating a lifetime of experiences, and in presenting intimate narratives that are personal and contextual. The focus on older participants within the North Coast of NSW helps map the landscape both historically and culturally, demonstrating the multi-storied nature of lives and localities, and exploring the intrinsic link between identity and place. Australia's population is ageing, and with this comes a need to extend research in ways which dignify, celebrate and honour the lives of ageing Australians. Reminiscence is both an enabling form for narrative, and a means for exploring participants' feelings of wellbeing, with the focus on individual local histories. The author's research reveals multiple benefits of reminiscence for participants, including improved health and wellbeing, recognition of value to self and others, and producing a narrative of their life achievements.

Research question

Many qualitative research studies use interview-based techniques for data-collection, however there is a distinctive gap regarding subsequent discussion about the ethics of chosen methods within the research itself, and often the unique particularity of participants' individual voices are neither discussed in relation to theory nor adequately represented within the research. My study attempts to redress the need to reclaim authority for the storyteller, respect the ways participants' organise meaning in their lives, and celebrate the subjective uniqueness of each individual voice. Using ethical and inclusive research methodologies and methods assist toward this objective and a clear discussion of the methods ensures a transparent approach to human-based research.

My aim is to examine the link between reminiscence as storytelling and therapy in an ageing Australia, with the focus on the subjective and particular experiences of participants themselves. Employing what Gilligan (as cited in Israel & Hay, 2006, p. 21) calls an 'ethics of care' approach ensures that the research is wholly informed by ethical research paradigms and the approach, practice, analysis and reporting of research is framed by an ethical best practice. Guba and Lincoln (1994) maintain that any research paradigm needs to respond to fundamental questions of ontology (form and nature of reality), epistemology (system/theory of knowledge) and methodology (system of processes and practices for research). By clearly identifying the approach and position as a researcher, not only will a reader be aware of standpoint positioning, but it will help ensure the research is clearly informed by theory and guided by an ethical best practice.

Methods

Being a multidisciplinary and mixed method approach, my study borrows and blends together a pastiche of influences and approaches to reminiscence and narrative in order to effect a more inclusive and pluralist relationship to human-related research. As such, it draws on theoretical elements from postmodernism and feminism, and elements from life writing, literary, and social science discourse. The phenomenological research is thus framed by a multidisciplinary approach using an oral history methodology informing the story collection, combined with a narrative approach to the form, presentation and analysis of these stories of lived experience. As Liamputtong and Ezzy note, a mixed method approach is best suited to qualitative research (2005). For interpretative researchers, reality is socially constructed and there are many local truths. Stories are an important means of forming and reforming not only social and cultural identity, but personal identity. It is the subjective particularity of individual narratives that are important in my research in that they offer a unique alternative to generalised or representative readings (Chase, 2005). According to Payne, postmodernism has enabled new forms of subjective knowledge to be accepted and validated (2000), and a pluralist approach enables attempts toward an in-depth understanding and overturns notions of science presented in a singular

universal voice (Wright, 2004). Similarly, feminist research stresses the importance of context and people's relationships. It is the collective diversity and plurality of each individual's voice that is of interest to me. Thus not only does my research employ strategies to minimise risk to ensure that all dealings with others encompass care and compassion and are framed by ethical considerations, but it is also grounded and defined by a clear epistemological framework that informs its overall procedure.

Ethics are a major consideration of all aspects of research, therefore ensuring compliance with the National Statement on Ethical Conduct in Human Research (2007) is paramount. Completing a National Ethics Application Form (NEAF) ensures consideration of all aspects of the research process, including methodology, sampling and participant criteria, as well as components such as cover letters, consent forms, interview questions and questionnaires, and also researcher responsibilities. University-based research requires that a NEAF be completed and approved through a Human Research Ethics Committee before commencing any research with humans.

My study explores the nexus between reminiscence as storytelling and therapy in an ageing Australia with the focus on fifty participants aged over sixty-five who are long-term residents of the North Coast of NSW. The use of purposive sampling through convenience method ensures that participants fit the required criteria. I am interested in the dual aspects of participants' stories about living in the region as well as their resultant feelings of wellbeing. The research encompasses pre- and post-tests and multiple methods, including feedback and follow-up interviews, to assist in triangulation and ensure internal validity.

Methods include establishing a rapport with participants to enable an informal sharing of information and help build trust. The use of time-use diaries enable participants to enter information at times suitable to them, however these require clear guidelines on what is required and reminders about their use. Valid, pre-existing questionnaires are useful because of their perceived reliability, and other questionnaires have been pilot tested. Questionnaires are limited to two pages in length.

Feminist approaches to interviews as a collaboration between interviewer and participant have addressed power imbalances and enabled greater autonomy and voice for participants. As Gubrium and Holstein say, interviews are narratives 'constructed *in situ*' (2003, p. 67). Collaborative forms of interviews encourage ethics, reciprocity, equity and involvement (Arksey & Knight, 1999). These new perspectives on interview processes challenge and overturn traditional hierarchal relationships and promote active, dialogic and reflexive research relationships and practices. Collaborative interviewing is thus used as a technique to enable narrative construction and is an effective means of creating and gathering information borne from the interaction between interviewer and interviewee as co-constructors of meaning. In-depth semi-structured interviews enable coverage of main themes while allowing participants to elaborate in detail according to their own sense of import. Maintaining appropriate eye contact, the use of interviewer silence, and having a genuine interest in the participant's story, helps facilitate dialogue and understanding. Other considerations include interview location, choice of recording technology, and using appropriate and ethical language.

A full verbatim transcription of interview-based data fulfils the research aims and needs. Transcription enables an immersion in the data and is part of the aim, process and analysis of ethical research. Including bracketed information on the participants' attitude or tone helps contextualise the information and better reflect and respect the uniqueness of their individual voice. The issue of voice is a central concern (Chase, 2005). Retaining the first-person voice when reporting, highlights the participants' individual vernacular and forms of expression, and creates an embodied and intimate first-person narrative.

Feedback is an essential and important aspect of ethical research. Each transcribed interview is condensed into a thick narrative and given to the participant for changes and feedback to ensure they are happy with their story. At the conclusion of research, all participants are given a copy of their completed story and full transcripts of their interviews.

Results

Based on results from my previous research in this area and expected results from current research, reminiscence leads to feelings of wellbeing, and the participation and telling of individual and particular stories has both personal and social benefits. The stories provide a written historical narrative that enriches the store of historical documentation of the district, as well as increasing feelings of worth and value within the individual participants. An ethical and contemporary approach to all aspects of research helps ensure that participants are treated with respect, and contributes to the development of research as a whole.

Implications for policy and practice

There is a pressing need to extend research in ways which dignify, celebrate and honour the lives of ageing Australians, particularly as a substantial increase in older population numbers and the associated longer life expectancy (Hugo, 2001) will impact greatly on the need for increased services and programs within aged care. Reminiscence has long been used in literary disciplines, however its application in aged health care has potential widespread benefits including improved health and wellbeing and a recognition of value to self and others. Health care practice can benefit from a pluralist approach to human-related care by implementing cross-disciplinary practices and techniques that demonstrate clear health benefits. This is particularly appropriate in aged health care and specifically in end of life treatment, where, as research by Kunz (2007) has shown, there is a desire for people to tell their stories. Research into reminiscence within health care has primarily focussed on its use in memory recovery for dementia patients, however reminiscence has multiple potential applications at individual and group levels, within private or public settings. The use of oral history methodology and narrative techniques and approaches to collecting and presenting people's stories could well augment holistic methods of treatment.

Summary

Reminiscence as therapy has multiple benefits for older people, including increased feelings of wellbeing and the telling of one's own story in one's own voice. Using contemporary ethical approaches to research creates an improved research environment, and grounding the practice of research within epistemology and methodological frameworks clearly locates the research and furthers ethical and inclusive research practices within the social sciences.

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WHERE IS ALL THIS GOING? – MIDDLE MANAGERS' PERSPECTIVE ON CURRENT CHALLENGES WITHIN THE NON-PROFIT AGED CARE INDUSTRY

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Abstract

Increased competition for funding, complex accreditation requirements, shortage of skilled personnel, changing client needs and the necessity for innovative service delivery models are drivers for change within the aged care industry. Additionally, a new pro-business zeitgeist impacts dramatically on non-profit organisations. They have reorganised, restructured and implemented new management approaches and strategies while aligning their operations for a more corporate approach. Tensions arise from the interaction of demands for adjustment in both service delivery models and management styles. This paper reports on the research design of the study and some emerging themes from pilot interviews in one large non-profit provider of community, retirement and residential aged care services. In the first phase of this research study, a purposive sample of 30 middle managers from different areas of operation will be interviewed using a semi-structured interview guide. The data will provide an in-depth understanding of how working more 'business-like' matters in non-profit human services, what challenges middle managers are facing and how they respond to them. It will also provide information on how participants adapt to change while dealing with the tensions constantly presented to them. Conceptually, the research adds to the understanding of organisational factors and individual characteristics that are important in assisting managers to adjust to continuous change. At an applied level, the research provides guidelines for enhancing the performance of middle managers in the non-profit sector while increasing job satisfaction and well-being.

Research question

Middle managers are particularly affected by on-going change (Spreitzer & Quinn, 1996). They need to ensure smooth operational running and act as internal change agents, while making sense of the changes for themselves. This study investigates current demands and challenges middle managers in aged care face, their perceptions of on-going change and whether or not this perception is influenced by employee identification. The research questions central to phase I of the study are:

1. What are the contemporary demands and challenges middle managers are facing in the non-profit aged care sector?
2. How do they respond to these challenges?
3. What are the salient reference groups in terms of identity?

Methods

In line with recent developments that assume knowledge is subjective and has to be personally experienced, mixed-method research has evolved as a third research paradigm within the research community (Johnson & Onwuegbuzie, 2004; Woodman, 2008). This mixed-method research study utilises document analysis, semi-structured interviews and questionnaires. An exploration of new themes as well as an in-depth understanding will best be achieved through interviews. Findings will aid the development of a quantitative instrument to explore further the critical factors in participant's adjustment to change. Sequential procedures are appropriate for this exploratory research study as a method to elaborate on the findings of earlier methods (Cresswell & Plano Clark, 2007).

Figure 1. Research design

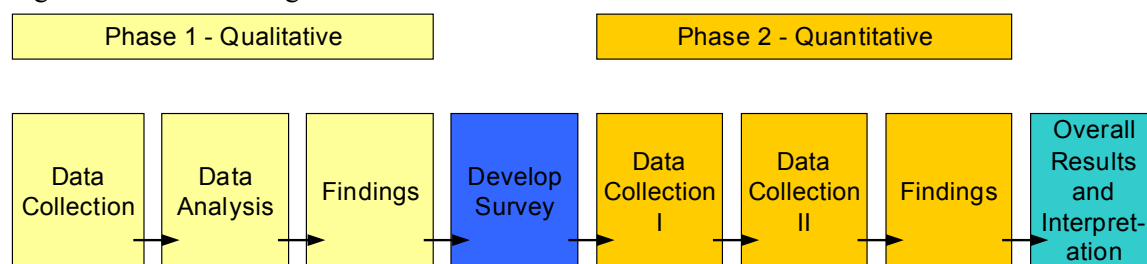


Figure 1 illustrates the sequence of the studies. A more detailed description follows providing information on data gathering and participant recruitment. In phase I of the research study, interviews and document analysis are conducted. Documents included in the analysis are role descriptions of the different positions within the group of middle managers. It allows the researcher to enter the interviews informed about expectations of the various positions (Alvesson & Deetz, 2000). Recent organisational surveys will also provide insight into pertinent themes within the organisation.

Recruitment of participants

A purposeful stratified sample of approximately 30 middle managers across areas, sites and business streams will be interviewed utilising a semi-structured interview guide. Positions included in this group relate to direct service delivery to older people in the community, residential care and retirement living, as well as the management of the business as a whole. Participants will be recruited depending on their gender and tenure with the organisation. The tenure will be divided into three groups: 1) less than a year, 2) between 1 and 5 years and 3) more than 5 years. These groups are based on the grouping within the organisation's annual employee survey. Moreover, it is argued that there will be significant differences between employees who have been with the organisation for more than 5 years, compared to the other two groups as the major restructuring and initial phase of the implementation of new management approaches started over five years ago.

Interview guidelines

At the start of each interview, participants will fill in a fact sheet which provides detailed information on their professional background. The semi-structured interview guide covers the following topics:

- Role in the organisation and professional background
- Challenges in current position
- Professional networks and identity
- Changes within the broader industry and the organisation
- Personal experience with change and managing change

Preliminary results

In the following section two emerging themes from the pilot interviews supported by the literature are presented. These emerging themes will be further investigated in the interviews of phase I of the research study. These pilot interviews were conducted with people who are managers of the potential participants.

Hybrid management

Within the aged care service organisation an understanding prevails that nurses naturally become managers over time (see also Hewison, 2004). However, the increasing influx of managers from non-clinical backgrounds shifts this self-image significantly. This provides opportunities to add value by bringing in a diversity of perspectives as differences can be found between professional managers who identify strongly with their managerial role and nurses in management position who tend to identify more readily with their professional role than with their managerial function (Dopson & Stewart, 1990). However, previous research (e.g. Harrison & Politt, 1994) as well as the interviews suggests that a bipolar division between managers and professionals is too simple. Interviews with middle managers from various backgrounds will further investigate how various groups *within* each profession manoeuvre for advantage in emerging organisational contexts. In the context of the changing organisation middle managers have to make sense of their construction of identity. This in turn influences their attitude towards change initiatives, and ultimately how they adapt to and implement change within their area of responsibility.

Changing culture

Organisational culture and climate research shows that employees use cultural references as a resource to make sense of and interpret their environment as well as respond to changes. Within complex organisations, members are offered a variety of sources from which to derive a sense of belonging (Lewis, 1994). On one hand, interviewees suggest that the organisation should not be any different to for-profits; on the other hand, they perceive a non-profit culture in some parts of the organisation which makes it more difficult to implement change. They also perceive the organisation as not as high pressure in terms of overall human resource practices. At the same time, a need to work leanly and focussed on effective resource management is emphasised. More generally, interviewees perceived a change in customer expectations, e.g. increased understanding about why the organisation, as a non-profit asks customers for accommodation bonds. Financial viability is mentioned as crucial for the organisation and so is the provision of quality care and services to older people in the community.

In conclusion, the competing agendas middle managers face in a volatile policy and funding environment require continuous attention and adjustment. At the same time, they are dedicated to the provision of high quality services to a vulnerable group of people. How are they maintaining their professional (and personal) roles and identities through major changes? Due to the need to develop innovative and collaborative approaches for effective service delivery, more investigation into the demands placed on managers within the non-profit sector, and the skills required to operate within this demanding environment, are needed (Paulsen, 2005; Sehested, 2002). This is the aim of phase I of the research study.

Implication for policy and practice

Evaluations of the non-profit sector in the context of public reforms have mainly focused on structural changes, management processes and the implementation of quality improvements rather than its impact on organisational culture, management of changing roles and the perceptions of employees. That is, the impact on organisational cultures and professionals has not been studied sufficiently (Butterfield, Edwards, & Woodall, 2005). This research study will provide a greater understanding of changing professional and organisational identities and their implications for service delivery in a non-profit organisation. Identity is central for meaning and motivation, stability and change and the logics of action and decision-making (Sveningsson & Alvesson, 2003). Therefore, by obtaining greater insights into the perceptions of employees working within the environment, the research supports professionals in forging new identities which embrace the logics of both service and accountability, but which retain a focus on client advocacy. The emergent complexity and tensions in the professional service setting create sets of behavioural and managerial challenges that are imperfectly understood. Particularly, the exposure of non-profits to the market forces creates a number of clinical and ethical dilemmas for professionals such as tensions between the logics of service and accountability (Carpenter & Platt, 1997). Studying middle managers of various professional backgrounds in an emerging organisational structure will shed light on how working more 'business-like' matters in non-profit human services, what challenges they are facing, and how they adapt to change while dealing with the tensions constantly presented to them.

Summary

This study is particularly interested in the impact of changes on organisational roles and identities of middle managers. The role of middle management has become increasingly significant, particularly for professionals in health care. Although research has been carried out to investigate the challenges of management, very little work has focused specifically on middle management in the non-profit aged care sector. Understanding how managers perceive on-going changes and adjust to them, will provide evidence on the utility of the organisation's change management approach, as well as strategies to support personal and professional development. Furthermore, this research study will contribute to the understanding of the challenges these managers face in a changing environment. During the qualitative phase a conceptual understanding of how professional identity influences adjustment to on-going organisational change will be developed. Build on these findings a guiding exploratory model of critical factors for adjustment to change such as salient reference groups and organisational climate will be tested in the quantitative phase.

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RAISING COMMUNITY AWARENESS ABOUT DEMENTIA AND ITS RISK FACTORS

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Abstract

Increased community awareness of dementia risk factors may encourage healthier lifestyles that could potentially reduce the incidence of this disease. We offered a dementia survey to adult patients attending their general practitioner (GP), 453 in Australia and 61 in the United Kingdom (UK). We used the Alzheimer's Australia 'Mind Your Mind' dementia risk factor summary as an intervention, distributing this information randomly either with or on completion of the survey. We found that 30% of Australian and 41% of UK patients learned about dementia from an acquaintance and 16% and 10% respectively from their doctor. Only 6% of Australian and 3% of UK patients recalled having a memory test although 53% and 48% respectively would accept one, with 93% and 90% respectively wanting to be told if they had dementia. The intervention group were more likely to agree that dementia risk factors could be reduced ($p=.000$), and more likely to suggest tasks to reduce dementia risks ($p=.000$), more likely to suggest two or more tasks to reduce risks ($p=.002$), including 'physical exercise' ($p=.000$) and 'brain exercises' ($p=.001$). Our results produced similar trends in knowledge about dementia in Australia and UK and demonstrated that the Alzheimer's Australia 'Mind Your Mind' risk reduction summary increased awareness of ways to reduce modifiable dementia risk factors, especially 'physical exercise', an activity supported by increasing evidence.

Research questions

As people live longer, their risk of cognitive impairment increases (Brookmeyer, Johnson, Ziegler-Graham, & Arrighi, 2007). Although there is widespread awareness of the risk factors for treatable diseases such as diabetes and heart disease, there is less awareness of dementia risk factors (Coulson, Strang, Marino, & Minichiello, 2004; Yaffe et al., 2004). Current evidence supports reduction of modifiable dementia risk factors to reduce the incidence of this disease (Prince et al., 2007; Scalco & van Reekum, 2006), benefiting both patients and the health system (Brayne, 2007). Our study explores current community awareness of dementia and its risk factors, distributing a survey to adult patients in GP waiting rooms, and testing the impact on survey responses of the Alzheimer's Australia 'Mind Your Mind' risk reduction summary (MYM). Risk reduction strategies benefit from cooperative and collaborative partnerships and shared understanding between patient and doctor (Simons, Simons, McCallum, & Friedlander, 2006; Speechly, Bridges-Webb, & Passmore, 2008). Health messages from a GP can bring about positive lifestyle changes (Ashenden, Silagy, & Weller, 1997). We extend this concept to the GP waiting room as a suitable environment to promote discussion and positive action in combating a disease which might otherwise be viewed as hopeless (Fillit et al., 2006). Our project has been reviewed by the ethics committees of James Cook University, Townsville Health District and Mackay Heath District.

Methods

Our study design consists of a multi-centre survey distributed to GP patients in Australia and UK, expanded to a randomised controlled trial using the intervention of the MYM information sheet, randomly distributed with or after the survey.

Our study population is patients attending their GP who are invited by the receptionist to complete our survey while seated in the waiting room. Although we are targeting patients over the age of 30 years, adult patients under this age may participate if interested. Our UK sample was surveyed during a recent visit to UK, mainly from a practice in Hertfordshire where I had previously worked. The National Health System Ethics committee in UK advised our survey did not require ethics review for distribution in UK as participation was voluntary and data de-identified.

The project aims for 1000 participants to match similar government surveys. This paper discusses the responses of our first 514 participants, 453 from Australia and 61 from UK.

The survey consists of twenty-five questions on one page, some answers requiring selection of 'yes, no, unsure' and others allowing for free text 'string' responses. We have resisted supplying answers for participants to select to encourage spontaneous answers from their own knowledge rather than guessing. The questions cover patient understanding of dementia, attitudes toward the disease, where they have learned about dementia, what they think causes or could prevent the disease, whether their GP has discussed dementia with them or offered a memory test and what they might do if they thought they had the disease.

Our survey data is entered on SPSS software for analysis. Each different string response is entered as a separate answer resulting in up to ninety different answers for one question. For example, 'What could you do to reduce your risk of dementia?' may be answered 'healthy diet' or 'healthy diet and brain exercises'. To assist analysis, each string answer is transformed and re-coded to create a new set of variables with yes or no answers. The above examples would produce new variable 1 'mentioned healthy diet to reduce risk', new variable 2 'mentioned brain exercises to reduce risk', new variable 3 'mentioned more than one action to reduce risk'. Analysis primarily describes patient perceptions of dementia and its risk factors and secondarily compares the effect of the MYM intervention on responses.

Results

Australian and UK data

For reporting purposes, we have annotated results from our Australian sample 'A' and UK, 'U'. The samples were 38%A and 44%U male with median age group 50-59 years in both samples. 'Media' was mentioned as a source of dementia knowledge by 39%A and 54%U with 30%A and 41%U mentioning 'acquaintances'. Dementia was described as 'memory loss' by 60%A and 48%U, as 'brain problem' by 15%A and 31%U, as 'old age' by 4%A and 7%U and 'mental illness' by 6%A and 16%U. Only 14%A and 10%U answered 'yes' to the question, 'have you heard about dementia from a doctor?' However, 79%A and 87%U mentioned 'doctor' as the person they would turn to for help with memory problems. Only 6%A and 3%U recalled having had a memory test but 53%A and 48%U answered 'yes' to the question, 'would you like to have a memory test?' When asked if they like to be told if you had dementia, 93%A and 90%U answered 'yes'. When asked if they thought dementia risk factors could be reduced 53%A and 59%U answered 'yes'.

Table 1. Responses of Australian and UK samples

Variable	UK	Australia
Male participants	44%	38%
Median age group	50-59years	50-59 years
Learned about dementia from the media	54%	39%
Learned about dementia from acquaintances	41%	30%
Learned about dementia from a doctor	10%	16%
Dementia is memory loss	48%	60%
Dementia is a brain problem	31%	15%
Dementia is mental illness	16%	6%
Dementia is old age	7%	4%
Has a doctor told you about dementia? 'Yes'	10%	14%
Would seek help for memory problems from a doctor	87%	79%
Have you had a memory test? 'Yes'	3%	6%
Would you like a memory test? 'Yes'	48%	53%
Would you like to be told if they have dementia? 'Yes'	90%	93%
Can dementia risks be reduced? Yes	59%	53%

Comparing intervention and non intervention groups

Participants receiving the MYM intervention were more likely to agree that dementia risks could be reduced ($p=.000$) and more likely to answer the question, 'what could you do to reduce the risks of dementia?' ($p=.000$) with 41% of the total sample either not answering or responding 'unsure'. The intervention group were more likely to mention 'physical activity' ($p=.000$) or 'mental activity' ($p=.001$) or two or more tasks ($p=.002$) as methods of risk reduction.

Table 2. Responses of Australian participants with MYM information versus those without

Answer	Access to pamphlet	No access to pamphlet	<i>p</i> value
Can dementia risk factors be reduced? Yes	141/232 (61%)	98/221 (44%)	.000
Answered question ‘how would you reduce your dementia risk factors.’	158/232 (68%)	110/221 (50%)	.000
Suggest 2 or more tasks to reduce dementia risks	101/232 (44%)	67/221 (30%)	.002
Suggest physical activity to reduce dementia risks	86/232 (37%)	45/221 (20%)	.000
Suggest brain exercises to reduce dementia risks	114/232 (49%)	76/221(34%)	.001

Implications for practice

Community dementia knowledge is gathered mainly from the media and acquaintances, with scope for increased GP involvement. The GP waiting room offers a suitable environment for distribution of the Alzheimer’s Australia MYM information with patients receptive to learning about dementia risk factor reduction. However, further research is needed to measure how this knowledge is translated into practice, as there is no guarantee people will change their lifestyles despite having understood the educational message (Coulson, Strang, Marino, & Minichiello, 2004).

Discussion

Distributing a survey in a GP’s waiting room may impose an additional task on patients who are already burdened with health problems or life events. Patients are receptive to instructions from GP staff and may feel obliged to complete a voluntary survey. On one occasion we were aware of a distressed patient accepting a survey, but supportive staff quickly settled the patient, with satisfactory resolution that may have been less likely in another setting. Comparison of sample populations in Australia and UK indicates similar trends in dementia awareness, with the implication that our results may apply to a wider population. A recent advertising campaign as part of the UK dementia strategy may explain the higher UK response of ‘media’ as a source of dementia information. We asked patients what they thought dementia was, to measure their awareness of symptoms that might prompt them to seek help. ‘Memory loss’ was frequently mentioned by both groups, with ‘brain disease’ and ‘mental illness’ featuring more strongly in the UK sample, possibly due to an association in UK between dementia and mental health services. Our participants were less likely to believe that dementia risk factors could be reduced than the 72% of participants in a recent Australian telephone survey (Low & Anstey, 2009). More complete data collection in a telephone survey may raise the percentage compared with our written survey where participants could leave questions unanswered. Both of our samples proposed ‘doctor’ as the person they would be most likely to approach for help with memory problems and a majority would like to be told if they had dementia, consistent with guidelines that recommend doctors tell their patients the diagnosis (Frenette & Beauchemin, 2003). However, the number of memory tests offered despite a willing patient population was disappointing, also a finding of other researchers (Renshaw, Scurfield, Cloke, & Orrell, 2001). GPs with inadequate dementia training are less likely to test for the disease (Millard & Baune, 2009). Our results demonstrate that MYM increased awareness of tasks that might reduce dementia risks, especially ‘physical exercise’, for which there is increasing evidence (Solfrizzi et al., 2008).

Summary

Most people learn about dementia from acquaintances and the media and increase their understanding of activities which could reduce their dementia risk after reading the Alzheimer’s Australia ‘Mind Your Mind’ dementia risk reduction summary.

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HOW CARERS SPEND THEIR TIME ON ACTIVITIES IN A RESIDENTIAL AGED CARE HOME

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Abstract

Objectives: This paper describes how carers utilize their time on activities in a residential aged care home (RACH).

Methods: An observational work sampling study was undertaken at a RACH using a data collection tool with 7 classifications of nursing activities. Participants included 13 Registered Nurses (RNs), 4 Endorsed Enrolled Nurses (EENs), 52 Personal Carers (PCs) and 6 Recreation Activity Officers (RAOs). The study lasted 5 days.

Results: 6,538 observations were recorded. Overall, carers spent 39.7% of their time communicating, 30.2% in direct care and 11.8% on documentation. They spent equal time in transit and indirect care activities (6.4% each). 5.1% of their time was utilized on personal errands and the remaining time (0.4%) was spent on other nursing tasks. A significant difference was found in time spent on activities in the low and high care units. Carers in the low care unit spent less time in both direct care (23.2% vs 36.0%, $p<0.01$) and personal activities (4.9% vs 5.2% $p<0.01$), but they spent more time in transit (8.7% vs 4.5%, $p<0.01$). Carers in both units spent equal time in communication, documentation, indirect care and other nursing tasks.

Conclusion: Communication of care was the most time consuming activity for carers at the RACH. Carers required less time to provide direct care to the elderly in the low care unit as most are physically able.

Key words: Residential aged care home, work sampling, observation, nurse, time.

Introduction

The ageing population in Australia is rapidly growing with the proportion of those aged 85 years and above expected to grow the fastest from 1% in 2002 to 11% in 2101 (Australian Bureau of Statistics [ABS], 2007). This increase in population could potentially affect many sectors including aged care (ABS, 2007). For example the workload of carers in aged care facilities is likely to increase as a result of the high number of elderly individuals in need of residential aged care services. However, there is limited information about time required to accomplish activities in a RACH. Pelletier, Duffield, and Donoghue (2005) explored the amount of time spent on documentation tasks in two different hospitals with aged care facilities in Australia. The authors found 6.8% to 7.5% of time is spent on documentation tasks and 14.5% to 16% of time is spent on verbal communication of care. However, this study was limited in several ways; first, the study participants were patients in a hospital and not elderly individuals in a RACH. The investigation also covered only a portion of the carers' activities i.e documentation and communication. This implies that comprehensive information about how carers spend time in a RACH still remains scarce.

With the increasing use of computerized information systems in Australia's aged care homes, information about how carers spend their time on activities is necessary in providing baseline information against which to measure change. Thus, this paper provides a detailed investigation about the distribution of time on activities in a RACH.

Methods

This investigation was conducted at Albion Park Rail, a not for profit 110 bed residential aged care home located in Albion park, New South Wales in Australia from 16th to 29th March 2009. There are two houses at the facility, a 53 bed high care house which caters for the elderly with full dependence on carers to accomplish activities of daily living such as showering, and a 57 bed low care house for those who require minimal assistance. All carers including RNs, EENs, PCs and RAOs working in a day shift (6.45am to 3.15pm) at the facility participated in the study. Carers working on afternoon or night shifts were excluded from the investigation as well as carers on orientation, those on stand-by and RNs assigned with administrative tasks.

Work-sampling technique was used to collect data for this study. The method requires a trained observer to use a predefined classification of activities to record specific activities being undertaken at a particular moment

based on a predefined or randomly selected time interval. By using a single observer, inter-observer errors, often associated with observational studies are much reduced and cost of data collection is minimized. Based on the advantages of this approach, the current study also utilized a single observer to record activities of several carers.

Potential nursing activities were identified from previously published instruments (Bosman et al., 2003; Korst, Eusebio-Angeja, Chamorro, Aydin, & Gregory, 2003). The list of activities were validated in a pilot study conducted in a different aged care home and in a meeting at the study site with the Residential Service Manager (RSM), four senior RNs and two EENs. The resulting instrument contained 48 activities and seven classifications (see Table1). Using the formula recommended by Sitting (2005) ($n=p(1-p)/\alpha^2$), a total of 2,944 and 2,500 observations were required for high care and low care houses respectively.

Ethical approval was granted by the University of Wollongong's Ethics Committee after approval of the study by the aged care home and the management organization to which the home belongs. Following carers signed consent, observations commenced from 6.45am to 3.15pm (8.5hours). Data collection was carried out in five days for one week (Monday, Tuesday, Wednesday, Saturday, and Sunday). Observations in the high care house were conducted at an interval of 9 minutes per hour and an interval of 5 minutes per hour in the low care house. The observer followed the same route in each house and recorded all activities being undertaken by each carer at any given round of observation. A maximum of 68 and 136 rounds of observations were made per day in the high care and low care houses respectively during the 8.5 hour observation period. This gave rise to an average of 712 observations in high care and 590 observations in low care per day.

Raw data were entered into an Excel spreadsheet and exported to a Statistical Package for Social Sciences (SPSS) version 15.0 for analysis. The percentage of time spent on an activity was calculated using descriptive statistics. Data were also analyzed using one-way ANOVA, and independent samples t-test. Statistically significant differences were assumed when the p value was less than 0.05.

Table 1. Carers' work categories and activities in a day shift

Categories	Work activities
Direct care	Direct care consists of assessment/subsequent assessment, hygiene/oral care/bathing/toileting/shaving, resident mobility/passive and active exercises/turning resident in bed, medication administration/preparation, assisting with procedures/wound care, specimen collection/urine collection, nutrition/feeding/entero-feeding system, preparing a resident for transfer.
Communication	Communication consists of information about a resident, discussion with allied health workers, receiving a phone call/making a phone call, staff orientation, on job training/induction, class training, co-ordination of care, staff meeting, resident interaction, family interaction, oral hand over, non-resident related communication.
Documentation	Documentation included taking records from the storage place, flipping through to identify the correct page, reviewing resident information/reading notes/viewing results, writing progress notes/ charts/forms/care plans, putting records back to filing area, medication documentation, admission documentation.
Indirect care	Indirect care activities included identifying correct supplies, packing supplies to trolley, re-stocking supplies in residents' cupboards, equipment set up /sling set-up/shower chair set-up/entero-feeding set up, bed-making, transporting linen to and from laundry, transporting waste/clinical waste for disposal, cleaning up spills, personal hygiene set-up, answering to buzzers.
Personal	Personal activities consist of personal errands/meal breaks.
In-transit	In-transit included time between residents and tasks
Others	Others included tasks not elsewhere classified above

Results

Seventy-five carers including 13 Registered Nurses (RNs), 4 Endorsed Enrolled Nurses (EENs), 52 Personal Carers (PCs) and 6 Recreation Activity Officers (RAOs) were observed for a period of five days. A total of 6,538 observations were recorded. Overall, carers spent the majority of their time on communication activities (39.7%) followed by time on direct care (30.2%) and documentation tasks (11.8). The remaining time was utilized on indirect care (6.4%), in-transit (6.4%), personal (5.1%) and other activities (0.4%).

No significant variation was found in the proportion of time spent on direct care, communication, documentation, in-transit and other activities in the different days of the study. Carers spent significantly more time on in-direct care activities performed on Saturday (71.8%) than on Monday (28.2%) ($p<0.05$). They spent significantly less time attending to their personal errands on Sunday (34.6%) than on Monday (65.4%) ($p<0.01$) and on Saturday (49.6%) than on Tuesday (50.4%) ($p<0.01$).

Table 2 shows a distribution of the proportion of time spent on various tasks by the different carers in the study. Registered Nurses spent the majority of their time on communication and relatively equal time on direct care and documentation tasks. Endorsed Enrolled Nurses spent most of their time on communication activities followed by documentation and direct care tasks. The PCs utilized the majority of their time on communication tasks followed by direct care and documentation activities. Whereas RAOs spent most of their time on communication tasks followed by time on direct care and documentation tasks.

We also analyzed the proportion of time spent on activities in the high and the low care house to establish whether there were any time differences. Carers working in the high care house spent significantly longer time on direct care (36.2% vs 23.2%; $p<0.00$) and personal (5.2% vs 4.9%; $p<0.00$) activities than those in the low care house. However, carers in the high care house spent significantly less time in-transit between residents and activities compared with their counterparts in the low care house (4.5%, vs 8.7%; $p<0.00$). No significant variation was found in the proportion of time spent on communication, documentation and indirect care tasks between the two houses.

Table 2. A summary of the distribution of time spent on activities by the different carers at the residential aged care home

Activities	RNs (n = 430) n (†%)	EENs (n = 331) n (%)	PCs (n = 5276) n (%)	RAOs (n = 501) n (%)
Communication	208 (48.4%)	123 (37.7%)	2024 (38.4%)	240 (47.9%)
Direct Care	101 (23.5%)	64 (19.3%)	1645 (31.2%)	167 (33.3%)
Documentation	86 (20.0%)	107 (32.3)	547 (10.4%)	31 (6.2%)
Indirect care	0 (0.0%)	1 (0.3)	405 (7.7%)	12 (2.4%)
In-transit	13 (3.0%)	9 (2.7)	370 (7.0%)	25 (5.0%)
Personal	22 (5.1%)	26 (7.9)	270 (5.1%)	14 (2.8%)
Others	0 (0.0%)	1 (0.3%)	15 (0.3%)	12 (2.4%)

n=Number of observations

†= Percentage of the total observations per category of carer

Implications for policy and practice

An insight into care staff members' use of time in a RACH provides a benchmark against which to measure change after the introduction of an electronic information, as well as useful information required in allocation of nursing resources.

Conclusion

Carers spent most of their time on communication and direct care of elderly people at the RACH. There was a variation in time required to complete tasks in the low care and high care nursing sections, for example time on direct care, in-transit and personal activities. But similar time was required to complete documentation, communication and indirect care tasks in the two houses.

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THE EXPERIENCE OF CARING FOR A PERSON WITH DEMENTIA WITH LEWY BODIES: PRESENTING RESEARCH FINDINGS AS AN EDUCATIONAL RESOURCE.

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Abstract

This paper discusses a novel presentation of the research findings associated with caring for a person with dementia with Lewy bodies. This dementia is poorly understood, yet it is the second most prevalent dementia in the ageing population. Initially, it is often diagnosed as mild cognitive impairment, Alzheimer's disease or Parkinson's disease. The experience of caring for a person with dementia with Lewy bodies was explored in a qualitative study using heuristic methodology which requires the researcher to draw the findings into a creative synthesis. This paper focuses on that synthesis; an audio-visual presentation portraying the researcher as a carer sharing experiences with family and friends. Through this medium the unique challenges faced by these carers are explored, including dementia without memory loss, knowing, maintaining continence in the presence of physical and visuospatial impediments, and issues of ongoing management and care. The implications of presenting research findings in this way are discussed. It has the potential to translate research into practice as an accessible educational resource in order to quickly reach target audiences, family and professional carers.

Research Question

A significant motivator for embarking on doctoral studies was a personal lack of knowledge. I am an allied health professional with experience of working in the aged care sector and as a carer of a family member with dementia – I thought I understood dementia. However, when asked at Alzheimer's Australia Victoria (AAV) to review a paper on dementia with Lewy bodies (DLB) I realized that there were not gaps but yawning chasms in my knowledge base which needed plugging. So I set out to explore the experience of caring for a person with DLB.

My first task was to ascertain if the knowledge was "out there" but not easily accessible. Today, almost three years after that first search, a Medline query on "DLB" raises 1,929 hits ("dementia" 63,815 hits) but when the search is refined to include "carer" it collapses to three! Through my research I now understand why this is so and I recognise that my challenge will be to ensure "*wide dissemination of (my) findings to effect changes in community awareness, clinical practice and health policy*" (Draper, Low, Withall, Vickland, & Ward, 2009 pS72). It could be argued that this is a completely unrealistic expectation for an emerging researcher in psychosocial research but there is a critical need to raise the profile of this disease. McKeith (2009), an acknowledged researcher of DLB, stated in a webinar hosted by Alzforum in June 2009 that DLB is a common disease but for every person correctly diagnosed there are two or three people not diagnosed or misdiagnosed, even although there are established diagnostic criteria available (McKeith et al., 2005). The criteria are predictive of Lewy body pathology in 90% of cases. From a care perspective, the literature suggests that the functional disabilities of DLB are much greater than those found in other dementias, care costs are higher and carer burden significant (Bostrom, Jonnson, Minthorn, & Londos, 2007; Burns, 2005; Davis & Tremont, 2007).

Methods

The experience of caring for a person with DLB was explored in a qualitative study using heuristic methodology (Moustakas, 1990). I recruited thirteen Victorian spousal carers of people diagnosed with DLB through memory clinics and Parkinson's support groups. After gaining their written consent, my first contact with them was by telephone at which time they provided demographic information, an overview of the assessment processes and an indication of the early signs of decline that carers noticed in their spouses. The carers then participated in face to face in-depth unstructured interviews which focused on their caring experiences. Seven also participated in a focus group. I transcribed the interview data and categorised it using a priori and emergent themes and presented the results as individual vignettes and thematic analyses. Heuristic methodology also demands that the findings be presented as a creative synthesis and it is this process which I will focus on in the remainder of this paper.

Developing the synthesis

Creative synthesis is "*an original integration of the material that reflects the researcher's intuition, imagination, and personal knowledge of meanings and essences of the experience*" (Moustakas, 1990 p50). As I reflected

on the synthesis it seemed that I had two goals – the first, and of critical importance, is the fulfillment of the requirements of my thesis for examination and, with that goal in mind, I embarked on the process.

Heuristic research is a journey of discovery and that meant I had to explore and understand every aspect of DLB from neuro-anatomy and pathology to the processes involved in arranging alternative care so that I could interpret the experiences of the carers in a meaningful way. The challenge in developing the synthesis was to integrate that knowledge and the carers' experiences into a cohesive, believable vignette, using an audio visual (AV) presentation. The presentation needed to incorporate the essence of the care experience whilst highlighting how and why that experience had been influenced by misconceptions and ignorance.

The consensus from the focus group was that much knowledge and understanding of DLB and its diversity of presentation had been gained through participating in the research project. That provided me with a framework for the synthesis – the voice of a now informed carer reflecting on her journey with new insight. Even with this framework there were a number of contextual issues that I still had to resolve as I developed the role play such as should I take the Alzheimer's or Parkinson's route? Was my husband still at home or in care? Which symptoms did he have? How could I appropriately raise issues that I had not detected but which may be central to the experience of others? In resolving these questions I chose options which allowed me license to be empathically creative from the carer perspective whilst remaining authentic with respect to DLB and our understanding of it. Immediately that raised another question – were these options valid?

According to a synthesis of contemporary views of validity, "*attention to both process and product, art and science, contribute to validity and subsequently quality in qualitative research*" (Whittemore, Chase, & Mandle, 2001 p534). In reaching that conclusion, the authors present four techniques associated with the presentation of research which attest to validity: acknowledge, audit, provision of evidence and thick description. I feel confident that all these suggestions are integral components of the synthesis. My acknowledgement of the researcher perspective is transparent in that it is disclosed in the introduction of the synthesis. The written version of the synthesis follows the convention of the analyses in the thesis in that when I express a view in the verbatim voice of one of the research participants it is coded. Ultimately the thesis will contain the conventional audit trail and be audited. The evidence used to support the interpretations is continual reference to the diagnostic criteria for DLB and the synthesis is a thick description of the experience.

The thematic analyses of the research data provided rich evidence of the difficulties encountered by the carers. The quotes (in italics) are representative and provide an illustration of each theme which I have incorporated into the synthesis. Whilst they are disconcertingly negative, they are balanced in the fuller discussion by comments of understanding, support, deep love and commitment.

- Ignorance of DLB as a disease
 - *My husband has Parkinson's not Alzheimer's... then they (the neuro-psychologists) said 'tell the doctor he has Alzheimer's and he has Parkinson's'.*
- Difficulties of getting a diagnosis
 - *We went (to doctors) on several occasions and they didn't seem to know. They thought that maybe he was suffering with another bladder infection or something like that.*
- Health professional / carer relationships
 - *I kept on saying to them (hospital staff) he is not just a vegetable lying in a bed.*
- Lack of appropriate information and support
 - *No one told us (about services). How are you supposed to know? No one tells you.*
- Relationship disintegration within the spousal dyad
 - *So I really believe I have just closed up and haven't communicated because there is no point. Somebody said to me recently (after he went into care) 'how do you like being on your own?' and I said I have been on my own for years.*
- Stressors of care provision
 - *I would get him all settled down and I would have to lift his legs upand by the time I would walk from here to there to get into my bed he was out again (to go to the toilet) and this went on nearly all night.*

Overwhelmingly, the experience of caring for a person with DLB is complex, challenging and confused by perceptions of the nature of Parkinson's disease and dementia. It has been said that public misconceptions have

the capacity to act as barriers in the acquisition of new understandings (Draper et al., 2009), and for many, dementia, memory loss and Alzheimer's disease are seen as interchangeable labels. The experience of DLB, where the ability to reason, recognize and interact with others is often retained well into the disease state adds another dimension of burden for the carer as illustrated by this quote:

- *He can't do anything but then I feel I wouldn't like him not to know who I am.*

Implications for practice

The second goal is that as an AV presentation the synthesis has the potential to be a tool in my toolkit! Throughout my research I have taken every opportunity to use my skills as an adult educator and share my knowledge. To date these opportunities have utilized the traditional paper, poster and powerpoint techniques which have been adequate for the "background" information but are limiting when presenting the voices of others.

A united voice of the focus group was that government, doctors, carers, both family and professional, and the general public all need to be educated about DLB. For me, who came to this study from fields that should have afforded opportunities to at least be cognizant of some of the research on DLB, I now see that I was not alone in my ignorance. In order to redress this situation messages about DLB, and its impact on carers, must be disseminated in a way which is accessible, particularly to those who are not readers of research journals, the traditional method of research dissemination. This is my challenge as I continue my research.

There is an increasing expectation, particularly in dementia research, that the researcher should be both a knowledge producer and a knowledge broker – potentially the dedicated expert (Draper et al., 2009; Graham et al., 2006). Although Draper and his colleagues demonstrated that there is considerable argument about what are the most effective knowledge transfer strategies applicable for disseminating dementia research to the divergent groups of service providers, consumers and the public, I believe this tool will enable me to be effective. I have found from past experience that the integrated use of an AV presentation and directed discussion enhances learning and I am hopeful that I will have the opportunity to use my creative synthesis in presentations to diverse audiences.

Summary

DLB is a common, devastating yet poorly understood neuro-degenerative disease of ageing which exacts a high toll from spousal carers. The methodology of my research project has provided an opportunity to present the findings as a creative synthesis and to do this I have utilized AV techniques. The synthesis will give me a tool which I can use to disseminate my findings and raise the profile of this disease.

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BUILDING THE TOOLKIT OF QUALITY MONITORING CLINICAL OUTCOMES AS A MEANS OF ASSESSING QUALITY IN RESIDENTIAL CARE

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Abstract

Residential aged care in Australia does not have a system of quality assessment related to clinical outcomes, creating a significant gap in quality monitoring. Clinical outcomes represent the results of all inputs into care, thus providing an indication of the success of those inputs. To fill this gap, an assessment tool based on resident outcomes (the ResCareQA) was developed and evaluated in collaboration with residential care providers. A useful output of the ResCareQA is a profile of resident clinical status, and this paper will use such outputs to present a snapshot of nine residential facilities. Such comprehensive data has not yet been available within Australia, so this will provide an important insight. ResCareQA data was collected from all residents (N=498) of nine aged care facilities from two major aged care providers. For each facility, numerator–denominator data were calculated to assess the degree of potential clinical problems. Results varied across clinical areas and across facilities, and rank-ordered facility results for selected clinical areas are reviewed and discussed. Use of the ResCareQA to generate clinical outcome data provides a concrete means of monitoring care quality within residential facilities; regular use of the ResCareQA could thus contribute to improved care outcomes within residential aged care.

Background

Despite high levels of assessment within the sector, there is no comprehensive, clinically based system of monitoring quality of residential aged care within Australia (O'Reilly, Courtney, & Edwards, 2007). Donabedian (1988, 1992) suggested that three areas could be scrutinised to draw conclusions about quality of care: *structure*, *process*, and *outcome*. Within the Australian residential aged care system, assessment tends to focus on either structure or process, with little emphasis on outcomes. While debate exists regarding the relevance or accuracy of outcomes as a measure of quality (Cotter, Salvage, Meyer, & Bridges, 1998; Kiefe, et al., 1998), they have at least been shown to influence quality of life for residents of aged care facilities (Courtney, O'Reilly, Edwards, & Hassall, In Press). The ResCareQA (*Residential Care Quality Assessment*)¹ was developed through extensive literature review, industry consultation and piloting (Courtney, O'Reilly, Edwards, & Hassall, Under review; Courtney, O'Reilly, Edwards, & Hassall, 2007). It is a four-page assessment using terminology from existing Australian residential care assessments² in order to maintain familiarity and to use information already available on resident charts (Courtney, et al., 2007). It covers 24 areas of clinical care within four domains (*Resident Health*, *Personal Care*, *Resident Lifestyle*, and *Care Environment*), takes approximately 30 minutes to complete and is viewed favourably by those using it (Courtney, et al., Under review; Courtney, et al., 2007). The ResCareQA presents data in the form of Clinical Care Indicators (CCIs) which, rather than being direct or definitive measures of quality, *indicate* areas of care requiring greater scrutiny. Each CCI is expressed as a percentage score, representing the proportion of residents with an adverse clinical outcome (e.g. pressure ulcers, taking nine or more medications). *Table 1* provides an overview of the clinical areas assessed by the ResCareQA, with their respective CCI's. To illustrate the utility of the assessment, this paper presents clinical outcomes from a sample of facilities, providing an important insight into the state of residential care in Australia.

1 Formerly, the Clinical Care Indicators (CCI) Tool

2 Residential Care Scales (RCS); Aged Care Funding Instrument (ACFI); Accreditation

Table 1. The ResCareQA - Care Domains and Clinical Areas Assessed

CARE DOMAIN	CLINICAL AREA	CLINICAL CARE INDICATORS
Resident Health	1. Pressure ulcer rates	Presence of Ulcers
	2. Skin integrity	Presence of Lesions
	3. Infections	Presence of Infections
	4. Medication	a. Polypharmacy b. No Pharmacy Review
	5. Pain management	a. Pain frequency: Daily Pain b. Pain severity: Severe pain
	6. Cognitive Status	Decline in Cognitive Function
	7. Unplanned Hospital Visits	Multiple unplanned hospital admissions
Personal Care	8. Toileting & Continence	a. Bladder Continence b. Bowel Continence c. Toileting Appliance d. Faecal Impaction
	9. Hydration status	Poor Hydration
	10. Activities of daily living	Activities of Daily Living Decline
	11. Dental Health	Poor Dental Health
	12. Care of the senses	a. Sensory Decline b. Sensory Aids
Resident life style	13. Nutrition	a. Poor nutritional status b. Fed by tube
	14. Meaningful activity	Meaningful Activity
	15. Sleeping patterns	a. Sleep disturbance b. Use of sedatives
	16. Communicating	a. Communication difficulties b. Communication difficulties without use of communication aids c. Difficulties with English language without access to translators
	17. Adaptation & behaviour patterns	Disruptive Behaviour
Care Environment	18. Restraints	a. Physical Restraints b. Chemical Restraints
	19. Falls	Falls in the last month
	20. Depression	a. Symptoms of depression b. Symptoms of depression without treatment
	21. Family involvement	Family support
	22. Allied health	Allied Health Contact
	23. Medical visits	Medical Visits
	24. Multi-disciplinary case conferences	Multi-disciplinary case conferences

Methods

Registered Nurses from nine facilities completed ResCareQA assessments for all residents (N=498) and returned the data in de-identified form. The facilities, from two different care providers, were spread throughout Queensland, ranging in size from 20 to 120 beds, with a mean of 55 beds. For each facility, numerator–denominator data were calculated to create the CCIs. Comparisons with national residential care data (Australian Institute of Health & Welfare, 2008), indicated that the sample had similar demographic features and was thus representative of the population.

Results

Results are listed in *Table 2*, with facility scores for each CCI shown in ascending order of magnitude, followed by the percentage score for the sample as a whole³. Because each CCI represents a less desirable outcome, low percentage scores suggest that a facility's care procedures were effective, whereas a high percentage score suggests that care procedures required review.

Table 2. Facility Clinical Care Indicators - Arranged in Ascending Order

		Low									High
											Full Group
	<i>Stage 1-4 pressure ulcers</i>	0.0	2.1	5.3	8.3	8.5	10.2	10.5	17.8	19.2	10.9
	<i>Skin lesions</i>	0.0	27.5	30.6	31.9	38.3	38.6	44.7	65.9	76.2	40.1
	<i>Infections</i>	4.1	8.3	11.7	14.9	17.1	20.9	29.2	33.3	45.0	17.5
	<i>Polypharmacy</i>	20.8	21.3	28.3	31.1	33.3	34.3	40.8	50.0	59.5	32.1
	<i>No pharmacy review</i>	12.5	20.5	20.8	28.4	73.2	75.0	79.2	83.0	88.1	46.0
	<i>Daily pain</i>	0.0	6.0	7.3	8.2	8.9	10.4	21.3	25.0	33.3	11.1
	<i>Severe pain</i>	0.0	0.0	0.0	0.0	2.2	4.2	4.2	4.3	8.2	2.8
	<i>Multiple Hospital Admissions</i>	0.0	0.0	0.0	0.0	0.0	2.0	2.1	4.3	10.5	1.2
	<i>Bladder Incontinence</i>	14.6	25.0	45.0	57.5	64.2	70.0	82.2	83.3	83.7	59.8
	<i>Bowel Incontinence</i>	4.2	6.7	10.0	23.4	34.2	46.9	52.2	66.7	80.0	36.6
	<i>Faecal Impaction</i>	0.0	0.0	0.0	0.0	0.0	0.0	2.5	11.1	19.6	3.5
	<i>Dehydration</i>	0.0	0.0	2.1	2.4	3.0	5.0	24.4	26.7	55.5	19.7
	<i>Poor Dental Health</i>	0.0	0.0	0.0	1.5	2.0	2.5	5.0	24.4	25.0	4.8
	<i>Significant hearing loss without aids</i>	0.0	23.1	41.7	50.0					100.0	47.6
	<i>Significant visual loss without aids</i>	NA	0.0	14.3	14.3	14.3	16.7	40.0	40.0	66.7	24.5
	<i>Poor nutritional status.</i>	0.0	4.1	6.8	7.1	8.3	8.9	9.0	12.8	15.0	7.7
	<i>Fed by tube.</i>	0.0	0.0	0.0	0.0	0.0	1.5	4.1	4.2	5.0	1.9
	<i>Little or no meaningful activity</i>	10.4	29.8	48.3	50.0	52.5	55.0	63.4	77.6	84.4	52.8
	<i>Sleep disturbance</i>	15.6	17.1	23.3	40.8	60.8	62.5	64.4	89.6	100.0	54.5
	<i>Sedative use.</i>	14.6	15.8	20.0	20.5	20.8	21.4	23.3	23.9	37.3	21.6
	<i>Communication difficulties.</i>	13.3	20.8	40.0	51.0	56.7	68.1	70.2	77.8	83.3	53.8
	<i>Communication difficulties without aids.</i>	85.7	94.1	95.5	96.4	98.5				100.0	97.0
	<i>English difficulties without translators.</i>	NA	NA	NA	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	<i>Behaviour affecting others.</i>	15.0	16.7	25.0	41.8	46.9	49.2	56.8	59.5	61.7	43.2
	<i>Daily physical restraints.</i>	0.0	0.0	2.4	11.9	13.3	14.9	36.7	52.5	69.1	27.2
	<i>Daily chemical restraints.</i>	0.0	0.0	0.0	0.0	0.0	0.0	0.0	17.8	19.2	6.4
	<i>Falls in last month.</i>	5.0	9.5	13.3	13.3	13.4	14.6	15.6	16.3	31.9	15.1
	<i>Depression symptoms*.</i>	0.0	1.7	4.1	8.5	14.6	15.6	22.9	23.7	30.0	10.5
	<i>Depression without treatment.</i>	NA	0.0	35.7	50.0	50.0	50.0	54.6	57.1	100.0	44.2
	<i>Limited family support.</i>	15.0	24.4	26.9	27.7	30.0	34.7	41.7	48.7	52.4	36.2
	<i>Limited allied health contact.</i>	0.0	0.0	2.4	3.0	5.0	5.8	10.0	36.2	52.1	11.5
	<i>Limited medical visits.</i>	21.3	28.9	33.3	43.3	45.0	45.8	55.1	60.0	77.6	46.2
	<i>No multidisciplinary case-conferencing.</i>	10.0	60.0	62.5	78.7	82.2	83.3	87.4	94.0	95.9	78.7

³ Decline in cognitive function, ADL decline, and sensory decline, being incidence indicators, could not be calculated with only one time point available. They are therefore not included in the results.

Inter-facility data

Resident Health

There was much variability in results for some of the CCIs within this domain. For example, 0 to 76% of residents had skin lesions, 4 to 45% had infections, and 13 to 88% had not had their medications reviewed in the last three months. Prevalence of residents taking nine or more medications had a narrower range (21 to 56%). Presence of daily pain (up to one third of residents in a facility) was more common than presence of severe pain (up to 8% of residents), and multiple hospital admissions were low in all facilities, except for one, in which 10.5% of residents had had two or more unplanned presentations to hospital in the previous three months.

Personal Care

Incontinence rates ranged from 14.6 to 83.7% (bladder) and 4.2 to 80.0% (bowel). Faecal impaction – a highly undesirable outcome – had very low prevalence rates for most facilities, but reached almost 20% in one facility. Similarly, dehydration – also highly undesirable – was very low in most facilities, but was present in one quarter of residents in two facilities and just over half the residents of one facility. Less than 5% of residents in the whole sample had signs of poor dental health; however, in two facilities this outcome was found in one quarter of their residents. Hearing aids were not well used; in five of the nine facilities they were not used at all by residents with significant hearing loss. As might be expected, glasses were more commonly used, although in one facility two thirds of residents with significant visual impairment did not use glasses.

Resident Lifestyle

Nutrition appeared to be reasonably well contained in this sample, with 0-15% of residents exhibiting poor nutritional status ranging from and less than 2% of the whole sample being fed by tube (facility prevalence ranged from 0 – 5%). Participation in meaningful activity and sleep disturbance varied greatly, with prevalence of residents participating in little or no activities ranging from 10.4 to 84.4%, and prevalence of sleep disturbance ranging from 15.6 to 100%. In contrast, use of sedatives had a relatively narrow range of prevalence (14.6 - 37.3%). More than ½ of the residents in six of the nine facilities had communication difficulties (range = 13.3 - 83.3%), and of those with communication impairments, very few used aids to assist them. Behavioural symptoms affecting others were also quite prevalent, ranging from 15 to 61.7% of facility residents.

Care Environment

There was considerable variation in the daily use of physical restraints; less than 3% of residents within 3 facilities were restrained on a daily basis, but usage increased steadily up to just under 70% of residents in one facility. Use of daily chemical restraint was less common, only occurring in two facilities, where its prevalence was just under 20%. Falls in the last month occurred in all facilities, with 5 to 32% of residents having had at least one fall in the previous month. Prevalence of depression ranged from 0 to 30% of residents, while depression without treatment ranged from 0 to 100%.

Intra-Facility Data

As well as comparing facilities, individual facilities can compare their own CCI results against each other, enabling staff to find reasons for poor outcomes in specific areas. For example, in the current sample, the facility with the highest rate of multiple hospital admissions (10.5%) also had the highest prevalence of infections (45.0%), suggesting the higher hospitalisation rate might be related to the higher infection rate. This provides a tangible track of investigation, which could then lead to analysis of infection control procedures. When reviewed as a whole, results for each facility were mixed, with no facility achieving consistently low scores or consistently high scores. However, despite this variation, some facilities tended to achieve better overall clinical outcomes than others.

Implications for Policy & Practice

Focusing on concrete clinical outcomes enables an understanding of whether care processes have been effective. Adverse outcomes should prompt staff to ask why such outcomes occurred, and seek solutions for improvement. If external factors such as casemix or risk groups are determined to be contributing factors, they should not be considered a complete explanation for poorer outcomes, rather in understanding the limitations or challenges of a particular group, facilities should then be prompted to implement strategies and care processes to best manage the clinical needs of their residents. While this study demonstrated the utility of between and within facility comparisons, the ability to make judgements about quality are limited by the performance of other facilities. If all facilities are struggling to provide high quality care in a particular area, then achieving an average, or even comparatively low CCI result does not necessarily indicate the presence of good care. For this reason, benchmarks are necessary to enable objective judgements about quality. However, because a number of factors beside care processes can influence outcomes, a range of scores - described by upper and lower thresholds - is considered more desirable. Such benchmarks for the ResCareQA are currently in development, and will be discussed in a later paper. In the meantime, it is recommended that aged care facilities consider using the ResCareQA on a regular basis to inform quality improvement. However, it is not recommended that the ResCareQA be used as an absolute measure of quality; all results should be read in context and used as trigger-points for investigation. The ResCareQA and its benchmarks would then constitute a powerful tool for the analysis and improvement of quality care within Australian residential aged care facilities.

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INTERVIEWING, MEMORY AND TRAUMA: A CASE STUDY OF OLDER PEOPLE IN ACEH, INDONESIA

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Abstract

Through presentation of a case study of fieldwork experience interviewing older people in post-conflict, post-tsunami Aceh, Indonesia, this paper discusses ethical issues about the impact of the interview experience on people potentially suffering from post-traumatic stress disorder (PTSD), illness or depression. Using theoretical analysis from the field of memory studies, it is argued that the process of recollection during such interviews may be similar to the involuntary remembering associated with trauma, and that engaging with the present experience of the interview, as well as the historical content it raises, may require adjustments to the researcher's expectations of fieldwork outcomes.

Research Question

The role of interviews in qualitative research is well established. Interviewing older people about their past, and asking them for their life stories, is one way of obtaining valuable data on the perspective of older people about their life trajectory, their development over the life course, and on their changing relationship with the natural environment.

In the case of an interviewee whose life history is coeval with prolonged military occupation, civil conflict or unprecedented natural disaster, there are abysses of traumatic memory into which the interviewer may unwittingly plunge both the interviewee and themselves via a simple request for a roughly chronological life history. In so doing, trauma may be caused or reinforced in the present.

This paper describes a case study of an interview process I undertook with older people in Aceh, Indonesia, and examines it at theoretical, ethical and practical levels.

Methods

The fieldwork methodology I developed in Australia and presented to the University Ethics Committee was based on obtaining roughly chronological life stories through open-ended interviews from a sample of older people with shared culture and livelihoods. 'Older', for the purpose of my study, would be anyone over the age of 65 years. The narratives thus obtained would then be analysed using theories about life course stages, gerotranscendence, eco-identity, and methodologies based on narrative analysis and historiography.

The fieldwork was in many ways blessed with good fortune. I quickly found a highly skilled Acehnese interpreter who respected and enjoyed talking with older people. I obtained assistance in locating older people through the Asia Development Bank, HelpAge International, and academics at two universities in Aceh and my home university. Most serendipitously, I had the opportunity to briefly discuss my project with Byron Good, Professor of Medical Anthropology at Harvard Medical School, who was completing a psychosocial needs assessment in Aceh at the same time (International Organization for Migration 2007), and who advised me how to be mindful of symptoms of depression and post-traumatic stress disorder (PTSD) in the people I would be interviewing.

While there was some keenness in older Acehnese people to tell their stories, the political and ethical dilemmas in the position of a researcher undertaking 'extractive' research have been eloquently argued (England 1994, , Gade 2001, , Scott et al. 2006, , Till 2001). On the other hand, such research can lead to increased understanding between cultures, and the potential to make theory more accountable, which are positive outcomes ((Hyndman 2001, , Scheyvens & Storey 2003). Moreover, informants have the capacity to exercise some 'research resistance' at both individual and community level (Scheyvens & Storey 2003, p.5)

However in addition to the potential power imbalances, expropriation and misrepresentation of the voices of others discussed in these writings, there were other ethical (and emotional) imperatives which arose during my interviews with older people in Aceh. Responding to these during each interview experience resulted in significantly different interview 'content' from that which I had envisaged, but also, it turned out, provided an opportunity for a new theoretical perspective and a change in methodological direction.

Historical background of Acehnese old people

Most of the 24 people I interviewed were between 70 and 90 years of age, that is born before World War II. Many had lived as children through the time of the Dutch occupation (up to 1942), then through the Japanese invasion and occupation (1942-1945), the 1945-46 Tjumbok rebellion which overthrew the old aristocracy, the 1950s Darul Islam movement for Acehnese independence, the 1960s Communist purges of the Suharto Government, then 30 years of conflict between the Free Aceh Movement ('Gerakan Aceh Merdeka' or GAM) and the Indonesian military which officially ended in 2005. Three of the four villages where I conducted interviews had been inundated and destroyed by the 2004 tsunami, resulting in the deaths of many family members, the destruction of homes and livelihoods, and at least two years of living in temporary barracks. These conflicts and the tsunami disaster had resulted in:

- Trauma, both physical and psychological
- Prolonged periods of fear and anxiety
- Overwork, exhaustion and physical debility from a young age
- Loss and grief

Interviews conducted January/February 2009

As a result of this traumatic regional history, the interviews did not proceed on a neat trajectory over the life course of each interviewee, but were marked by the following:

- The telling of stories which were not chronological accounts, but collections of anecdotes, many traumatic or sad
- Interviewees forgetting or not wanting to talk about the past
- Interviewees weeping, becoming impatient or irritable, or laughing often in a self-deprecating or ironical way
- Evidence in some people of severe depression or PTSD symptoms (agitation, lack of eye contact, withdrawn manner, severe aches and pains)
- Interviewees relaxing and becoming more animated when the conversation turned to their children, grandchildren, or to work, for example a craft, farming, home-based factory, fishing

The following physical manifestations of past trauma and current poverty also affected the interaction between interviewer and interviewee:

- Physical discomfort for the interviewees who spent often more than an hour sitting cross-legged on a thin mat on a concrete floor.
- Shortness of breath and exhaustion after an hour of interview.
- Vision problems for many interviewees suffering from cataract and scarring of the eyes, which meant they were unable to see me or my interpreter.

In response to these factors, I often curtailed interviews or reverted to a topic on which the interviewee had appeared more relaxed or animated. Sometimes it was necessary to 'let go' of the concern about younger people answering questions on behalf of their older relative, and engage family members in a wider conversation in order to reduce an apparent sense of isolation and anxiety of the interviewee.

Results

The resulting transcripts will be analysed over the next few months as part of my doctoral research, using some of the theoretical frameworks and narrative/thematic analysis methodologies I had already proposed. While the interviews are not the collection of 'life stories' I had envisaged, there are some conceptual frameworks which illuminate the interview experiences and point to another way of viewing their content.

Theoretical reflections from memory studies

The temporal locations of recollection (in the present), and 'what happened' or 'our experiences' (in the past) are relatively uncontentious. However James Burton (2008) draws a distinction between '*memory*' and '*recollection*' in temporal terms. He suggests that our memory (what he terms 'pure memory') has duration and continuity, but does not consist of a 'set' of memories about specific moments or periods: "pure memory corresponds to our ongoing existence, our own endurance, unconscious and undivided" before we separate out individual memories (Burton 2008, p.328).

Rather than seeing memories engraved on the 'wax tablet' of the mind' it might be more accurate, according to Burton, to say that "when we *recall* something we are writing it on a wax tablet...since it is only in making the recollection a part of the present that we actualize it" (Burton 2008, p.330). Burton suggests that we

consciously or unconsciously apply 'archival rules' when we recollect in the present, depending on which set of recollections best serves our 'current needs and interests' (Burton 2008, p.326, 324). Recollecting, then, is an action, something we do in the present, either for our own 'needs and interests' or, in the case of an interview, at least in part to meet the needs and interests of the interviewer.

In the case of traumatic memories however, the active sense of 'recollect' is replaced by the more passive 'be reminded of', a kind of involuntary remembering which has little to do with the subject's choosing how best to meet current needs and interests. This is reflected in Bahasa Indonesia's terms '*ingat*' – to remember – and '*teringat*' – to be in a (passive) state of being reminded or remembering. Byron Good suggests that the latter is often the term used by Acehnese people when recollecting their past (B. Good, personal communication, January 18, 2009). The recollective mining of 'pure memory' in such instances is replaced by a process more like an 'occupation', where the memory moves in and occupies the memorist. The recollection of such memories might be articulated, as one anthropologist has suggested, by 'no more than a scream' (D. Birchcock, personal communication, February 27, 2009).

These invasive memories or recollections offer a response to the postmodernist claim that every experience, including trauma, is 'constructed', rather than a valid subjective experience. Ball suggests that the experience of 'traumatic remembering' manifests and validates the suffering of the 'remembering subject' (Ball 2000, p.28). Of course in Aceh, evidence and reminders of past trauma lie not only in recollections, but in bodies which have suffered from physical trauma, poverty and malnourishment, and in the home, the village and the community which today bear the signs of prolonged poverty, insecurity and losses.

Ethical issues and consequences for practice

An interview, however structured, is likely to set up expectations about appropriate responses from the interviewee. The 'current needs and interests' of the interviewer become a factor in those of the interviewee. The cultural courtesy and personal kindness of many of the older people I interviewed, and the attenuated communication process via an interpreter, meant that interviewees at times extended themselves to the point of distress in order to answer my questions. Thus the interview process called forth 'recollections' more akin to the involuntary remembering ('teringat') than the controlled and selective presentation of anecdotes and facts which might be elicited in other contexts.

Early in the series of interviews, I realized that I was modifying or ignoring my stated intention of gaining a chronological 'life story' from each individual, in the (unrealized) hope of doing no harm. This became the most important ethical principle for me as an interviewer, not only because it seemed like a good general principle for all fieldwork, but because my particular informants had already suffered a great deal of harm and were nonetheless offering me cooperation, information and hospitality at some cost to themselves. It was a relief to me, because of the apparent relief to them, when the topic was turned to the rice fields, to salt-making, grandchildren, or the role of the modern mid-wife. It was not only a relief, but showed me another way of gaining an insight into people's past as well as their present.

"...It may be precisely by giving up the scientific detective's urge to know 'everything' that we gain access to those very partial vistas that our informants may desire or think to share with us" (Malkki 1995, p.51)

As a result of these interview experiences, the content of the interviews will now be analysed with a greater focus on how the emerging field of memory studies can inform our understanding of recollection and ageing, and on the social and psychological aspects of trauma.

Summary

To ask older people to talk about the past is to delve into an incommensurable reservoir of experience and has the potential to cause emotional and physical pain in the present.

"The event is not what happens. The event is that which can be narrated" (Malkki 1995, p.107). In the end, the interview is what it can be, a window to those 'partial vistas' which people are able or willing to share with us. Most importantly, it is a lived present-day experience which involves both the interviewer and the interviewee emotionally, intellectually, and physically. Particularly in post-traumatic environments, it is the interview experience, as much as the events related in the content, which raises ethical issues for the researcher and which will determine the outcomes of fieldwork and the theoretical and methodological approaches to its analysis.

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SHARING KNOWLEDGE: AN ACTION RESEARCH STUDY

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Abstract

One of the core business functions of the residential aged care industry is meeting the end of life care needs of dying residents. The number of frail, older Australians dying of chronic progressive non-malignant illnesses in residential aged care facilities is increasing therefore the demand for compassionate quality end of life care is growing in importance. The purpose of this paper will be to discuss the appropriateness of action research as a methodology for exploring end of life care delivery with aged care nurses. Action research aims to engage participants to influence practice or facilitate change. The process requires participants to identify issues that are relevant to their practice and develop solutions or strategies to change practice or improve situations. Action research has been criticised as being a 'soft' research methodology, a style of research and the poor second cousin of 'true' research. Accusations of vague findings, unrefined themes and controversial data analysis have surrounded the methodology for decades. This paper will report how action research was used in two, rural residential aged care facilities to explore issues surrounding end of life care and how the aged care nurses examined practice issues including the constraints to practice. Recommendations are made, aimed at closing the theory-practice gap in aged care and acknowledging the importance of improving the support for those who deliver end of life care.

Research Question

Death equates to 88% of separations from residential aged care facilities in Australia. 45% of those who die in residential aged care facilities are being cared for from one to five years in the facility in which they die (Australian Institute of Health and Welfare, 2008). Many of the people who die in residential aged care facilities, die from a non-malignant disease. In Australia in 2007, non malignant diseases represented three of the top four leading causes of death, these included ischaemic heart disease, stroke, dementia and Alzheimer's disease (ABS, 2009).

This paper demonstrates that action research as a methodology supports aged care nurses to explore end of life care practices delivered to residents dying from non malignant diseases and examine nurse/relative relationships. The methodology assisted nurses to implement their findings into clinical practices to maximize the likelihood of appropriate end of life care.

Methods

Given the stated aims and objectives of this study an action research and reflection methodology was used. Action research methodology must meet a definitive set of requirements including being collaborative, action orientated, contextualised, reflective and verifiable (Minichiello, Sullivan, Greenwood, & Axford, 1999). Action research is a particularly useful means to structure, organize and facilitate regular clinician meetings with the purpose of collaborating and gaining insight into practices and planning improvements.

A number of rural residential aged care facilities were approached to participate in this study. In the two facilities that agreed to participate an overview of the study was presented separately to each facility. These sessions provided prospective participants with some insight into the research problem, aim and objectives of the research, a brief overview of the action research process, expectations of each participant's involvement and my contribution as the researcher. An invitation was extended to staff to participate in a series of meetings with the purpose of reflecting on end of life care practices. Fourteen participants who had cared for residents dying from a non malignant disease joined the study. Twelve participants were nurses, and two were ancillary staff. Seven relatives were interviewed by the researcher. Each facilities group met separately, over a twenty week period. The groups met weekly, and the meetings were facilitated by the researcher.

The action research methodology incorporated five main phases. Firstly in the foundation building phase action research processes were outlined, the meeting structure determined and the first reflections focused participants on building personal profiles, sharing end of life care work situations, with which they were pleased or not pleased, and in which they were the central character. To allow the processes of reflective research to develop participants were coached in developing interpersonal trust, openness and a group commitment to working together on practice issues around end of life care. Due to the sensitive nature of the topic, meetings were held in a quiet place in the facility, separate to the resident care areas.

Multiple data sources were used to collect data including detailed minute taking of group meetings, reflective drawings, the sharing of sections of relatives of dying residents' interview transcripts, and the researcher maintaining a reflective journal. The researcher recorded detailed minutes at each meeting. The minutes of the previous meeting were shared at the commencement of each meeting and read to participants to confirm they were a reasonable recount of their experiences and if necessary, corrected. Member checks were used to ensure that participants agreed with statements used in the research and to verify that the minutes truly represented discussions (Roberts & Taylor, 2002). In the second phase, reflection on practice stories involved discussing end of life care to assist participants to identify commonalities in practice, form bonds within the group and discuss ways to improve nursing practices related to end of life care.

The researcher maintained a reflective journal throughout the research in the form of a type written file. The purpose of the researcher keeping a reflective journal was to acknowledge the researcher as part of the process of action research, while maintaining an element of detachment and to keep the researcher visible in the process. The interconnectedness of the researcher in the group meetings and the sharing of relatives' interview statements with the groups added depth to the research. Reflective journaling assisted the researcher to further develop reflective skills, coach participants in reflection, learn from the research and research processes, examine her own subjectiveness in interpreting what was happening in end of life care and examine the influences surrounding nursing practice.

The third phase of the action research methodology comprised identifying thematic concerns. In this phase analysis sheets were developed, on which practice stories had been copied. Participants were asked to carefully read the relevant stories in the practice story table and ask the question, what is this story about? With one or two word answers participants were asked to label each story to identify a theme or themes related to the account. Each story was reduced to common themes, which were then further reduced by the group, to identify key themes or concerns. In the following meetings, using a process of group consensus participants prioritised themes, grouped themes into sub categories and common, major themes. Themes were identified, refined and confirmed or discarded by the relevance of the statements to the research objectives. The major themes were those, end of life care practices that focused the group on a key issue for action.

The groups explored and discussed the identified common themes to attempt to uncover any root causes of the issues, determine why the themes were an issue in end of life care in their facility, what work had been previously attempted to address the issues, identify what were the constraints to practice around the issues and what needed to change to improve end of life care practices in their facility. Prioritising those issues of importance to action first and developing practical and useful plans for implementation was achieved through group discussion and consensus.

An action plan was created to address and prioritise identified thematic concerns, plan actions for changes and to discuss various strategies for moving beyond present constraints. The action plan was implemented and then followed by a period of observation. In the final critical reflection phase the groups discussed the action plan outcomes, and revised and evaluated the effects of the actions implemented.

Results

Two major thematic concerns are emerging from this study. Both facilities have identified end of life care pain management practices as problematic and opportunities for staff to debrief following the loss of a resident are limited.

Pain Management

Pain is one of the commonly reported symptoms in end of life care with up to 65% of people dying from a non-malignant disease reporting pain (Colvin, Forbes & Fallon, 2006).

The barriers identified so far in the study that are contributing to a reduced likelihood of effective pain management are many and varied. Barriers include workplace culture, failures in communication, ineffective teams, education and practical medication issues.

One facility focused on improving pain management and incorporated a number of strategies to address the issue in their action plan. Some of the strategies included standardized pain assessment tools, the use of end of life clinical pathways, and ongoing audits and case reviews.

Debriefing

Debriefing can be used as a first step toward maintaining physical, mental and spiritual health following a patient's death (Brunelli, 2005). In both facilities participants were aware of the number of deaths they experienced in the workplace, however, their responses both in their communication and behaviour did not demonstrate they understood the complexity of the emotions they were experiencing or the connection to their place of work.

Barriers identified in addressing grief and loss in the workplaces included staff avoiding the issue of death and dying, staff using self protective behaviours such as avoiding relatives, limited opportunities to debrief, infrequent discussion on residents' deaths, poor utilization of recognized sources of information to address grief and loss issues and a lack of appreciation of the impact of unresolved grief and loss on clinical practices.

In both facilities formal opportunities to debrief were incorporated into their action plans.

Implications for policy and practice

This study has demonstrated that the assumption that end of life care guideline, are reaching the people for whom they are intended and that they are being used in practice, is incorrect.

This action research could be further expanded, by exploring and comparing strategies used in pain management across an increased number and diverse range of aged care facilities, to identify those strategies that best meet medical and nursing needs and those that demonstrate improved residents' outcomes.

The availability and the use of specialist palliative care services in rural residential aged care requires' further exploration. Pilot projects that trial palliative care specialists in reaching into aged care facilities to assess and manage end of life care may provide insights into improved methods of overseeing care and provide alternative ways of supporting staff delivering end of life care in aged care facilities.

A study to determine aged care nurses' attitudes and reactions to end of life care or aged care training requirements is needed, to reveal those issues considered of importance to work effectively in the setting. Survey data could be collected to identify the number of nurses currently working in aged care with a background of, or experience in, palliative care nursing, as this information may shed light as to why end of life care issues can be problematic in the aged care setting.

Summary

The gains being achieved in this action research and reflection study can be maintained in practice, if the aged care facilities involved continue to prioritize grief and loss issues, and implement a range of strategies to address pain management. Critical to the success of these initiatives is the support for staff, who deliver end of life care, to believe they have a voice and feel supported by their facilities to constantly examine clinical practices and plan and implement strategies to improve care.

This project has demonstrated that action research and reflection can provide opportunities for nurses to explore, reflect, plan, act, evaluate and create improvements to providing end of life care.

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A TOOLKIT FOR STORIES OF WOMEN WHO WERE CHILD EVACUEES IN WWII BRITAIN AND ALSO POSTWAR BRITISH IMMIGRANTS TO AUSTRALIA

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Introduction

This paper addresses my PhD research which explores the stories of 16 women living in Gippsland, Australia; women in their 70s who are both former British WWII child evacuees and postwar British immigrants. The paper provides an overview of my PhD methodology which I argue could be used as a toolkit to explore other people's stories in ways that are relevant, interesting and transferable to further qualitative research on ageing. The paper commences with a brief background of the topics of evacuation and migration and signals how my research interest first arose and was conceptualised. The paper then outlines the methodological approach I used to construct my study which not only enhances our knowledge of both evacuation and migration, but also our understanding of how that knowledge is produced and how it is accommodated or resisted by the women. The paper thus illustrates how this particular methodological approach can be applied and its potential to produce research which is enlightening, enabling and empowering.

Background

My research interest emerges from my mother's stories of being evacuated during the war and immigrating to Australia. Mum was evacuated in 1939 when she was ten and she spent the war years coming and going between her home in Birmingham and various rural locations throughout England and Wales. While my mother was on her own when she was evacuated, she was not alone. Up to four million other British children were similarly evacuated from city areas deemed too dangerous for children in a government scheme ironically called 'Operation Pied Piper' (Padley, 1940).

Poignant images of evacuees clutching their gas mask and belongings have recurred over the years, represented by Paddington Bear with his small battered suitcase and a 'please look after this bear' label around his neck (Bond, 1958). On buses and trains, evacuees poured out into the countryside to be billeted with strangers. Billeting arrangements were somewhat random and there are many stories of children being the last to be selected from village halls once they arrived at their secret destinations. Billetors appeared reluctant to accept city children, despite the government making it compulsory, resulting in a decided lack of welcome for many children (Padley, 1940). One of the participants in my study was four years old when, sewn into her clothes for the winter, she was put on a train and told she was going to see Father Christmas. With no vetting of host families, and many children away for months and years at a time with little or no contact with family, evacuation experiences were often fraught.

By the 1960s, when my mother was a married woman with children, she immigrated to Australia. This was another experience shared by a million or so other British people. In an official postwar immigration scheme consisting of free passages for ex-servicemen and a ten pound fare for civilians and funded initially by both Australian and British governments, selected Britons were encouraged to immigrate to Australia (Appleyard, 1988). Growing up hearing Mum's evacuation and migration stories, I often wondered whether there were other women in similar 'boats', and what kind of stories they might tell about *their* experiences.

Three Levels of Data Analysis

Thus began the conversion of a personal interest into an academic research project, an essential part of which was finding a way of telling or representing the stories of the 16 women I subsequently interviewed. I needed a method of analysing the women's stories to understand how their narratives, and thus their experiences, were produced. As Solis (2004) explains, there is a narrative produced by the narrator and the existing narrative available to the narrator, and narrative analysis looks for the points of conflict or rupture between those two. In other words, I wanted to explore the stories the women told and the stories they *could* tell.

To do this, I used three levels of analysis beginning with the preliminary preparation of the data which included transcribing the interviews and making decisions about what to include or omit. The second layer of analysis

involved the particular form I used to present the data and the third level was the in-depth sociological analysis performed on those representations. Exploring the data using these analytic strategies avoids the 'boiling down' problems Freeman (2004: 68) cautions against, where an essential 'truth' is sought. Rather, I tried to follow Anderson and Jack's (1991: 11) advice to perform analysis which can be likened to rummaging through an old attic "always hopeful of finding treasures".

Poetic Representation

Transforming the women's stories into poetic representations in the second level of analysis helped to illustrate the ways particular cultural narratives construct people's experiences. Constructing these poetic representations also enabled me to hear the women's voices, their accents, pauses and hesitations; I heard again the joy and the emotion of their spoken words, often lost in transcriptions as prose. Indeed, we all use poetic devices of the pause and rhythm in our speech, our talk does not emerge perfectly scripted into tidy prose (Richardson, 2003). This form of play-with-language is enabling because of the way it tumbles around language, at times leap-frogging superfluity, and at others alighting tenderly on poignant words and phrases. I found this way of representing my data rich, exciting and humbling; at the same time it also felt ethical and respectful of the participants. Moreover poetic representation does not swamp the data with the researcher's narrative because it allows the *reader* to participate in the research (Evelyn, 2004). Further, it acts as a constant visual reminder that the interpretations are constructions because in my project, while the words belonged to the participants, it is important to remember that the representations were mine (Richardson, 2003). When transforming my transcripts I elected not to re-order words, maintaining the chronicity of the stories, except very occasionally when it obfuscated the story. 'Intervention' on my part was limited by a desire to remain faithful to interviewee multivocality.

Transforming the women's stories into poetic representations allowed me to move more easily into the third level of analysis in which I performed the sociological unpacking, or deconstructing, of the women's stories looking for the cultural narratives they drew on to construct their senses of self. In analysing the data, I asked iterative questions of the representations; what was the *point* of particular stories, what did they highlight, and what were they markers of? I looked for evaluative comments and reflections, as the following poem illustrates:

*From being evacuated
Coming here is more or less the same
Only we were children then
We couldn't quite cope with it
But here we're adults so we could cope
You had more choice
You had more say in it (Nancy)*

In this story, Nancy reflects on her evacuation experience through the lens of her migration. Sometimes the women used a more dramatic style of story telling, in which the tense of the language changes from past to present (Pasupathi, 2006) as highlighted by underlining in the following representation:

*Our mothers didn't know
Where we were going
Or even when
All in our crocodile we went
Up the road to a bus stop
All the children ushered on
It starts to go
I see this crowd of women come
Amongst them was my mother
They are running full tilt
The word had got round
That the children are going
So she came down the road
And when she caught up
When the bus goes too far
She puts her apron right over her head
She just stood there
And that was terrible, terrible (Beth)*

Such tense changes and the repetition of words contribute to a more dramatic, immediate and evocative story. Constructing poetic representations of the women's stories in this way contributes to our knowledge of evacuation and migration and enables a sociological analysis of not only how that knowledge is produced, but also how it might be opposed, disrupted, accommodated or embraced by the women. Poetic representation is thus a practical, powerful and enduring methodological tool for understanding women's lives and the narratives which constrain their lives.

Findings

My task in analysis was to locate the ways in which the women positioned themselves, as well as the ways they were positioned by the various cultural narratives available to them (Bamberg, 2004). Traditional social narratives of evacuees and migrants have portrayed them in stereotypical and one-dimensional ways, such as powerless evacuee victim or unwanted immigrant. From these particular conceptions the ubiquitous 'dirty evacuee' or 'whingeing Pom' narratives have emerged; constructions with which the women struggled. Furthermore, I came to learn that the women's experiences were told in the context of *other* experiences as well. The women's stories of being, and becoming, evacuees were told in light of being a daughter, a sister, girlhood and the many cultural stories which shaped the ways in which they were permitted to be evacuees. The women's migration stories too, were articulated in the cultural context of what it meant to be a British migrant in the 1950s through to the present; told through gendered and class-based expectations of motherhood and womanhood. Many of the women told stories of resistance against constraining narratives, particularly the dominating narratives of femininity and its overlap with enforced roles of childhood. However, what the women's stories show are the possibilities contained therein for older women to live viable, resilient and productive lives with experiences framed by and through various narratives. While Matthews (1984: 195) claims that, "[w]ithin the Australian gender order the notion of an old woman is a derogatory one", there is great potential and imperative for research which challenges and resists such assumptions.

Conclusion

Because of its potential for a reconceptualisation of particular ways of thinking and understanding not only women's stories but men's stories too, the methodological tools outlined in this paper are important and useful for other researchers. Such reconstructions and re-thinking are optimistic ways of envisaging recovery and improvements in people's lives. I also contend that our readerships should be wider than the academy. Taking such research beyond the academy shows the potential for broadening knowledge and the possible reverberations of this type of research work. Further research using similar tools of analysis can only contribute to understanding the lives of an ageing population in valuable and enabling ways.

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BABY BOOMERS AND RETIREMENT ADVICE: WHAT ARE THE CHARACTERISTICS OF THOSE THAT ARE SEEKING ADVICE?

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Abstract

The economic downturn and policy changes are leading many Australian baby boomers to reassess their financial security and needs in retirement. Good information is crucial in making sound decisions and minimising risk in the midst of continuing debates and uncertainties about complex and volatile superannuation and taxation arrangements. This preliminary study aims to identify which baby boomers are seeking financial advice prior to retirement. It analyses data on people who were aged 45 to 62 years in 2007 (n=2731) from Wave 7 of the national Household Income and Labour Dynamics in Australia (HILDA)⁴ survey. The survey was conducted just after the 2006 'New Super' policy changes and before the Global Financial Crisis of late 2008. Only 41 percent of boomers were found to have sought advice for retirement planning. Logistic regression showed that the chances of seeking retirement advice were greater among those who had completed a bachelor/diploma degree or higher, those who were employed in a clerical or sales position, those who had thought about their expected retirement income, and those who were relatively older. Gender was not significant nor was income (except those on the highest incomes were less likely to have sought advice). The low and variable use of retirement advice requires further examination. Whether or not boomers access financial advice is important in understanding their capacities to achieve positive leisure, family and work outcomes in retirement.

Research Question

Retirement incomes and strategies for Australian baby boomers has become a topical area, as highlighted in the Federal Budget in 2009. A number of studies over the past five years have shown that there is a distinct need for improved retirement advice and planning in Australia (Joo & Grable, 2001; Knox, 2003; Orel, Ford, & Brock, 2004; Quine, Bernard, & Kendig, 2006; Warren, 2006; Warren & Ogozuoglu, 2007). As the baby boomer cohort (born between 1946 and 1965) approaches retirement, there is a need to evaluate the use of retirement advice. The link between seeking advice for retirement planning and a more satisfied retirement transition are evident both in the Australian context as well as internationally (Onyx & Baker, 2006; Rosenkoetter, Garriss, & Engdahl, 2001).

As shown in the work by Joo and Grable (2001) in the United States (US), important characteristics include a range of socio-economic indicators including age, gender, marital status, education, occupation and income. In the Australian context, socioeconomic status is an important factor, as highlighted by the superannuation co-contribution policy by the Australian Government for low income earners.

This preliminary study draws on the retirement module data in HILDA Wave 7 (2007), which was conducted just after the 2006 'New Super' policy changes and before the Global Financial Crisis of late 2008. The significant changes that were occurring at the time of this survey, combined with the limited investigation within the literature, have led to our posing two research questions:

1. Are baby boomers seeking advice to help them plan for their retirement?
2. What are the characteristics of those who are seeking advice and those who are not yet seeking advice?

Methods

Data in the latest release (Wave 7, 2007) of the HILDA survey were used. HILDA is a comprehensive and nationally representative panel dataset that surveys both individuals and households. The population for this paper was defined as baby boomers aged 43 to 62 years in 2007 that are not yet retired. Our age range was restricted to those aged 45 to 62 years in 2007 and the analysis was based on the 2731 who responded to the question "Have you sought any advice and information to help plan for your retirement." Univariate analysis was undertaken to test whether there was an association between the indicator variables and seeking

⁴ This paper uses unit record data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey. The HILDA Project was initiated and is funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and is managed by the Melbourne Institute of Applied Economic and Social Research (MIAESR). The findings and views reported in this paper, however, are those of the author and should not be attributed to either FaHCSIA or the MIAESR.

retirement advice to determine suitable inclusion within the model at $\alpha=0.2$ level of significance⁵. Binary logistic regression was used with a 5% level of significance.

As a result of gender being related to income, an interaction term was included within the model to capture these effects. In addition to this, income, occupation and education were recoded for ease of analysis, and following the method used by Joo and Grable (2001). Analyses were then undertaken using SPSS 16.0. A binary logistic regression was used to examine the relationship between seeking retirement advice and predicted significant factors.

Results

Overall only 41 percent (n=1122) of individuals had sought retirement advice. A large majority (78 percent) were either married or living with someone in a relationship, and over half had an education at certificate level or higher. As shown in Table 1, 40 percent of the sample was employed in the professional or managerial occupations, showing a bias towards higher status occupations.

Logistic Regression

This exploratory study used a forward stepwise procedure to find the most parsimonious model, with only seven of the eight variables being significant (Table 1). With a pseudo R^2 between 0.232 (Cox and Snell) and 0.300 (Nagelkerke), this model may be considered adequately specified⁶. Based upon these figures, the model may be considered as a good fit for predicting the factors influencing baby boomers seeking retirement advice.

Income

Only the highest level of income was found to be a significant (p-value = 0.033) factor in predicting the likelihood of seeking retirement advice compared to the lowest income level. Individuals with incomes over \$100,000 are 1.675 times more likely to seek retirement advice than those earning under \$15,000.

Table 1. Descriptives and Odds Ratios for Baby Boomers that Sought Retirement Advice

Variable	Percentage and number of total population % (N)	Odds ratio (95% CI)
Sought retirement advice		
Yes	41.1% (1122)	
No	58.9% (1609)	
Age group		
45-49	32.9% (340)	1 **
50-54	39.6% (329)	1.264 (1.012 – 1.580)**
55-59	52.1% (301)	2.022 (1.579 – 2.590)**
60-62	54.7% (133)	2.115 (1.500 – 2.983)**
Gender		
Male	42.6% (596)	
Female	39.5% (526)	
Education		
HSC or equivalent	32.7% (320)	1
Certificate	36.4% (260)	1.548 (1.121 – 2.139)
Bachelor or Diploma	49.5% (330)	1.321 (1.017 – 1.715)*
Postgraduate degree or graduate diploma	57.3% (212)	1.287 (1.000 – 1.657)*
Occupation		
Machinery workers and Labourers	23.8% (90)	1**
Clerical and Sales Staff	38.7% (221)	2.404 (1.723 – 3.355)**
Techs, Trades/Community and personal services	34.9% (190)	1.569 (1.121 – 2.195)*
Professionals and Managers	54.9% (550)	1.869 (1.333 – 2.620)**

⁵ We chose 0.2 as the threshold based on a conservative estimate documented elsewhere – please see (Hosmer & Lemeshow, 1989) for further information.

⁶ Future analysis may include different model specifications.

Variable	Percentage and number of total population % (N)	Odds ratio (95% CI)
Marital Status		
Divorced/Separated/or never had a partner	32.8% (239)	1
Married/living together	44.1% (883)	1.363 (1.091 – 1.704)*
Income		
<\$15,000	27.4% (82)	1
\$15,000 to \$24,999	33.9% (85)	1.163 (0.718 – 1.886)
\$25,000 to \$34,999	34.0% (111)	1.252 (0.798 – 1.965)
\$35,000 to \$49,999	34.3% (192)	1.061 (0.703 – 1.601)
\$50,000 to \$74,999	44.4% (305)	1.155 (0.772 – 1.728)
\$75,000 to \$99,999	52.4% (173)	1.365 (0.875 – 2.219)
\$100,000 and over	62.6% (174)	1.675 (1.043 – 2.690)*
Gender*Income		1.076 (0.876 – 1.323)
Current Financial Satisfaction		1.149 (1.093 – 1.208)**
Thought about Expected Retirement Income		0.174 (0.140 – 0.216)**

*p < 0.05, ** p < 0.001

Age Group

The median age was 51 years, with most (38.5 percent) individuals in the 45 to 49 year age range. The sample was heavily skewed toward the younger age group of 45 to 49 years. Despite a disproportionate weighting to the youngest age category⁷, older baby boomers are more likely to seek retirement advice, especially the 60 plus age group (OR 2.115 95%CI 1.500-2.983)

Gender and Marital Status

Surprisingly, gender was not found to be a significant factor in seeking retirement advice. As income and gender are related ($\chi^2 = 226.29$, p-value < 0.001) an interaction term was entered with these two variables. The inclusion of this interaction term was not significant. The odds of having sought advice were higher if the individual was married or living with their partner (OR 1.36, 95%CI 1.0-1.70). This indicates that single men and women who are approaching retirement may not be seeking advice as often as their married counterparts.

Current Financial Satisfaction and Expected Retirement Income

Current financial satisfaction was found to be a significant predictor of seeking advice (p-value <0.001). Individuals who were satisfied with their current financial situation were more likely to seek retirement advice (OR 1.149, 95%CI 1.093–1.208). For those dissatisfied with their current situation, they may be more concerned with improving their income now, rather than planning for retirement. Respondents who had thought about their expected retirement income were much more likely to have sought retirement advice compared to those who had not thought about it (OR 0.174, 95%CI 0.140–0.216). This variable predicts a large component of seeking retirement advice and accounts for 0.22 of the R² value.

Implications for Policy and Practice

From a policy standpoint, there is a need for further implementation of educational resources to direct baby boomers towards advice services. Such services are partially available through various government departments, but the scope should be expanded to focus upon factors other than government transfer payments. With only 41 percent of individuals seeking retirement advice, there is a need to investigate the channels through which this

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This is due to oversampling in HILDA for this age group as compared to the Australian Estimated Resident Population proportions for a similar group. For further information, please see (ABS, 2008)

information is sought. In the period post the Global Financial Crisis, there is an opportunity for the Australian Government to review the organisations that are eligible to give retirement advice. There is the potential to target individuals who are likely to be relying upon the age pension in retirement, and to make advice more readily available before retirement. This will help those approaching retirement to be better prepared and to access advice that they require in a timely manner.

Summary

To allow for adequate planning for all factors related to retirement, not just financial, the source of information is an important factor in deciding whether or not to seek advice. As shown in the results, there is an increasing need for further analysis of the sources that individuals seek retirement advice from, as these sources will determine the actions that individuals will take. These actions may have implications for the individual's entire retirement period, including leisure, familial and employment prospects both now and in retirement. For those that have sought retirement advice, the sources of advice may provide further explanation for the puzzles encountered in these preliminary results.

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HOW ARE YOU TODAY? - THE SHOP AND ITS SIGNIFICANCE FOR THE WELL-BEING OF OLDER PEOPLE.

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Abstract

During the early stages of my proposed study, I prepared this paper with two aims: to outline my study - exploring the relationship between visits older people make to shops and their well-being; and to give account - using the 'Toolkit' as a metaphor - of three lessons learnt about methodology selection.

I had observed shoppers chatting and sharing a joke with shopkeepers and I suspected that these interchanges were of special significance for the well-being of older people. This idea seeded questions: Was interaction in shops part of social bonding and required for well-being? Did older people visit certain shops not only to buy, but because they sought, either consciously or subconsciously, social interaction, a boost to their self-esteem, information exchange or a sense of connectedness? And I decided I must investigate.

If the study succeeds in identifying a positive relationship between the well-being of older people and their interaction in shops, consideration will be given for how to best communicate this to shop keepers and older people and those who guide, fund or design urban planning.

Context

Where it exists, the local store or market place is where community members meet, chat about their lives and voice opinion about local and global issues. I suspect it is also an arena where personal identity can be sustained and sense of self bolstered. And although it has been suggested that urbanisation has disconnected community institutions such as the local shop, strong social bonds have been identified between shoppers and certain stores and store workers (Stone, 1954).

Now while this suggests significance for maintaining well-being, I propose it is especially so for older people who have relinquished roles associated with careers or for those who have little social interaction. Who do they chat to, exchange a joke with, or confide in? How do they establish and project social identification and maintain sense of self? Is interaction in shops important? And what is the shopkeeper's understanding of the interaction?

It seems that the people to ask about this are shopkeepers and older shoppers, and early in 2009 I proposed a study.

This paper gives a brief overview of my review of the literature and describes some important lessons I learnt during the task of methodology selection.

Literature review

According to research protocol (Polgar & Thomas, 1995), I conducted a 'summary and critical evaluation of previous research and theory' (p.25), relevant to the investigation, to become informed and to identify 'gaps' (p.25). Boolean search techniques - combining multiple search terms (words) with And / Or (or Not) - were used to search library catalogues and databases. Refer Table 1. References also provided a rich source of material.

Table 1. Overview of Search Terms (Grouped)

older / people / individuals / aged / elderly
shopping / shop going / local shop / village shop / retail
social cohesion / neighbourhood / community / social ties / place / social spaces
interaction / sense of belonging / social networks / relationships / families / social ties / contact
coping / resilience / mastery / adaptation / self-determination / motivation
sense of coherence / belonging / social participation
confidantes
positive emotions / well being / successful ageing
social geography
reciprocity

Although I found no studies specific to shop-going and older people, I discovered literature from a variety of areas to support my proposed study and guide further investigation.

For example, The Great Good Place (Oldenburg, 1991), defined bars, coffee shops and general stores as *third places* (after home first, and workplace, second) which ‘united the neighbourhood’ (p.20) and served as ‘the people’s own remedy for stress, loneliness, and alienation ...’ (p.20).

A study involving interviews and survey with shopkeepers and shoppers, and aimed at identifying the role and function of the independent small shop in Scotland (Smith & Sparks, 2000) revealed that the shop provided ‘a sense of community or identity both for a place and its inhabitants’ (p.208).

I also discovered interesting literature about relevant social phenomena. For example, reciprocity (exchange of deeds, goods and services) had been described as an integral part of all societies (Simmel, 1950) and considered an important social function mechanism (Gouldner, 1960).

Next, I explored the literature to identify relevant theoretical frameworks. Refer Table 2.

Table 2. Overview of Theories / Models

Theory / model	Reference	Essence of theory	Focus
Broaden-and-build model	Fredrickson, 2001	Positive affect and incremental increase in well-being	Emotions
Socioemotional Selectivity	Carstensen et al. 1999	Motivation as relates to time context	Emotions
Selective Optimisation with Compensation	Baltes, 1997	Adaptation throughout life	Resilience / adaptive process for counteracting loss / decline
Sense of Coherence	Sagy et al, 1990	Coping mechanisms and rationale for supportive resources	Stable disposition of personality
Self-Determination Theory	Ryan and Deci, 2000	Intrinsic motivation	Innate psychological needs
Sense of Community	McMillan and Chavis, 1986	Defined elements and their dynamics for maintenance	Values / Identity

Things were progressing nicely and I began to think about methodology choice, a task I considered rather straightforward.

I now devote the remainder of this paper to describe - using the conference theme of ‘The Toolkit’ as a metaphor - three lessons that I learnt during part of that task.

I had a preference for symbolic interaction as I had used the methodology for a previous study and considered I was well-informed; thought I would ‘pull out’ the trusted old tool and save time and effort. Why reinvent the wheel? Nevertheless, re-acquaintance with the methodology literature was undertaken, partly influenced by awareness that (self)-plagiarism - recycling previous work - is unethical.

Lesson 1 - Never assume the old tools are OK if they have not been used recently

If you have not used your tools for some time, do not assume: you remember how they work; if they will work today; or if they are right for the current job.

My re-acquaintance dispelled the belief that old tools can be picked up again easily; I discovered such a lot had changed and is still changing. Philosophies underpinning established methodologies are not static; they have been, and continue to be, challenged and modified, and even among learned scholars there seems to be confusion, interpretation dilemma, and contention. Why had I not noticed this last time around? Sociological philosophies (structuralism, functionalism, post modern symbolic interactionism) continue to expand, contract and converge where once they clashed. There is ‘cross-fertilization’ (Fine, 1993) p.74, and in the style of Six Sigma⁸ - a set of practices designed to improve manufacturing processes – innovators *shamelessly steal*.

Lesson 2 – Make sure it is the right tool for the job?

Researchers pursuing research into a particular aspect of human behaviour or society may presume that their research design will sit beneath the qualitative paradigm ‘umbrella’. But we are warned ‘It is erroneous to equate a particular research design with either qualitative or quantitative method (de Vaus, 2001, p. 10). For the proposed study, I could have surveyed shopkeepers and older shoppers, treated the data statistically, and would have arrived at an understanding of a phenomenon. So structured, my study would be quantitative.

I did choose a qualitative paradigm of enquiry and as I wanted to promote positive ageing I noted that positive psychology and the theories that align well with positive psychology such as Socioemotional Selectivity Theory, and Selection, Optimisation, and Compensation Theory, also align closely with symbolic interactionism. Carstensen and colleagues, in describing Socioemotional Selectivity, suggested that people were active agents who constructed social worlds to match their social goals (Carstensen, Isaacowitz, & Charles, 1999). However, re-acquaintance with grounded theory (GT) - an inductive method sometimes aligned closely with symbolic interaction and aimed at describing phenomenon - reminded me that versions of GT advise no prior exploratory work be undertaken. Another dilemma. Was my proposed study really about describing phenomena, interpreting meaning or theory testing or building? Perhaps I could adapt a tool by adding a part from another tool. Fortunately I explored this idea and discovered there are risks associated with hybrid methods; which leads to Lesson 3.

Lesson 3 - Respect your tools

Use a screwdriver as a chisel and it will work somewhat but the result will be untidy and you will damage the tool.

This applies equally to methodologies and methods. There has been discussion in the literature about method slurring (Baker, Wuest, & Noerager Stern, 1992; Fine, 1993), remodelling (Glaser & Holton, 2004), and researchers who ‘claim methods they are really not using, and not claim the method they are using’ (Sandelowski, 2000). Not to be confused with mixed method research, such practices when coupled with ignorance of underpinning philosophy or intent of method, chance invalid results. But for those who will, we are reminded that such practices must be fully disclosed and limitations discussed (Baker, Wuest, & Noerager Stern, 1992).

⁸ Motorola claims that its people invented Six Sigma, but the principles behind the methodology date back to 1809 when Carl Gauss, a German mathematician, published ‘Theoria Motus Corporum Arithmeticae’ in which he introduced the concept of the bell curve, a shape that often represents variation occurring in a controlled process.

Where to next?

I had narrowed methodology choice to three: ethnomethodology, the way people perceive, describe and explain the world (Polgar & Thomas, 1995); phenomenology, the researcher puts aside preconceptions to study personal experience and gain understanding of the nature of human consciousness (Polgar & Thomas, 1995); or symbolic interaction, core principles of meaning, language and thought leading to conclusions about the creation of a person's self and socialisation into a larger community (Griffin, 1997).

Now, at the time of writing, I have chosen symbolic interactionism, and following ethics approval, I will interview shop-keepers from a variety of localities and their older customers. The interview material will be analysed using coding which involves clustering of concepts, identification of themes (Minichiello, Aroni, Timewell, & Alexander, 1992), and interpreting manifest and latent content (Berg, 1989), 'the symbolism underlying the physically presented data'(p.107). This will be conducted either manually or assisted by a computer program such as NVivo.

Should the study define a positive relationship between the well-being of older people and their interaction in shops, I will consider how to best communicate this for the benefit of older people; perhaps a stage play featuring the interplay of overt and covert interactions of older shopper and shopkeepers. Another option would be to use the findings to raise awareness among those who guide, fund or design urban planning.

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STABILITY OF THE LEARNING AND DEVELOPMENT SURVEY: FINDINGS FOR MATURE AGED LOCAL GOVERNMENT AND PRIVATE HEALTHCARE ORGANISATIONS

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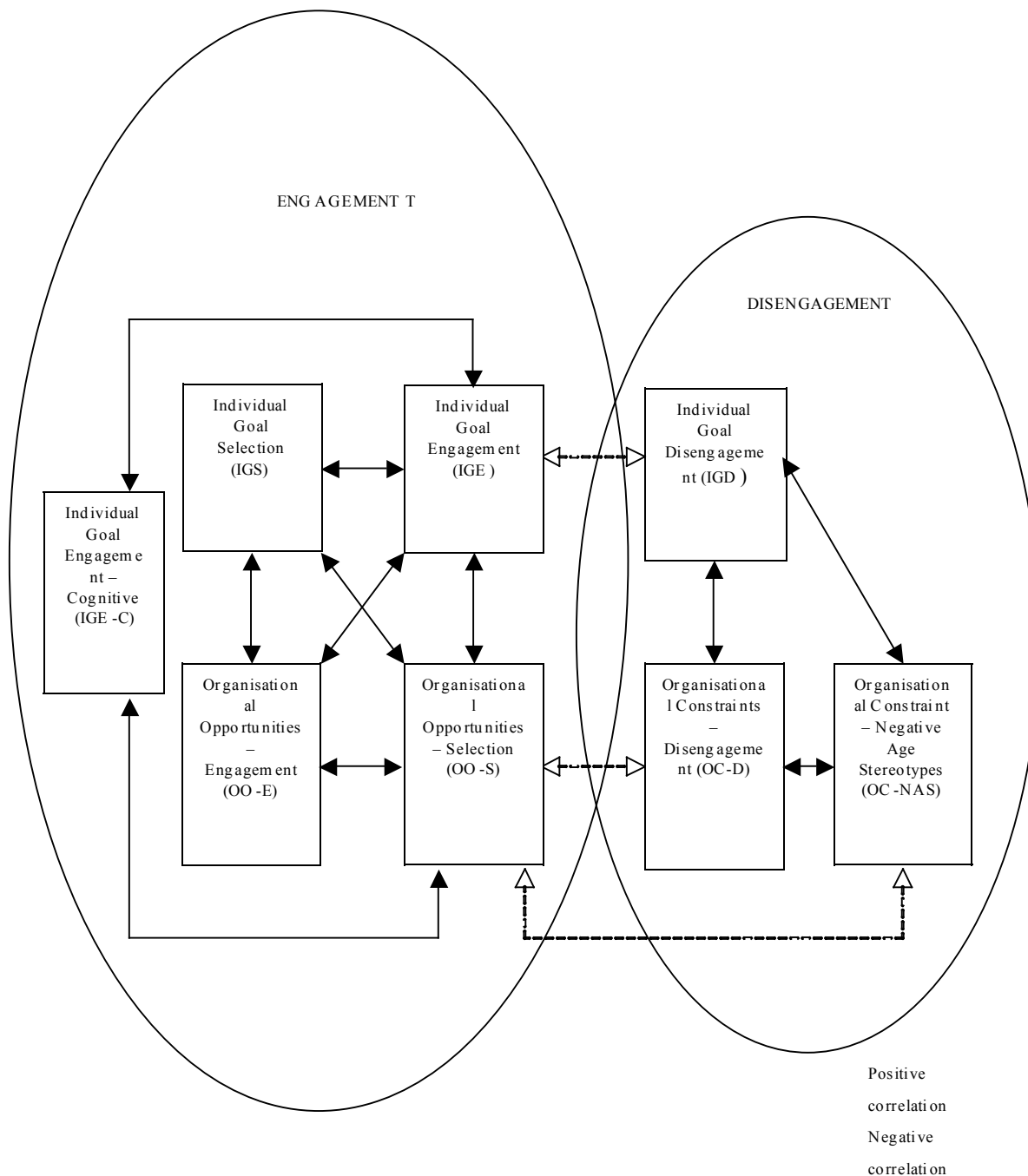
Abstract

This article investigates work related learning and development amongst mature aged workers from a lifespan developmental psychology perspective. The current study follows on from research regarding the construction and revision of the Learning and Development Survey (LDS; Tones & Pillay, 2008). Designed to measure adaptive development for work related learning, the revised LDS (R-LDS) encompasses goal selection, engagement and disengagement from individual and organisational perspectives. Previous survey findings from a mixed age sample of local government workers suggest that mature aged workers aged over 45 years are less likely to report engagement in learning and development goals than younger workers, which is partly due to insufficient opportunities at work. In the current paper, exploratory factor analysis was used to investigate responses to the R-LDS amongst two groups of mature aged workers from a local government (LG) and private healthcare (PH) organisation to determine the stability of the R-LDS. Organisational constraints to development accounted for almost a quarter of the variance in R-LDS scores for both samples, while remaining factors emerged in different orders for each data set. Organisational opportunities for development explained about 17% of the variance in R-LDS scores in the LG sample, while the individual goal disengagement factor contributed a comparable proportion of variance to R-LDS scores for the PH sample. Findings from the current study indicate that opportunities for learning and development at work may be age structured and biased towards younger workers. Implications for professional practice are discussed and focus on improving the engagement of mature aged workers.

Research Question

An emerging field of research has investigated the application of lifespan development psychology to mature age workforce issues (Kanfer & Ackerman, 2004; Robson, Hansson, Abalos & Booth, 2006), although few studies investigate work related learning and development (Robson & Hansson, 2007). Tones and colleagues (Tones, 2009; Tones & Pillay, 2008) developed the model of adaptive development for work related learning from an integration of lifespan development psychology models (see Boerner & Jopp, 2007; Tones & Pillay, 2008). Major processes in adaptive development include the selection of goals (selection), pursuit of goals (engagement), and adaptation to developmental losses (disengagement). The model was tested and refined via the Learning and Development Survey (LDS), which was designed to measure these three processes from the perspective of the individual respondents, as well as their perspective of opportunities and constraints for learning and development in the workplace. A pilot study was conducted which involved the survey of 113 local government (LG) workers aged 18-65 and exploratory factor analysis (EFA). Eight factors encompassing 38 items emerged from the EFA, which are shown in Figure 1 (Tones, 2009). In order of total variance explained in LDS scores these factors were Organisational Opportunities – Selection (OO-S), Individual Goal Engagement (IGE), Organisational Constraints – Disengagement (OC-D), Individual Goal Selection (IGS), Organisational Opportunities – Engagement (OO-E), Individual Goal Engagement – Cognitive (IGE-C), Individual Goal Disengagement (IGD), and Organisational Constraints – Negative Age Stereotypes (OC-NAS).

Figure 1. *The Model of Adaptive Development for Work Related Learning*



The aim of the current study was to evaluate the 38 item revised LDS (R-LDS) on two samples of mature aged workers, defined as aged 45 to 64 by the Australian Bureau of Statistics (ABS, 2004). It was expected that the responses of mature aged workers would differ from the findings in Tones and Pillay's (2008) pilot study in two ways. First, OC-D and OC-NAS were expected account for a greater proportion of variance in R-LDS scores compared to OO-S and OO-E as the literature indicates that organisational and social barriers to learning and development are evident for mature aged workers, whereas younger workers are likely to receive more encouragement to learn and develop in organisational and social settings (Nagele, & Walker, 2006). Second, IGD was anticipated to contribute a greater proportion of variance in R-LDS scores than IGS, IGE and IGE-C due the organisational constraints associated with learning and development in mature aged workers compared to younger workers.

Methods

The participants were 119 mature aged workers from a LG (57) and private hospital (PH; 62) organisation. The LG sample consisted of a mix of males and females from managerial, professional and lower level occupations. By contrast, the PH respondents were mostly females from managerial or professional roles. The R-LDS was distributed via the internet for the LG, and print for the PH.

Data analysis involved exploratory factor analysis (EFA) using the maximum likelihood function on SPSS. Items were retained if they exhibited a loading of ± 0.4 or greater, and did not share cross loadings of ± 0.3 . Internal consistency analysis was conducted to omit redundant items.

Results

An oblique rotation provided the most meaningful solution in each EFA. Retained items are shown in Table 1. The R-LDS was reduced to seven factors and 24 items for the LG data set, and six factors and 18 items for the PH data set.

Table 1. Retained Indicators of the R-LDS: LG and PH Data Sets

Indicator	LG	PH
Organisational Constraints – Disengagement (OC-D)		
OGD1 In my workplace, older workers are encouraged to retire.	.984	1.068
OGD2 Older workers are not offered training and development in my workplace.	.743	.886
OGD3 In my workplace, knowledge of the latest technologies is valued over direct industry experience.	.763	-
OGD5 In my workplace, younger workers are considered to be more competent than older workers.	.867	.832
OGD7 In my workplace, I have been given fewer learning and development opportunities as I get older.	.733	.759
OGD9 In my workplace, younger workers are considered to be more successful in learning and development activities than older workers.	-	.832
OGD11 In my workplace, older workers are thought to be unwilling to learn.	.581	-
Organisational Opportunities – Selection (OO-S)		
OGS1 My workplace provides job opportunities that are appropriate for me.	.857	-
OGS3 My workplace provides learning and development opportunities that meet my needs	.851	-
OGS7 My workplace helps me to decide which skills to improve.	.740	.401
OGS10 In my workplace, learning and development activities are designed to develop a range of skills.	.625	.836
OGS12 My workplace is willing to change learning and development activities to suit my needs.	.756	-
OGE13 In my workplace, I can get help when my job becomes difficult.	.494	-
OGE14 In my workplace, I have the opportunity to participate in training.	.558	.523
Organisational Opportunities – Engagement (OO-E)		
OGE2 In my job, I have to make difficult decisions.		.881
OGE3 In my job, I have to make quick decisions.	.813	.692
Individual Goal Selection (IGS)		
IGS1 It is important for me to teach work skills to younger workers.	.698	-
IGS2 It is important for me to influence the future of my workplace.	.492	-

Individual Goal Engagement - Behavioural/ Selection; Loc. Gov't (IGE-B); Priv. Hosp. (IGSE-B)		
IGS3 It is the right time for me to improve my work skills.	-	.407
IGE1 I am willing to work hard at developing new work skills.	.722	.549
IGE2 I try to obtain challenging jobs in order to develop my skills.	-	.737
IGE3 If training and development opportunities are available within my workplace, I will participate in them.	.398	-
IGE5 I design better ways of doing my job when it becomes challenging.	.739	-
Individual Goal Engagement – Cognitive (IGE-C)		
IGE13 I have the ability to achieve my learning and development goals.	.513	.608
IGE15 I stay focused on my learning and development goals.		-
IGE16 When I have set a learning and development goal for myself, I am confident that I will achieve it.	-	1.054
Individual Goal Disengagement (IGD)		
IGD2 Learning and development goals are not important to me.	-.542	-.593
IGD4 When my learning and development goals do not work, it's because I am unlucky.	-	-.796
IGD6 I do not need to participate in learning and development because I am competent in my job.	-.979	-.725

Table 2 contains the total variances explained (TVE), eigenvalues and Cronbach's alphas (α) for each factor solution. Organisational constraints – disengagement (OC-D) explained almost a quarter of the variance in R-LDS scores in each sample. Organisational factors explained a dominant proportion of variance in the LG solution. The opposite was observed in the PH data set as individual factors influenced variance in R-LDS scores to a greater extent than organisational factors.

Table 2. Eigenvalues, Total Variances Explained and Cronbach's alphas, LG and PH Factor Solutions

Factor	LG			PH		
	Eigenvalue	TVE	α	Eigenvalue	TVE	α
Organisational Constraints – Disengagement	8.784	23.115	.904	8.622	23.303	.929
Organisational-Opportunities - Selection	6.662	17.532	.899	2.133	5.765	.724
Organisational Opportunities - Engagement	2.548	6.706	.835	1.613	4.360	.700
Individual Goal Selection	2.349	6.181	.737	-	-	-
Individual Goal Engagement – Behavioural (Selection)	1.934	5.090	.794	2.785	7.526	.839
Individual Goal Engagement-Cognitive	1.696	4.462	.718	1.969	5.322	.813
Individual Goal Disengagement	1.315	3.460	.718	6.751	18.247	.789

Table 3 shows the inter-correlations between factors for both data sets. Common to both solutions are the strong negative correlation between OC-D and OO-S, and the positive correlations between OO-S and both IGE-B/ IGSE and IGE-C, IGE-B/ IGSE and IGE-C and OO-E. The main difference between the two solutions was the pattern of correlations between IGD and other factors. For the LG data set, IGD was negatively correlated with IGS, IGE-B and IGE-C, which suggested that mature aged workers who were disengaged from learning and development goals failed to engage with learning and development at work. By contrast,

for the PH data set, IGD was positively correlated with OC-D and negatively correlated with OO-S, which indicated that mature aged workers may disengage from learning and development goals in response to a lack of opportunity for learning and development at work.

Table 3. Factor Inter correlations: LG and PH Data Set

	OC-D	OO-S	OO-E	IGS	IGE-B/ IGSE	IGE-C	IGD
OC-D	1.000	-.340**	-.100	Factor not identified in PH data set.	-.053	-.059	.251**
OO-S	-.512**	1.000	.187		.274**	.195*	-.189*
OO-E	.012	.065	1.000		.333**	.166	-.218*
IGS	.027	.152	.274**	1.000	Factor not identified in PH data set.		
IGE-B/ IGSE	.011	.217*	.199*	.496**	1.000	.464**	-.448**
IGE-C	.175*	.182*	.206*	.388**	.499**	1.000	-.369**
IGD	-.048	.018	-.095	-.253**	-.268**	-.384**	1.000

** Correlation is significant at the 0.01 level (2-tailed); *. Correlation is significant at the 0.05 level (2-tailed).

Note: Lower (unshaded) diagonal – LG data set; Upper (shaded) diagonal – PH data set

Discussion and Conclusion

Outcomes of the EFA analyses indicated a reduction in the number of factors and quantity of items in each factor for both data sets compared to the findings of the pilot study, which was conducted on a mixed age sample (Pillay & Tones, 2008). Hypotheses concerning the prominence of disengagement factors were partially supported. The OC-D factor accounted for the greatest proportion of variance in both data sets, ahead of OO-S and OO-E. However, IGD was observed to explain more variance than individual selection and engagement factors for the PH model only, while this hypothesis was refuted in the LG solution.

The factors structures of the R-LDS differed for the LG and PH mature aged data sets, in that organisational opportunity factors were more salient in the former structure, while IGD was more salient in the latter. Although the original study was conducted within the LG which may have introduced some bias to retained items, differences in occupational status between the two mature aged data sets used in the current study may account for the disparate findings.

Private hospital employees may have been less sensitive to opportunities in the workplace than LG employees due to their professional or managerial status, as their high occupation level may have left limited scope for further career progression within the organisation. This is supported by correlations between IGD and OC-D and OO-S for the PH data set.

By contrast, mature aged LG employees tended to hold lower level jobs, so there may have been greater scope for career progression and learning and development opportunities within the organisation. There was also a positive correlation between IGE-C and OC-D for the LG data set, which implies that mature aged workers draw on internal motivational resources for learning and development in the context of organisational constraints. However, the strong negative correlation between IGD and IGS, IGE-B and IGE-C for the LG data set suggested that mature aged workers were either willing to engage with opportunities for learning and development at work, or disengaged from learning and development altogether. Furthermore, IGD was not correlated with OC-D, so disengagement was unrelated to constraints for learning and development at work.

Findings of the current study indicate that age related constraints to learning and development are salient to mature aged workers even in high level occupations. The patterns of individual factors in relation to organisational factors indicate diversity within mature aged worker populations and possibly organisational cultures with respect to learning. Improvement of learning and development opportunities for mature aged workers and encouragement of engagement in such opportunities is imperative, as has been suggested in the prior literature (eg. Nagele & Walker, 2006). However, learning and developmental opportunities will be required to be tailored to both individual and organisational needs and capabilities.

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DOES RETIREMENT CALL FOR ANOTHER IDENTITY? IT DEPENDS ON THE DEFINITIONS!

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Abstract

Some theories have proposed that the retirement process requires a reconstruction of individual identity. However, the constructs of both retirement and identity are often loosely defined in the literature. The lack of definition leads to conflicting research results and a lack of clarity in advice to retirees and in reports to government bodies for policy purposes. This new study aims to provide much-needed clarity by charting a history of retirement from peer-reviewed journals and from the transcripts of focus group discussions, where participants were asked to comment on the differences between their retirement experiences and those of their parents. The types of retirement thus identified will be illustrated using available statistics. In addition, new retirement trends will be identified to enable projections into the future. Prevailing models on identity formation during emerging adulthood from the literature will be tested for applicability to the different types of retirement.

Introduction

Côté and Levine (1987) based their definition of identity on Erikson's pioneering work in life-cycle development. Identity, they said is 'the sense of self, supported by recognition from the social environment'. Kroger (2007) observed that Côté extended this definition by stating that there is no identity without society, and that society steers identity formation. For baby boomers, re-formation of the identity is therefore related to societal changes during the retirement transition.

Both retirement and identity are 'rubbery' constructs that are difficult to operationalise.

The term 'retirement' is said to be problematic for social research (Luborsky & LeBlanc, 2003). A systematic literature search of databases such as PsychInfo resulted in nearly 1300 articles with the word 'retirement' in the title. Examination of these articles showed that retirement is rarely defined in detail: among the articles identified, 'retirement' was explicitly defined in only ten percent of articles, not defined in half, and defined in some way in the remainder. Retirement can be categorised by type, such as early, sudden, phased, or traditional retirement, but retirement can also mean a moment in time, a process of transition to retirement, and the state of being retired. In many instances the definition of retirement becomes clear from the context of the article, but that does not excuse the omission. Ghilarducci (2006) even argued that retirement no longer exists, which would make any study on changes in retirement obsolete and irrelevant. Further reading of the article made it clear however that the author referred only to the retirement security system in the United States of America.

The construct of identity is even more complex as it seems to evoke more typologies than any other psychosocial construct. These range from core to global, from personal to social, and from work to leisure.

Potential models of the interaction between the personal identity and the environment of retirement within the many domains of life therefore need to be embedded firmly in the precise definitions of the two constructs to enable precise measurements and sophisticated statistical analysis.

Research question

Only 41% of Australian baby boomers sought financial retirement advice in 2007 (Snoke, Kendig, O'Loughlin, & Black, 2009). Cronan (2009) showed that retirement has developed beyond financial security and leisure; yet no evidence-based planning models for the psycho-social adjustment to retirement are available. The extensive literature on adolescent development invites the question, whether the prevailing adjustment models can be generalised to late mid-adulthood, when people consider their retirement options.

There is no doubt that retirement has developed over the years. Reitzes and Mutran (2004) suggested that retirement has changed since World War II due to a higher life expectancy, higher labour force participation by women, and a trend towards early retirement, all of which removed the reliance on a fixed retirement age, and changed the moment of retirement from a particular age to being a marker of a new life-time stage. Hardy (2002) confirmed the changing role of women in the labour force and suggested that the introduction of compulsory superannuation made retirement available to the general population. Collins (2003) added that

retirement became an expectation, a dream to look forward to. As retirement is defined in terms of non-work or non-employment (Hardy, 2002), changes in the work environment have also affected retirement: for example, technological advances have resulted in an increase in the number of people who are still physically fit at the end of their working life, but may suffer work-related injuries like RSI. Jackson, Walker, Felmingham, and Spinaze (2006) estimated that the transition from full-time paid work to retirement had increased to six years, which is in sharp contrast to the abrupt retirement experienced by our parents. Indeed, Collins (2003) quoted a Civics Venture Survey in which eighty percent of the participants denied that their retirement would be similar to that of their parents.

An extensive literature describes the formation of identity in adolescence and emerging adulthood, where the progress of the identity formation can be ascertained through the status measures of diffusion, foreclosure, moratorium, and achievement (Marcia, 2002). Cote and Levine (1987) pointed out, however, that Erikson viewed the ego identity formation as a lifelong process extending across all eight of his postulated psychosocial stages. Kroger (2002) lamented that there is hardly any current research on identity re-formation in later adulthood, despite the similarities between adolescence and late-adulthood. The research question in this study centres on the validity of using the status measures as delineators for the re-formation of identity in different types of retirement. Identity formation during emerging adulthood is a trial-and-error method with a fall-back position: independence is created by moving out of and back in to the parental home; 'work' can be tested through part-time jobs and work-experience; social contacts are many, intensive, and often brief. At retirement, however, the fall-back position is more precarious or non-existent: gaining independence from children can be a mutually satisfactory process, but leaving full-time work may be more difficult for some, who struggle to make new friends when the social contacts with former colleagues fall away. Identity formation in emerging adulthood is relatively automatic and is associated with the normative expectations of getting a job, becoming independent from one's family, and establishing a permanent intimate relationship. In contrast, the retiree-identity formation is not subject to societal norms, as there are no agreements yet on what retirement is, nor is it automatic as the retired person has a range of choices in adapting to the new environment of retirement. Hence, the retiree identity model is expected to be different from the original identity formation model with the identification of additional status measures.

Methods

A literature review was undertaken to document a history of retirement since World War II.

Additional information was obtained from the transcripts of the focus groups conducted nationally late in 2008 as part of the Ageing Baby Boomers in Australia (ABBA)⁹ project, in which the 73 participants were asked to describe the differences between their retirement experiences and those of their parents.

Secondly, an in-depth qualitative analysis was undertaken of the literature and the transcripts of the ABBA focus groups, selecting all references relating to a re-forming of identity in retirement. A yet-to-be constructed Internet-based questionnaire will test emerging patterns thereby providing the main evidence-base for this study, whose ultimate aim is to describe the changing construct of retirement against the parameters of the adjusted model of Marcia's identity formation.

Results

The qualitative analysis of the literature identified sixteen themes in articles on retirement. At face value, these themes seem to be equally represented in each of the six decades since the 1950s. Some notable exceptions were 'gender', which was not paid much attention in the early years but became much more prominent from the 1960s onwards, whereas the theme of retirement of professionals decreased in prominence over the same period.

Several participants in the focus groups mentioned that their parents did not even reach the retirement age of 65, which is supported by the prognosis that the current generation of baby boomers can expect to live longer than the preceding generation. The Australian Bureau of Statistics (2008) shows that men aged 65 can now expect to live another 18.3 years, whereas this figure stood at 13.1 years only 30 years ago, an increase of five years of life. The life expectancy for women at 65 increased from 17.1 to 21.5.

Additional statements emerged from the focus groups that did not fit the current understanding of retirement. These statements may give an insight into new developments in retirement. For example, several participants expressed the concern that their children would not be able to care for them in old age, as they lived interstate

⁹ This paper uses focus group data from the Ageing Baby Boomers in Australia (ABBA) project, an Australian research Council Linkage Project 2008 to 2010 (LP0882748).

or overseas, or were only children. This was in contrast with the care-giving role participants fulfilled for their own parents, which was often shared by a number of siblings. The current phenomenon of a sandwich generation that cares for parents, whilst still having adult children at home is therefore likely to disappear among the baby boomers, and may be replaced by a generation of older people living in the community with formal support.

Summary

The lack in definition of the constructs of retirement and identity in the scientific literature has prompted a description of the changes in retirement concepts over time, as every type of retirement calls for a different adjustment to the identity of the retiree. A qualitative analysis of the literature and focus group transcripts is expected to clarify historical trends in the development of retirement, and enable projections into the future, which will be extremely valuable to retirees and policy makers. Finally, the study will focus directly on self-reported identity formation in retirement. This will lead to a new theory of identity formation in later adulthood.

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CONSORT: A VALUABLE TOOL TO IMPROVE RESEARCH IN THE AGED WITH VENOUS LEG ULCERS

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Abstract

Currently up to 20 per 1000 Australians over the age of 80 have an active leg ulcer, greatly affecting quality of life. Among younger affected persons venous ulcerations also result in days off work. The management of venous ulcers causes considerable strain on the health system and is likely to worsen in future. Analysis performed ten years ago in Australia estimated that venous ulcers were responsible for \$400 million annually in health costs. Strategies to improve management of this condition are essential.

The multi-layer high compression system is described as the current gold standard for treating venous ulcers. To date, despite advances in venous ulcer compression bandaging therapy, no convincing low cost, easy to apply compression therapy study has been conducted that may improve wound healing and compliance. A recent meta-analysis of bandaging systems found that multilayer compression bandages appeared to be superior to single-layer bandages in promoting venous ulcer healing. However, it was noted that many of the studies had small sample sizes and the quality of research in the area was poor.

There is a need for well designed studies based on the CONSORT statement. Clinicians need to be able to discern high quality studies from ones of poorer quality. This paper discusses how CONSORT was used as a template to design and implement a multicentre randomised controlled trial to evaluate the efficacy and safety of two compression bandaging systems in patients with chronic venous ulceration.

Introduction

Venous ulcer is a severe clinical manifestation of chronic venous insufficiency (CVI). It is responsible for about 70% of chronic ulcers of the lower limbs (Baker, Stacey, Jopp-McKay, Hoskin, & Thompson, 1991). The high prevalence of venous ulcers has a significant socioeconomic impact in terms of medical care, days off work and reduced quality of life. Long-term therapeutics are needed to heal venous ulcers and recurrence is quite common, ranging from 54 to 78% (Abbade & Lastoria, 2005). Up to 20 per 1000 Australians over the age of 80 have an active leg ulcer, greatly affecting quality of life (Heinen, van Achterberg, op Reimer, van de Kerkhof, & de Laat, 2004; Persoon et al., 2004). Among younger affected persons venous ulcerations also result in days off work (Herschthal & Kirsner, 2008). The management of venous ulcers causes considerable strain on the health system and is likely to worsen in future. Analysis performed more than ten years ago in Australia estimated that venous ulcers were responsible for \$400 million annually in health costs (Baker et al., 1991). Strategies to improve management of this condition are essential. There is a need for well designed studies based on the CONSORT statement to help clinicians to be able to discern high quality studies from ones of poorer quality.

Randomised controlled trials (RCT) are the gold standard for judging the benefits of treatment (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). They are quantitative, comparative, controlled experiments in which a group of investigators study two or more interventions by administering them to groups of individuals who have been randomly assigned to receive each intervention. (Altman, 1991).

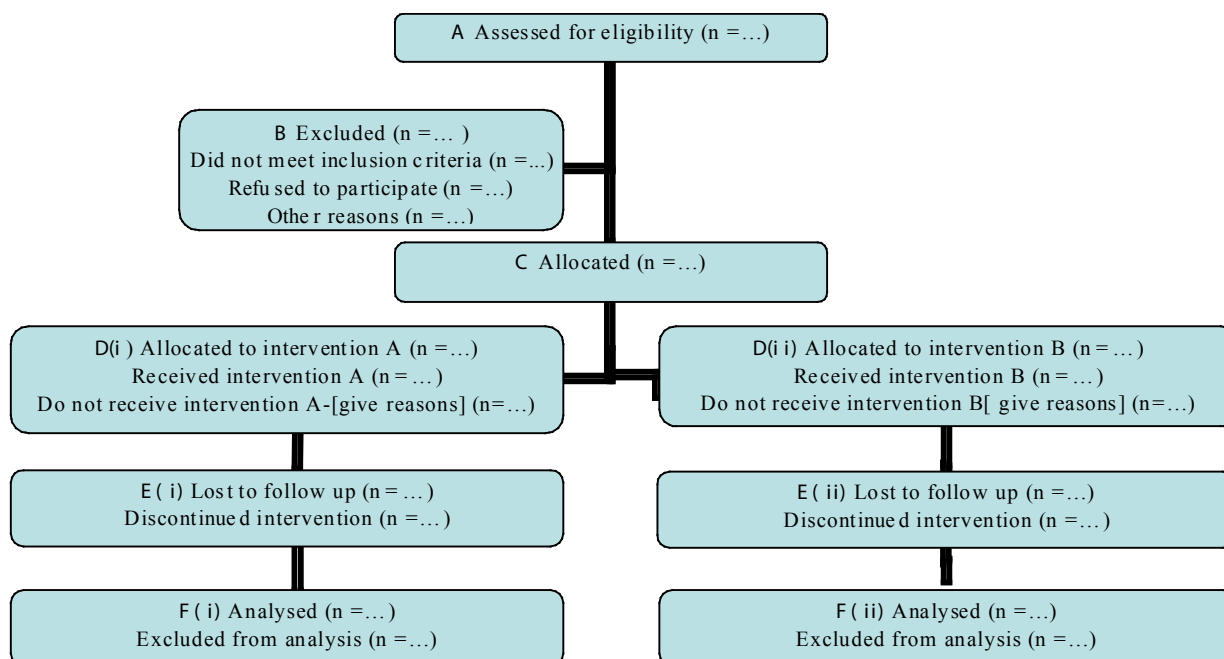
To interpret the results of a randomised controlled trial (RCT), readers must understand a variety of aspects of their design, analysis, and interpretation (Keech, Pike, Granger, & GebSKI, 2007). That goal can be achieved only through detailed reporting. Investigators and editors developed the original CONSORT statement to help authors improve reporting by use of a checklist and flow diagram (Moffatt et al., 2003; Moher, Schulz, & Altman, 2001).

The application of randomised controlled clinical trials to treatments of venous ulcer healing has lagged behind that of other areas of medicine (Begg et al., 1996; Enoch, Grey, & Harding, 2006). According to a recent review of all 519 RCT reports indexed in PubMed during 2002, most trials included less than 100 subjects and most involved patients from a single site. In a systematic review of compression therapies used in the treatment of venous leg ulcers Palfreyman et al concluded that more high-quality trials are required and more emphasis should be placed on economic and quality of life measures (Palfreyman, Lochiel, & Michaels, 1998).

CONSORT (Consolidated Standards of Reporting of Trials)

CONSORT was designed by a group of epidemiologists, biostatisticians and journal editors to assist the reporting of RCTs with 2 groups and those with parallel designs (Stolberg, Norman, & Trop, 2004). The CONSORT statement is an evidence-based guide consisting of 22 item checklist and a four-point flow diagram for reporting two-group parallel RCTs. The CONSORT flow diagram should include the flow of participants through each stage. For each group authors should report numbers of participants randomly assigned, receiving intended treatment, completing the study protocol and analysed for the primary outcome. If there are any protocol deviations, these should be described and reasons given. The 5 key stages that guide the RCT process are Enrolment, Allocation, Intervention, Follow-up, Analysis (Moher et al., 2001) as shown in Figure 1 Flow diagram 1.

Figure 1. CONSORT Checklist flow diagram



There is a broad consensus that the reporting of RCTs should be improved and standardised, with many journals adopting the CONSORT recommendations as a way to achieve this goal (Wood et al., 2008). However, the use of the consort statement in the key journals of would care do not routinely require reporting in this fashion.

Objectives

Most clinical trials have a general objective, such as to identify if one treatment is 'better' than another. However such broad aims must be consolidated into a more defined, specific and measurable primary aim that encapsulates the purpose of the study. For example, the specific aim might be to compare the rate of complete healing achieved by two treatments. Complete healing would require a pre-specified and objective definition, such as complete epithelialisation in the absence of scab or eschar (VenUS I trial definition) (Nelson, Iglesias, Cullum, & Torgerson, 2004).

Clinical trials are sometimes divided into two groups. The first group is 'explanatory' trials that determine the effect of an intervention on a specific technical outcome such as 'extent of epithelialisation at the end of an intervention period'. In these trials, representativeness is less important than ensuring 100% compliance and 100% follow-up. The other type of trial is a 'management trial', which typically employs an intention to treat approach and focuses on a more holistic outcome such as quality of life. The latter type of study typically seeks to integrate the positive and negative effects of an intervention and assess its overall value as a clinical intervention.

Randomisation

Randomisation is the process of assigning trial participants to treatment groups and gives each participant a known (usually equal) chance of being assigned to either group. A fundamental requirement of trial design is

to avoid selection of who goes into which treatment arm. This is particularly relevant to venous ulcer healing studies, where blinding is difficult to achieve and pre-existing opinions may exist about which treatment may be most effective in particular situations.

Sufficient detail should be provided about the details of sequence generation, allocation concealment and implementation to satisfy the reader that group allocation is random and that selection bias is unlikely. In multicentre studies, randomisation should be carried out centrally. In our study patients were randomised to receive either control or intervention group using a central computer generated random number generated by a central computer generated randomisation sequence.

Selection of participants

The choice of participant determines the type of patient to whom the results will apply. For example if the patients are restricted to first presentation of venous ulcer the results may not be applicable to long term unhealed venous ulcers. Choice of participant will be controlled to some degree by outlining inclusion and exclusion criteria in the protocol. In some instances, so many exclusions are listed that criteria of the final participants are not 'typical' of a venous ulcer patient and the applicability of the results may be questioned. On the other hand if the patient selection criteria are very broad then a benefit or otherwise in one group may be submerged in the result as a whole. The eligibility criteria for trial participants should be decided before recruitment, and kept as simple and unambiguous as possible.

Interventions

The interventions used in a randomised clinical trial should be clearly defined in the protocol and reported in enough detail to be replicated. In general it is desirable to make the intervention and control arms as different as possible to maximise their chances of detection. For example if two approaches to bandaging are being compared using different pressures of application it would be desirable to ensure that the difference in pressures is at the upper limit of an acceptable range.

With multicentre trials, attention must be given to standardising the interventions so they are similar amongst the different sites. For example, training sessions are needed to ensure that all the research assistants are trained to bandage in the same way. Specific quality control measures, such as sub bandage pressure measurement, may be necessary to ensure that there is a standard application of the compression bandage. Standardised approaches should also be documented in standard operating procedures.

Outcomes measures

Most trials involve a single outcome measure that should be measured systematically at the completion of the intervention period. The outcomes will depend on the aim of study. Complete healing may provide a more clinically convincing result, but will extend numbers and duration. Typically x% of wounds will heal by y months. If outcome is speed of healing, then we should measure decrease in wound size with an objective measurement instrument. Sample size will be smaller, since all patients contribute to the ultimate result.

Standard measurement criteria are essential for the results to be accepted by the clinical community. For example, in wound healing studies, the size of the wound is often measured by area calculation or estimating by multiplying length by width using acetate tracing of wounds (Flanagan, 1997, 2003). Measuring response to treatment by wound area is a widely accepted practice, but the date of complete healing may also be used, and does not require serial tracing. Clearly defined primary and secondary outcome measures should be clinically relevant and, where possible, measured objectively. A description of any methods used to enhance the quality measurements such as training of assessors, is worthwhile so that the study can be reproduced and added to the evidence based literature.

Sample size

To ensure that research time, patient effort and support costs are not wasted, the number of participants required for a clinical trial must be estimated in advance. The number will depend on the variability of response, and the difference in outcomes to be detected. If the sample size is too small, large treatment effects may be missed. This is known as a type 2 error (Keech et al., 2007). Recruiting patients for underpowered studies could also be considered unethical, as the trial cannot show meaningful information about the tested intervention.

In venous ulcer healing trials, the rate of complete healing by three months is typically of the order of 10%. An intervention producing an additional 10% increase in healing rate (ie 20%) would be considered highly efficacious. To be able to detect this difference with a probability of 80%, 80 participants would be required

in each treatment arm. If the absolute difference in effect between the two groups was increased to 20% (ie 10% versus 30%) then the required number of participants would be 40 in each group. To detect a 1% difference between the groups 8,000 per treatment arm would be required. The sample size required is inversely proportional to the treatment effect squared (Rosner, 2006).

Ideally, clinical trials should be large enough to detect the smallest clinically relevant differences in the primary outcome. When comparing rates of events, such as healing, one estimates the event rate in the control group by extrapolating from a population similar to the population expected in the trial.

Bias control

Many wound management studies are conducted in open randomised design because blinding is often not feasible or ethical. A single blinded randomised design is commonly employed, in which the individuals responsible for the assessment of key endpoints are unaware of what treatment has been given. Whenever possible, this should be accompanied by objective measures such as measurement of the ulcer size with a coded acetate tracing or a digital photograph. These measures may be presented to assessors in a coded fashion that allows concealment of both the treatment and the stage when the measurement was taken. Several studies have found that trials with inadequate concealment of treatment tend to exaggerate the estimates of the intervention effects when compared with adequately concealed or adequately blinded trials (Kjaergard, Villumsen, & Gluud, 2001; Moher et al., 1998; Schulz, Chalmers, Hayes, & Altman, 1995).

A method to correct for differential drop out rates between one arm of the study and another is to analyse data by the intention to treat. This simply means that data are analysed in the way the patients were randomised, regardless of whether or not they received the intended intervention. The intent to treat correction is a form of protection against bias and strengthens the conclusions of a study (Jadad & Enkin, 2007).

Conclusion

The development of new approaches to the treatment of venous leg ulcers has led to an increase in the number of RCTs evaluating these treatments. Wound care practitioners have an extensive range of different dressings at their disposal and it is important that there is reliable evidence to determine how they compare with standard care. However, the conduct and reporting of wound clinical trials has often been inadequate.

In this paper we have discussed a variety of issues specific to healing studies involving venous leg ulcers. The CONSORT statement provides a method by which wound care practitioners can discriminate high quality studies from ones of poorer quality in their day-to-day practice. Wound care consultants need to advance this field by participating in RCTs. In this paper we have highlighted various design issues that should be taken into account when designing studies involving elderly with venous leg ulcers.

In summary, the CONSORT statement and its related extension papers can only improve the quality of reports of randomised trials and therefore improve healing outcomes for elderly. There is a need to review evidence and the general interpretation of the results of trials in context of current evidence. This would help wound care clinicians answer the common clinical question 'what are the likely effects of one treatment compared with another?'

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AN EFFECTIVE APPROACH TO REDUCE ANTIPSYCHOTIC AND BENZODIAZEPINE USE IN AGED CARE HOMES: THE 'REDUSE' PROJECT

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Abstract

The majority of residents of aged care homes have mental health conditions, including challenging behaviours of dementia, anxiety and sleep disturbance. Although non-drug strategies are recommended, medications such as antipsychotics and benzodiazepines are commonly used to manage these conditions, and residents often remain on sedative medications for extended periods despite limited effectiveness and significant side effects. The aim of the 'RedUSE' (Reducing Use of Sedatives) project was to evaluate a multi-faceted, interdisciplinary intervention to reduce the use of antipsychotics and benzodiazepines in aged care homes. The RedUSE project was a controlled trial conducted in 25 aged care homes in Tasmania. A series of pharmacist-led strategies were provided to intervention homes, including medication audit cycles, staff education and interdisciplinary review. Data on medication use was collected at baseline, 12 weeks and 26 weeks, with approximately 1600 residents audited for each measurement. Over the six-month trial, there was a significant reduction in the percentage of intervention home residents regularly taking benzodiazepines (31.8% to 26.9%, $p < 0.005$) and antipsychotics (20.3% to 18.6%, $p < 0.05$), whereas control home use increased slightly. There were also significantly more dose reductions/cessations in intervention homes than in control homes (benzodiazepines: 39.6% vs 17.6%, $p < 0.0001$; antipsychotics: 36.9% vs 20.9%, $p < 0.01$). Our findings suggest that strategies coordinated through community pharmacies, and incorporating the dissemination of local data on medication use, offer an effective approach to reduce sedative use in aged care homes.

Research Question

Non-drug treatments are recommended as first-line approaches to manage sleeping disturbance, anxiety and the psychological and behavioural symptoms of dementia, all of which are commonly observed in aged care homes. However, it is known that in practice, antipsychotics and benzodiazepines are often used to treat these disorders, despite limited effectiveness and significant side effects; including falls, cognitive impairment with benzodiazepine use and increased risk of stroke and death associated with antipsychotic use in patients with dementia (Madhusoodanan & Bogunovic, 2004; Schneider, Dagerman, & Insel, 2006). Although current professional guidelines (International Psychogeriatric Association, 2004; Royal Australian College of General Practitioners, 2000) recommend that these medications are regularly reviewed and dosage reductions attempted, many aged care residents remain on sedative medications for extended periods of time (Selbaek, Kirkevold, & Engedal, 2008). As defined by the Royal Australian College of General Practitioners (RACGP), a medication review is a critical review of medications undertaken to optimise therapy and minimise medication-related problems (Australian Government, 2009).

Australian researchers and government bodies have expressed concern over the high rates of use of these agents in aged care homes (Australian Senate, 1995; NSW Health, 1997). Over the past ten years, studies have reported regular benzodiazepine usage rates ranging from 15%-37% of aged care residents, and that antipsychotics were taken by up to a quarter of residents (Roberts et al., 2001; Snowden, Day, & Baker, 2005). A recent international review of aged care home studies into sedative use reported that over two thirds of use was inappropriate (Hughes, 2008).

The overall aim of the RedUSE project was to promote the appropriate use and review of these sedative medications in aged care homes through a range of strategies, co-ordinated and delivered by community pharmacy. If the project succeeds in achieving a successful reduction of prevalence rates and decreases in doses of sedative medication there are likely to be multiple flow-on benefits for older people, including increased mobility and alertness, decreased fall rate and improved well-being (Crotty et al., 2004).

Methods

The study design was a controlled trial conducted in 25 nursing homes in Tasmania. The intervention group included 13 Hobart nursing homes and 12 control nursing homes were located in Launceston. The primary outcome measure in the RedUSE project was the nursing home prescribing rates of antipsychotics and benzodiazepines. As required or 'prn' medications were only included in prescribing rate measures if they were taken on four or more days per week over the preceding month. Secondary measures included the rates of dosage reductions/cessations.

Data Measurement

As an integral part of the RedUSE project, a computer programmer developed a dedicated IT medication audit tool which assimilated community pharmacy nursing home prescribing information from packaging programs used to manage each resident's medications. Measures were taken at baseline, 3 and 6 months. The outcome measures were calculated utilising de-identified data obtained from these audits. The computer program also generated a 5-page 'benchmarked' report for each nursing home listing sedative prevalence rates alongside rates reported in Sydney 2003 (15% benzodiazepine usage and 24% antipsychotic usage) and Tasmania 2006 (42% benzodiazepine usage and 21% antipsychotic usage) (Snowdon et al., 2005; Westbury, Jackson, & Peterson, 2009).

After full ethical approval was granted in April 2008, all nursing homes in Hobart and Launceston were invited to participate. Both nursing home and their supply pharmacy had to agree to participate before the nursing home was accepted.

Intervention

The main strategies of the RedUSE project included two medication audit cycles, nurse educational sessions and a targeted sedative review. The primary focus was on informing health professionals about the risks and modest benefits associated with antipsychotics for dementia, and benzodiazepines for sleep disturbance and anxiety management in older people, and promoting regular review of these agents. Non-pharmacological approaches were also advocated. Guidelines based on recommended best practice regarding antipsychotics and benzodiazepines were formulated and distributed to intervention participants (International Psychogeriatric Association, 2004; Royal Australian College of General Practitioners, 2000).

Educational Strategies

Ten community pharmacists representing the eight supply pharmacies entering the intervention arm of the study received two days of training. Sixteen of the leading nursing home GPs servicing the intervention aged care homes participated in an individualised academic detailing session with a researcher (N.B. 147 GPs provided services for the 13 intervention aged care homes).

Two training sessions were developed for the nursing staff at the intervention homes and were delivered two weeks after the baseline and three month audit. Community pharmacists delivered all nursing staff education where the sedative audit results for each nursing home were presented and discussion regarding sedative use was encouraged. A total of 102 nursing staff attended the first educational session and 70 nursing staff attended the second session.

Sedative Reviews

When the baseline audit was conducted, the RedUSE IT program generated an individual 'sedative review' form for each resident prescribed regular doses of sedative agents. This sedative review included three sections; one for pharmacist, another for nurses and a final section for the GP's comment. These forms were intended to foster interdisciplinary communication about residents' sedative medication.

Analysis

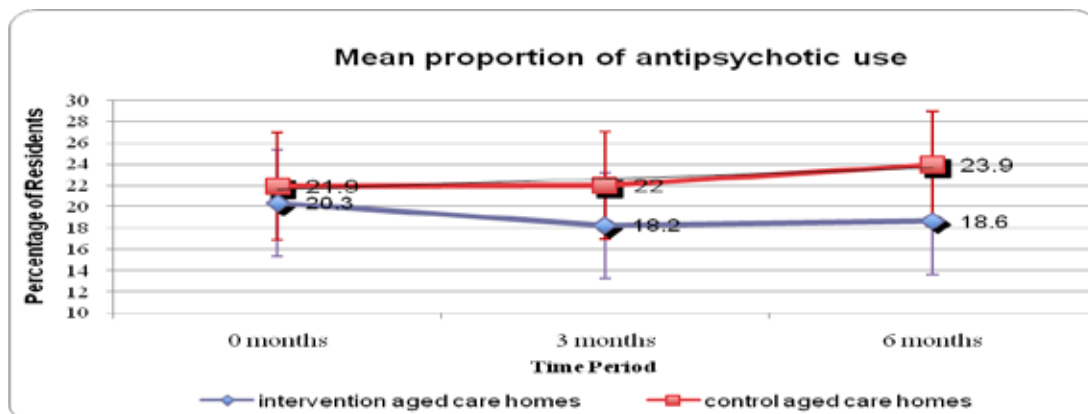
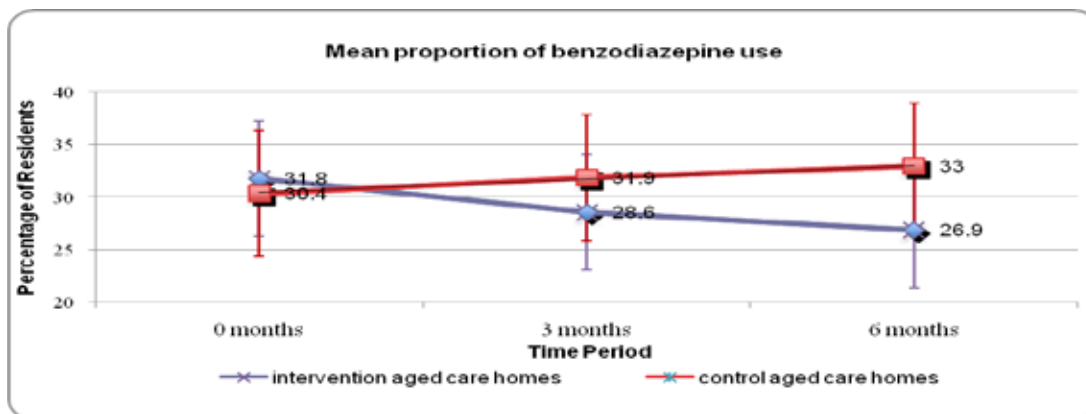
Paired t-tests and repeated measures analysis of variance (R-ANOVA) were used to test for differences in continuous outcome variables for baseline, 3 months and 6 months comparisons between control and intervention nursing homes. Analyses were performed using SPSS (Statistical Program for Social Science) package version 15. All tests were two-sided and p -values < 0.05 were considered statistically significant.

The RedUSE project was registered as a controlled trial at the Australian New Zealand Clinical Trials Registry: registration number: ACTRN12608000221358. Approval for the trial was granted by the Human Research Ethics Committee (Tasmania) Network.

Results

The RedUSE project led to a statistically significant reduction in the percentage of residents receiving benzodiazepines (31.8% to 26.9%, $p < 0.001$) and antipsychotics (20.3% to 18.6%, $p < 0.05$). The rates of sedative use in control homes increased slightly throughout the trial; albeit not significantly i.e. benzodiazepines (30.4% to 33.0%, $p = 0.2$) and antipsychotics (21.9% to 23.9%, $p = 0.16$).

Figure 1: Mean proportion of benzodiazepine and antipsychotic use in intervention vs. control aged care homes over time.



The RedUSE project also promoted review of sedative medication. Doses of both antipsychotics and benzodiazepines were significantly more likely to be reduced in intervention homes than in control homes over the 6-month duration of RedUSE. Approximately 40% of antipsychotic and benzodiazepine doses were either reduced or ceased completely in residents taking these agents in intervention homes compared to 19% of sedative doses in control homes (for antipsychotics: 36.9% vs. 20.9%, $\chi^2 = 7.4$, $p < 0.01$; and for benzodiazepines: 39.6% vs. 17.6%, $\chi^2 = 23.4$, $p < 0.0001$).

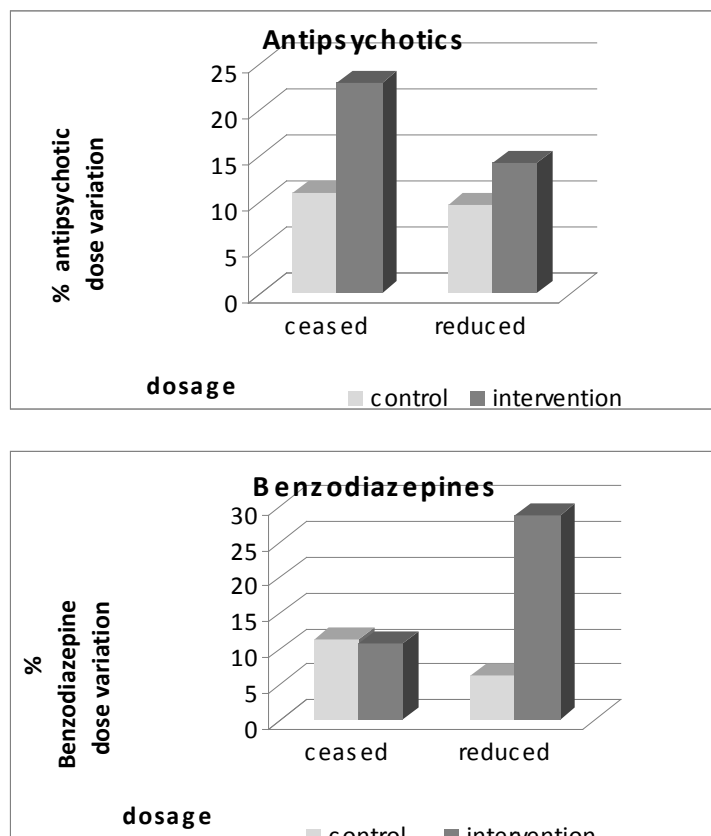


Figure 2: Variation in resident's antipsychotic and benzodiazepine use in intervention vs control nursing homes throughout the RedUSE trial

Implications for policy and practice

In 1995, a Senate committee report, 'Psychotherapeutic Medication in Australia', suggested that 'the lack of monitoring, or review of sedative agents, led to high levels of antipsychotics and benzodiazepines being prescribed for excessive periods, for little apparent benefit'(Australian Senate, 1995). One of the reported recommendations was that pharmacists become more involved in the monitoring and review of psychotropic medication (Australian Senate, 1995).

The RedUSE project was a novel Australian intervention study which evaluated the impact of pharmacist-led strategies on aged care home sedative rates. The RedUSE project strategies, including medication audit, staff education and interdisciplinary review, successfully reduced benzodiazepine and antipsychotic use and resulted in a marked increase in the number of antipsychotic and benzodiazepine dosages reviewed, with a more than doubling of dose reductions/cessations in intervention homes when compared to control homes.

Sedative use in nursing homes is a national and international concern. The perceived overuse of medication to manage common older age mental health conditions in aged care homes is impacted upon by a number of factors such as staff capacity, GP access and a lack of training on medications. The RedUSE project has shown that sedative rates and the frequency of dose reduction can be influenced positively by community pharmacist-led strategies, in particular staff training and sedative review, as predicted in the 1995 Australian Senate Report (Australian Senate, 1995). The project endorses the pharmacist as an important health professional in the aged care home setting with the vital role of optimising medication management.

The RedUSE project strategies and design should be made widely available for other regions of Australia and, indeed, in other countries where prescribing data can be measured and benchmarked and where healthcare systems are open to interdisciplinary training approaches.

Summary

The RedUSE project led to a statistically significant reduction in the proportion of residents in aged care homes receiving benzodiazepines and antipsychotics, and the number of antipsychotic and benzodiazepine dosages ceased or reduced in intervention homes was double that reported in the control aged care homes. Our findings suggest that strategies coordinated through community pharmacies offer an effective approach to reduce sedative use in aged care homes

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