

Improving Mental Health in Residential Aged Care Facilities: A Feasibility Study

Improving Mental Health in Aged Care Facilities: A Feasibility Study in partnership with GPpartners, Deakin University, *beyondblue*, University of Queensland and Carers Queensland (funded by the Australian Government Department of Health and Ageing).

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This report is dedicated to the residents in residential aged care facilities, their families and the staff and volunteers who care for the aged and their families in our community.

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Preface and Acknowledgments

GPpartners aged care team and the GP Panels behaviour management special interest group were concerned about the difficulties and stresses faced by newly admitted residents and their families to residential aged care facilities.

Equally concerned were the staff who were expected to give care to residents, when they had not been trained to detect, assess and treat depression, anxiety and agitation. The stress experienced by all groups was high.


Born from these concerns, the project *'Improving Mental Health in Residential Aged Care Facilities: A Feasibility Study'* was designed, implemented and tested.

The principle investigators were Ms Franceska Jordan AM, Associate Professor Gerard Byrne, School of Medicine, The University of Queensland and Dr Richard Kidd, previously Aged Care Director, GPpartners.

Ms Jordan is the author of this report. Associate Professor Gerard Byrne and Dr Richard Kidd assisted with the design and planning of the project. Associate Professor Byrne assisted with questionnaire design, quantitative data analysis and presentation of tables and write up for the report. We are greatly indebted to Professor Byrne for the expertise he brought to this project and his very generous assistance.

The research team included:

- Ms Amanda Bushell – Aged Care Project Liaison Officer, GPpartners, assisted with the design, planning and implementation of the project and analysis and write up of qualitative data. Special mention is required of Ms Bushell, who was 'an angel' in the guise of research assistant. Ms Bushell's organisational skills, clarity, abilities as a psychologist, trainer and data entry, analysis and write up person were exceptional.
- Ms Jordan and Ms Bushell provided the *beyondblue* aged care depression training program in the intervention groups.
- Dr Richard Kidd and Ms Helen Hoare were instrumental in the development of the original idea for this project. Their enthusiasm and commitment to providing quality care for residents, staff and families in residential aged care has been an inspiration.
- Ms Lorna McDonagh – Aged Care Project Liaison Officer, GPpartners, conducted the majority of assessments pre and post intervention with residents, their families and staff and brought her practical knowledge and experience of aged care nursing to enhance the project.
- Ms Helen Hoare – Aged Care Project Manager, GPpartners, was a constant source of assistance and guidance throughout the project.
- Ms Hoare's and Ms McDonagh's enthusiasm were a source of sustenance to all the team on the project.
- Ms Abbe Anderson, CEO of GPpartners, provided quiet, calm, thoughtful and balanced advice in a number of areas.



We are indebted to Dr Tanya Davison, Professor Marita McCabe, Dr David Mellor and Ms Sarah Russo from the School of Psychology, Deakin University for allowing us to supplement their study on 'Depression Training Program for Caregivers of Elderly Care Recipients: Implementation and Qualitative Evaluation' and use of their depression training material.

They also analysed data from the pre and post staff training questionnaires and prepared the results.

The Aged Care Taskforce, Behaviour Management Group and Advisory Committee for the project provided challenging debate, guidance and direction for the project. Special thanks to:

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- Tarry Brae Hostel – Mrs Nadia Fletcher, Residential Care Manager
- Iona Nursing Centre – Ms Kim Kratz, Director of Nursing
- Berlasco Court Caring Centre – Mrs Athena Ermides, General Manager
- St John's Home for Aged Men – Mr Joshua Hart, Director of Nursing
- Regis Corinya – Ms Elaine Simpson, Director of Nursing
- Ozcare, Palm Lodge Nursing Home & Hostel – Ms Alice Plevier, Director of Nursing

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Ms Carol McKinnon, Facility Manager, Tri-Care Nursing Home and Hostel generously allowed the ABC 'Stateline' report to film and report on the project from this facility. The staff and residents were very gracious in allowing the filming and responding to questions.

Carers Queensland designed and delivered their component – for the staff and the support groups for family carers. The ongoing support, compassion and practical assistance to family carers have been most beneficial and appreciated.

This research has been successful due to the agreement of residents and/or their substitute decision makers to be part of the study. The staff in the aged care facilities that completed the training and conducted the intervention were a delight to deal with, even when they were very pressured with other tasks to complete.

We have learnt an enormous amount from everyone's views, replies and impressions and trust this report will bring understanding, increased knowledge, confidence, assistance and services to residents, their families and staff.

Franceska Jordan AM



Executive Summary

This report presents the findings from a feasibility study of residents newly entered into residential aged care facilities (RACF), as well as their families and the care workers and nurses.

There were three distinct components of the feasibility study.

1. Examined whether the staff's depression training program:
 - Increased their knowledge
 - Improved their confidence
 - Changed their attitudes to residents with depression, and
 - Improved their ability to differentiate between depression, anxiety and dementia.
2. Assessed whether the three interventions implemented for residents reduced their depression, agitation and encouraged social interaction.
3. Assessed whether support groups for family carers reduced their distress and provided tools to assist with their adjustment to their family member's move into a facility.

The major findings of the study were:

Profile of respondents

Staff in the depression training program


The participants were 76 staff members with 53 (SD 12.78) personal carers and 23 (SD 9.84) nurses. Fifty-two personal carers were female and one male, while in the nurses group there were 20 females and 3 males. The mean age for personal carers was 43 and 46 years for the nurses. The average length of time worked within age care was 78 months (SD 83.94) for personal carers and 98 months (SD 117.45) for nurses.

Residents in the study

The participants were 50 RACF residents recently admitted to 12 different nursing home units. There were 29 (58%) females and 21 (42%) males whose mean age was 83.2 years (SD 9.88; range 52 - 99). On average, they left school at the age of 14.6 years (SD 2.1; range 9 -18). Thirty-nine (78%) were admitted to high care environments and 11 (22%) were admitted to low care environments. Most participants spoke English as their first language (45; 90%) and most had been born in Australia (30; 68%).

Informants – family carers, nurses and other professionals

There were 41 informants, of whom 31 (75.6%) were family members. The remainder (10; 24.4%) were nurses or other professionals. Of the informants who were family members, most (21; 51.2%) were adult children of the older person. The majority of informants (22; 53%) reported that they saw



the older person more than once a week but less than daily. On average, informants had known the older person for 41.7 years (SD 25.9; range 0.01 – 73).

Staff learnings from depression training program

Our statistical evidence shows that staff knowledge of depression and self-efficacy appears to have increased from Time 1 to Time 3 (refer to design chart page 23) for the treatment group, while mean scores of the control group are similar on both occasions, regardless of whether they were personal carers or nurses.

The first analysis examined the effects of nurses or personal carers and group (treatment vs. control) on participants' knowledge of depression at Time 1 to Time 3. The results showed that the staffs knowledge of depression increased significantly and remained over time. The second analysis looked at the effects of carers and group (treatment vs. control) on participants' self-efficacy over Time 1 to Time 3. Similar to the results of the first analysis, this result revealed that staff confidence increased and was significant. Moreover, time had a substantial effect on self-efficacy of the treatment group. On the other hand, self-efficacy of the control group stayed constant from Time 1 to Time 3.

The third analysis looked at the effects of carers (higher or lower) and group (treatment vs. control) on participants' attitude at Time 1 to Time 3. Unlike the above two analyses, the results indicated that time itself did not have a significant effect on attitude.

The only significant interaction that had an effect on carer attitude was time and levels of care. Mean scores of attitude Time 1 to Time 3 between higher and lower levels of carers seem to reflect different trends. While the overall mean scores of higher level carers slightly increased from Time 1 to Time 3, the overall mean scores of lower level carers were relatively stable between Time 1 to Time 3. In contrast, mean scores on attitude remained comparatively constant when only time was concerned. Likewise, mean scores of both treatment and control groups stayed relatively stable Time 1 to Time 3.

In the qualitative data nursing and care staff overwhelmingly and consistently commented that the program had increased their knowledge of depression in the elderly (100%), and provided them with knowledge that could be applied in their everyday work and life. A positive outcome for some participants was an increased empathy for their residents as well as increased confidence to communicate with residents and respond to symptoms of depression.

The response from staff that they found the depression training program very interesting (87.5%) and very useful (95%) is an indication the information and learning had practical applications for staff.

The majority of respondents reported that the training program was appropriate for their level of knowledge and skills (93%), with one registered nurse commenting that she felt it was targeted more towards carer level. The training program is particularly relevant for care workers and for nurses who have had limited information on depression for the elderly.

The changes that occurred with the detection of depression in residents and the subsequent referrals from care workers (87.5% of respondents) to registered nurses and general practitioners ensures that residents are not left with undetected and untreated depression, anxiety or dementia. The involvement of care workers as respected and fully functioning members of the care team resulted in increased job satisfaction for staff and improved care to residents.

Specific knowledge and skills gained

The ability and improved skills of staff to use assessment tools such as the Depression Checklist, Geriatric Depression Scale and the Cornell Scale for Depression in Dementia equips staff to recognise symptoms and signs of depression and assess the level of depression. This should then lead to treatment for residents. Research and practice show that depression improves for 60 to 80 per cent of cases with standard treatment (Mellor et al, 2008).

A substantial number of care staff also reported that the program provided them with increased knowledge and skills around the causes, prevention and treatment of depression (77.5% of participants). Many participants reported feeling better able to communicate with residents about their feelings and mood.

Fifteen percent of staff suggested that information about anti-depressant medications and specific referral options and support services (5%) could be included in the program in the future.

Presentation of program

Compelling positive feedback was provided regarding the presentation of the program, with staff consistently stating that they enjoyed the interactive delivery of the program. The majority of respondents (67.5%) reported that they found the group discussions to be interesting and thought-provoking, making particular mention of the insight and knowledge learnt through hearing their colleagues' points of view.

The training required a small investment of time from staff with the sessions ranging from 90 minutes for 5 sessions, to 120 minutes for one session over a six-week period. The delivery of the training worked best when it was provided on site, and was usually arranged in the afternoon, around staff handover time. The receipt of a certificate of completion is a valuable and important aspect of the training program.

Residents' perceptions and experiences of the interventions

Key worker/carer


65% of residents said that the key worker regularly came to talk to them and 30% said they were visited most days.

The majority of residents rated the visits and contact from the key worker as 'enjoyable' to 'most enjoyable' and would have liked more time with the key worker. This indicates the importance of routinely having someone to take an interest in the resident, be his or her advocate and take the time to talk.

Life Story book

When residents were asked how they enjoyed doing the life storybook, 55% said it was 'sometimes enjoyable' to 'very enjoyable'.

Sensitivity is required when delving into a residents' life history, significant life events, sorrows, joys and likes and dislikes. Staff were advised to seek permission from residents regarding what they wished to have recorded in the life storybook. Training on how to take a history, how to ask questions



respectfully and sensitively is required for staff. Residents might not enjoy completing the life storybook as was the case for 20% of respondents in this study, even when the approach was sensitive and respectful. Residents have the right to refuse and object to a life storybook being completed.

Walking and Talking Program

The walking and talking program received less response from the residents in terms of their views about this program. However 45% of responses were that they 'liked it' to 'liked it a lot'. Some residents even wished to walk and talk more frequently.

How residents felt entering the aged care facility

Residents' comments about how they felt when initially entering the aged care facility and then after a further four to six months showed that half of the respondents felt it was 'alright' to be in the home. The responses after the four to six months following entry showed more positive feelings than previously. There are many factors that influence residents' feelings and reactions to entering a facility. Time itself could be a factor in assisting residents to adjust. However it is considered that having a key worker, staff knowledge about a resident's likes and dislikes, and providing individual time for exercise and conversation, can assist residents to settle into a facility, perhaps quicker than would otherwise occur. Staff expressed that the interventions assisted residents to 'settle in' and found the program to be a very valuable resource.

Staff response to the use of interventions with residents

Key worker

The positive and difficult aspects of being a 'key worker', and the support provided to residents, were all covered in staff responses.

The positive aspects of being a key worker


The majority of staff said they enjoyed the key worker role and that it gave the resident someone to talk to. The second major group of respondents said that it helped the worker to get to know the resident and their needs; improved the relationship between the resident and staff; and that the key worker was the main contact person for the resident.

For residents to feel valued and included, it is very important that they have a confident, interested person to talk to regularly, and with whom they can express their feelings.

Difficulties with being a key worker

Some of the difficulties that staff have experienced point to a lack of acceptance of the role of key worker as part of the carer worker's normal responsibilities and that it is not routinely incorporated into the care system within a RACF.

The researchers have also questioned whether some staff see the role of key worker as important. Those staff may consider that being a key worker requires extra work and is not a routine part of the job. Some staff expressed that they were unable to find sufficient time to be the key worker.



Some of the comments made by staff about residents with cognitive impairment and dementia indicates training is required for communicating with residents with dementia.

Communicating with people with cognitive impairment requires particular knowledge, skills and abilities. Staff require training to help them to understand how to communicate verbally, non-verbally and emotionally with residents. Staff need to learn how to connect with residents with memory loss and understand that their attitudes and feelings can affect a resident's response to them.

Life Story book

Seventy-two per cent (72%) of the Life Story books were fully completed, 21% partially completed, with 7% not completed. The majority of staff found the Life Story book an important and valued resource as it helped staff to know the resident better. Residents were able to recall memorable events in their life, which opened communication and trust between residents and staff.

Walking and Talking Program

The walking and talking program provided good exercise, strength and balance, built and increased trust and support and was an opportunity for residents and staff to chat.

The responses from residents and staff showed that the walking and talking program made a difference to how residents felt. The attention they received when walking and talking and the feeling of being special improved the residents' wellbeing and identity. This program gave staff tools and activities that were meaningful to residents and could be used within the scope of their daily routine.

Time constraints were mentioned by a few staff who said that 30 minutes three times a week was very hard to do in a busy week. Staff thought that 10 to 15 minutes three times a week would be more practical for the walking and talking program. It was also thought that more one-on-one, uninterrupted time was needed to engage with the resident.


Where staff experienced time constraints in doing the walking and talking we had suggested that walking to the dining room in the morning, noon and evening for ten minutes at a time would count towards the 30 minutes required for the walking program.

Creative ways need to be found to do the program within the usual routine of care, so that it is more likely to be completed. The average time spent on the walking and talking program per week was 45 minutes per resident. This time is considerably less than the intended 30 minutes three times per week as prescribed in the intervention.

These results therefore have an impact on the expected outcome for residents. However, even though this result was below our expectations, the qualitative data from residents and staff shows that this program was both beneficial and important.

Overall views of staff on the interventions

The overall response of staff to the interventions was that it 'assisted staff and residents to get to know each other and that it was an enjoyable and interesting program'. It also provided respect and reassurance to the residents. This program needs to be available to all new residents as it helped residents to 'settle in'.



It could be interpreted from some of the staff comments that they view their work as only attending to the physical care needs of residents. The researchers have considered whether some staff viewed the interventions as a luxury and something you only did if you had free time, which staff do not have. The interventions may not be seen as routine care that provides for holistic and appropriate care for residents, especially newly admitted residents.

One of the facility managers in the intervention group expressed the intention to implement the key worker model of care across their facility for both newly admitted and existing residents.

Encouragingly, the majority of respondents saw these interventions as being an important, valuable and creative process.

Family carers

Seventy-three per cent (73%) of the family carers in the study did not attend the support groups with only 17% partially and 10% fully attending and completing the support group program. Recruitment of relatives (both intervention and control groups) was very difficult.

Some of the reasons given for non-attendance at the support groups were that many family members were happy for their relative (resident) to be involved in the interventions, but not themselves. This was surprising given the evidence and expression of family carer stress levels.

Some families expressed greater need for such a group in the time leading up to admission. Some carers expressed relief following their relative's admission and a few took the opportunity to have a holiday.

One of the positive outcomes was the collaboration with Carers Queensland. The support group program seemed to be relevant and well received for the few that did attend (see family carer's case study, pg 29). A further positive outcome was the ability for families to be referred for individual counselling through Carers Qld, which has been shown in the studies of Mittleman et al (2004, 2007 & 2008) s to be very important at reducing carer stress levels, distress and depression.

Recommendations

The Australian community places importance on older people having access to high quality and cost effective aged care services. This is reflected in current institutional and regulatory arrangements that give considerable weight to achieving equity of access and a minimum acceptable standard of service quality (Productivity Commission 2008).

The 'standardised' care system needs review to reflect the diversity among older people and to address the lack of psychological services in a significant number of residential aged care facilities (RACF). Management in residential aged care facilities need to be flexible and responsive to residents and family needs. They need to consider how simple and routine interventions can be incorporated into the care system for newly admitted residents and their families, to alleviate the difficulties that can be experienced.

1. Depression training program

The low level of detection of depression and the suffering experienced by the older person and those that care for them has become a major health problem. The way to improve this situation is to provide care workers and nurses with the skills to detect depression, know the difference between depression, anxiety and dementia, and have the ability and confidence to refer residents to a general practitioner and mental health worker for diagnosis and treatment.

Recommendation 1.1

That the '*Beyondblue aged care depression training program*' be offered to all nursing and care workers in RACF's, with a view to the training becoming mandatory.

Recommendation 1.2

That the '*Beyondblue aged care depression training program*' be considered as a prerequisite for working in residential aged care facilities and that this training program be considered for incorporation into Certificate III qualifications in Aged Care

Recommendation 1.3

An advanced program needs to be designed for registered nurses who have completed their basic training in depression and additional information in the training program is needed on anxiety and the differences between depression and dementia.

Recommendation 1.4

That training on anti-depressant medication is included in the depression training program.

Recommendation 1.5

That training is provided to staff on how to communicate verbally, non-verbally and emotionally with residents who have dementia.

2. Psychological services for aged care residents

Currently there is no Medicare rebate for psychologists to provide psychological services to residents of nursing homes. Under the rules of the *Medicare Better Access to Mental Health Care* initiative, patient eligibility for rebates for focused psychological services (MBS items 80100 to 80170) and psychological therapy services provided by a clinical psychologist (MBS items 80000 to 80020) do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital, therefore excluding access for residents of an aged care facility.

Given that nursing homes do not fund the provision of psychological services themselves, there is a consequent gap in the provision of psychological services in nursing homes. This is particularly lamentable given that there exists significantly high level of psychopathology in nursing home residents.

Research has found the prevalence of major depression in nursing home residents to range from 9% to 26% with up to 40% of residents suffering depressive symptoms that do not meet the criteria for a diagnosis of major depression (Mann et al., 2000).

Recommendation 2.1

That the provision of focused psychological services to residents be eligible for rebates under the MBS items 80100 to 80170 and psychological therapy services provided by a clinical psychologist under MBS items 80000 to 80020.

3. Assigning a key worker and ensuring consistency of staff

The reaction of people entering a nursing home can be characterised as one of loss followed by anger and depression. So-called 'difficult behaviours' can be a reflection of emotional despair – a result of entering a nursing home without receiving consolation or understanding. The importance of a key worker is for the resident to have a staff member that they know they can talk to, identify with and have as an advocate.

Recommendation 3.1

Nominate a dedicated care worker to be responsible for the new resident's needs, 'settling in' and adjustment.

Recommendation 3.2

That the management and staff within aged care facilities receive information on what a key worker does, how to implement this service routinely within the facility, what the benefits are for residents and staff, and then decide whether they wish to incorporate this service into their routine and care plans.



4. Residents Life Story book

Reminiscence and life review significantly improved depressive symptoms of residents. It is important for care workers and nursing staff to understand and appreciate the resident's preferences, interests, significant life events and relationships.

Recommendation 4.1

That the Life Story book be implemented routinely within the RACF for newly admitted residents.

Recommendation 4.2

That this knowledge of residents and their needs, be incorporated into the planned care of the resident in order to provide individualised, holistic and quality care and to promote the resident's choice.

Recommendation 4.3

That staff be given training on how to take a history and how to ask questions respectfully and sensitively for completion of the life storybook.

5. Walking and Talking Program

To combine exercise and conversation in order to assist in the functional mobility of residents, engage the resident in social interaction and decrease levels of depressive symptoms and/or agitation as well as assist with resident's 'settling in' process. Regular exercise such as walking can reduce aggression and restlessness in residents.

Recommendation 5.1

That a regular walking and talking program be introduced for residents who are mobile, with passive exercises in place of walking for wheel chair and bed-bound residents and that walking to the dining room, walking to showers and outside the facility be utilised as part of the program.

Recommendation 5.2

That 10 to 15 minutes of walking and talking provided three times a week and one-on-one uninterrupted time be provided to engage residents.

6. Family carers support groups

To assist relatives with emotionally stressful transitions when a family member enters a residential aged care facility by providing interventions that better prepare the family carers for placement transition and treat their depression and anxiety following placement. Effective counselling and support interventions can reduce symptoms of depression, anxiety and guilt and improve understanding of residential aged care processes and hopefully result in a decrease of complaints from family carers.

Recommendation 6.1

That individual and family counselling and support groups are provided for family carers before and after entry into a residential aged care facility.

Recommendation 6.2

That the management staff in residential aged care facilities consider involving and working with Carers Associations in the states and territories to provide counselling and support groups for family carers. That family carers be included in caregivers holidays organised by the Carers Associations, to relieve the pressures and provide rest, recreation and alternative ways to deal with their stressors.

7. Management styles

Previous studies conducted on management practices in terms of communication openness, participation in decision-making, relationship-oriented leadership and formalisation had an effect on those outcomes related to residents' prevalence of aggressive behaviours, restraint use, complications of immobility and rate of fractures (Anderson et al 2003).

Recommendation 7.1

That management practices facilitate self-organisation in terms of:

- Greater communication openness – being able to say what you mean without fear of retribution;
- Nurses participation in decision making;
- Use of relationship-oriented leadership, giving constructive feedback, helping staff resolve conflict, generating trust and being approachable; and
- Formalisation, specifying work procedures and rules in combination with surveillance to be tempered with a respectful approach to staff as well as residents.


8. Use of various types of interventions

Apart from the three interventions chosen for use in this study, there are numerous other types of interventions that can be considered for use in RACF. (See the extensive range of interventions that can be used as reviewed in the literature section of this report).

Recommendation 8.1

That the following interventions be considered:

- Music – used to calm, for aggressive behaviours, agitation and wandering;
- Mozart Effect;
- Nostalgic Music;
- Therapeutic storytelling and poetry therapy;
- Painting;

- 
- Dancing;
 - Singing;
 - Yoga and Meditation to Treat Depression; and
 - Relaxation and Treating General Disorders.

9. Maintaining interventions over time

One of the most important issues concerning the introduction of change in an institutional setting is that of maintaining the intervention.

Recommendation 9.1

That individual staff feedback be implemented on the interventions introduced, through a recording sheet for key worker visits, the completion of life storybook and a 'walking and talking tracking sheet'. See appendices X, Y and Z for examples.

Recommendation 9.2

That interventions not be time limited as per the study, rather that management incorporate the interventions into the routine and planned care of residents.

10. Workforce issues

Low pay, lack of career path, insufficient staff numbers per residents, occupational health and safety issues, (in particular those associated with managing challenging behaviours, the amount of lifting associated with frailty) and longer working hours to cover absences, all contribute to a difficult and unsatisfying work environment (HRSCHA 2005).

All these conditions were observed by the researchers and it was obvious that these conditions impacted on the interventions being fully implemented and completed, even though many of the key workers were enthusiastic and enjoyed the training and conducting the interventions.

Recommendation 10.1

That the remuneration to personal care workers be reviewed and that the staff to resident ratios, especially in high level care, be reviewed and increased.

Recommendation 10.2

That a culture of safety, development opportunities, job design, conflict resolution, cultural sensitivity, and equity and diversity for staff be provided in residential aged care facilities.



Section 1 – Introduction

Admission to a nursing home is a major life event, not only for the future resident, but also for the family, who must recognise that their family member has reached a stage of physical and/or mental frailty, and that they no longer can manage living at home. In addition, admission to a residential care facility is often a challenge for staff, who can face negative emotions from the new resident and their family carers.

Research has shown that the quality of such transitions can be linked to staff knowledge of the mental and physical conditions encountered in nursing homes, as well as their ability to form productive alliances with the resident and their family (Ryan, 2002). Thus the overall aim of this feasibility study was to develop a set of tools and procedures to attempt to reduce stress and offer support to residents and their families as well as staff in the residential facilities.

Focus of the study

The study examines the interrelationship between training, thorough assessment, and support and activities to reduce depression and distress in residents and their families. It also provides staff with the skills and confidence to detect and deal with depression and distress.

This report discusses:

- Increasing professional carers' knowledge of depression, their skills and confidence in detecting and monitoring depression among the older people for whom they care, and their confidence in referring onto other health professionals;
- The objective clinical data that needs to be collected to evaluate the cognitive, physical, psychological and emotional state of residents being admitted to nursing homes, which will enable general practitioners and staff to shape better care plans;
- The three interventions for residents including how they were implemented and evaluated; and
- The effect of the support groups for family carers.

We will further report on whether:

- Training to increase the level of knowledge and confidence of staff in detecting and dealing with depression can ameliorate the psychological distress experienced by people entering nursing homes; and
- The key worker, life story review and 'walking and talking' interventions can reduce distressing behaviours such as agitation and depression, and improve the general wellbeing and sociability of residents.

It is the intention of this feasibility study to look at how behavioural interventions that address the emotional and psychological needs of residents can assist in reducing depression and improving their quality of life.



Literature

Introduction

The literature review and discussion in this section informed the parameters of the study and builds on our understanding of depression in the elderly and their families upon their initial entry into a Residential Aged Care Facility. Staff knowledge and confidence in dealing with depression, anxiety and dementia, was also investigated in the literature.

The evidence-based criteria used to determine which interventions should be chosen for residents' interventions were as follows:

- Placing the resident's benefit first
- Considering questions of direct practical importance to residents, their families and staff; and
- Searching objectively and efficiently for best practice relative to our study on depression, agitation and distress (Hull, Redfern & Shuttleworth, 2005), using key words: intervention, assessment, behavioural, nursing home.

Other criteria included:

- The ease by which personal care workers could deliver interventions
- Whether the interventions were able to be incorporated as part of the routine, daily tasks of staff and yet still be meaningful for residents and their families.
- Whether small and manageable amounts of time were required from staff to do the interventions.


Studies included systematic reviews, meta-analysis and randomised control trials. Studies from 1987 to 2008 were considered for inclusion. Only studies in English were considered for inclusion.

As care giving poses multiple challenges, a multicomponent intervention model looking at three areas of the resident's life that can cause concern in the initial move into an aged care facility was considered. The three areas are:

- Being able to identify and connect with a consistent and significant person/staff member who can advocate on their residents behalf, check on how they are 'settling in' and their general well being
- Obtain information on the resident's life prior to entering the aged care facility, their likes, dislikes and particular preferences, as well as significant life events of importance and relevance to the resident.
- A walking and talking program to enhance activity, communication, social well-being and reduce depression and agitation.

Psychological training and support of aged care staff

Late-life depression has become a major public health problem, leading to suffering among older people where depression is not detected and burdening those who care for them. This serious but treatable medical condition results in substantial health care and social costs to the community (Berardi et al., 2002). As life expectancy increases and the population ages, the burden of this illness



is likely to rise considerably (Llewellyn-Jones, et al., 2001; Reynolds & Kupfer, 1999; Walker & Osgood, 2000). While depression among older people in the community has been estimated to be approximately 3%, prevalence rates are much higher among older people in residential care (National Institute of Health [NIH] Consensus Conference, 1992). Research has found the prevalence of major depression in nursing home residents to range from 9% to 26% (Baker & Miller, 1991; Banerjee & Macdonald, 1996; Benazzi, 1998; Samuels & Katz, 1995; Valvanne, Juva, Erkinjuntto & Tilvis, 1996), with up to 40% of residents suffering depressive symptoms that do not meet the criteria for a diagnosis of major depression (Mann et al., 2000). Previous research by the Deakin University's School of Psychology team, found that 16.9% of residents in low-level care residential facilities met DSM-IV criteria for Major Depressive Disorder (MDD) (Davison et al., 2007a). A key finding of this previous research was the low recognition rate of depression, with less than half of those older people with MDD being diagnosed and treated (Davison et al., 2007a).

Given this set of circumstances, one way to improve the situation would be to encourage care staff, who have the most contact with care recipients, to place a greater focus on the emotional state of care recipients. However, research has found that care staff may lack knowledge of depression and also self-efficacy in taking action should they recognise depression in a care recipient (Davison et al., 2006; Mann et al., 2000; McCabe et al., 2008). Further, there are often organisational barriers, such as poor communication between carers and senior staff, which would impede any action that an informed and confident carer may decide to take (McCabe et al., in press). In light of these issues, it has been recommended that training programs be developed to increase the knowledge and self-efficacy of care providers in dealing with depression (e.g., National Institute of Health Consensus Conference, 1992) and to overcome some of the organisational barriers that restrict depressed older care recipients from accessing appropriate treatment for their condition (Davison, 2006; McCabe et al., in press).

(Literature cited from Mellor and McCabe et al – The Beyondblue training program for professional carers in recognising late-life depression, School of Psychology – Deakin University 2007).


Pharmacological and non- pharmacological interventions

Literature on pharmacological and non- pharmacological interventions for residents was considered.

Over-prescription of drugs to seniors is a contentious issue in Canada after a 2005 investigation by the Canadian Broadcasting Council found that 3,300 seniors were dying annually from adverse drug reactions.

Bird et al (2001) considers that 'depending on what assessment reveals, a psychosocial package for a case of challenging behaviour may include medication and, in certain cases medication must be the prime component'. Whereas Peisah and Brodaty (1994) imply that psychological approaches should be tried first. Bird et al (2001) disagree in that, if depression or pain is a major aetiological factor in a case of challenging behaviour the appropriate medication needs to be tried first.

Further discussions from NSW Health (1967); Nyaard et al (1994); Thapa, Meador, Gideon, Fought & Ray (1994), say the problem is not psychotropic medication, but inappropriate and often excessive use of medication aimed at suppressing behaviour rather than treating its causes.



This highlights the need for assessment and intervention methods that do and do not involve the use of drugs in nursing homes. However, Canadian authorities are concerned about the overuse of antipsychotic drugs in nursing homes. A recent study (Rochon et al, 2007) showed that hundreds of people in Ontario nursing homes were on antipsychotic drugs they may not need. 'Seniors taking the medications may lose their balance, appear sedated or shake like someone with Parkinson's disease.' The study, involving 47,000 nursing home residents in 500 institutions, found that more than 800 patients, who had no prior indication of either dementia or psychosis, were on these drugs. Relatives were also concerned about this and often did not know their relatives were on anti-psychotic medication until afterwards. There is now a bill before the Ontario Parliament to reduce the use of antipsychotic drugs in nursing homes. (CBC News April, 2007).

Interventions targeting the elderly as a group

"Different types of interventions have been successful to different degrees in improving the mental health of older populations, including exercise, improving social support through befriending, patient education among chronically ill elderly and their caregivers, early screening, interventions in primary care and programmes using life review techniques," (Saxena et al, 2006). Saxena et al, (2006) compiled an article by representatives of WHO organisations in Europe in 2006, and reviewed the current status of knowledge of prevention of mental disorders in all age groups. Studies evaluating the effects of interventions like these can be divided into those that target the elderly as a group and those that target particular disorders or problem behaviours.

The World Health Organisation group gave the example of a study (Li et al, 2001) showing that "exercise, such as aerobic classes and Tai Chi, provide both physical and psychological benefits in older populations". These include increased life satisfaction, positive mood states and mental well-being, reductions in psychological distress and depressive symptoms, lower blood pressure and fewer falls.

Interventions targeting specific disorders or behaviours

One of the most common disorders in the literature is dementia. Although many of the studies focus on testing the efficacy of pharmacology, some have also considered other forms of behavioural intervention.

"Activity programs, music, behaviour therapy, light therapy, caregiver education, and environmental changes have all been shown to have some benefit" (Opie et al, 1999). "Behaviour management techniques were shown to be as effective as trazodone or haloperidol for agitation in patients with Alzheimer-type dementia (Teri et al, 2000)." (Omelan, 2006)

Several studies have used mobilisation, in the form of walking or exercise. One study focussed on walking and conversation with frail aged with dementia, a group who are usually excluded from such studies. They used 30 minutes of self-paced assisted walking interspersed with rest as needed to delay fatigue, three times a week for 16 weeks, in combination with 30 minutes of conversation treatment based upon a special technique designed for individuals with dementia (Bayles and Kaszniak, 1987). Conversations were based on topics from their environment that were of personal interest and any attempt to communicate was encouraged. See methodology section regarding the 'Walking and talking' program for details (pg. 20).

Prevalence of aggression and agitation

One of the most prevalent and difficult behaviours to manage is aggression. A study from Quebec (Voyer et al, 2005) involving a very large number of subjects (n=1332) found that 21% displayed both verbal and physical aggression. The results, in a nutshell, were:

- Physical aggressive behaviour was associated with older age, male gender, neuroleptic drug use, mild or severe cognitive impairment, insomnia and psychological distress.
- Verbal aggressive behaviour was associated with benzodiazepine and neuroleptic drug use, functional dependency, mild or severe cognitive impairment and insomnia.
- Cognitive impairment severity was the most significant predisposing factor.
- Physical and chemical restraints were also significantly associated with aggressive behaviour.

An interesting feature of the methodology in this study was the use of the MOSES Scale.

The MOSES - Multidimensional Observation Scale for Elderly Subjects, is an instrument that provides an overall evaluation of older adults. It consists of 40 closed questions regarding quantified observations carried out in the week preceding the data collection in five domains: (1) functional autonomy; (2) cognitive status; (3) psychological distress; (4) disruptive behaviour; (5) isolation and withdrawal behaviour. The MOSES has good internal consistency of 0.80 ($p < 0.05$) and correlates well with the Zung Depression, Robertson Short Mental Status, Kingston Dementia and the Physical and Mental Impairment-of-function Evaluation.

Overall, the methodology was impressive and is worth a closer examination.

A review of behavioural disturbances in dementia (Desai et al, 2001), found that 90% of those with dementia develop behaviour problems. Agitation occurs in 75% of nursing home residents (Rovner et al, 1990). Verbal aggression threats (54%) and physical aggression/agitation (42%) constitute the two most frequent behavioural disturbances in patients with Alzheimer's Disease and related disorders (Colenda, 1995). Other behaviours such as sleep disturbances (38%), restlessness (38%) and wandering (30%) are also prevalent (Colenda, 1995).

The more cognitively impaired the person, the more likely the occurrence of agitation (Cooper et al, 1990, Teri et al, 1988). Increased functional impairment is correlated with screaming and vocal outbursts, depressed affect and poor social networks (Cariaga et al, 1991, Cohen-Mansfield & Marx, 1988, 1990).

Aggression in Alzheimer's Disease patients occurs in the context of a high level of physical dependency for hygiene, dressing and toilet needs (Deutsch & Rovner, 1991). Staff-patient interaction was found to be the most frequent precipitant of physical aggression in state hospital dementia patients (Colenda, 1991). This observation is important as it tallies with the Ombudsman for Institutionalised Elderly's Report, New Jersey (Corzine et al, 2006) to be discussed later.

It is important to identify the precipitants for specific behaviours and the context of staff-resident interaction. A review (Abhilash et al, 2001) of the management of disruptive behaviour advocates using behavioural measures: "Many behavioural disturbances can be prevented by avoiding inappropriate medications and educating patient, family, caregivers, and health care providers".

Self destructive behaviour

A study (Draper et al, 2002) of 610 nursing home residents in Sydney found that 61% had displayed indirect harmful behaviour within the week prior to the investigation, while 14% had shown directly harmful behaviour. Results showed that younger age, chart diagnosis of dementia, greater incapacity, and a higher suicide score predicted a higher degree of self harming behaviour. The results did not show that depression was associated with self harm.

Depression and behavioural symptoms


In a survey of 647 residents from 11 eastern Sydney nursing homes it was found that over 90% of the residents exhibited at least one behavioural disturbance, 60% displayed evidence of psychosis, 42% displayed evidence of depressed mood and 82% experienced activity disturbance or aggression (Brodaty, et al., 2001). Similarly, other studies have estimated that approximately 14% of residents meet the criteria for a Major Depressive Disorder, while around approximately 44% of residents have significant levels of depressive symptomatology (Teresi, Abrams, Holms, Ramirez & Eimicke, 2001). A previously larger study of 46 Sydney nursing homes (2414 residents), found that approximately 30% experienced high levels of depression (Snowdon, Burgess, Vaughan & Miller, 1996). As such there is good evidence that a significant number of nursing home residents are in need of psychological services, yet these services are not provided in Australian nursing homes.

Whitney and Snowden (2007) recommend the use of behavioural activation and pleasurable events in the treatment of depression in patients with significant dementia due to the significant decline in executive functioning, which is necessary in the use of other therapeutic interventions (such as Interpersonal Therapy; IPT and Problem Solving Therapy; PST). They also recommend that by using behavioural therapy, the facility based care manager is able to implement some of the behavioural therapy in conjunction with therapists and social workers, which therefore makes it an attractive intervention. There is also evidence that exercise based programs are useful in improving positive mood and decreasing negative mood in nursing home residents with dementia (Williams & Tappen, 2007).

The merger of these two findings supports the development of walking and talking programs as a useful intervention for emotional problems in nursing home residents with and without dementia.

Assigning a key worker and ensuring consistency of staff

The aim of the Key Worker Intervention is to ensure continuity of care of the resident by nominating a dedicated care worker to act as an advocate and liaison person to take a particular interest in the new resident, assisting with their settling in and adjustment. The reaction of people entering a nursing home can be characterised as one of loss followed by anger and depression. Entering a nursing home is a most difficult time of life, with all of its changes and losses. The more assistance and care staff can give residents and their families, the easier it will be for them (Ryan 2002). Jean Harker (1997) described what it is like for someone to enter a nursing home. She says so-called 'difficult behaviours' can be a reflection of emotional despair – a result of entering a nursing home without receiving consolation or understanding. Physicians from the University Tromsø in Northern Norway (Talseth et al, 2003) have developed a framework for talking with people who are experiencing difficult emotions. It is important for the resident to have a staff member that they know they can talk to and identify with, and know who their advocate is (Colenda 1991). Listening to residents is also important as they share



their story. Listening helps them to express this story outside of themselves, and it is also most helpful to staff in understanding residents thoughts, concerns, and grief (Hoifodt 2007).

The Resident's Life Story

Bohlmeijer et al (2003) found that reminiscence and life review significantly improved depressive symptoms. It is important for carers and nursing staff to understand and appreciate the resident's preferences, interests, significant life events and relationships.

This knowledge needs to be incorporated into the planned care of the resident in order to provide individualised, holistic and quality care and to promote a resident's choice. Residents, in their journals reflected on the spiritual meaning of physical and mental health in a study by Pope et al (2006) in describing their 'Perceptions of Depression in Long-Term-Care Residents'. Residents, with and without dementia, could achieve more consistent and positive evaluations of their past, through a process of recollection and life reviews of unresolved conflicts. They could accept personal losses and preserve a sense of usefulness and satisfaction with their lives.

Staff and family caregiver(s) could simply use a photo of the past event or a familiar song to encourage the resident to relive his/her past experience. Life stories are a historical and psychological process and if several persons, with and without dementia, are grouped together to do the reminiscence activities, social interaction and emotional release could be further facilitated (Wacks 1989). The life story review also equips the staff with detailed knowledge about the resident and provides a basis for conversation and engagement (Hoifodt, 2007). As staff understand a resident's story better, staff can be of more help to residents in this part of their life. Staff should encourage residents to tell them how they feel, so that they can better understand residents. One of the greatest gifts staff can give is to be a good non-judgmental listener. Listening indicates that staff really care and feel concerned, and also that staff really want to help (Talseth, 2003).


Walking and Talking program

The Walking and Talking program aims to combine exercise and conversation in order to assist in the functional mobility of residents, engage the resident in social interaction and decrease levels of depressive symptoms and/or agitation, as well as assist with the resident's 'settling in' process. Regular exercise such as walking can reduce aggression and restlessness (Williams & Tappen, 2007).

In Bayles and Kaszniak's study (1987) the exercise was conducted for 30 minutes of self-paced assisted walking interspersed with rest as needed to delay fatigue, three times a week for 16 weeks in combination with 30 minutes of conversation treatment based upon a special technique designed for individuals with dementia. Conversations were based on topics from their environment that were of personal interest and any attempt to communicate was encouraged.

The interesting aspect of this study was that the frail aged were divided into three groups, one who just walked without conversation, one which conversed only, without walking, and a third group which combined walking and talking.

Their results showed that "30 minutes of assisted walking three times a week is an effective intervention for preventing deterioration in functional mobility in nursing home residents with Alzheimer's Disease."



Importantly, the combined group who experienced both walking and talking had the best results. Bayles & Kaszniak findings also suggest that social interaction during walking exercise is essential in order to achieve a level of compliance sufficient to produce a response to the exercise.

Psycho-social interventions for family and carers

The intervention for family/carers aims to assist relatives with emotionally stressful transitions when a family member enters a residential aged care facility; provide interventions that better prepare the family carers for placement transition; and treat their depression and anxiety following placement (Schulz 2004).


Caregivers' reactions to admitting a family member/friend to a long-term care facility were investigated by Schulz et al (2004). In a prospective study from 1996 to 2000 a total of 1222 patients and their caregivers from 6 US sites were followed up. A total of 180 patients were placed in a long-term care facility during the 18-month follow-up period. Results showed that caregivers reported depression and anxiety at levels as high as when their family member was still at home. Overall depression and anxiety scores did not change when the family member was admitted to the nursing home. These effects were most pronounced among caregivers who were married to the resident. The findings from this study have been incorporated into the topics to be discussed by the family carers in support groups in order to improve family caregivers psychological distress.

Ali Javadpour et al (2008) in his educative support group for female family caregivers and the impact on caregivers psychological distress and patient's neuropsychiatry symptoms found this study supports the use of a non-pharmacologic intervention focusing on education in a feasible and cost benefit setting for dementia caregivers.

They ran a non pharmacological intervention focusing on dementia education, behavioural problems and an interactive self support group. Twenty nine female family caregivers were assigned and divided in two groups of 15 and 14. Two hour weekly sessions were conducted for 8 weeks. Baseline and outcome measures were assessed using neuropsychiatry Inventory (NPI), a general health questionnaire and perceived stress scale (PSS).

Their results demonstrated a significant correlation between GHQ and total NPI scores but not for PSS. Paired sample testing revealed a significant change from baseline and at the end, in both GHQ score and neuropsychiatry symptoms.


The Mittelman MS, Roth DL, Coon DW, Haley WE.(2004) study focussed on sustained benefit of supportive intervention for depressive symptoms in caregivers of patients with Alzheimer's disease. Their objective was to look at the long-term effect of counselling and support on symptoms of depression in spouse-caregivers of patients with Alzheimer's disease. The participants were 406 spouse-caregivers of Alzheimer's disease patients who lived at home at baseline. The caregivers were randomly assigned to either a group receiving enhanced counselling and support treatment or a group receiving usual care (control group). Caregivers in the enhanced treatment group were provided with six sessions of individual and family counselling, agreed to join support groups 4 months after enrolment, and received ongoing ad hoc counselling. The Geriatric Depression Scale was administered at baseline and at regular follow-up intervals for as long as the caregiver participated in the study. Their results showed after baseline differences were controlled, caregivers in the enhanced treatment group had significantly fewer depressive symptoms after the intervention than did the control



subjects. These effects were sustained for 3.1 years after baseline, similar across gender and patient severity level, and sustained after nursing home placement or death of the patient. They concluded that counselling and support lead to sustained benefits in reducing depressive symptoms in spouse-caregivers of Alzheimer's disease patients and should be widely available to provide effective, evidence-based intervention for family caregivers.

Mittelman MS, Roth DL, Clay OJ, Haley WE (2007) looked at preserving the health of Alzheimer caregivers and the impact of a spouse caregiver intervention. The objective of this study was to determine the effects of counselling and support on the physical health of caregivers of spouses of people with Alzheimer disease. A randomised controlled trial, conducted between 1987 and 2006 at an outpatient research clinic in the New York City metropolitan area compared outcomes of psychosocial intervention to usual care. Structured questionnaires were administered at baseline and regular follow-ups. A referred volunteer sample of 406 spouse caregivers of community dwelling patients with Alzheimer disease enrolled over a 9.5-year period. Enhanced counselling and support consisted of six sessions of individual and family counselling, support group participation, and continuous availability of ad-hoc telephone counselling. Indicators of physical health included self-rated health (SRH) of caregivers and the number of reported illnesses. Their results, controlling for baseline SRH (mean: 7.24), showed that caregivers in the intervention group had significantly better SRH than control group caregivers based upon model predicted mean scores four months after baseline (6.87 versus 7.21), and this significant difference was maintained for two years (6.70 versus 7.01). The effect of the intervention on SRH remained significant after controlling for the effects of patient death, nursing home placement, caregiver depressive symptoms and social support satisfaction. Similar benefits of intervention were found for a number of illnesses. They concluded counselling and support preserved SRH in vulnerable caregivers. Enhancing caregivers' social support, fostering more benign appraisals of stressors, and reducing depressive symptoms may yield indirect health benefits.

Psychosocial intervention studies with biological measures of physical health outcomes were warranted (Mittelman MS, Brodaty H, Wallen AS, Burns A., 2008) A three-country randomised controlled trial focussed on a psychosocial intervention for caregivers combined with pharmacological treatment for patients with Alzheimer disease and the effects on caregiver depression. Their objective was to evaluate the effectiveness of a combination of cholinesterase inhibitor therapy for patients with Alzheimer disease (AD) and psychosocial intervention for their spouse caregivers compared with drug treatment alone, in three countries simultaneously. Structured questionnaires were administered at baseline and at regular follow-up intervals for 24 months by independent raters blind to group assignment. The settings were at outpatient research clinics in New York City, U.S., Manchester, U.K. and Sydney, Australia. A volunteer sample consisted of 158 spouse caregivers of community dwelling patients with AD. The interventions included five sessions of individual and family counselling within three months of enrolment and continuous availability of ad hoc telephone counselling were provided for half the caregivers. Donepezil was prescribed for all patients. The main outcome measure was depressive symptoms of spouse caregivers measured at intake and follow-up assessments for 24 months using Beck Depression Inventory (revised). Depression scores of caregivers who received counselling decreased over time, whereas the depression scores for caregivers who did not receive counselling increased. The benefit of the psychosocial intervention was significant after controlling for site, gender and country was not accounted for by antidepressant use and increased over two years even though the individual and family counselling sessions occurred in the first three months. They



concluded that effective counselling and support interventions can reduce symptoms of depression in caregivers when patients are taking donepezil. Harmonized multinational psychosocial interventions are feasible. Combined drug and supportive care approaches to the management of people with AD and their caregivers should be a priority.

Maintaining interventions over time

One of the most important issues concerning introducing change in an institutional setting is that of maintaining the intervention. A study, which introduced procedures to help residents with continence problems, found that there was a gradual decline in staff performance following the initial intervention (Burgio et al, 1990). The staff management system included self-monitoring, recording of prompted voiding activities, supervisory monitoring, and feedback based on group performance of these activities. The results showed that, although the procedure was effective, there was a gradual decline in staff performance 4 to 5 months after the initiation of the new intervention. Provision of individual feedback restored staff performance to previous levels. (Burgio et al, 1990). These findings are confirmed in our study, where the researchers needed to remind staff and visit them regularly in order for the intervention to be maintained for 12 weeks of the intervention program.

Entering a nursing home – residents' reaction

The reaction of the people entering a nursing home can be characterised as one of loss followed by anger and depression.

Fear, isolation, and a sense of numbing helplessness characterize the nursing home, the mental hospital and other institutional experiences for the majority of residents. To enter a hospital, especially a mental hospital or a nursing home, either as a visitor or a patient, is to encounter an environment that has no equal in barrenness anywhere in our culture except for the prisoner's cell in the view of Mayer Spivack Institutional Environments, Art and Minds Web Journal, Nov. 2007

There are some research findings that confirm that the experience of entering a nursing home is associated with guilt, anger, despair, resentment and general psychological distress (Ryan, 2002)


Jean Harker (1997) described in ordinary language, a story simply called "Help Me", which told what it was like for someone to enter a nursing home. This article assists in understanding the emotional reactions of seniors and their families to this major life change.

It is possible that the so-called 'difficult behaviours' are a reflection of emotional despair – a result of entering a nursing home without receiving consolation or understanding.

Talking to seniors

There is very little in the literature concerning how we might try to overcome the feelings of anger and loss in residents and their carers as they contemplate entering a nursing home, and throughout the process of settling in. However, there are a few groups of researchers trying to tackle this problem. One is a group of physicians and nurses from the University of Tromsøe in Northern Norway and the other are nurses from the University of Ulster in Northern Ireland.

Anger, irritability and depression in people with dementia can be caused by undiagnosed pain. Researchers in Holland (Zwakhalen et al, 2006) have reviewed the literature and found that pain



among nursing home residents is “a common and major problem. The prevalence of pain in elderly nursing home residents is 40–80%.” Difficulties occur due to the dementia, when residents have difficulty communicating their sense of pain to others.

Cognitive decline can also be the results of lack of motivation to stay engaged with life. This may have happened before the person entered the nursing home, but is then later compounded by the emotional distress they experienced upon entering the nursing home.

One reason that seniors seem to be losing their memories is that they are becoming more detached from life. It's not that they are forgetting things, they are not noticing them in the first place. In other words, they are paying less attention to what is going on around them. – (Paying Attention A Talk to Seniors on the Problem of Memory Loss - <http://www.themoorings.org/life/talks/seniors.html>)

We know that practicing the mind helps us retain our memory, but in order to practice there has to be some motivation, and for many elderly people, that motivation has been lost. Life is no longer engaging their interest.

The need for consolation


Norwegian professionals from Tromsø University (Talseth et al, 2003) have developed a framework for talking with people who are experiencing difficult emotions using five themes The themes are: 'longing for closeness', 'desiring connectedness', 'struggling to open up inner dialogue', 'breaking into outer dialogue', and 'liberating inner and outer dialogue'.

Another theme is the process of struggling to become ready for consolation.

A framework for learning to talk about difficult emotions

In another article (Høifødt et al, 2007), the group described the process of how professionals learn to meet the needs of people who are experiencing difficult emotions:

1. **Getting tools and training skills:** The informants reported that it was extremely important in the beginning to have treatment plans and procedures. They referred to practicing by role-playing, how to relate to a patient, how to phrase their questions and deal with different types of feelings that emerge. The informants reported on the importance of being challenged about their own attitudes.
2. **Gaining experience from treating patients:** The informants emphasised the importance of learning from the practical experience of meeting patients in real life situations.
3. **Storing memories and recognising similarities and differences in patients:** The informants told how they had a memory store of patients in their minds, with both cognitive and affective elements. This was as if they had acquired their own "history databank". When sitting with a new patient, different images of former patients passed before them. They compared and recognised general as well as special aspects of the situation.
4. **Being an apprentice:** The physicians expressed the usefulness of working in interdisciplinary teams and together with more experienced professionals.

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5. **Relating clinical stories and receiving feedback:** The informants expressed that telling their stories about different clinical situations served as a way to reflect on their experiences and make them feel more secure in handling the situation.
 6. **Sharing emotions from clinical experiences:** The informants expressed their need to share feelings and to communicate insecurity and doubt about their decisions. Talking to a colleague about a difficult situation or critical incident was experienced as a relief and as important for working through their own reactions.
 7. **Receiving support from peers:** The informants used each other to talk through clinical situations, sometimes both before and after the actual event, getting advice and response to their way of handling the situation. They wanted their peers to ask questions as a check so that they felt that they had thought about the essential parts of the problem.
 8. **Having an unarticulated awareness:** The informants described a knowledge that was experienced physically. Some called it a "gut feeling". They described it a little differently, but related it to aspects of the contact with the patient – the content and presentation, the verbal and non-verbal queues. This developed during the contact and was related to how they could make sense of the situation and understand the problem. They used this unarticulated awareness as a factor in their assessment of the clinical situation. The informants also report that the "gut feeling" had changed during their time in practice.
 9. **Having emotional knowledge:** The informants were concerned about using all of themselves in the role of the physician. Knowledge and understanding of one's own way of reacting made it easier for them to more adequately relate to the patient. One informant said: "*I think that it is very important to think about how you yourself are doing, one's own reactions, not to analyse so much, but to think about my patterns of reacting to what is going on around me.... try to think how I would have felt in a similar situation.*"
 10. **Achieving self-confidence:** The informants described a process of gaining their own understanding of the patient's situation and acquiring an awareness of clinical patterns. A thorough involvement in the problems of the patient over time was necessary to acquire this perspective.

Talking to seniors about moving to a nursing home

Even before a person enters a nursing home, the issue of moving needs to be discussed openly.


See article '*Talking with Seniors About Moving: Empathetic Approach Can Diffuse a Difficult Conversation*', By CaregiverZone, which is included in the reference list.

Other types of evidence based interventions for residents

For a discussion of a range of other potential interventions that have been found to be useful with aged care residents, see Appendix 27.

Management styles in Nursing Homes

Duke University School of Nursing in the United States conducted an evaluation of management styles of nursing home staff (Anderson et al, 2003).



The researchers wanted to know whether management practices seen in terms of communication openness, participation in decision-making, relationship-oriented leadership, and formalization, had an effect on outcomes for residents, which they defined as the prevalence of aggressive behaviour, restraint use, complications of immobility and rate of fractures. The study looked at 164 nursing homes in Texas. Investigators administered self-report surveys onsite. Other data was obtained from Medicaid Cost Reports and the Texas nursing home Minimum Data Set (MDS). The results were controlled for case-mix, size, ownership, and director of nursing tenure and experience.

They found that “management practices that facilitate self-organization contribute to better resident outcomes. The results also suggest that more experience and longer tenure of the Director of Nursing are important factors in achieving better resident outcomes”.

Commenting on management styles, the researchers said that nursing homes are often organised along an authority structure, top down model. The authorities watch nursing homes and funding bodies to see whether they are following the rules.


“They are fined or even shut down if rules are violated and so attending to the rules has become part and parcel to nursing home management. In addition, the primary caregivers, certified nurse assistants are unskilled workers with only short training and orientation programs.” Thus, traditional views of management seem to call for a disciplined, top-down approach, which nurses are familiar with from the hospital environment.

“The results of this study, however, suggest that a different type of management is required for better outcomes, confirming the theory that effective management practices are those that support self-organization.”

The specific results were summarised as follows:

1. Greater communication openness, defined as being able to say what you mean without fear of retribution, was related to lower use of restraints.
2. Nurses' participation in decision making, defined as the use of existing or creation of new organisational connections and relationships to exchange information in decision making, was related to lower prevalence of aggressive/disruptive behaviour among residents.
3. Greater use of relationship-oriented leadership, defined as giving constructive feedback, helping staff resolve conflict, generating trust and being approachable, was related to two of the four resident outcomes - prevalence of complications of immobility and rate of fractures.
4. Formalisation, defined as specifying work procedures and rules in combination with surveillance to ensure that they are followed, was higher in homes with a higher prevalence of complications of immobility.

The researchers concluded that there was a need to develop alternative management strategies – “ones that increase connections and interaction among people and increase cognitive diversity” They emphasised the need to “look beyond the traditional emphasis on clinical processes and the skills of care providers. Management practices provide a critical new lever that contributes directly to better resident outcomes.”



The training package used in this study *The Beyondblue aged care depression training program*, from the School of Psychology, Deakin University, went some way to giving the personal care workers knowledge, confidence and a system in which they could detect depression in the residents and voice their concerns. The training also encouraged the registered nurses and general practitioners to listen, give credence and feedback to staff regarding their assessments and diagnosis from general practitioner and mental health workers.

Professional job satisfaction

Despite the importance of job satisfaction, studies examining the determinants of job satisfaction in nursing homes are sparse. These studies and the factors of job satisfaction they examined were:

- Parsons and associates (2003), found four factors associated with nursing assistants' job satisfaction were: personal opportunity, supervision, benefits, and co-worker support.
- Chou et al. (2002) found nurses' satisfaction to be related to workload, team spirit, and professional support.
- In another study of nursing assistants' job satisfaction was associated with job security, potential for job growth, socialisation, and challenging work (Atchison, 1998).

In their own study of 251 Registered Nurses, Licensed Practical Nurses and Nurse Aides, job satisfaction data, collected from two nursing homes over a two and a half year period in five waves of data collection at six-month intervals, Castle et al (2006) found that professional job satisfaction was strongly linked to their perception of whether the quality of care in the nursing home was high or not. In other words, if staff felt that a resident's needs and feelings were being ignored, they had little job satisfaction.

Section 2 – Sample and response

Aged care facilities in the study

In this study one group of nursing homes was in the intervention group and another group of nursing homes was in the control group (treatment as usual). The staff of the facilities were trained and learnt about depression and simple intervention strategies to deal with and reduce the signs and symptoms of depression and agitation. Older people who had recently been admitted – that is from day 1 up to 6 months after admission were the study participants. The time frame of 1 day to 6 months was selected as the Aged Care facilities advised that is the time frame in which the residents' assessments needed to be completed for the Aged Care Funding Instrument (ACFI).

Procedure

The Residential Aged Care Facilities were selected from 17 nursing homes that indicated they were prepared to participate. Because this was a feasibility study, a total of 9 facilities were asked to participate this time, divided into one group of five for the intervention and another group of four in the control group. As this was a feasibility study the sample was not randomised.

Intervention Group vs. Control Group

The groups were matched for religious and private ownership, size of aged care facility and level of care. One group of nursing homes in the intervention group and another group of nursing homes in the control group (treatment as usual), were as follows:

Intervention Group

Nursing home	Category of care	No. of beds
Blue Care		
Iona	High Care (HC)	60
Tarry Brae	Low Care (LC)	60
Baptist Care Queensland		
Hill Top Gardens	HC /LC	30 / 79
Private homes		
Tri Care – Stafford	HC / LC	60 / 10
Regis Crana – Herston	HC	69

Control Group

Nursing home	Category of care	No. of beds
OZ Care		
Palm Lodge	HC / LC	77 / 44
Anglicare		
St John's Home	LC	61
Private homes		
Regis – Corinya	HC	70
Berlasco Court	HC	60

We were aware that any process of change/intervention must be done with the full cooperation of nursing staff, so the research was designed to include an introductory phase of group meetings with managers and regional managers to explain the research design and receive feedback on any possible issues for them, as well as receive their commitment to being involved in the study.

The participants in the intervention and control group were:

Intervention	Pre	Post 1	Post 2
Aged Care Facility Staff (All levels of care staff)	N = 76	N= 61	N= 52
Recently admitted residents day 1 to 6 months	N = 30	N= 28	N/A *
Family members and/or friends of newly admitted resident	Non-support group N=21	Non-support group N=18	N/A *
	Support group N= 8	Support group N=8	
Control	Pre	Post 1	Post 2
Aged Care Facility Staff (All levels of care staff)	N = 49	N= 32	N/A *
Recently admitted residents day 1 to 6 months	N = 20	N= 17	N/A *
Family members and/or friends of newly admitted resident	N= 13	N=7	N/A *

* The original design of the study had three time lines for all participants. There are three time line measures for the staff training in the intervention group. However due to the extended time required to recruit residents and family, only two time lines pre and post interventions were measured. The same applies to the staff in the control group.

Methodology

A Controlled Experiment methodology was used to assess the psychological distress accompanying admission in aged residents and their family carers and the stressors for staff.

Participation was voluntary for staff, residents and families. The Manager approached the residents and family carers who were able to give consent and the substitute decision-maker or legal guardian for those residents unable to give consent for themselves. To determine whether the resident had cognitive capacity to consent to this study, we were guided by the Directors of Nursing of the aged care facilities and/or their organisational policy. Decisions made were based on whether the resident was capable of (as per the Guardianship & Administration Act, 2000):

1. Understanding the nature and effect of their decision to be involved in the study
2. Freely and voluntarily giving their consent
3. Communicating their decision in some way.

A participant information sheet was provided to potential participants (See Appendices 1-3 & 8-10). When the researchers attended the residents and family carers for the first interview, they went through the sheet with them, encouraged any questions and if the potential participant was agreeable, they were invited to provide written consent for inclusion in the study, as were the legal guardians of residents requiring their consent (See consent forms, Appendices 4-7 & 11-14).

Thirteen residents were unable to give valid informed consent due to dementia. In such cases, the resident's substitute decision-maker, usually an attorney (EPoA), guardian (GAAT) or a close relative, was approached to give consent on their behalf.

Health professionals who were trained by an experienced practitioner implemented the intervention. Each participant was allocated a coded number. There were three components of the study. The first part of the study comprised of:

Staff training on depression in aged care

This training program for residential staff aimed at increasing professional carers' knowledge of depression, and their skills and confidence in detecting and monitoring depression among the older people for whom they care. We used a training package developed by the School of Psychology at Deakin University, Melbourne – titled *The Beyondblue aged care depression training program*, which allowed for 5 sessions for the personal care assistants and one session for the registered nurses and managers. A Social Worker and Psychologist from GPpartners delivered the training program. The training sessions for sessions 1 to 4 and 6 last for one and a half hours and session 5 for two hours.

The training covers:

- Basic package for all care staff (5 sessions)
 - Unit 1: Understanding depression
 - Unit 2: Detecting depressive symptoms
 - Unit 3: Detecting depressive symptoms in residents with anxiety or dementia
 - Unit 4: Responding to their depressive symptoms
 - Unit 5: Training in the use of validated screening tools to detect depression

- Advanced package for nurses (1 additional session)

Unit 6: Skills in interfacing with health care professionals

- Additional sessions

Session 7: Family Carer Awareness for staff (for all staff)

This two hour training session covered the following topics:

- Family Carers – Who are they? What is their role and contribution in a nursing facility?
- Pathways into Care – Case studies
- Transition issues for family carers entering residential care
- Addressing carer expectations
- Communication – The agitated and less agitated carer: Managing difficult situations well
- Making family carers welcome

Session 8: Interventions to support new residents – final training session (for all staff)

- This 1.5 hour training session aimed to inform care staff about the three interventions to be implemented with new residents as part of this study, equipping the staff with knowledge and skills about what the interventions involved and how to implement them.

The second part of the study comprised:

- Interventions to assist recently admitted residents 'to settle into' the aged care facility.

Following the training program, staff implemented the interventions with residents for 12 weeks.

The three interventions comprised:


Key worker

Aim

By nominating a dedicated care worker to act as an advocate and liaison person to take a particular interest in the new resident and their needs, it is anticipated that continuity of care will be ensured for the resident.

The main role of the key worker was to:

1. Assist the residents with their overall care needs and settling in to the facility.
 - To advocate for the resident and their needs – to talk on their behalf and be the known main point of contact, and this needed to be made very clear to resident, family and staff.
 - Communicate resident's needs which were relevant to others – staff, family, and diversional therapist.
2. To work with the resident to complete their Life Story 'The Key to Me' and to understand and get to know the resident and their needs (partly through using The Key to Me).

- 
3. Regular contact and visiting the resident.
 - Spend at least 5 – 10 minutes each shift with the nominated resident using open-ended questions to find out how the resident is feeling.
 - If family members are present questions should be asked about how the resident is settling in, satisfaction with care received, how the family are feeling and any concerns experienced.
 - The Key Worker needs to introduce themselves and explain their role to the resident and their family/friends at the commencement of contact.
 - It is important to continue to build on this relationship.
 4. Seek and obtain feedback on the nominated resident
 - Check the resident's progress notes from previous shifts to get an update on what's been happening for the resident and any changes in their care needs or care plan.
 - Get an update on their social activities and behaviours over the week.
 - Check the 'Walking & Talking' Tracking Sheet (Appendix 25) for comments/feedback.
 - Staff were advised that if there were difficulties in their relationship with the resident and there was a lack of rapport that they should speak to their manager about this.

See Keyworker Progress Notes Template – Appendix 26.

The Resident's Life Story

Aim

Recording the resident's life in a storybook would assist the nursing staff to understand and appreciate the resident's preferences, interests, significant life events and relationships. This information was incorporated into the planned care of the resident in order to provide individualised, holistic and quality care and to promote resident's choice.

What is the Life Story 'The Key to Me'? (Giles 2007) (Appendix 23) is a tool to obtain and document information about the resident's preferences, interests, life events and relationships from their past and present life. It covers:

- Relationships
- Abilities / activities
- Habits / routines
- Personal stories
- Past work / home life

This booklet is a separate document to the resident's nursing / medical chart. Staff are required to obtain consent and direction from the resident about what can actually be written in the booklet (Giles, 2007).

Walking and Talking program

This is self-paced assisted walking combined with conversation for 30 minutes, three times a week, interspersed with rest as needed. This program was conducted for 12 weeks.

Aim

To combine exercise and conversation in order to:

- Assist in the functional mobility of residents.
- Engage the resident in social interaction.
- Decrease levels of depressive symptoms and/or agitation.
- Assist with the resident's 'settling in' process.

Description

Residents are engaged in self-paced walking, assisted or accompanied by a staff member for 30 minutes, three times a week in combination with conversation.

- Residents in wheel chairs were walked in the wheel chair and both wheel chair and bed bound residents received passive exercises that utilise different parts of the body.
- Conversations were based on topics from the resident's environment that were of personal interest and from their life storybook
- Any attempt at conversation was encouraged.
- Dates and times the resident completed the walking and talking program was recorded in the 'Walking & Talking Tracking Sheet' (Appendix 25) at the end of each 30-minute program session.

Timeframes and responsibilities were discussed with the managers, registered nurses and personal care workers and they were required to consider:

1. Who will be the key worker?
2. How and who will do the Life Story with the resident?
3. How and who will do the Walking and Talking Program with the resident?

Support was given by the research team through weekly contact with the 'key workers' during the intervention with new residents. This was to encourage and monitor the staff with the interventions, as well as to ensure their recording.

The third part of the study comprised of:

Training and support group for family carers

Aim

To assist relatives with emotionally stressful transitions when a family member enters a residential aged care facility and to provide interventions that better prepare the family carers for placement transition and treat their depression and anxiety following placement.

Description

Support Group Program - The four separate support group sessions for family carers was conducted fortnightly over eight weeks. The group sessions were held at the aged care facility, with one group in the north and one group in the west of Brisbane. The parameters of the program were decided in consultation with Carers Queensland, and Carers' Queensland personnel were responsible for the preparation and delivery of the program.

Topics covered:

1. Sharing the care
2. Developing a relationship with staff in sharing the care
3. Financial and legal matters
4. Self care for family carers.

Recruitment and inclusion criteria

Aged care residents with dementia and cognitive impairment were included in the sample. About 50% of residents in the study had dementia and as the most disturbing behaviours dealt with in the residential aged care facilities were often exhibited by people with dementia, it was important to include them in the study. There were also participants who had high dependency needs and the research tools used were sensitive and considerate to these groups of people. The assessment tools and interventions were designed so that they could be flexibly delivered by the qualified health professionals on the research team and by the nursing staff within the facilities.

Inclusion criteria were simply that the resident had been admitted to the facility within the past 6 months; there were no specific exclusion criteria other than absence of informed consent from the resident or their substitute decision maker.

Outcomes, significance and measures

The main benefits were to try to reduce the level of stress associated with admission to residential care facilities, as experienced by both staff and residents and their families.

The Aged Care Funding Instrument (ACFI) (Commonwealth of Australia 2007) was initiated in all nursing homes in March 2008. We used the same scales and measures as those included in the ACFI assessment pack. They were: Psycho-geriatric Assessment Scales (PAS) and The Cornell Scale for Depression. Additional measures used were: The Cohen-Mansfield Agitation Inventory for the residents, and the General Health Questionnaire 28 for family carers.

All these assessment tools were used to compare those who were admitted under the new settling in procedure introduced in four nursing homes (intervention group) with those admitted under existing procedures in the other four nursing homes (control group) – over a period of 6 months. The study comments on whether a 'settling in procedure', devised in cooperation with nursing staff as an intervention, is feasible and acceptable to residents, family carers and staff.

Outcome measures

All nursing home residents were assessed at baseline and post interventions on the following primary outcome measures: PAS (Cognitive Impairment), CMAI (behaviour) and the CSDD (depression) scales. Secondary outcome measures included the following: (a) family carer distress on the GHQ-28; and (b) staff knowledge, confidence and attitudes in relation to depression in the elderly were measured on purpose-designed Likert scales.

Statistical analysis used

Analysis of the data for the staff depression training program was performed using the SPSS 17.0. for Windows statistical package. Repeated Measures Multivariate Analysis of Variance (MANOVA) was used to investigate the effects of the program on carers' knowledge of depression, self-efficacy and attitudes across the two different time periods – Time 1 to Time 3.

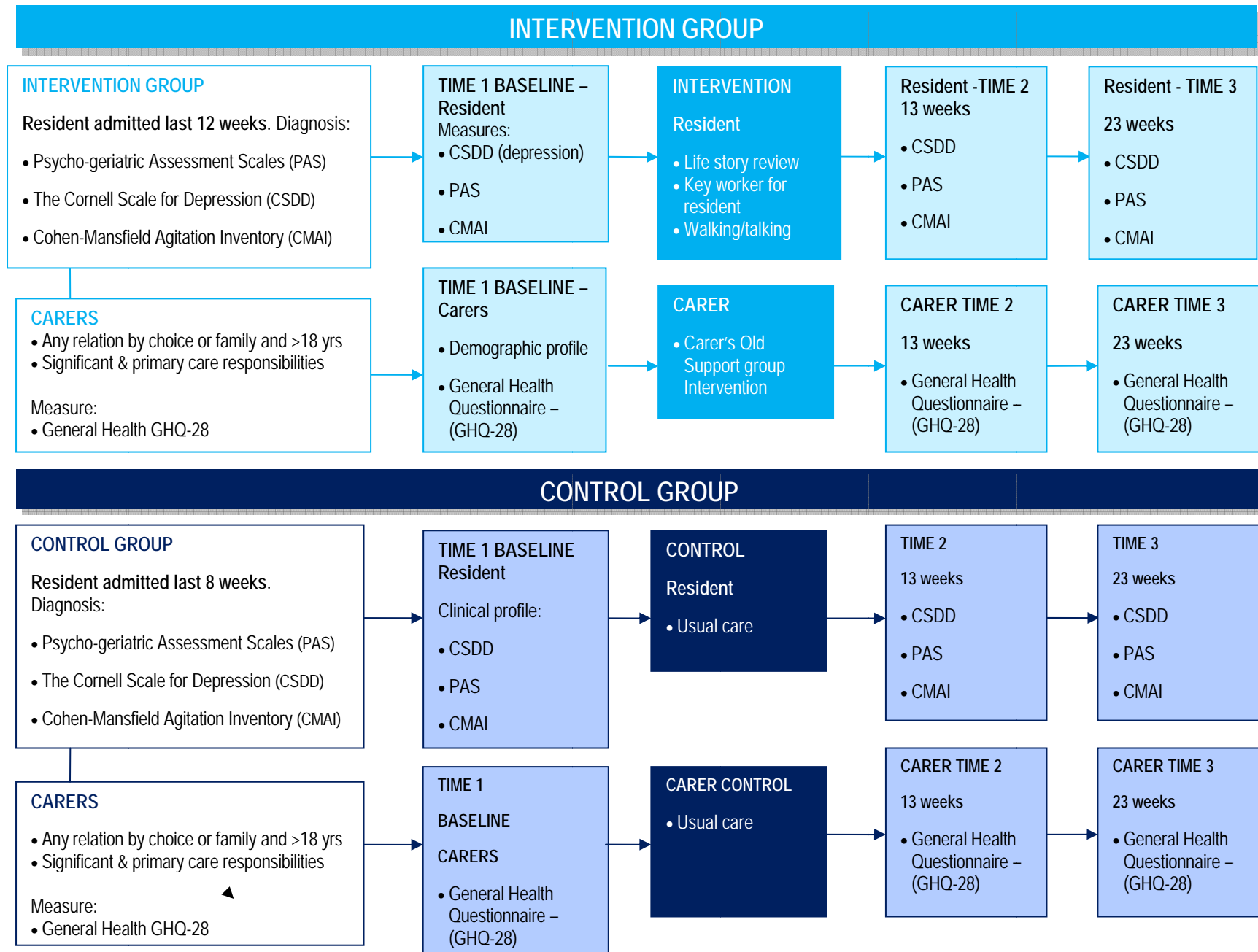
Basic parametric and non-parametric descriptive statistics were reported for both groups of nursing home residents (control and intervention) and their family carers.


Feasibility and acceptability were assessed via participant interviews and was qualitative in nature using Nvivo 8 to categorise responses.

The primary quantitative analysis involved a two-group Anova, controlling for baseline characteristics. The primary outcome variables are resident behavioural agitation as measured on the CMAI and resident depression as measured on the CSDD.

No power analysis has been undertaken for the residents and family carers, as this was a feasibility study designed to generate the data to enable a power analysis to be undertaken prior to a larger definitive study, which would be the subject of a separate study.

Resident with behaviour of concern and carer repeated measure design





Staff: Pre, post and follow up questionnaires for intervention group (Appendix 19)

- Knowledge of late-life depression,
- Confidence in working with depressed older people, and
- Attitudes to depression, using purpose designed Likert scales.

Residents: Pre and post intervention

1. Psycho-geriatric Assessment Scale (Jorm et al, 1995) (Appendix 15)
2. Cornell Scale for Depression in Dementia (Alexopoulos et al, 1988) (Appendix 16) covers the following domains:
 - Mood related signs
 - Behavioural disturbance
 - Physical signs
 - Cyclic functions
 - Ideational disturbance
3. Cohen Mansfield Agitation Inventory (Cohen-Mansfield et al, 1989; Cohen-Mansfield, 1997) (Appendix 17)

Family carers: Pre and post measure

General Health Questionnaire 28 (Goldberg et al, 1997) (Appendix 18)

Section 3 – Results

Profile of respondents

Staff depression training

The participants were 76 staff members of whom 53 (SD 12.78) were personal carers and 23 (SD 9.84) were nurses. Fifty-two personal carers were female and one was male, while in the nurses group there were 20 females and 3 males. The mean age for personal carers was 43 and 46 years for the nurses. The average length of time worked within age care was 78 months (SD 83.94) for personal carers and 98 months (SD 117.45) for nurses.

Analysis of the data was performed using the SPSS 17.0. for Windows statistical package. Possibly reflecting the natural dropout rate common in longitudinal studies, there were significant amounts of missing values for Time 2 and 3. In particular, no data for the control group were existent at Time 2 for either high or low level carers and due to time and funding constraints, we were unable to collect data for time 2. Because of this, and the deliberate nature of these values, it was not appropriate to simply replace these missing values. Hence, the main analyses were conducted using a complete set of data that was available at both Time 1 and 3. Nevertheless, preliminary analysis found that the remaining data did not violate assumptions necessary for the main statistical analyses in this section.

Descriptive data

Table 1 shows mean scores of carers in both the treatment and control groups at the two different times. It can be noted that regardless of the levels of carers, mean scores appears to have increased in between Time 1 and 3 for the treatment group, while mean scores of the control group are similar on both occasions.

Table 1 – Descriptive Data of Scores on Knowledge of Depression, Self-Efficacy and Attitudes of Treatment and Control Groups at Time 1 and Time 3

Treatment/Control Groups	Knowledge of Depression <i>M (SD)</i>			Self-Efficacy <i>M (SD)</i>			Attitude <i>M (SD)</i>		
	Time 1	Time 3	<i>N</i>	Time 1	Time 3	<i>N</i>	Time 1	Time 2	<i>N</i>
Treatment - High level carers	63.54 (6.51)	72.85 (4.83)	13	50.25 (11.30)	60.50 (10.88)	16	59.80 (3.73)	62.47 (3.89)	15
Treatment - Low level carers	61.95 (4.84)	66.65 (5.03)	20	38.41 (6.87)	47.59 (5.62)	57	62.61 (4.03)	63.06 (4.11)	18
Control - High level carers	68.50 (7.09)	67.50 (5.82)	6	53.33 (9.72)	54.89 (10.97)	9	60.22 (6.94)	63.56 (2.65)	9
Control - Low level carers	63.35 (4.03)	64.63 (5.22)	17	39.00 (5.56)	39.24 (9.04)	21	63.90 (4.62)	62.65 (3.99)	20

Effects of the program on carers' knowledge and self-efficacy at Time 1 and Time 3

Repeated Measures Multivariate Analysis of Variance (MANOVA) was used to investigate the effects of the program on carers' knowledge of depression and self-efficacy across the two different time periods. Two separate analyses were conducted for knowledge of depression and self-efficacy, respectively. The first analysis examined the effects of levels of carers (higher or lower levels) and group (treatment vs. control) on participants' knowledge of depression over the two time periods (Time 1 and 3). The results showed that there was a significant main effect of time $F(1, 52) = 19.88, p < .01$, and significant interactions between time and group, $F(1.52) = 18.27, p < .01$, as well as for time, group, and levels of carer, $F(1, 52) = 4.63, p < .05$. There was no significant main effect for time and levels of carer, $F(1, 52) = .52, p = ns$.

Overall participants' knowledge of depression increased over time from Time 1 ($M = 64.33$) to Time 3 ($M = 67.91$). Both higher and lower levels of carers reported a similar increase in their knowledge of depression between Time 1 (higher level carers, $M = 66.02$, and lower level carers, $M = 62.65$) and Time 3 (higher level carer, $M = 70.17$, and lower level carer, $M = 65.65$). Next, the second analysis looked at the effects of carers (higher or lower) and group (treatment vs. control) on participants' self-efficacy over the two different time periods (Time 1 and 3). Similar to the results of the first analysis, these results revealed that time has a significant main effect, $F(1, 69) = 17.96, p < .01$, while there was a significant interaction between time and group, $F(1, 69) = 12.40, p < .01$. However, interactions between time and carer, and time, carer and group were not significant, $F(1, 69) = 0.23, p = ns$, and $F(1, 69) = 0.01, p = ns$, respectively. Irrespective of the effects of levels of profession and the assigned group, self-efficacy also showed an increase from Time 1 ($M = 45.25$) to Time 3 ($M = 50.56$). Similarly, both high and low levels of carers experienced a similar pattern of increase in their self-efficacy between Time 1 (higher level carers, $M = 51.79$; lower level carer, $M = 38.70$) and Time 3 (higher level carers, $M = 57.69$; lower level carers, $M = 43.42$). Moreover, Time had a substantial effect on self-efficacy of the treatment group (Time 1, $M = 44.33$) and Time 3, $M = 54.05$, respectively). On the other hand, self-efficacy of the control group stayed constant at Time 1 ($M = 46.17$) and Time 3 ($M = 47.06$).

The third MANOVA looked at the effects of carers (higher or lower) and group (treatment vs. control) on participants' attitude over the two different time periods (Time 1 and 3). Unlike the above two analyses, the results indicated that time itself did not have a significant effect on attitude, $F(1, 58) = 3.11, p = ns$. Similarly, there was no significant interactions between time and group, $F(1, 58) = 0.12, p = ns$, nor between time, levels of carer, and group, $F(1, 58) = 0.64, p = ns$. The only significant interaction that had an effect on carers' attitudes was time and levels of carer, $F(1, 58) = 5.33, p < .05$. Mean scores of attitude at Time 1 and Time 3 between higher and lower levels of carers seem to reflect different trends. While the overall means of higher level carers slightly increased from Time 1 ($M = 60.01$) to Time 3 ($M = 63.01$), the overall means of lower level carers were relatively stable between Time 1 ($M = 63.26$) and Time 3 ($M = 62.85$). In contrast, mean scores on attitude remained comparatively constant when only time was concerned (Time 1, $M = 61.63$; Time 3, $M = 62.93$). Likewise, mean scores of both treatment (Time 1, $M = 61.21$; Time 3, $M = 62.76$) and control (Time 1, $M = 62.06$; Time 3, $M = 63.10$) groups stayed relatively stable between Time 1 and Time 3.

Recently admitted residents in residential aged care facilities (RACF)

The participants were 50 RACF residents recently admitted to 12 different nursing home units. There were 29 (58%) females and 21 (42%) males whose mean age was 83.2 years (SD 9.88; range 52 - 99). On average, they left school at the age of 14.6 years (SD 2.1; range 9 - 18). Thirty-nine (78%) were admitted to high care environments and 11 (22%) were admitted to low care environments. Most participants spoke English as their first language (45; 90%) and most had been born in Australia (30; 68%).

Informants

There were 41 informants, of whom 31 (75.6%) were family members. The remainder (10; 24.4%) were nurses or other professionals. Of the informants who were family members, most (21; 51.2%) were adult children of the older person. The majority of informants (22; 53%) reported that they saw the older person greater than once a week but less than daily. On average, informants had known the older person for 41.7 years (SD 25.9; range 0.01 - 73).

Baseline characteristics of RACF Residents

There were 20 females and 19 males in high care. There were 9 females and 2 males in low care.

Consent to participate was provided by the resident in 21 cases (42%) and by a substitute decision maker in 29 cases (58%).

At the time of the first interview the RACF residents had been in the RACF environment for an average of 75.1 days (SD 107.5; range 6 - 763). At the time of the second interview residents had been in the RACF environment for an average of 176.8 days (SD 110.6; range 92 - 849).

There were 30 participants (60%) in the intervention group and 20 participants (40%) in the control group. There were 19 females and 11 males in the intervention group and 10 females and 10 males in the control group.

Sample size varies due to dropouts and missing data on some variables.

Psychometric findings

By chance, RACF residents randomised to the control condition seemed to be more symptomatic than RACF residents randomised to the intervention. These differences were not statistically significant, but are likely to have made it difficult to demonstrate differences in efficacy between the intervention and control groups. Overall, between the first and second interviews, scores on the CSDD fell by one point (14.3% of mean baseline score), scores on the CMAI fell by 1.5 points (3.3% of mean baseline score), and scores on the PAS fell by 1.8 points (52.9% of mean baseline score) (See Table 1 for details).

However, these differences between the intervention and control groups were not statistically significant. This likely reflects the small sample size and the inequalities at baseline. In addition, the dropouts (participants without time 2 scores) had much higher Time 1 scores than participants who did not drop out. Thus, when intention to treat (ITT) analyses were performed using the last observation carried forward (LOCF) approach (not shown), the magnitude of changes was diminished.

Table 1 – Resident Psychometric Scores by Group

	Intervention Mean (SD)	Control Mean (SD)	Total Mean (SD)
RPASD 1 N = 37	3.0 (2.5)	4.1 (2.9)	3.4 (2.7)
RPASD 2 N = 29	1.2 (1.1)	2.3 (2.9)	1.6 (2.0)
RPASD Δ N = 29	1.2 (1.8)	1.1 (3.4)	1.1 (2.4)
CMAI TOTAL 1 N = 49	44.0 (19.2)	48.3 (20.0)	45.7 (19.4)
CMAI TOTAL 2 N = 47	42.6 (18.0)	47.8 (36.3)	44.8 (27.1)
CMAI Δ N = 47	2.3 (13.5)	0.5 (34.2)	1.5 (24.2)
CSDD 1 N = 49	6.3 (4.4)	10.0 (7.4)	7.7 (6.0)
CSDD 2 N = 44	5.0 (4.1)	9.1 (7.9)	6.6 (6.0)
CSDD Δ N = 44	0.9 (5.3)	1.2 (6.3)	1.0 (5.7)

Note: difference scores (Δ) are based on paired samples.

Codes:

RPASD 1 Residents Psycho-geriatric assessment scale (PAS) depression scale pre intervention
 RPASD 2 Residents Psycho-geriatric assessment scale (PAS) depression scale post intervention
 CMAI 1 Cohen-Mansfield Agitation Inventory pre intervention
 CMAI 2 Cohen-Mansfield Agitation Inventory post intervention
 CSDD 1 Cornell Scale for Depression in Dementia pre intervention
 CSDD 2 Cornell Scale for Depression in Dementia post intervention

Informants

Family carers were rated on the General Health Questionnaire (GHQ). Mean GHQ scores dropped 3.2 points (14.9% of mean baseline) score between the first and second interviews. However, there was no statistically significant difference between the Intervention and Control groups. The sample size was small, the intervention and control groups were unbalanced with respect to informant GHQ score at baseline and dropouts had higher mean baseline GHQ scores.

Table 2 – Family Carer/ Informant Psychometric Scores by Group

	Intervention Mean (SD)	Control Mean (SD)	Total Mean (SD)
GHQTOT 1 N = 33	20.4 (10.0)	23.2 (18.3)	21.5 (13.7)
GHQTOT 2 N = 25	18.6 (10.6)	13.0 (7.1)	17.0 (9.9)
GHQTOT Δ N = 24	1.3 (10.3)	7.9 (10.8)	3.2 (10.7)

Note: the difference score (Δ) is based on paired samples

GHQTOT 1 General Health Questionnaire total pre intervention
 GHQTOT 2 General Health Questionnaire total post intervention

Summary

Improvement was evident in RACF resident and informant ratings from Time 1 to Time 2 in both the intervention and control groups. However, it was not possible to determine whether the intervention was superior to the control condition due to the small sample size of this pilot study, unbalanced scores at baseline and differential dropout of highly symptomatic residents and family carer informants.

Case Study – Family Carers experiences from Support Group

The family carer presented is female and aged 58. She cared for her mother in her home for five years prior to her mother’s entry into the residential aged care facility.

The carer described that ‘she felt really bad and also a sense of relief when her mother went into the home’. The pressure of working and caring for her mother on her own was very exhausting both physically and emotionally. The carer also had other family illnesses and losses to deal with.

The carer felt relieved to know her mother was getting her meals and other care she needed. However she also felt enormously guilty about her mother going into the facility and was deeply depressed and had suicidal thoughts.

The carer said that attendance at the support groups was ‘invaluable, it helped me to understand and accept my decision was right about my Mum being in the home and that my reactions and feelings were natural and normal’. ‘The components of the support group I found most useful and helpful were how to speak to the facility’s staff, especially when I am concerned about my mother’s care. I also learnt how important it is to take time out for myself and that I need to schedule into my diary time for myself otherwise I get so depleted. The value of looking after myself was reinforced and I was able to think of where I was and where I wanted to go. Three months after the support groups were concluded I still feel I am on course of what I mapped out. The legal aspects I also found interesting.’

The GHQ 28 score for this carer pre-intervention was 43 and following the Intervention had reduced to 38 (higher scores indicated a greater level of distress).

Qualitative analysis of staff training and residents interventions

Responses to the qualitative questionnaires for staff regarding training and intervention and for residents regarding interventions were analysed and categorised into themes using NVivo 8.

Staff training questionnaire

At completion of the training program, participants were asked to complete a questionnaire about the effectiveness and evaluation of the training program in addition to the three Questionnaires from Deakin University regarding Knowledge of Depression, Self Efficacy and Attitudes to depression (Appendix 20). Of the 76 participants who completed the training program, 40 (53%) completed the Feedback Questionnaire. Respondents included 16 nurses and 24 Assistant Nurses/Personal Care Assistants. All respondents were asked 10 questions with a further 2 questions for nurses only. Questions addressed the following:

- How interesting and how useful did you find the training program?
- Did the program increase your knowledge and skills in recognising and responding to depression?
- Was the level of the training appropriate to your level of knowledge/skill?
- Elements of training that were most useful and would be used in practice?
- Specific feedback regarding the presentation of the program
- Any topics left out of the program?

For Nurses

- Do you feel better able to encourage carers to express their concerns about depression in residents?
- Do you feel better able to discuss your concerns about a resident with GPs and/or refer the resident on to a mental health professional?

Knowledge of depression

Caregivers overwhelmingly found the program to be both very interesting (87.5%) and very useful (95%), see results Tables 1 and 2.

Table 1 – How interesting did you find the training program?

Interest	Frequency	Percentage
Not at all	0	
Slightly	0	
Interesting	5	12.5%
Very Interesting	35	87.5%
Total	40	100%

Table 2 – How useful did you find the training program?

Usefulness	Frequency	Percentage
Not at all	1	2.5%
Slightly	0	
Moderately useful	1	2.5%
Very Useful	38	95%
	40	100%

Ninety-five per cent (95%) of caregivers reported that the program had increased their knowledge of depression in older people and 97.5% reported the program had increased their skills in recognising and responding to depression. See Table 3 below.

Table 3. Did the Program increase your knowledge and skills about recognising depression in older people and knowing how to respond?

	Increased knowledge?	Percentage	Increased skill?	Percentage
Yes	38	95%	39	97.5%
No	1	2.5%	0	
Unanswered	1	2.5%	1	2.5%
Total	40	100%	40	100%

The majority of respondents reported that the training program was appropriate for their level of knowledge and skills (93%), with one Registered Nurse commenting that she felt it was targeted more towards carer level.

Registered Nurses and Care Managers unanimously reported that they now felt better able to encourage care staff to detect and report depression with the majority (87.5%) further reporting that they felt better able to refer their concerns about a resident on to a GP or mental health professional, See Table 4.

Table 4. Nurses Only: Do you feel better able to encourage carers to express their concerns about depression among residents? Do you feel better able to discuss your concerns about a resident with GPs or refer to mental health professionals?

	Encourage Carers to detect and report depression?	Percentage	Refer to GP or Mental Health Professional	Percentage
Yes	16	100%	14	87.5%
No	0		1	6.25%
Unanswered	0		1	6.25%
Total	16	100%	16	100%

Qualitative responses


Nursing and care staff overwhelmingly and consistently commented that the program had increased their knowledge of depression in the elderly (100%), both extending and reaffirming previous knowledge and providing them with knowledge that could be applied in their everyday work and life. Comments were made such as:

- *“My level of knowledge about depression has improved greatly”*
- *“I am now better equipped with relevant knowledge”*
- *“Useful knowledge that we can apply in everyday life”*
- *“Reaffirmed a lot of knowledge I already had”*

A number of care staff (25%) specifically identified that an important outcome of the program was an increase in their knowledge of the differences between depression, dementia and anxiety, with one staff member stating her key learning was *“the differences between anxiety, depression and dementia and how they can be confused”* (Personal Care Assistant, residential nursing home). A further positive outcome for some participants was an increased empathy for their residents as well as increased confidence to communicate with residents and respond to symptoms of depression. Feedback included: *“(the program) gave me the opportunity for more empathy towards the residents”* and *“gave me some idea of walking in residents or families shoes”* as well as *“gave me confidence to deal with new residents and their concerns”*.

Specific knowledge and skills gained

There were several specific aspects of the program that were mentioned by care staff as being the most useful and informative. 92.5% reported that the program had equipped them with tools for the detection and assessment of depressive symptoms with several staff specifically acknowledging the usefulness of the Depression Checklist, the Geriatric Depression Scale and the Cornell Scale for Depression in Dementia. The most frequently mentioned specific learning from the program was the ability to recognise the signs and symptoms of depression (20 of the 40 respondents made reference



to this 31 times), with staff stating, *“It was helpful in recognizing that some of the residents behaviours might be related to depression”*, and now *“I have clearer knowledge re what to look for”*.

A substantial number of care staff also reported that the program provided them with increased knowledge and skills around the causes, prevention and treatment of depression (77.5% of participants). For example, care staff commented:

- *“(the program) made me think about ways of preventing depression from occurring in the elderly”*
- *“Depression can be treated and there is help available”*
- *“I found it very helpful in understanding depression in elderly people and different ways to care for them and their family members”*
- *“The program was useful - being able to assess residents and implement strategies to prevent depression in residents, improving their quality of life.”*

Many participants reported feeling equipped with improved communication skills learnt during the program, feeling better able to communicate with residents about their feelings and mood.

The majority of care staff felt that there had been nothing left out of the program, with only 15% suggesting areas that could be included in the program in the future, such as information about anti-depressant medications (5%) and specific referral options and support services (5%).

Presentation of program

Overwhelmingly positive feedback was provided regarding the presentation of the program, with staff consistently stating that they enjoyed the interactive delivery of the program. The majority of respondents (67.5%) reported that they found the group discussions to be interesting and thought-provoking, making particular mention of the insight and knowledge learnt through hearing their colleagues' points of view. Feedback included:

- *“I really enjoyed the group interaction activities”*
- *“Enlightening to hear about how other people think and react to different situation”*
- *“We learnt from each other”*

Many participants commented that the program was clear and well presented as well as informative, relevant and practical. Staff frequently commented on the usefulness of the resources (80% of staff) and the ability to use them for later reference. Further, half of respondents reported that they found the homework tasks to be valuable exercises. 67.5% of care staff found the role plays to be interesting and thought provoking, while 17.5% commented that they found the role plays to be challenging and/or did not enjoy them.

Overall, many staff made positive comments about the program as a whole, commenting that it was an *“excellent course”* and was *“a very worthwhile and valued training exercise”*.

Several carers reported that the program should be extended to other aged care staff, stating *“it’s a wonderful tool to be used in all nursing homes”*, and *“it should become compulsory/mandatory training”* and *“This program should be made available to all staff members”*.

Impressions and discussion of staff training program

Staff responses to the depression training program were rated as very interesting (87.5%) and very useful (95%). This indicates the usefulness of the information staff obtained and the practical application of this learning. The changes that occurred with the detection of depression in residents and the subsequent referrals by care workers (87.5% of respondents) to registered nurses and general practitioners ensures that residents are not left with undetected and untreated depression, anxiety or dementia.

The involvement of care workers as respected and fully functioning member of the team would likely bring job satisfaction to staff and improve care to residents. The ability and improved skills of staff to use assessment tools - Depression Checklist, the Geriatric Depression Scale and the Cornell Scale for Depression in Dementia, equips staff to recognise symptoms and signs of depression and assess the level of depression. This would then lead to treatment of the residents.

This training elicited increased empathy for residents as well as increased confidence to communicate with residents and respond to symptoms of depression. The training required a small investment of time from staff with the sessions lasting from 90 minutes for 5 sessions to 120 minutes for one session over a six-week period. The delivery of the training worked best when it was provided on site, and was usually arranged in the afternoon, around staff handover time. The receipt of a certificate at the end of the training was considered valuable and important to care workers.

This training needs to be considered for incorporation into Certificate III qualifications in Aged Care.

Residents' responses to interventions and move to residential aged care

Of the 26 residents in the study post intervention, we received 20 responses from residents who were able to answer the questionnaire (Appendix 21). The following table shows the demographics of the respondents.

Resident Demographics	
Resident response to Qualitative Qn.	20
Females	15
Males	5
Age Range	68-97
Average Age	86
High Care residents	11
Low care residents	9

Residents' perceptions and experiences of the interventions

The following tables show how residents perceived and experienced the interventions of key worker (we used the term carer in the questionnaire), life storybook and the walking and talking program.

Key worker/carer

Sixty-five per cent (65%) of respondents said that the key worker came to talk to them and 30% said they were visited most days. Seventy-five per cent (75%) said it was 'enjoyable' to 'most enjoyable' with 5% saying it was 'not enjoyable'.

The residents enjoyed the relationship and being involved with the key worker. They would have liked more time with the key worker.

Some of the comments from the resident's were, 'enjoyed sharing with key worker and relating about living in PNG', 'The carer is a lovely lady and she brings a cup of tea with her' and 'I like to see the carer'.

Resident Questionnaire - Response to Key-worker Intervention		
Question	Responses	Percentage
Total responses	20	
Q.8 Did a nurse/ carer come to talk to you?		
Yes	13	65%
No	4	20%
Unsure / can't recall	3	15%
Q.9 How often?		
Not at all	2	10%
Some days	3	15%
Most days	6	30%
Every day	1	5%
Every week	4	20%
Unsure / can't recall	4	20%
Q.10 Did you enjoy the nurse/carer seeing you?		
Not enjoyable	2	10%
Enjoyable	6	30%
Very Enjoyable	9	45%
Unsure / can't recall	2	10%
Blank - unanswered	1	5%

Life Story Book

When residents were asked how they enjoyed doing the life storybook, 55 % said it was ‘sometimes’ to ‘very enjoyable’. Twenty percent did not enjoy it, saying that it felt like staff were prying a bit and asking questions too frequently and also feels it is nobody else’s business. Whereas the resident’s who enjoyed it said,

‘it made me think back over my life.’

‘I enjoyed sharing with keyworker’.

Resident Questionnaire – Response to Life Story Intervention		
Q.11 How did you feel about life story book?		
Not enjoyable	4	20%
Sometimes enjoyable	3	15%
Enjoyable	4	20%
Very Enjoyable	4	20%
Unsure / Can't recall	4	20%
Blank - unanswered	1	5%

Walking and Talking Program

Forty-five percent (45%) of respondents ‘liked’ the walking and talking program to ‘liking it a lot’. Some of the residents would have liked to walk and talk more frequently and enjoyed the company, while one resident after a recent fall, had lost confidence.

When residents were asked ‘How did you find the Walking and Talking program?’ The following responses were from ‘did not like it’ to ‘liked it a lot’.

Resident Questionnaire – Response to Walking & Talking Intervention		
Q.12 How did you find the walking and talking program?		
Did not like it	1	5%
Liked it a little	1	5%
Liked it	6	30%
Liked it a lot	3	15%
Unsure / Can't recall	2	10%
Blank - unanswered	7	35%

How residents felt entering the aged care facility

Responses ranged from sadness and loss, not happy about being in the home, to feeling OK and happy to remove the burden from family. The responses can be divided into positive and negative feelings of residents as follows:


Residents feelings on initial entry into residential aged care facility	
Positive Responses	Negative Responses
Wonderful experience	Sadness and loss coming into home
Happy with new environment	Out of comfort zone
Happy to remove burden from family	Not happy about being in home
Feel OK about coming to home	Did not like home at first
	Feels like life was not worth living at times
	Difficult to settle in

Some residents did not want to leave their home, wished they were in their own home and had to adjust after living in their own home for 68 years. Whereas 50% of the respondents felt it was alright to enter the home, saying *'I am not worried, had some idea what it would be like, knew it was necessary and expected to enjoy it'*.

The following table shows the responses of residents after four to six months of being in the facilities. They are categorised into positive and negative responses:

Residents feelings after 4 to 6 months in residential aged care facility	
Positive Responses	Negative Responses
Lovely staff make a difference	Still miss home
Have made new friends	Loss of independence
Grateful to be in home	Not what I expected
Feel alright about living in home	
Feel happier and more settled	
Acceptance of being in home	

The responses following entry after four to six months in RACF show there was an increase in the positive responses. Residents said they were much better, happy and content. Expressions of acceptance of being in the RACF included *'accepted it to a point', 'accepted being here', 'feel I have lost my independence but fine', 'have adjusted to it' and 'I am getting used to it and am trying hard, and take it in my stride'*.



However there is also a feeling of loss and having less independence, with residents saying, 'I can't do things I used to and that's frustrating, I still miss my home and my independence and still struggle with loss of independence.'

Impressions and discussion of residents' responses to interventions

The majority of respondents found the visits and contact from the key worker enjoyable to most enjoyable and would have liked more time with the key worker. This indicates the importance of routinely having someone to take an interest in the resident, be his or her advocate and take the time to talk.

Sensitive dealing with residents is required when delving into their life history, significant life events, sorrows, joys and likes and dislikes. Staff were advised to seek permission from residents about what they wished to have recorded in the life storybook. Staff require training on how to take a history and how to ask questions respectfully and sensitively. Residents may not enjoy completing the life storybook, as was the case for 20% of respondents in this study, even when the approach is sensitive and respectful. Residents have the right to refuse and object to a life storybook being completed.

The walking and talking program received less response from the residents in terms of their views about this program. However 45% of responses were that they 'liked it' to 'liked it a lot'. Some residents even wished to walk and talk more frequently.


The comments about entering the facility initially and then the subsequent four to six months after entry showed that half of the respondents felt it was 'alright' to be in the home. The responses after the four to six months following entry showed more positive feelings than previously. There are many factors that influence resident's feelings and reactions to entering a facility and time itself could be a factor in assisting residents to adjust. We however consider that having a key worker, the staff knowing about resident's likes and dislikes and providing individual time, with exercise and conversation can assist residents to settle into the facility, perhaps more quickly than would otherwise occur. The staff expressed that the interventions assisted residents to 'settle in' and was a very valuable resource. See comments pages 40-43.

Case study – Resident's experience with the key worker

The resident that is presented in detail is female, aged 70 and had been in the aged care facility for two months prior to intervention commencing.

Diagnosis – a MMSE score of 23/30 with loss of points for orientation and recall. She also displayed frontal lobe dysfunction and difficulties with praxis though these were mild. There was also significant impairment of verbal new learning. There was a differential diagnosis of major depressive disorder and adjustment disorder with depressed mood.

Background – The resident's husband died in 1989 and her relationship with her son was problematic with an alleged episode of domestic violence from her son, which precipitated her entry into the residential aged care facility.



The resident won a scholarship as an ice skater and went on to be a singer and dancer. Her husband had been a corporate executive. The resident had an active and high profile social life style. She had extensive contact with politicians, corporate and sporting personalities.

After coming to the facility, the resident was moved to high level care following a fractured (L) tibia, while gardening in the facility. The resident is a smoker and the move to higher level care and being in a wheel chair created conflict with staff, as the resident needed to rely on staff to take her out to smoke. The resident wanted to go out every half hour to smoke. The resident was dependent on staff for her physical and social functions and had lost her independence.

Key worker

A key worker was appointed following the residents inclusion in the study and intervention. The resident would have nothing to do with the key worker and was very abusive and would swear at her. Staff also felt that the resident might hit them.

The staff and especially the key worker persisted in a respectful and pleasant manner in calling into the resident's room and greeting her. Within 10 days the resident's behaviour became more engaging. She knew that part of the intervention was to compile her 'Life Storybook'. She came to the key worker with her photo album and asked the key worker if she was ready to talk to her. The response from the staff member was an emphatic "Yes".

The key worker's comment on the resident was 'A beautiful lady, I have a lot of time for her'.

When resident was asked 'what would you like to begin with?', the resident chose the photo albums, which she had previously retrieved from her cupboard.

Every morning that the key worker was on duty, she would pop her head into the resident's room. At rest time when the key worker popped in, the resident would sometimes say 'no I don't want to talk or have company'. At other times she enjoyed the time when the key worker listened and the key worker felt 'she needed someone she can trust'. She would ask key worker not to divulge what she had told her.

When the key worker was on duty over the weekend, the resident was offered an outing. As the staff can sometimes be more relaxed over the weekends, the key worker was able to go with the residents to the markets next to the facility and they would have a coffee together. She often wanted to go in the car, but key worker encouraged walking, as part of the walking and talking program.

The resident looked out for the key worker when she was on duty and when she heard the worker's voice would come into the office to say hello and discuss anything she was annoyed about.

The key worker found the resident to be a young 70 and very alert and considered the resident had been 'thrown into the facility'.

The key worker and resident would joke and share womanly interests, such as sewing, clothing choices and past life experiences.

The key worker considered that through gentle, respectful and continued contact with the resident that she began to see that she had someone she could trust, talk to and go on outings with. The fact that the key worker did not talk about the details of resident's life prior to moving into the facility further confirmed the respectful and confidential nature of the interaction.

Resident's scores

Pre Intervention	Post Intervention
CSDD 3	CSDD 1
CMAI 80	CMAI 34

As per scores above, the resident's response to the interventions and over time show a decline in both depressive symptoms and levels of agitation.

Staff's response to use of interventions with residents

Key worker

The responses of staff to being a 'key worker' covered the difficulties, positive aspects and the support provided to residents (see Staff Qualitative Questionnaire – Appendix 22).

Positive aspects of being a key worker

The majority of staff said they enjoyed the key worker role and that it gave the resident someone to talk to. Respondents commented:

- They found it interesting and supportive, enjoyed the personal interaction, found it very satisfying, they enjoyed getting to know the new residents and it was excellent to be a key worker.

Giving the resident someone to talk to means that:

- *'Staff were able to sit and listen to resident's wartime stories or just a chat about general news. When the resident was feeling down, a chat and laugh can cheer him up. Resident liked to see a familiar face and would often go for a walk with key worker and talk about anything she wished. It also encouraged residents to voice their feelings. The resident I spoke to had such varied number of topics and by chatting she started to open up. The resident was also able to say what she had done for the day, as well as sharing their wonderful stories of their childhood. Being a sounding board and someone to talk to when the resident is upset.'*


The second major group of responses were that it helped the worker to get to know the resident and their needs; improved the relationship between the resident and staff; and that the key worker was the main contact person for the resident.

Difficulties with being a key worker

The major difficulty was the time constraints that staff experienced and they voiced their views as follows:

- *'Being a key worker is time consuming and we needed more time. There is not a lot of spare time to spend with the resident and you have to make time to talk to them.'*
- *'It is also hard to make time to spend with the resident while working on the floor and when other residents need your attention. We need to be given extra time to do it properly and others said it took a lot of time away from important jobs.'*

They also saw being a key worker as adding responsibility and it was a challenge to provide consistent support due to work scheduling. The added responsibility was 'a bit stressful and it's too full



on and at first challenging'. The other difficulties for the key worker were the resident being unable to recognise or communicate with the staff carer. Key workers said 'he didn't remember me and wasn't able to communicate well nor express his thoughts and feelings, wasn't helpful. The resident had difficulty remembering many things including my name'.

Knowing the resident and their needs

Respondents commented that it was interesting to know about resident's history and life and it gave staff a better knowledge base on which to take actions. It helped them to recognise the support, assistance, care and comfort that the resident needs. Comments included:

- *'I was also able to recognise if the resident was depressed, anxious or lonely.'*
- *'It was fabulous getting to know such a lovely, warm, funny man.'*

Improved the relationship between resident and staff

- *'Being the key worker meant that the resident was friendlier and built up trust with the key worker.'*
- *'We both got to learn and know each other and I got to love her. The resident would look forward to seeing me and it was fantastic knowing information that could expand my relationship with her.'*
- *'The resident felt very comfortable talking to me and it was important in establishing a relationship with the new residents.'*

Improved communication with other staff and family

- *'As the key worker I was able to inform and direct other staff of resident's needs, experiences and fears. When particular personal needs were recognised I was able to ask the appropriate personnel to deal with it.'*
- *'I was able to liaise with family and other staff, as well as refer to registered nurse and doctor to check resident and see if medication was needed. It also kept the lines of communication open.'*

Support provided as key worker

- *'Discussed were the emotional support, advice and encouraging interaction and participation in activities by the residents, and providing practical assistance for residents.'*
- *'I was able to provide extra assistance for the resident to settle in and be available for advice and general support. Being the key worker I was aware of when the resident needed someone to comfort her when she was down and when she was missing her family. She was able to voice any concerns when I talked with her.'*
- *'The practical assistance took the form of helping the resident read notice boards as a number were vision impaired. Other assistance and responses were, 'Trusting me with appointments and arranging transport and taking the resident shopping fortnightly'.'*
- *'I was able to assist resident with certain things they could not do and with their personal washing (laundry) and health, as well as assisting with the 'littlest thing'.'*

Life Story book

Seventy-two per cent (72%) of the Life Story books were fully completed, with 7% not completed. The staff found the Life Story book an important and valued resource, as it helped staff to know the resident better and residents were able to recall memorable events in their life and it opened communication and trust between residents and staff.

There were a few difficulties with some staff feeling uncomfortable asking certain questions and getting photos from family. A range of responses were:

- *'Helped staff to relate better to residents, good for understanding the resident better, helpful in assisting diversional therapist with assessments, knowing more about the likes and dislikes, very good to know about resident's life and utilise necessary information to assist resident.'*
- *'Interesting to find out about resident's background and present situation. As well as knowing what subjects resident laughs at and lift their spirits and just to get them going in the morning.'*
- *'Helped me to know the resident as a person of many different interests and knowledge about their family and life style.'*
- *'Taught me what resident was comfortable sharing with me and how the resident felt in general.'*

Opening communication and trust and helping residents recall memorable events in their life was noted by a number of staff.

- *'The life storybook made communication easier, as it gave me ideas on the questions I could ask new residents coming into the facility. The life storybook opened many avenues for discussion with the resident and I can talk about things other than the weather.'*

A few of the residents felt uncomfortable answering some of the questions and some residents did not want to do the Life Story book. For some it also stirred up unwanted memories and some questions were found to be intrusive.

The majority of residents and staff found the exercise worthwhile and enjoyable.

Walking and Talking Program

The walking and talking program provided good exercise, strength and balance, built and increased trust and support and was an opportunity for residents and staff to chat. The staff remarked on the program:

- *'Giving the resident more opportunity for extra activities and exercise and to talk and exercise at the same time'*
- *'An important time in which to demonstrate to the resident how valued and important they are to the key worker as well as other staff. The resident 'open up' with exercise included'*
- *'It gets the resident out of his room and doing other activities'*

The resident had the opportunity to chat with staff, some of the comments were:

- *'He takes an interest in telling his story even when we can't understand all the things he says'*
- *'She was able to talk about things that may not have been brought up in other discussions'*

- *'Residents were able to talk freely and the program helped to reminisce and reflect.'*
- *'The residents felt special and more comfortable in their new home.'*
- *'The resident expressed they felt it made them feel special and gave them something to look forward to and someone special to relate to.'*
- *'She loves the attention'.*
- *'After commencing the program the resident felt more comfortable within the facility and were able to go out of their wing and see the whole area of their new home. This also helped to settle her into the new surroundings.'*

Time constraints were mentioned by a few staff saying that 30 minutes three times a week was very hard to do in a busy week. Staff thought that 10 to 15 minutes would be more practical three times a week. It was also thought that more one on one uninterrupted time was needed to engage a resident.

The overall views of staff on the interventions

- *'Assisted staff and residents to get to know each other and that it was an enjoyable and interesting program, as well as providing respect and reassurance to the residents. This program should be available to all new residents, as it helps residents to 'settle in'.*
- *'The key worker needs more time to do the interventions and there was not enough time to spend with residents while working. More quality time would be great but not always possible and needed extra time to complete it (interventions) fully'.*
- *'These interventions are important, valuable and a creative process. It is a really useful program and most worthwhile. I thoroughly enjoyed the experience and the program worked well. The education we received has become a valuable tool that I can use in my day- to- day work as a carer'.*

Impressions and discussions of staff responses to interventions

Key worker


Some of the positive aspects of being a key worker and the difficulties of being a key worker have all been covered in staff responses (refer preface page xii)

The importance of having a confidant, regular and interested person to talk to and express feelings outside of the resident is very important for the resident to feel valued and included.

Further issues identified include:

The management staff at the aged care facilities require information about what key workers do, how to implement this service routinely within the facility, what the benefits are for residents and staff, and then need to decide whether they wish to incorporate this service into their routine and care plans.

When staff make comments like, *'he didn't remember me and wasn't able to communicate well nor express his thoughts and feelings, and this wasn't helpful'*, we need to ask what training and information have been provided to staff on how to communicate with people with cognitive impairment.



Communicating with people who have cognitive impairment requires particular knowledge, skills and abilities. Staff would need training to understand how to communicate verbally, non-verbally and emotionally with residents. Learning how to connect with residents with memory loss and understanding that the attitudes and feelings of staff can affect the resident's response to them. Time, training, skills and understanding can improve communication with residents and assist key workers to respond to such situations.

Life Story book

During the training provided on implementing the interventions, it was stressed that it was important to ask residents what they wanted recorded in their Life Story book, as for some residents they did not necessarily want family to know certain information. Completing the life storybook needs to be approached with sensitivity and with respect to the resident's wishes, information and feelings.

Walking and Talking Program

The responses from residents and staff showed that the walking and talking program made a difference to how residents felt, the attention they received when walking and talking and how feeling special improved the residents wellbeing and identity. This program gives staff tools and activities that are meaningful for residents and yet within the scope of their daily routine.

Where staff experienced time constraints in doing the walking and talking we had suggested that walking to the dining room in the morning, noon and evening for ten minutes a time would count for the 30 minute part of the walking program. Creative ways need to be found to do the program within the usual routine of care, so that it is more likely to be done and completed. The average time spent on the walking and talking program per week was 45 minutes per resident. This time is considerably less than the intended 30 minutes three times per week as prescribed in the intervention.

Overall views of staff on the interventions

The comment, *'the key worker needs more time to do the interventions'* and *'there was not enough time to spend with residents while working'*, could mean working is seen only as the physical care needed by residents. The researchers have considered whether some staff viewed the interventions as a luxury, something you only did if you have extra or free time, which staff do not have. The interventions may not be seen as routine care that provides for holistic and appropriate care for residents, especially newly admitted residents.

Conclusion

Staff depression training

Our statistical evidence shows that staff knowledge of depression and self-efficacy mean scores appears to have increased in between Time 1 and 3 for the treatment group, while mean scores of the control group are similar on both occasions, regardless of whether they are personal carers or nurses.

The first analysis examined the effects of levels of carers (higher – nurses or lower level - personal carers) and group (treatment vs. control) on participants' knowledge of depression over the two time periods (Time 1 and 3). The results showed that the increase in knowledge of depression was significant and remained over time. The second analysis looked at the effects of carers (higher or lower) and group (treatment vs. control) on participants' self-efficacy over the two different time periods (Time 1 and 3). Similar to the results of the first analysis, this result revealed that confidence increased and was significant. Moreover, time had a substantial effect on self-efficacy of the treatment group. On the other hand, self-efficacy of the control group stayed constant at Time 1 and Time 3.


Training was interesting and useful

The responses provided by staff that they found the depression-training program very interesting (87.5%) and very useful (95%) is an indication of the useful information staff obtained and the practical application of this learning. The changes that occurred with the detection of depression in residents and the subsequent referrals from care workers (87.5% of respondents) to registered nurses and general practitioners will ensure that residents are not left with undetected and untreated depression, anxiety or dementia. The inclusion of care workers as a respected and fully functioning member of the team should increase staff job satisfaction and improve care to residents.

The results indicated that time itself did not have a significant effect on the attitude of the staff. The only significant interaction that had an effect on carers' attitudes was time and levels of carers. Mean scores of attitude at Time 1 and Time 3 between higher and lower levels of carers seem to reflect different trends. While the overall means of higher level carers slightly increased from Time 1 the overall means of lower level carers were relatively stable between Time 1 and Time 3. In contrast, mean scores on attitude remained comparatively constant when only time was concerned. Likewise, mean scores of both treatment (Time 1 to Time 3) and control (Time 1 to Time 3) groups stayed relatively stable between Time 1 and Time 3.

Residents in residential aged care facilities and family carers

Improvement was evident in RACF resident and informant ratings from Time 1 to Time 2 in both the intervention and control groups. However, it was not possible to determine whether the intervention was superior to the control condition due to the small sample size of this feasibility study, unbalanced scores at baseline and differential dropout of highly symptomatic residents and family carer informants.



Informants (family carers) were rated on the General Health Questionnaire 28 (GHQ). Mean GHQ scores dropped 3.2 points (14.9% of mean baseline) score between the first and second interviews. However, there was no statistically significant difference between the Intervention and Control groups.

The scoring results for the residents and family carers show improvement in depression and agitation and less distress for family carers, however they are not statistically significant. This study was a feasibility study and the intention was to discover the trends, the ease and difficulties of providing interventions and the perceptions and experiences of residents and staff.

The trends and categories that emerged from the qualitative evaluations were:

For residents –

- Enjoyable to have a Key Worker
- Sensitive questioning required when completing Life Story book
- Liked the walking and talking program with a desire for more frequent walking and talking.

For staff –

- Difficulties of being a key worker – time constraints
- Positive aspects of being a key worker – advocate and confidant for resident
- Life storybook is an important and valued resource
- Walking and talking program provided good exercise, strength and balance, built and increased trust and support and provide time to converse.

For family carers –

- Attendance at the support groups assisted with feelings of guilt and provided understanding and acceptance of decisions.
- Obtained tools on how to communicate with staff re concerns
- Learnt self care techniques.

Staff shortages, low pay and lack of adequate and mandatory training needs to be addressed in order for staff to give quality care to residents and families.

The three interventions assessed and discussed need to be incorporated into routine management of residents.

To conclude the discussion, the following thoughts are left with readers:

One of the greatest gifts staff can give anyone is to be a good non-judgmental listener. Listening indicates that staff really care and feel concerned, and also that staff really want to help (Talseth 2003)

and

Happiness is not simply a feeling or emotion; it is a connection to the world, a realisation of one's place in it, including being in a residential aged care facility.

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