Making a difference: Implementing person-centred practice to promote older people’s mental health and wellbeing

A blended-learning training program for enrolled nursing students
Project team
Marie–Anne Schull
Older Adults Project Manager
beyondblue

Robyn House
Education Consultant
House & Associates

Quality assurance
Content for the program was developed by the project team with input from the following experts:

- Susan Beaton, Suicide Prevention Advisor, beyondblue
- Dr Brian Graetz, General Manager Research, Child & Youth, beyondblue
- Professor John Snowdon, Old Age Psychiatrist, Sydney South West Area Health Service
- Sally Garratt, Aged Care Consultant, Adjunct Associate Professor Australian Centre for Evidence Based Aged Care, La Trobe University
- Chris Harrison, Aged Psychiatry Assessment and Treatment Team, St Vincent’s Aged Mental Health Service, Kew, Victoria
- Dr Sue Aberdeen, Aged Care Consulting and Education
- The NSW Elderly Suicide Prevention Network (ESPN)

The materials were then reviewed externally by:

- Louise Edgar, Advanced Skills Teacher – in Aged Care and Diploma of Nursing (Enrolled) Canberra Institute of Technology
- Dr Sue Aberdeen, Aged Care Consulting and Education

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INTRODUCTION

About the program

Welcome to Making a difference: implementing person-centred practice to promote older people’s mental health and wellbeing. This blended-learning training program was developed by beyondblue for students undertaking the unit HLTEN515B: Implement and monitor nursing care for older clients as part of their Diploma of Nursing.

This program has been specifically designed for students who will become enrolled nurses working in aged care, in either residential or community settings. You may have completed other beyondblue programs, and/or learnt about depression and anxiety in older people through your work or through other studies. This resource, Making a difference: Implementing person-centred practice to promote older people’s mental health and wellbeing is the third stand-alone program in beyondblue’s series of the ‘Making a difference’ programs.

The program has three key outcomes for students. Completing it will enable you to:

• understand mental health conditions and their impact in older people
• implement a person-centred, strengths-based approach to improve care outcomes for older people experiencing depression, anxiety disorders or dementia
• enhance the enrolled nurse’s role in care planning and person-centred practice to promote older people’s mental health and wellbeing.

This student workbook reflects these outcomes in each chapter of the program.

The workbook is divided into three chapters. We suggest you do some reading before you begin each chapter to broaden and refresh your knowledge about issues which will be discussed and explored in the chapter.

Information for students

This student workbook contains information about depression and anxiety in older people and also about the potential positive impact of the enrolled nurse’s role and practice on the client’s and resident’s mental health and wellbeing.

Case studies, personal stories, good practice examples, activities, investigations (as online tasks) and discussion questions have been provided to assist you to develop your understanding and knowledge. As you work through the program you will also be enhancing your skills in analysis, critical thinking, investigation, applying learning, interpreting data, effective communication and reflective practice.

This program is being delivered via a blended-learning mode – a mixture of online and face to face. The student workbook will indicate which activities are completed in class and which are completed online. Your facilitator will assist you to complete both the face-to-face and online components.

The enrolled nurse plays a pivotal role within aged care. The content of the program reflects the significance of this role as a team leader, supervisor and mentor. It also identifies how you can have a positive influence on the organisational culture and quality of care provided to older people in residential or community settings.

The outcomes and content of this learning resource are intended to complement, rather than replace, the delivery and assessment strategies developed for the unit of competency by your training provider.
As students, you each bring to the learning experience your own knowledge and understanding. We hope that you will embrace this program, that your practice will reflect its goals, and that you will indeed make a positive difference in the lives of older people.

We trust you will enjoy your learning experience.

We want your feedback!

beyondblue receives feedback from your training provider but it’s important that we also receive feedback directly from you, the students! We want to ensure these materials are meeting your needs; your feedback will help ensure they do. Once you have completed the beyondblue program as part of your Diploma of Nursing, please submit your feedback by going online at [www.beyondblue.org.au/bldiplomastudentfeedback](http://www.beyondblue.org.au/bldiplomastudentfeedback) and completing the feedback form.

Icons key

Below is a list of helpful icons used throughout this workbook.

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<th>Text</th>
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<td><img src="image" alt="Icon" /></td>
<td>Think creatively</td>
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CHAPTER 1

Understanding mental health conditions and their impact on older people
Introduction

In this chapter you will develop your knowledge about four mental health conditions – depression, anxiety, delirium and dementia – that are commonly experienced by older clients and residents in your care. You will analyse risk and protective factors for these conditions and investigate the impact and implications of the conditions for your clients and residents, their families and carers. You will also consider how you can support older people who are at increased risk for depression or anxiety. Throughout the chapter you will be encouraged to critically reflect on how you can apply your learning to your role as an enrolled nurse.

This chapter explores the following topics:

1. Depression, anxiety, delirium and dementia – understanding the signs, symptoms and overlaps.
   - What is happening at a cellular level in the brains of people with these conditions.
   - Links between depression and chronic illness.
   - Relationship between depression and dementia.

2. Impact and implications of mental health conditions on your clients and residents.
   - Reactions to grief, loss and other life-changing events for older people.

3. Risks and protective factors for depression and anxiety in older people.
   - Implications for assessing, planning and evaluating care.

4. Specific risk and protective factors for:
   - lesbian, gay, bisexual, transgender and intersex (LGBTI) older people
   - Aboriginal and Torres Strait Islander older people
   - culturally and linguistically diverse (CALD) older people.

As you work through this chapter you will be:

- extending your knowledge of depression, anxiety and other mental health conditions to enhance your practice in aged care
- developing the ability to apply professional judgment when making care decisions for your clients and residents
- critically reviewing a range of information about depression, anxiety and other mental health conditions in older people
- testing assumptions within the context of attitudes and stereotypes around ageing and mental health conditions in older people
- developing skills in critical thinking and reflection to enhance your practice
- using evidence-based information on depression and anxiety in older people to evaluate your current workplace policies and practices
- developing your ability to translate ideas into action and to think creatively to achieve positive outcomes for your clients and residents.
Learning outcomes

Learning outcomes are important for you as the student. As you progress through the information and activities in this chapter, take a moment to record your knowledge and skills. These can also be used to show an employer and are often referred to as employability skills.

<table>
<thead>
<tr>
<th>Read each statement and record your ‘yes’ or ‘no’ response in the next column.</th>
<th>Yes or No?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can now analyse and distinguish signs, symptoms and overlaps of four mental health conditions experienced by older people.</td>
<td></td>
</tr>
<tr>
<td>I can explain the impact and implications of these conditions on older people in my care and evaluate a range of responsive care practices.</td>
<td></td>
</tr>
<tr>
<td>I can investigate risk and protective factors for depression and anxiety and implement evidence-based strategies to promote mental health and wellbeing for clients and residents in my care.</td>
<td></td>
</tr>
<tr>
<td>I have increased my understanding of, and sensitivity to, risk and protective factors in older people who may be at particular risk for depression and anxiety.</td>
<td></td>
</tr>
<tr>
<td>I am able to review, analyse and interpret results of research, and incorporate evidence-based findings into care to promote quality living for clients and residents.</td>
<td></td>
</tr>
<tr>
<td>In my workplace, and adhering to my role and responsibilities, I am able to apply knowledge and judgment to enhance my care practice.</td>
<td></td>
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</tbody>
</table>
Activities in this chapter

As you work through this chapter you will complete different types of activities, such as critically analysing case studies, accessing and interpreting research data, applying knowledge and professional judgment, completing quizzes and answering questions that encourage you to reflect and apply skills in the workplace. Some of these activities will take place in class and some will be completed online.

In-class activities

You will be undertaking the following activities during class time. Your facilitator will lead you through each activity.

You might like to keep a record of your progress and use the table below to do so.

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<thead>
<tr>
<th>Activity</th>
<th>Page number</th>
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<td>1.4 Case study: Enabling protective factors – learning from Nigel's story</td>
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<td>1.5 Case study: Living with risk and protective factors – Dawn's story</td>
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<td>1.6 Case study: Living with risk and protective factors – Percy's story</td>
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Online components in this chapter

There are several ways to participate in the online activities in this chapter.

1. Worksheets

The online tasks in this chapter are designed to build on the concepts you learn in class and further develop your understanding of depression and anxiety in older people. These online tasks will be provided as worksheets that you need to complete. You will see references to these online worksheets in your student workbook. As with your in-class program, your facilitator will guide you through each task and provide feedback on your responses.

2. Online discussion forums

There are several opportunities throughout the chapter where your facilitator may choose to further explore topics by establishing an online discussion forum with members of your group. These forums may be part of a worksheet and are designed to help you engage in the online environment by sharing your ideas and experiences. Your facilitator will lead you through these forums.

3. Online reading

Another way you can learn more about the topics covered in this chapter is by accessing relevant information sheets online. Links to these publications are included in your workbook. You may wish to discuss your reading with other members of your online group.
Getting started...

Online pre-reading for this chapter

To enable you to fully understand some of the concepts presented in this chapter, we suggest you undertake some online pre-reading.

The online reading for this chapter includes fact sheets and an information booklet from beyondblue. You can download these by going to www.beyondblue.org.au/resources

Search for the title and tick ‘publications’. You might like to keep a record of your reading.

<table>
<thead>
<tr>
<th>Title</th>
<th>Related to</th>
</tr>
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<tbody>
<tr>
<td>Fact sheet – Understanding anxiety</td>
<td>Step 1</td>
</tr>
<tr>
<td>Depression and anxiety: an information booklet</td>
<td>Step 1 and 2</td>
</tr>
<tr>
<td>Fact sheet – Depression and anxiety disorders in older people</td>
<td>Step 1</td>
</tr>
</tbody>
</table>

This chapter has three steps. When you have completed them, you are encouraged to reflect on your learning.

**STEP 1**
You will initially investigate the signs, symptoms and overlaps of four mental health conditions and analyse and interpret data. You will think critically about the impact and implications of these conditions for older people’s mental health and your role in caring for clients in residential or community care.

**Complete in-class activities and online tasks.**

**STEP 2**
Then you will analyse risk and protective factors for older people with depression or anxiety and identify ways to apply this knowledge to your daily practice.

**Complete in-class activities.**

**STEP 3**
In this step you will critically reflect on the impact and implications of mental health conditions for older people at risk, and identify specific protective factors to promote mental health and wellbeing.

**Complete in-class activities and online tasks.**

**LEARNING REFLECTIONS**
In learning reflections you have the opportunity to complete a short online quiz.

**FINAL REFLECTIONS**
In final reflections you are encouraged to reflect on your learning experience and apply your knowledge by completing three activities. You can complete these activities online.
Mental health is a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.¹

In this step we will examine four mental health conditions – depression, anxiety, delirium and dementia – commonly experienced by older clients and residents in your care and analyse the signs and symptoms of each condition and how they are likely to present in your clients and residents. We will also interpret research data around definitions, classifications and prevalence of depression and consider how this information can inform aged care practice. Finally, we will critically reflect on the nurse’s role in caring for older people in residential or community care.

**Facts about mental health conditions in older people**
- Mental health conditions are not a normal part of ageing.
- Older adults can be vulnerable to mental distress and/or illness.
- Some older adults develop a mental health condition as they age (late onset), while others grow older with a continuing experience of a mental health condition that developed earlier in their lives.
- Mental health conditions can be hard to detect in older adults as symptoms may not be reported or may be attributed to other physical conditions or to ageing.
- It is important that mental health conditions in older adults are identified and treated otherwise the symptoms can worsen and rapidly impact on a person’s quality of life.

**Understanding depression in older people**

Depression is a common condition that affects all age groups in the Australian community, but which is often unrecognised, misdiagnosed or untreated in older adults.

Depression is more than just a low mood. Did you know that depression has serious effects on physical and mental health? People with depression find it hard to function every day.

The symptoms of depression can present randomly but many of the symptoms are similar in nature and can be grouped together in particular categories.

The diagram on the following page shows the four main categories of symptoms.

A person may be depressed if, for more than two weeks, they have felt sad, down or miserable most of the time or have lost interest or pleasure in most of their usual activities, and have also experienced several of the signs and symptoms from at least three of the categories below.

The table below identifies each category and provides an example of a related symptom.

<table>
<thead>
<tr>
<th>Category</th>
<th>Example of related symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>‘Physical’ refers to the group of symptoms that are predominately physical in nature. An example of a physical symptom is disturbed sleep. People with depression often experience early waking and some may have trouble sleeping, or sleep longer than normal, but their normal sleeping pattern has been disturbed.</td>
</tr>
<tr>
<td>Feelings</td>
<td>‘Feelings’ refers to the group of symptoms that are predominately emotional in nature. Examples of these symptoms include feeling overwhelmed or feeling fearful.</td>
</tr>
<tr>
<td>Behaviour</td>
<td>‘Behaviour’ refers to the group of symptoms that affects an individual’s behaviour. An example of a behavioural symptom is social withdrawal. This can occur as people with depression may no longer wish to participate in social events.</td>
</tr>
<tr>
<td>Thoughts</td>
<td>‘Thoughts’ refers to the group of symptoms that affect an individual’s thinking. An example includes negative thinking patterns. A person with depression can have difficulty recognising the positives in their lives as they get caught up in a whirlpool of negative thinking.</td>
</tr>
</tbody>
</table>
If you have not already read beyondblue’s free booklet, *Depression and anxiety: an information booklet* as part of your pre-reading, you can find out more about depression and anxiety by doing so now.

You can download the booklet by going to [www.beyondblue.org.au/resources](http://www.beyondblue.org.au/resources). Search for the title and tick ‘publications’.

**Some important facts about incidence and impact of depression in older people**

- Frail older adults who require significant supports to remain at home are twice as likely to develop depression.
- One in three older people in residential care has depression.
- A recent Australian Institute of Health and Welfare report identified that over 50% of all permanent aged care residents had symptoms of depression.
- Depression in older people may occur for a range of reasons.
- Depression is a leading cause of disease burden and it is now regarded as being more damaging to health than some major chronic diseases.

**What’s happening at a cellular level?**

Significant research to identify what is happening to the brains of people who experience depression has been undertaken and is ongoing. We are starting to get a clearer picture of what is happening deep in the brains of people with depression.

**A closer look at our brains**

Before we understand what is happening in depression, we need to understand how our brains work.

The building blocks of our brain are nerve cells or neurones. Everything we do depends on neurones communicating with one another.

![Synapse Diagram](image)

Source: National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services.

Neurones (see diagram above) have filaments – called dendrites – that extend from the cell body towards the next neurone, but there is a small gap – a synapse – between neurones. Neurotransmitters (brain chemicals) are released by one neurone to help send messages on to the next. Neurones can have connections to thousands of other neurones, so at a microscopic level our brain tissue looks like a disorganised mass of threads or filaments.
According to Black Dog Institute, ‘In all depressions, it is likely that the transmission of serotonin is reduced or disrupted…’²

Serotonin is a neurotransmitter that has several functions, one of which is to help regulate mood. Other neurotransmitters can also be affected in particular types of depression. Black Dog Institute states, ‘… in people with melancholic and psychotic depression, other neurotransmitter pathways such as those for noradrenaline and dopamine are also likely to be functioning abnormally’. Noradrenaline and dopamine are other important neurotransmitters that affect a person’s mood.

There is considerable evidence that depression may also be secondary to brain damage from strokes and trauma to the left-anterior and right-hemisphere or parietal–occipital lesions.³

Think critically

Why do you think depression as an older person is the same condition as depression at other times of your life?

What leads you to this belief?

Depression in older people is essentially the same condition as it is in a younger person but it may present differently with more symptoms from the physical category than other categories.

Reflect and discuss

Think about a client or resident you have cared for who had, or was subsequently diagnosed with, depression.

Now write your responses to the following questions. We encourage you to share your thoughts with fellow students.

Q1) What symptoms did you notice?


Q2) Did your client complain of being down or sad?


Q3) What language did they use to describe how they felt?


Q4) Had any other member of the care team reported symptoms that were indicative of depression? If so, from which category did these reported symptoms represent? You can refer to the table on page 9.


The relationship between depression and chronic illness

Chronic illness and depression go together.

There is a link between chronic illness and depression: having a chronic illness increases your risk of developing depression. 80% of the older population have three or more chronic illnesses; older people are therefore at greater risk of developing depression.

Activity 1.1 Case study: A classic presentation of depression – Sally’s story

Sally Garrett, aged in her late sixties, lives in Tasmania. She was a professor of nursing at La Trobe University and Adjunct Associate Professor at the Australian Centre for Evidence-based Aged Care. Sally had a number of risk factors that contributed to her developing depression.

This activity has two parts.

Part A

In the DVD you are about to watch, Another Shade of Blue: Depression in Older Australians, Sally talks about some of the risk factors that contributed to her developing depression and her experience of day-to-day living with physical and mental illness.

As you watch the DVD, tune into the issues Sally raises and look for examples of risk factors for depression. Take care to also note the daily emotional and physical impacts on Sally of living with depression.

We encourage you to listen to Sally’s concerns about how health professionals responded to her situation. You might also make notes of particular concerns or issues you hadn’t previously considered when thinking about clients with similar stories to Sally.

Part B

Apply knowledge and professional judgment

Take some time to reflect on Sally’s interview then write your responses to the following questions.

Q1) **Sally’s depression is described as a classic presentation of depression in an older person. Identify the indicators of Sally’s depression that fit with this description.**

Q2) **What factors contributed to Sally’s depression being difficult to diagnose?**

Q3) **Identify three risk factors for Sally to develop depression.**

Q4) **What were some of the emotional/psychological impacts of the treatment Sally received from doctors, specialists and GPs?**

Q5) **What examples of stereotyping did you observe that had a significant impact on Sally’s sense of self?**
Q6) What did Sally want to hear from the doctors treating her that would have reduced her feelings of worthlessness and improved her quality of life?

Q7) Identify two protective factors Sally initiated herself.

Think critically
What is the key message for you from this case study? Please write your message in the space provided.
The relationship between depression and other health conditions

Depression can be a symptom of some health conditions, including:

- brain injuries and disease (e.g. stroke, heart disease, head injury, epilepsy, Parkinson’s disease)
- low thyroid function
- some forms of cancer
- infectious diseases
- blood vessel disease in the brain due to diabetes and/or hypertension
- anaemia
- chronic pain.

Depression may also occur as a reaction to or side-effect from some medications, such as some steroid (as in Sally’s experience) and hormonal treatments.

However, just as depression can develop as a consequence of having a chronic health condition, having depression can also be a risk factor for developing other conditions, such as heart disease.

There is a bidirectional relationship between chronic illness and depression.
‘Normal’ reactions to grief, loss and other life-changing events for older people

Events that might impact upon an older person’s mental health include:

- loss of a partner, friends or pets
- limited or loss of mobility
- moving from one’s usual place of living
- sensory impairment
- development of a chronic or terminal illness
- increasing frailty
- other life changing events such as:
  - role changes, including retirement
  - reduced financial income
  - changes in body image
  - pain associated with chronic illness.

Reactions to such life changes will present differently in each individual but can include:

- sadness
- disbelief
- guilt
- anger
- numbness
- anxiety
- trouble concentrating and making decisions
- loss of energy
- changes to sleeping and eating patterns.

These symptoms typically lessen over time through adjustment to the change/s.

It is important to recognise that you will also be working with families who may be experiencing grief and loss. There may be losses associated with:

- their loved one needing additional care
- changes in their relationship
- their loved one experiencing a chronic illness such as dementia
- the death of their loved one.

The symptoms of grief and loss and those of depression can be similar.

**Analyse and interpret**

Read beyondblue’s Fact Sheet *Grief, loss and depression*, then circle your answer to the following questions.

You can download the Fact Sheet by going to [www.beyondblue.org.au/resources](http://www.beyondblue.org.au/resources).

Search for the title and tick ‘publications’.
Q1) *Is grief and loss depression?* Yes/No

Q2) *Can it become depression?* Yes/No

Now briefly describe the difference between the presentation of depression and that of grief and loss.

---

**How would you know if one of your clients is depressed and not just sad?**

Your client may be depressed if, for **more than two weeks:**

- they have felt sad, down or miserable most of the time

- or

- they have lost interest or pleasure in most of their usual activities

- and

- they have also experienced several of the signs and symptoms from at least three of the categories described earlier.

**Activity 1.2 Reviewing, identifying and analysing classifications of depression**

**Background**

Depression, especially in a research or diagnostic context, is often further defined and classified. Two classification systems exist that use different criteria to classify depression as mild, moderate or major. This can make it difficult to compare research/diagnoses if different classification systems have been used. These classifications and terms may be used by certain health professionals within your aged care setting relating to your clients and residents.

The Diagnostic and Statistical Manual of Mental Disorders DSM-5 and the International Classification of Disease ICD10 are the classification systems often cited by researchers/diagnosticians to further define and classify depression.

There are two parts in this activity.

**Part A**

**Critically review**

We suggest you work in pairs or small groups to complete this activity.

Use the following links to access the relevant references.

- For information on the classification of depression using the ICD10: http://www.guiasalud.es/egpc/traduccion/ingles/depresion/completa/documentos/apartado04/definicion%20y%20diagnostico.pdf

- For information on the classification of depression using the DSM-5 (this also compares the DSM-5 to the ICD 10): http://www.nps.org.au/conditions-and-topics/conditions/mental-health-conditions/mood-disorders/depression/health-professionals/diagnosis
Take some time to become familiar with each classification system then compare the different criteria used to classify depression as mild, moderate or major.

**Part B**

**Analyse and interpret**

Use the relevant references provided above to answer the following questions. Write your responses in the space provided.

**Q1) Identify the different classifications used for describing depression of both the DSM-5 and ICD10**

**Q2) Why would this further classification exist through both the DSM-5 and the ICD10?**

In Worksheet 1 you will have the opportunity to build on this knowledge and consider how these classifications apply in practice.

**WORKSHEET 1 – Describing depression in an older person: analysing classifications of depression**

You are now ready to extend your learning by completing your first online task. Your facilitator will explain how to complete the task and when to submit your worksheet.

**Understanding anxiety in older people**

In this workbook, when we talk about anxiety, we are generally referring to an anxiety condition. If we are talking about anxiety that we all experience we will use the term ‘the feeling of anxiety’.

Anxiety is the most common mental health condition (at any age) and is generally characterised by persistent and excessive worry. Anxiety involves more than just feeling stressed – it’s a serious illness. People with anxiety find it hard to function every day.

You might be familiar with generalised anxiety disorders or panic disorders. There are, however, many different anxiety conditions, each with their own clinical criteria.

There are clinical criteria for each anxiety condition but, as with depression, the signs and symptoms of anxiety will present randomly across the four categories you analysed for depression: physical, feelings, behaviour and thoughts.

The table on the following page shows each category and provides an example of a related symptom.
<table>
<thead>
<tr>
<th>Category</th>
<th>Example of related symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>An example of a physical symptom related to anxiety includes disturbed sleep. People with anxiety often experience difficulty falling asleep as they can’t turn off from their thoughts. Muscle pain is another example as people with an anxiety disorder often hold their bodies tensely and may complain of neck or shoulder pain.</td>
</tr>
<tr>
<td>Feelings</td>
<td>Examples from this category could include sudden and intense panic as the feelings of anxiety escalate.</td>
</tr>
<tr>
<td>Behaviour</td>
<td>An example of a behavioural symptom is poor concentration. The anxiety may be so overwhelming that it may be very difficult to concentrate.</td>
</tr>
<tr>
<td>Thoughts</td>
<td>People with an anxiety disorder can experience constant worrying, rehashing or obsessive thoughts.</td>
</tr>
</tbody>
</table>

What is happening at a cellular level?

Source: National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services

Significant research has been conducted and is currently underway to determine what is happening at a cellular level in the brains of people with anxiety.

According to the National Institute of Mental Health (NIMH) (USA), several parts of the brain – principally the amygdala and the hippocampus (see diagram above) – are responsible for the production of fear and anxiety.

These parts will be involved in most anxiety conditions.

The NIMH (USA) states, "The amygdala is an almond-shaped structure deep in the brain that is believed to be a communications hub between the parts of the brain that process incoming sensory signals and the parts that interpret these signals.

It can alert the rest of the brain that a threat is present and trigger a fear or anxiety response. The emotional memories stored in the central part of the amygdala may play a role in anxiety conditions involving very distinct fears, such as fears of dogs, spiders, or flying."
The hippocampus is also involved as it is the part of the brain that stores these threatening events as memories.

We are all familiar with how the body might respond to a threatening event; it’s called the fight or flight mechanism. To respond to this threat, hormones – principally adrenaline, norepinephrine and cortisol – are released.

Recent research from the NIMH (USA) indicates that (as with depression), for some anxiety conditions, the levels of certain neurotransmitters may also be affected. Research studies are currently investigating which neurotransmitters may be involved.

**Anxiety and stress conditions in older adults**

- There can be situation dependent anxiety – where a person is fearful of a particular event.
- It is often easier to recognise symptoms associated with anxiety than those associated with depression. These symptoms might include:
  - being fearful
  - being agitated
  - experiencing sore muscles
  - verbalising multiple worries.
- Phobic conditions are the most common type of anxiety in older people.
- Post-traumatic stress disorder (PTSD) can occur in war veterans and in older people from certain cultural groups who may have experienced trauma or torture.
- It is more common that a person who has a history of anxiety will present with this condition again as an older person. In this situation, the family will be a great resource in finding out about the person’s history.
- If anxiety presents for the first time in an older person, it is more likely to be a symptom of depression than an anxiety condition. However some people may live most of their lives with a mild anxiety condition which can then become more evident and disabling when combined with age-related issues and dementia.

Anxiety increases older people’s risk of mortality, both from suicide and from physical illness such as cardiovascular disease.
What are the risks for anxiety in older people?

The risk of both anxiety and depression is increased for those older adults who:

• have multiple physical illnesses or limitations
• live in residential aged care or are hospitalised
• are homeless or at risk of homelessness
• have experienced oppression, racism and discrimination.

Some people most likely to have experienced oppression, racism and discrimination include:

• Aboriginal and Torres Strait Islander people
• people from culturally and linguistically diverse (CALD) backgrounds
• lesbian, gay, bisexual, transgender and intersex (LGBTI) people
• refugees and soldiers who may have experienced torture and other traumatic events.

Recognising the impact of anxiety on our clients and residents

Anxiety involves more than just feeling stressed – it’s a serious illness. People with anxiety find it hard to function every day.

In your role as an enrolled nurse it is important to understand the impact of anxiety for your clients.

**WORKSHEET 2 – Caring for a client with anxiety**

You can extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your worksheet.
Incidence of depression and anxiety in older people

A number of research studies have been undertaken to identify the prevalence rates for depression and anxiety in the general population and in older people. The key findings from three studies have been drawn together in the following table.

<table>
<thead>
<tr>
<th>Comparison of prevalence rates for depression and anxiety in the general population against prevalence rates for depression and anxiety in older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>General prevalence rates</td>
</tr>
<tr>
<td>Lifetime prevalence rates in the general population</td>
</tr>
<tr>
<td>Prevalence rates for older people</td>
</tr>
<tr>
<td>Older people living in the community</td>
</tr>
<tr>
<td>Includes all sub-threshold presentations of anxiety condition</td>
</tr>
<tr>
<td>Older people living in residential care</td>
</tr>
</tbody>
</table>

Analyse and interpret

Take some time to analyse the data presented in the table.

Consider the following questions and record your responses.

Q3) In reviewing the statistics for older people and comparing them to the statistics for the general population, what comments can you make about the prevalence of depression and anxiety in older people?

Q4) What possible explanations could be given for the rates of depression and anxiety in older people?
Depression and anxiety can occur together

Research indicates that anxiety and depression can often occur together in older adults.

It also shows that older people with a Major Depressive Disorder (MDD) also had a comorbid anxiety disorder, whereas approximately one-fourth of those with anxiety disorders also had a major depressive disorder.6

Reflect and discuss

Think about some experiences you have had nursing older people with depression or anxiety. Compare these experiences to the research findings.

Consider the following question and record your response.

Q1) What similarities or differences do you notice?

________________________________________

________________________________________

________________________________________

Discuss your responses with fellow students.

WORKSHEET 3 – Comparative analysis: interpreting the data on prevalence of depression in older people

You can extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your worksheet.

Understanding delirium

Delirium is a temporary neurocognitive disorder where the person affected often has sudden changes in mood, memory, attention and planning.

Delirium is typically sudden in onset. The person's condition fluctuates during the course of the day and will persist until the cause of the delirium is managed.

Delirium is relatively common in older people. It can be traced back to an underlying physical cause such as dehydration, urinary tract infection, unmanaged pain, the effect of medications, or changes to the person's environment.

Research (Dyer et al and Francis) demonstrated that delirium affects approximately one third ($\frac{1}{3}$) of older people during a hospitalisation and nearly three quarters ($\frac{3}{4}$) of post-operative older patients in intensive care units.² If an older person experiences delirium, they will have longer hospital stays and poorer outcomes which can include discharge to residential care or death.

**What is happening at a cellular level?**

Cellular changes will depend on the cause of the delirium. Often there can be abnormal electrolyte levels present in the body. Electrolyte levels can be influenced by the amount of water in the body. Electrolytes include elements such as sodium, potassium, calcium etc. In older people when these electrolyte levels go out of balance it can lead to confusion.

**WORKSHEET 4 – Caring for a client with delirium**

You can extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your worksheet.

**Understanding dementia**

Dementia is a major cognitive condition that involves the long term impairment of memory, thinking, understanding, planning and reasoning to such a degree that it affects the person’s ability to function normally. Many conditions can cause dementia including:

- Alzheimer’s disease (most common cause of dementia)
- vascular dementia
- dementia with Lewy bodies.

**What is happening at a cellular level?**

In each of the conditions listed above, changes which lead to dementia are occurring in the brain. For example, neurofibrillary tangles and amyloid plaque are proteins that build up in the brains of people with Alzheimer’s disease. These proteins affect the normal functioning of the brain and can lead to the death of brain cells. This ultimately causes the cortex (outer layer) of the brain to shrink. The image below demonstrates the loss of brain tissue associated with severe Alzheimer’s disease.


Significant research has been conducted to identify why these proteins build up in the brains of people with Alzheimer’s disease. The reasons are complex and likely to be multifactorial.

In vascular dementia and dementia with Lewy bodies, other changes will be occurring that affect the brain’s function. They will result in the person developing dementia.

Limited treatment options are available for some of these diseases. Generally the person’s condition can’t be treated but there might be a stabilising of symptoms for a short period.

In all situations where symptoms of memory impairment and confusion are noticed, or other intellectual functions have changed significantly, it’s vital to get an accurate diagnosis from an appropriate medical practitioner.

**Online reading**

For more information about dementia, go to [www.fightdementia.org.au](http://www.fightdementia.org.au) where you can download a number of Help Sheets including:

- *What is dementia?*
- *Types of dementia*
- *Drug treatments and dementia.*

**Distinguishing depression from dementia**

“*As a general rule, in depressed patients complaints are greater than their observed dysfunction, while in patients with dementia, observed dysfunction is greater than their complaints.*” – Dr Raluca Tudor, Senior Consultant Psychiatrist, Psychiatry of Old Age, Repatriation General Hospital, Daw Park, South Australia

It is important to ensure a correct diagnosis is made because the treatments for depression and dementia are different. A wrong diagnosis of dementia could mean a person with depression doesn’t get the support and treatment needed to recover. Likewise incorrectly diagnosing dementia as depression could lead to inappropriate treatment and unrealistic expectations of improvement.

An accurate diagnosis of depression involves more than simply identifying the symptoms. Factors which need to be taken into account include:

- the number of symptoms present
- the type of symptoms – particularly feelings of hopelessness, guilt and worthlessness
- the length of time the symptoms have been experienced.

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* Printed in Geriatric Medicine in General Practice Magazine
Recognising one condition in the presence of the other

For the older people in our care, the challenge might not necessarily be recognising depression in contrast to dementia, but recognising either condition in the presence of the other due to the symptom overlap. For example, a person with dementia may become withdrawn – is this the dementia progressing or is it a symptom of depression?

It can be difficult to recognise depression in the presence of dementia and the responsibility of discrimination and diagnosis must be made by a GP or psychiatrist.

A detailed history from the older person and family members is helpful in identifying what might be happening for this client or resident.

**WORKSHEET 5 – Critical review: The older person’s experience of their mental health condition**

You can extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your worksheet.

*Depression is a mood condition and dementia is a major cognitive condition – the result of physical damage to the brain.*

**Distinguishing between depression, anxiety, delirium and dementia**

The following table allows you to compare and contrast the essential features of the four mental health conditions covered in this chapter.

We encourage you to use this guide as a helpful reference to inform your nursing practice.

Please note: You will need to refer to this guide in Activity 1.3.
<table>
<thead>
<tr>
<th>Feature</th>
<th>Depression</th>
<th>Anxiety (Dependent on type of anxiety)</th>
<th>Delirium</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Can be abrupt or noticed over a relatively short period of time</td>
<td>Can be long-standing or triggered by a particular event</td>
<td>Sudden onset</td>
<td>Chronic – decline happens slowly</td>
</tr>
<tr>
<td>Duration</td>
<td>At least 2 weeks but can be months and/or years</td>
<td>May be short or long term</td>
<td>Short term – normally quickly responds to treatment of underlying cause</td>
<td>Months to years (can be very long term)</td>
</tr>
<tr>
<td>Course</td>
<td>Often worse in the morning</td>
<td>Can be associated with a particular event or may always be present</td>
<td>Variable – dramatic fluctuations in mental functioning</td>
<td>Progressive symptoms</td>
</tr>
<tr>
<td>Progression</td>
<td>Unpredictable</td>
<td>Often heightened at particular times or associated with particular anxiety-provoking events</td>
<td>Reversible with treatment of underlying condition</td>
<td>Generally deteriorating but often quite slowly</td>
</tr>
<tr>
<td>Language</td>
<td>Uses fewer words. Slow but normal language skills</td>
<td>May dwell on a particular event and may have difficulty being diverted from that event. Verbalising multiple worries</td>
<td>May be confused</td>
<td>Word-finding difficulties. Trouble writing or speaking</td>
</tr>
<tr>
<td>Memory</td>
<td>Patchy impairment – may remember but can be withdrawn or have difficulty concentrating</td>
<td>Memory should not be affected but may have difficulty concentrating</td>
<td>Will be impaired</td>
<td>Often impaired, especially recent or short term</td>
</tr>
<tr>
<td>Orientation</td>
<td>May be disoriented. Can be correctly oriented to the date and locations</td>
<td>Should not be disoriented</td>
<td>Disoriented</td>
<td>May be impaired especially as the dementia progresses</td>
</tr>
<tr>
<td>Thinking</td>
<td>Intact but themes of hopelessness and helplessness. Difficulty concentrating. Often unmotivated or withdrawn</td>
<td>Recurring obsessive thoughts which cause further anxiety</td>
<td>Confused</td>
<td>Disorganised, distorted, slow</td>
</tr>
<tr>
<td>Sleeping</td>
<td>Early waking typically but can experience sleeping more than usual</td>
<td>Difficulty getting to sleep (can’t switch off from thoughts)</td>
<td>Disturbed sleep-wake cycle</td>
<td>May be confused with day and night reversal</td>
</tr>
<tr>
<td>Physical symptoms</td>
<td>Slowed movement, agitated movements, appetite changes</td>
<td>Increased heart rate, headaches, tension, sore muscles</td>
<td>Erratic and unexpected behaviours</td>
<td>Change in behaviours – withdrawn, restless, agitated</td>
</tr>
</tbody>
</table>

Adapted from Screening for Delirium, Dementia and Depression in the Older Adults – Guidelines developed by the Registered Nurses Association of Ontario. Available at www.rnao.ca/bpg/guidelines/screening-delirium-dementia-and-depressionolderadult Retrieved 27 June 2013.
Misconceptions about mental health conditions

Now that you have gained insight into the facts surrounding mental health conditions in older people, we will cast a critical eye over some common misconceptions that might adversely impact on your clients and residents who are living with a mental health condition.

These misconceptions can include:

- Depression and anxiety are a normal part of ageing.
- Mental health conditions can’t be treated in older people.
- All mental health conditions are the same and will inevitably result in behaviours of concern.
- Medication – particularly antidepressants – is the only treatment for mental health conditions.
- People who live with others are not lonely or socially isolated and are therefore not at risk of becoming depressed.

Group discussion

In small groups, discuss each 'misconception' then consider the following questions.

Q1) What could be some of the reasons these misconceptions have become ‘accepted’ in our society?

Q2) Based on your experience, are there other misconceptions about mental illness that can have negative impacts on older people?

Q3) Would the term ‘stereotype’ be a more accurate description? Please give your reasons.
Now we would like you to think about the role of an enrolled nurse in aged care and discuss the following questions.

Q4) **What can be the impact of these misconceptions for your clients and residents in relation to their:**

- willingness to access aged care
- experience of aged care
- willingness of families to trust aged care staff to care for the person?

Q5) **What can you do within your role to address these misconceptions and promote more positive views for/of your clients and residents?**

---

**Implications of stigmas and misconceptions about mental health**

Stigma or misconception about mental illness can lead to:

- lack of diagnosis or treatment of the mental health condition
- delayed diagnosis
- shame and social isolation
- neglect and failure of staff to adequately manage co-morbidities (such as pain), or referral to other health service providers, for example to palliative care providers
- failure to support the person’s relationships with families and others or their spiritual and sexual wellbeing.

**Activity 1.3 Case study: Supporting a resident’s mental health – Marjorie’s story**

**Apply knowledge and professional judgment**

In this case study you will:

- identify signs and symptoms of mental illness or distress in an older person
- refer to the guide on the different features of depression, anxiety, delirium and dementia on page 27 to support your responses
- describe your role in responding to a resident’s mental distress.

This activity has two parts.
Part A

Analyse and interpret

Read Marjorie’s story. As you read, identify any signs or symptoms of mental distress Marjorie might be experiencing.

Marjorie Moore is an 82-year-old woman who is a resident in your aged care facility. On admission, Marjorie had a diagnosis of arthritis, cardiovascular disease and Alzheimer’s disease. Marjorie also had moderate hearing loss which requires her to wear hearing aids. Otherwise, according to her admission letter from her GP, she had been in reasonably good health most of her life.

Marjorie was admitted on the following medications: Atenolol, Lipitor, Meloxicam and Rivastigmine.

Marjorie’s dementia has resulted in her having problems with her recent memory and also some language difficulties. This has been compounded by Marjorie’s hearing loss. Also, Marjorie sometimes forgets to wear or turn on her hearing aids, or she loses them. She was able to remain at home with her husband’s support but when he died 15 months ago, it soon became apparent that Marjorie could no longer stay at home on her own despite the support of her family.

Marjorie has two children. Her daughter, Pamela, lives close to the residential facility and her son, Stephen, lives interstate.

She has been at this facility for almost eight months. Since the move into residential care, Marjorie has had regular visits from Pamela and occasionally her grandchildren. Recently, Pamela has had her own health issues and is visiting her Mum less often than she normally does. Marjorie’s sister was also a regular visitor, but she died suddenly two months ago.

The night staff have reported recently that Marjorie has been sleeping poorly. Pamela explained that her Mother regularly took a sleeping tablet at night prior to her developing dementia. The GP has commenced Marjorie on Temazepam at night to assist as needed. She does not require one every night but almost every second night and it seems to help her sleep better.

According to Pamela, her Mum normally always kept herself very busy attending to domestic chores and was also a sought-after dress maker – wedding dresses were her specialty.

Marjorie initially responded well to some of the activities that were organised at the facility but you notice that lately she has little interest in any of these activities. You also notice that she is having trouble with basic tasks which she normally could do unprompted.

Further, you have read in Marjorie’s case notes that the afternoon staff report Marjorie to have been verbally abusive to other residents.

Also, you chatted with Pamela after her most recent visit and she mentioned that her Mum no longer seems to enjoy her visits and, uncharacteristically, she has yelled at Pamela on a couple of occasions.

On reflection, you recently recall observing Marjorie crying after Pamela’s visit.
Part B

Think critically

Please write a short history about Marjorie.

Consider the following questions then write your responses in the space provided.

Q1) Referencing the depression, anxiety, delirium and dementia table, describe the onset and duration of the changes you have noticed in Marjorie.

Q2) What do you think might be happening to Marjorie?

Please provide a rationale for why you selected that response.

Apply knowledge to practice

Q3) Within your role as an enrolled nurse, describe what actions you would undertake based on your observations.
Q4) Who would you talk to about Marjorie’s situation?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Q5) What would you expect to be the outcome of these actions?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

We encourage you to share your responses with fellow students.
**STEP 2 ANALYSING RISK AND PROTECTIVE FACTORS FOR DEPRESSION AND ANXIETY IN OLDER PEOPLE**

We identified earlier that older people – especially those in residential care or those requiring supports to remain at home – are at greater risk of developing depression or anxiety.

In this step we are going to consider why older people are at greater risk of developing depression and anxiety and think critically about protective factors that can promote positive outcomes for our clients and residents.

**Understanding risk and protective factors**

With some conditions we can pinpoint the cause of that condition, whereas with depression and anxiety, the cause might not be so obvious.

We often use the model of risk and protective factors (see below) in relation to physical health conditions such as cardiovascular disease or diabetes but the same model can also be applied to depression and anxiety.

If we look at this model we can see that risk and protective factors rest on our genetics. Our genetics will influence the likelihood of us developing any condition. Risk and protective factors balance on either side of genetics.

In the case of cardiovascular disease, we may expose ourselves to certain risk factors such as smoking and lack of exercise which might increase our risk of developing cardiovascular disease and we might also engage in protective factors that reduce that risk such as seeing our doctor regularly.

This same approach can be used with depression or anxiety. We may be exposed to certain risk factors (such as family trauma) that can increase our risk, and we may engage in protective factors such as exercise.
Common risk factors

*It is important to understand that what happens as we age can increase our risk of developing depression and anxiety.*

The diagram below shows some of the most common risk factors for developing depression and anxiety in older people.

![Diagram showing common risk factors: Chronic illness, Being a carer, Moving into residential care, Grief or loss, Social isolation, Dementia.]

*It is important to note* that in addition to experiencing these common risk factors, some groups of older people may be at higher risk of developing depression and anxiety. These groups of older people include:

- women
- people from culturally and linguistically diverse (CALD) backgrounds
- lesbian, gay, bisexual, transgender and intersex (LGBTI) people
- Aboriginal and Torres Strait Islander people.

*But* people in these groups may also have particular protective factors which have supported their mental health, such as activism and extended family connections.

Later in this chapter we will look more closely at additional risks facing specific groups of older people, as well as protective factors that support their mental health.

**Implications for our care practice**

In our role as enrolled nurses, our aim is to mitigate or modify risk factors and to look for ways to promote protective factors. To do this, we must first develop an understanding of our clients’ and residents’ backgrounds, their living conditions and physical health. Then we need to understand what protective factors each client or resident may have engaged with in the past to support their mental health. We can then decide how we can assist them to continue to engage with these protective factors, even in a modified way.
Activity 1.4  Case study: Enabling protective factors – learning from Nigel’s story³

This activity has three parts.

Part A

Think critically

Read Nigel’s story. As you read, think about Nigel’s potential risk factors and the protective factors he has put in place to maintain his mental health, wellbeing and independence.

Nigel, aged 93

In the 1940s, Nigel was a Wireless Air Gunner in World War II. He was discharged from the RAAF after being diagnosed with Type 1 diabetes and took up a life of farming. His illness has contributed to gradual loss of sight, but this hasn’t prevented him from getting out in the fresh air and living an active life with his wife Annie, who has Alzheimer’s disease. Because of his wife’s illness, Nigel single-handedly tends to his five-acre farm, cooks, cleans and shops. His first love is horse riding and he still rides at least twice a week.

The farm includes a house, garden, paddocks and the ponies. He used to farm livestock and he has a Diploma in Agriculture. When he goes out horse riding on his nine-year-old pony, Joe, Annie rides their other pony. Riding is the one thing Nigel can still do because he doesn’t have enough sight to play bowls and he had to give up sailing.

Nigel works on his computer and goes to art lessons once a week. Because of his loss of sight, he finds it hard to read, but being able to enlarge the print on the computer screen, makes reading easier. One day when he finds the time, he’d like to develop his painting skills by doing a course at the University of the Third Age.

Even though “I can’t see well and I’m a bit deaf, I still manage to get out there and do things. Although it can be a challenge, you do get used to it and learn to live with it.”

Nigel has seen his fair share of tough times living on the land. He can’t really say how he got over them, but “…while things can seem awful at the time, once they pass you tend to realise it’s not so bad.”

For Nigel, the joy of country living has always been enhanced by horse riding which he continues to do locally and with a trail club. “I enjoy taking our horses up to the Flinders Ranges and riding with my daughter and her partner.”

³ Adapted from beyondblue Booklet: Older people and depression, pp. 24-25.
Part B
Reflect and discuss
Take some time to consider the following questions then write your responses in the space provided. We encourage you to share your responses with fellow students.

Q1) What aspects in Nigel’s life could be risk factors for depression or anxiety? Please include reasons for your decision.

Q2) What protective factors has Nigel incorporated into his life to maintain his mental health, wellbeing and independence?

Apply knowledge to practice
Q3) How could your organisation assist a client or resident with a similar life history to Nigel to engage with protective factors to maintain their health and wellbeing?

Q4) Describe your role in enabling this client or resident to engage with these protective factors.
Part C

Critical reflection

Now we would like you to reflect on a particular client or resident you have nursed who had experienced depression or anxiety.

Q5) How have you identified specific protective factors for your client’s or resident’s mental health in the past?

Q6) What protective factors did you introduce in your care practice to support this client’s or resident’s mental health?

Think creatively

Now that you have analysed Nigel’s case study and reflected on your past experience, here is an opportunity for you to think creatively about your practice.

Describe two new or innovative protective factors you could introduce into your organisation that would boost your clients’ or residents’ mental and/or physical wellbeing. Explain how your innovations would promote protective factors for your clients or residents.

<table>
<thead>
<tr>
<th>Innovation</th>
<th>How this will promote protective factors</th>
</tr>
</thead>
<tbody>
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STEP 3 SPECIFIC RISK AND PROTECTIVE FACTORS FOR THREE GROUPS OF OLDER PEOPLE

In this step we will focus on three groups of older people who are at increased risk for depression, anxiety or other mental health conditions and whose needs may be overlooked or go unrecognised.

As we think about specific risk factors for these groups, it is important to remember that there can also be specific protective factors that support their mental health.

Older lesbian, gay, bisexual, transgender and intersex people

Everyone has a sexuality, sex and gender. Diversity in these characteristics adds to the rich diversity of Australian society. It is estimated that approximately 8 per cent of the Australian population (1.7 million people) identify as lesbian, gay, bi, transgender or intersex. By 2051, the number of older LGBTI Australians aged 65 years and over is expected to reach 500,000.10

“Aged care must be relevant to the lives of gay, lesbian, bi, trans and intersex people and not the other way around.” – The Hon. Mark Butler (Minister for Mental Health and Ageing 2010 – 2012).

Understanding the letters... LGBTI

Lesbian is a woman whose primary emotional and sexual attraction is towards other women.

Gay primarily refers to a man whose primary emotional and sexual attraction is towards other men. However, this term can be used to describe both men and women who are attracted to members of the same sex.

Bisexual is a person who is emotionally and sexually attracted to people of both sexes.

Transgender is a term often used when people do not identify as the gender with which they were classified as at birth. People are usually classified at birth as female or male. Female-classified children are raised as girls. Male-classified children are raised as boys. A female-classified person who identifies as a boy or man might describe himself as a transgender man or simply as a man. Similarly, a woman classified as male might describe herself as a transgender woman or simply as a woman. Some transgender people identify trans as their gender.

Trans is also often used as an umbrella term to cover a diverse range of experiences of gender and ways of describing oneself – for example trans, transgender, transsexual, gender queer, or gender questioning.

Intersex is an umbrella term which refers to a diversity of physical characteristics of sex. Intersex people have natural variations that differ from conventional ideas about ‘female’ or ‘male’ bodies. These natural variations include genitals, chromosomes and a range of other physical characteristics.

*We have provided definitions here for clarity but it is useful to remember that an individual may use different language to describe their own identity, or may not use identity labels at all. If you are unsure of the appropriate term, just ask.*

**How does identifying as being lesbian, gay, bisexual, trans or an intersex person affect risk and protective factors for depression and anxiety?**

Research has identified that because of the stigma and discrimination which lesbian, gay, bisexual, trans and intersex people continue to face they can experience higher levels of depression and anxiety and are at a greater risk of suicide than the general population.

In a national survey in 2006, 60 per cent of LGBTI respondents had experienced personal insults or verbal abuse and nearly 14 per cent had been physically attacked or experienced other forms of violence.

On the plus side, lesbian, gay, bisexual, trans and intersex people may have additional protective factors. For instance, they may have cultivated supportive families of choice or are actively involved in the LGBTI communities.

*The majority of lesbian, gay, bisexual, trans and intersex people lead happy, healthy lives and contribute to the rich diversity of Australian society.*
Activity 1.5  Case study: Living with risk and protective factors – Dawn’s story

This activity has three parts.

Analyse and interpret

Part A: Learning about Dawn’s life experiences

Please read this extract from an interview with Dawn.

“It was married in 1964 as part of the expectation of my family I suppose you could say. … Back then I didn’t even know what a lesbian was. … I was a country kid, sheltered; just had a normal sort of an upbringing. So it really came as a surprise to me that I had these attractions. I was so busy being the perfect mother, the perfect wife, the perfect everything that I put my needs on the shelf.”

Dawn met Ann in the town she lived in and they realised they had strong feelings for each other and wanted to be together.

“I said I was leaving with Ann and the response I got was ‘you’re insane’. My parents actually … got me into the car and said we’ve got an appointment with … (a priest). They said ‘you’re a sick person; we’re going to take you to the priest’.”

Access to the children – having rights

“There was a lot of interference and pressure on my former husband to not allow the children to see me. That was their biggest fear, that I would corrupt the children and they would be deviants or something. I was encouraged by my parents to ‘butt out’. Leave them alone.

A well-meaning good friend said: well, it’s no use you fighting this to get the children because you’ll just drain all your money and you won’t win.

I had no rights. I might have had rights but I wasn’t able to exercise them.

I saw my children once a year for a couple of years. I was reconciled with my son after 30 years.”

Mental health

“I nearly went insane, because I’d been brought up to be this conservative, dutiful person and to be confronted with these sorts of decisions was just – was too much.

Outwardly I was very unstable because I was trying to deal with all these things. You just think of the list of stresses in your life. I had a loss of identity for a start, a loss of children, a loss of home, a loss of income, a loss of parents and family, a loss of friends. When you add all of those up, that is a major stress for someone who had lived a very sheltered life.

That affected my mental health. I was really very, very ill mentally. I was so distraught I can remember taking my old little car out in the bush with a few sleeping pills and tried to kill myself.”
Part B: Identifying Dawn’s increased risk factors

Critical reflection

Take some time to reflect on Dawn’s story, before you respond to the following questions.

Q1) Describe three factors that could have increased Dawn’s risk of developing depression and/or anxiety.

Q2) Although these events occurred many years ago, do you think they still have an impact on Dawn’s mental health? If so, why? Use examples from the case study to support your view.

Q3) What are two key messages learned from Dawn’s story that you can apply in your work with older people who identify as lesbian, gay, bisexual, transgender or intersex?

Part C: Focusing on the plus side – creating protective factors for Dawn

Apply knowledge to practice

Imagine that Dawn is accessing your aged care service. Take some time to reflect on your role as an enrolled nurse in providing appropriate care for lesbian, gay, bisexual, transgender or intersex clients and residents.

Now we would like you to focus on practical ways to enhance Dawn’s protective factors. For example, you might think about changes to procedures or protocols; increasing staff awareness of inclusive care practices; ensuring members of the care team understand and use appropriate language when communicating with lesbian, gay, bisexual, transgender or intersex clients and residents.

List five specific ways you and your team or your service may make a positive difference in Dawn’s life. We encourage you to share your ideas with fellow students.

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________
5. __________________________________________
Providing an inclusive service environment for older LGBTI clients and residents boosts their protective factors.

In Worksheet 7 you will have the opportunity to undertake further investigation in the area of depression and anxiety in older lesbian, gay, bisexual, transgender and intersex people.

**Older Aboriginal and Torres Strait Islander people**

Another group of older adults who experience additional layers of risk for depression and anxiety are Aboriginal and Torres Strait Islander people.

‘Elder’ has a particular meaning for Aboriginal and Torres Strait Islander people and can apply to people younger than 65.

In general, Aboriginal and Torres Strait Islander people experience chronic illness around 20 years earlier than other Australians.

Due to the range of chronic illnesses that Aboriginal and Torres Strait Islander people might experience, depression might be the last thing to be diagnosed.

**The prevalence of depression in older Aboriginal and Torres Strait Islander people?**

There is currently no specific data available on the prevalence of depression in older Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander people generally experience significantly higher levels of psychological distress than non-Aboriginal people.

The Australian Institute of Health and Welfare suggests that 44 per cent of Aboriginal people who had experienced discrimination reported high or very high levels of psychological distress, compared to 26 per cent of non-Aboriginal people.
Activity 1.6  Case study: Living with risk and protective factors – Percy's story

This activity has two parts.

Analyse and interpret

Part A: Learning about Percy’s life experiences

Please read Percy’s story.

Percy is an 85 year old Aboriginal man who was living in a remote Aboriginal community. Percy has several medical conditions; he takes antihypertensive medication, has recently had a stroke and has subsequently been diagnosed with vascular dementia.

His family aren’t able to care for him, because he is unable to walk and needs the help of two people to stand up to move from his wheelchair to his bed. Their house isn’t built for a wheelchair. The local hostel is unable to care for Percy because it is already full. Percy has moved to the closest regional centre and is staying in a non-Indigenous nursing home. He has become withdrawn and sometimes staff observe him crying. He refuses care, most meals and tells the staff to leave him alone.

Percy had never left his remote Aboriginal community. Anything he ever wanted was there: Country, family and community. He hunted in his younger days and all his life he has eaten traditional foods. He speaks simple English and Creole, but his first language is an Aboriginal Traditional language.

Before he became ill, he used to tell stories and talk about traditional culture to the children by making drawings in the dirt. Younger people would often ask his advice on life and ceremonies.

He is a very well respected Elder. When people in the community spoke to Percy, they had certain cultural protocols to follow.\(^{11}\)

Part B: Identifying Percy's risk factors

Critical reflection

You are the enrolled nurse leading a small health care team and Percy has become one of your clients or residents.

Take some time to reflect on his story before you respond to the following questions. We encourage you to share your responses with fellow students.

\(^{11}\) Adapted from Dementia Learning Resource for Aboriginal and Torres Strait Islander communities. © (2007) Commonwealth of Australia as represented by the Australian Government Department of Health and Ageing.
Apply knowledge to practice

Q1) What are Percy’s risk factors for depression or anxiety?

Q2) Describe your initial actions in relation to Percy’s mental health.

Q3) What other members of the health care team need to be involved in Percy’s care? What support services could they provide?

Q4) What type of support do you think Percy’s family needs?

Q5) What could you do, within the scope of your role, to support his mental health longer term?
Reflect and discuss

In pairs or small groups consider the following questions. You might wish to make notes of the group responses.

Q6) How could Percy's aged care service ensure his cultural beliefs and traditional ties are respected?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Q7) What is the role of the enrolled nurse in maintaining Percy’s connection to his culture?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Q8) How can non-Indigenous aged care services provide culturally sensitive care that promotes appropriate protective factors?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

In Worksheet 7 you will have the opportunity to undertake further investigation in the area of depression and anxiety in older Aboriginal and Torres Strait Islander people.
Older people from culturally and linguistically diverse (CALD) backgrounds

We will now look at our third group of older people who might have particular risk factors for depression and anxiety. Importantly, we will also identify protective factors that are culturally inclusive and will contribute to your clients’ and residents’ mental health and wellbeing. Research has identified a number of factors that may increase the risk of depression and anxiety in older adults from CALD backgrounds. These factors include:

- migration experience
- English proficiency
- service barriers
- family relationships
- acculturation – level of adaptation to a new culture
- racial and cultural discrimination.

Note: Refugees who may have experienced trauma may be particularly vulnerable to post-traumatic stress disorder.

*Cultural identity in this sense is what binds people together, the social glue which connects us to each other.*

Cultural diversity

For older adults from CALD backgrounds, differences may occur due to:

- time of arrival in Australia
- length of settlement
- socio-economic background
- level of education
- rural or urban residence
- identification with cultural and religious background
- different life experiences, including the experience of migration.

*ibid*
How does an older person’s cultural background influence their daily living?

In our nursing practice it is important for us to be aware of, and sensitive to, the cultural needs of our clients, particularly where there is an increased risk for depression or anxiety.

Some areas where older people’s cultural background may have an impact on their daily life include:

- the foods they eat, or don’t eat
- the way they prepare and cook their food
- how food is handled
- when they eat or don’t eat
- how and when they wash
- what special days are important to them
- whether they like to be touched or not
- how they treat the people who care for them
- how important their family is and what they expect of them
- how and when they worship
- what medical treatment they will accept
- what they would like to have happen if they are dying
- how they would like to be treated after death
- the language they speak.

**WORKSHEET 6 – Case study: Living with risk and protective factors – Joe’s story**

You can extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your worksheet.
Mental health is the embodiment of social, emotional and spiritual wellbeing.

In Worksheet 7 you will have the opportunity to undertake further investigation in the area of depression and anxiety in older people from culturally and linguistically diverse backgrounds.

**WORKSHEET 7 – Implementing evidence-based strategies to promote inclusive practices in your aged care service**
You can extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your worksheet.

**WORKSHEET 8 – Quiz – Learning reflections**
You are now ready to check your learning by completing a short online quiz. Your facilitator will explain how to record your answers and when to submit your worksheet.

**WORKSHEET 9 – Final reflections**
In the last online task for this chapter, we ask you to reflect on your learning and consider how you can apply your new knowledge to your care role and share it with the rest of the team. Your facilitator will explain how to complete the task and when to submit your worksheet.
Information and references

There are many sources of information and useful references available to you. Here are some suggestions relevant to the information discussed in this chapter to help you on your learning journey.

**beyondblue** publications – When you visit [www.beyondblue.org.au/resources](http://www.beyondblue.org.au/resources) you will have access to many free fact sheets and resources, including:

- A guide to what works for depression Booklet
- A guide to what works for anxiety Booklet
- Depression and dementia Fact Sheet
- Depression and anxiety disorders in older people Fact Sheet
- Depression and anxiety: an information Booklet
- Grief, loss and depression Fact Sheet
- Anxiety and depression in older people Booklet
- OBE .... Our stories. A marvellous collection of personal stories from older Australians Booklet


The ABS is Australia’s official statistical organisation. This data is then freely available to everyone and informs planning of services. We all contribute data by completing the census every five years.

The **Black Dog Institute** was established in 2002 and focuses on providing expertise in clinical management and undertaking research to improve the lives of people living with mood conditions such as depression and bipolar disorder.

Log onto [http://www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au) and click on the grey tab at the top of the page titled FACT SHEETS for more useful information about mood disorders.

Dementia Learning Resource for Aboriginal and Torres Strait Islander communities. © Commonwealth of Australia as represented by the Australian Government Department of Health and Ageing (2007) (Source for Activity 1.6 Case study: Living with risk and protective factors – Percy’s story)


Some images used in this chapter have been sourced from the following websites:

Image of neurones on page 10

Image of brain relating to anxiety on page 19
Image showing loss of brain tissue associated with severe Alzheimer’s disease on page 24
www.nia.nih.gov/sites/default/files/02_healthybrain_lg.jpg viewed 29/1/14

For information on the classification of depression using the ICD-10:
www.guiasalud.es/egpc/traduccion/ingles/depresion/completa/documentos/apartado04/definicion%20y%20diagnostico.pdf

For information on the classification of depression using the DSM-5 (this also compares this to the ICD 10):
www.nps.org.au/conditions-and-topics/conditions/mental-health-conditions/mood-disorders/depression/health-professionals/diagnosis

For information on bereavement being included in the DSM-5:
CHAPTER 2

Implementing a person-centred, strengths-based approach to improve care outcomes for older people experiencing depression, anxiety or dementia
Introduction

In this chapter you will examine a person-centred, strengths-based approach to assessment of depression and anxiety in older people. You will explore the links between depression, anxiety and suicide and consider appropriate responses for clients who are at risk of suicide. You will also analyse responses to the needs of older people who may be experiencing depression, anxiety or dementia and identify protocols for interventions and referrals within your scope of practice.

The chapter explores the following topics:

1. Making an assessment.
   - Understanding a person-centred, strengths-based assessment.
   - Factors that can inform assessments for depression and anxiety.

2. Using screening tools as part of our assessment and evaluation of care for older people with depression and anxiety.
   - Why screen?
   - Common screening tools for depression and anxiety in older people.
   - Culturally inclusive screening tools.
   - Outcomes from screening.

3. Understanding and responding to the needs of older people at risk of suicide.
   - What is suicide?
   - Links between depression, anxiety and suicide.
   - Starting a conversation with your older clients and residents.
   - Reporting and documentation – including the use of safety plans.
   - Getting support – for yourself and for families.

4. Evidence base for current approaches to treatment and evaluating outcomes.
   - Depression can be treated.
   - Individualised treatment options.
   - Your role in evaluating treatment options.
   - Emerging treatment options.

5. Older people with dementia and depression.
   - Treating depression and dementia: what options are available?
   - What can we do to reduce the risk of depression and dementia?

6. Accessing treatment options.
   - Options for older people living in the community or in residential care.
   - Making psychological support more accessible: what is available online for clients or residents and their carers?

7. Understanding referral.
   - What referral services are available for clients?
   - What are the protocols and procedures for referral?

8. Successful interventions for older people with dementia and depression: analysing research findings.
   - Features of successful research projects.
As you work through this chapter you will be:

- critically reviewing a range of information about depression, anxiety and suicide in older people
- developing an ability to identify when an intervention is within your scope of practice and when referral is necessary
- applying professional judgment when assessing, planning and evaluating care for your clients and residents
- accessing current evidence-based research data to inform your nursing practice
- testing assumptions around suicide in older people to identify implications for your clients and residents
- critically reviewing selected research reports and distilling information relevant to the needs of your clients and residents
- developing your ability to translate ideas into action and find creative, tailored responses to promote positive outcomes for your clients and residents
- evaluating care outcomes.

Learning outcomes

Learning outcomes are important for you as the student. As you progress through the information and activities in this chapter take a moment to record your knowledge and skills. These can also be used to show an employer and are often referred to as employability skills.

<table>
<thead>
<tr>
<th>Read each statement and record your ‘yes’ or ‘no’ response in the next column.</th>
<th>Yes or No?</th>
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<tbody>
<tr>
<td>I can explain the purpose and process of assessment and screening for depression, anxiety and dementia in older people and how the outcomes can inform care decisions for clients and residents.</td>
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<tr>
<td>I can now analyse and evaluate common screening tools for depression and anxiety in older people and select tools appropriate for different clients and residents.</td>
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<tr>
<td>I have increased my understanding of the links between depression, anxiety and suicide and examined appropriate responses to clients at risk of suicide.</td>
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<tr>
<td>I can evaluate the evidence for treatment options and referral strategies to improve outcomes for older people with depression, anxiety and dementia.</td>
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<tr>
<td>I am able to identify when intervention is within my scope of practice and when referral is necessary.</td>
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<tr>
<td>I have increased my understanding of the benefits of working within a multidisciplinary team to achieve positive outcomes for clients and residents in my care.</td>
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<tr>
<td>I can identify and apply effective interpersonal, oral and written communication skills to enhance my role and practice.</td>
<td></td>
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<tr>
<td>I am able to critically evaluate and use research findings to promote quality living for clients and residents in my care.</td>
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Activities in this chapter

As you work through this chapter you will complete different types of activities, such as critically reviewing information from different sources, accessing and interpreting research data, testing assumptions, applying knowledge and professional judgment, completing quizzes and answering questions that encourage you to think critically, reflect on your role and apply skills in the workplace. Some of these activities will take place in class and some will be completed online.

In-class activities

You will be undertaking the following activities during class time. Your facilitator will lead you through each activity. You can tick off the activities as you complete them in the table below.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Page number</th>
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<tr>
<td>2.1 Reflecting on the concept and practice of person-centred care</td>
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<tr>
<td>2.2 Assessment for depression or anxiety: How does your team work?</td>
<td>63</td>
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<tr>
<td>2.3 Comparing a screening tool for adults and a screening tool specifically developed for older adults</td>
<td>69</td>
</tr>
<tr>
<td>2.4 Applying communication skills to your role in screening for depression or anxiety</td>
<td>72</td>
</tr>
<tr>
<td>2.5 “What is the point of going on?”: A suggested response to a client or resident with suicidal ideation</td>
<td>79</td>
</tr>
<tr>
<td>2.6 Reflecting on your experience in responding to suicidal ideation</td>
<td>85</td>
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<tr>
<td>2.7 Analysing a scenario: A conversation with your client – Clem’s story</td>
<td>87</td>
</tr>
<tr>
<td>2.8 Exploring the benefits of reminiscence for your clients and residents</td>
<td>96</td>
</tr>
<tr>
<td>2.9 Stories from the field: Creative strategies to meet clients’ and residents’ social needs</td>
<td>99</td>
</tr>
<tr>
<td>2.10 Reducing the risk of depression in dementia: Three interventions that can be implemented in your organisation</td>
<td>102</td>
</tr>
<tr>
<td>2.11 Analysing your role in a client’s treatment</td>
<td>106</td>
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Online components in this chapter
There are several ways to participate in the online components of this chapter.

1. Worksheets
The online tasks in this chapter are designed to build on the concepts you learn in class and further develop your understanding of depression and anxiety in older people. These online tasks are provided as worksheets that need to be completed. You will see references to these online worksheets in your student workbook. As with your in-class program, your facilitator will guide you through each task and provide feedback on your responses.

2. Online discussion forums
There are several opportunities throughout the chapter where your facilitator may choose to further explore topics by establishing an online discussion forum with members of your group. These forums may be part of a worksheet and are designed to help you engage in the online environment by sharing your ideas and experiences. Your facilitator will lead you through these forums.

3. Online reading
Another way you can learn more about the topics covered in this chapter is by accessing relevant information sheets online. Links to these publications are included in your workbook. You may wish to discuss your reading with other members of your online group.

Getting started...

Online pre-reading for this chapter
To enable you to fully understand some of the concepts presented in this chapter, we suggest you undertake the following online pre-reading.

<table>
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<th>Title</th>
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<tr>
<td>Scoping study of health professional education and training in older age depression and anxiety produced by the National Ageing Research Institute (NARI) – provides information about screening tools. Available at <a href="http://www.beyondblue.org.au/peac">www.beyondblue.org.au/peac</a></td>
<td>Step 2</td>
</tr>
<tr>
<td>Dementia, anxiety and depression fact sheet available at <a href="http://www.beyondblue.org.au/resourcesSearch">www.beyondblue.org.au/resourcesSearch</a> for the title and tick 'publications’.</td>
<td>Step 5</td>
</tr>
</tbody>
</table>
This chapter has four steps. When you have completed them, you are encouraged to reflect on your learnings.

**STEP 1**
You will initially explore the complexity and scope of an assessment of the older person with suspected depression, anxiety and/or lowered mood. You will then analyse the results of screening together with other information about a client to complete a person-centred assessment for depression and anxiety.

*Complete in-class activities and online tasks.*

**STEP 2**
Here you will explore the use of screening tools for the assessment of mental health conditions and the evaluation of care. You will analyse common screening tools that can be used to recognise depression or anxiety in older people.

*Complete in-class activities and online tasks.*

**STEP 3**
In this step you will examine issues around suicide including the links between depression, anxiety and suicide and the interventions available to care staff to support older people’s mental health and wellbeing.

*Complete in-class activities and online tasks.*

**STEP 4**
In the final step you will investigate the range of treatment options for older people with a diagnosis of depression or anxiety as well as dementia and learn the importance of using an evidence-based approach to selecting interventions and evaluating the outcomes of care provision. You will also consider how to implement an effective referral process. Finally you will analyse current research and consider how you can apply the findings to your practice.

*Complete in-class activities and online tasks.*

**LEARNING REFLECTIONS**
In learning reflections you have the opportunity to complete a short online quiz.

**FINAL REFLECTIONS**
In final reflections you are encouraged to reflect on your learning experience and apply your knowledge by completing three activities. You can complete this reflection online and then participate in the online activities.
STEP 1 MAKING A PERSON-CENTRED, STRENGTHS-BASED ASSESSMENT FOR DEPRESSION AND ANXIETY

In this step, we address the following questions and topics:

- What is a person-centred, strengths-based assessment?
- Making an assessment that is person-centred.
- Who is involved in assessment?
- The role of the enrolled nurse in assessment.
- Organisational processes for conducting assessments.
- Other assessments that can inform care decisions.

A person-centred assessment of a client for depression or anxiety means that we work with the client to incorporate their preferences into our thinking about their care. Further it requires that we assess not only to establish problems but also to discover their strengths which can then be used to counter their problems.

A strength-based assessment, means that you focus on the individual’s strengths equally with their problems in assessment and in turn, care planning. You will need to consider this across the following domains and you can use the acronym CAUSED to help you remember what they are.

- Communication and social environment: What are their preferences for social interaction? How do they prefer to be approached or involved? What are their goals for themselves when they socialise?
- Activities: What can the person do for themselves? What are their preferences and routines? What sort of assistance do they need to enable them to continue to be independent?
- Unwell or uncomfortable: physical health. What are they coping with and how are they coping? What do they want to achieve for themselves?
- Story: life and family history, culture, spirituality, attitudes and beliefs etc. The past influences the presents but also contains many clues about how to help clients. For example, religious beliefs can be comforting and previous ways of coping might be useful now.
- Environment: is it enabling or disabling the person and what needs to change?
- Dementia: what cognitive strengths does the person have as well as deficits for example do they have some insight into their situation? Can they interact with their environment and understand verbal communication? How can we help them use these strengths?
To illustrate this, Mrs A enjoys and actively participates in the reminiscence activities in the day room but can become upset if seated beside a particular resident. This can potentially be seen as a problem for her and other residents but if you utilise a strengths-based approach you will see it differently. Her strengths are that her long term memory is intact, she enjoys herself, she can make choices about who she want to interact with socially and has found a way to communicate her preferences through her behaviour.

If the client cannot participate in an assessment, the care planning team should bring together information about a client from different sources, including family or any other significant people in their lives. This is an essential step in identifying and tailoring care provision to the unique needs of the client.

From a collaborative assessment for care planning or care evaluation you may be able to identify:

• a history and treatments for depression or anxiety – from medicine
• the outcomes of depression, anxiety and other health screening tools or assessments – from the registered or enrolled nurse involved
• ways in which the person has previously coped with their mood; strategies and triggers; and information about the client’s likely choices for interventions or care – from family
• what currently seems to upset or cheer the person, what they can do for themselves, and their responses to current interventions – from care workers.

Remember that there is always more than one cause for a problem and more than one solution and sometimes problems interact with each other to make the whole picture worse than it needs to be. A depressed and introverted lady, suffering arthritic pain and forced to shower in a communal bathroom with other noisy residents feeling rushed, cold and shameful = distress. Fix the pain and the noise and respect her feelings and things will be better for her to the extent that she may be able to cope better.

**Making an assessment that is ‘person-centred’**

There are four key knowledge and skill areas that contribute to effective, person-centred assessments, as illustrated in the following diagram. In this section we will explore them.

![Diagram](Diagram.png)

**Person-centred care**

In 1961, Carl Rogers, a psychologist, developed the idea of client-centred counselling. The idea was to shift the power of the counselling sessions away from the therapist to the client. In 1997, Tom Kitwood applied this same idea to dementia care, and the concept of person-centred care as it relates to aged care was introduced.
In Tom Kitwood’s book, “Dementia Reconsidered”, he compared the two cultures of care – the old care system and person-centred care by identifying how this relates to dementia care.

<table>
<thead>
<tr>
<th>Title</th>
<th>Old culture</th>
<th>Person-centred culture</th>
</tr>
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<tbody>
<tr>
<td>General view of dementia</td>
<td>Devastating diseases where ultimately the person’s identity is lost (<strong>depersonalisation</strong>)</td>
<td>Sees dementia as a disability. Care and the environment will have a big impact on the outcome of care.</td>
</tr>
<tr>
<td>Sources of knowledge</td>
<td>Doctors and brain scientists hold the ultimate sources of knowledge relating to dementia.</td>
<td>Skilled and insightful practitioners of care.</td>
</tr>
<tr>
<td>Research emphasis</td>
<td>Research to understand the biomedical processes associated with dementia.</td>
<td>Build human insight and skill in caring for people with dementia.</td>
</tr>
<tr>
<td>What is caring?</td>
<td>Safe environment meeting basic needs and providing physical care.</td>
<td>Care is associated with enhancing and maintaining personhood (&quot;...status that is bestowed upon one human being, by others...&quot;).</td>
</tr>
<tr>
<td>Priorities for understanding</td>
<td>Understanding the decline in a person’s cognition.</td>
<td>Understanding a person’s abilities, interests etc..</td>
</tr>
<tr>
<td>Problem behaviours</td>
<td>Problem behaviours must be managed skillfully and efficiently.</td>
<td>‘Problem behaviours’ must be viewed as an unmet need.</td>
</tr>
<tr>
<td>Carer feelings</td>
<td>Get on with the job – set aside your concerns, feelings and responses to those in your care.</td>
<td>Be in touch with your concerns, feelings and responses to your clients and turn this into a positive regard for your clients.</td>
</tr>
</tbody>
</table>

**How does person-centred care relate to depression and anxiety?**

Tom Kitwood’s original work on person-centred care related specifically to dementia care but is now applied to aged care generally.

The relationship between person-centred care and depression and anxiety is more fully explored in Chapter 3. However, the literature indicates that there are benefits of person-centred practice to those older people experiencing depression and/or anxiety and those at risk of depression and anxiety.

**“The person-centred care model is the provision of care that is developed with the client and their family in mind, not for them.”**

Person-centred care is an underpinning principle of care practice and is widely accepted in aged care. However, because we are working in aged care with older clients and residents we need to consider how to involve older people in their care when they are frail and/or have cognitive difficulties. We may not be able to involve their equally elderly spouse or partner, family members or representative – none of whom may want to be making decisions about care.

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Activity 2.1  Reflecting on the concept and practice of person-centred care

Reflect and discuss

Take some time to reflect on the benefits and/or complications of applying a person-centred approach to your role, particularly if you are involved in making assessments for your clients and residents.

You might make notes on your reflections. We encourage you to share your thoughts with fellow students.

Critical thinking

Consider the following questions then record your responses.

Q1)  What impact does depersonalisation have on older people at risk of depression and anxiety?

Q2)  What can be done to overcome depersonalisation in aged care settings?

Q3)  What should person-centred care look like?

Q4)  How can partnerships with clients and residents be achieved?

In Chapter 3 of this workbook you will look more closely at applying person-centred care.
Effective communication

Effective communication is an essential part of person-centred care. Making an assessment of a client or resident involves a range of communication and interpersonal skills and abilities, including:

- active and responsive listening
- the ability to work with others and respond sensitively to client and resident needs
- the ability to empathise with clients and residents, and their families
- advanced oral communication skills including:
  - interviewing techniques
  - being able to ask questions in a respectful manner
  - seeking clarification from clients and residents and others involved in the assessment.

When conducting assessments and gathering information from a client or resident (or their family) your ability to establish rapport, create a non-threatening environment and develop a trusting relationship will make the assessment process less stressful for all concerned.

When preparing for assessment think about the communication skills you will need in different interactions or situations such as:

- working with clients or residents who have sensory losses
- reassuring the client or resident and family members their privacy and confidentiality will be maintained throughout the process
- being sensitive to individual cultural needs
- allowing time – rushing the assessment will unsettle your client and will not contribute to developing a trusting relationship.

Critical reflection

Bringing empathy to your role in assessment

Imagine that you are being interviewed to assess your mental health and are being asked the following questions:

How are you coping? How is your mental health? Have you had any mental health issues in the past?

You hear the word ‘assessment’ being mentioned by the health professionals who are conducting the interview.

Take some time to reflect on this scenario, then answer the following questions:

Q1) Describe how you would feel being asked those questions. Choose words that convey your feelings.
Q2) Describe how you would like this 'interview' to be conducted.

You might wish to make some notes for further reflection.

You will look more critically at the role of communication in your practice in Chapter 3 of this workbook.

**Cultural considerations**

The older person’s cultural and religious background impacts upon their whole life including their view and expectations of their health.

Sometimes we might stereotype people from different cultures but there will be great diversity among the older people within specific cultural groups.

We need a person-centred approach to help us understand what is important culturally to each of our clients and residents. It may take some time to develop this understanding.

When an assessment with an older person from a different cultural, ethnic or language background is being planned, keep in mind that the greater the cultural difference between you, as the enrolled nurse, and other health professionals, and the client or resident, the greater time required to conduct the assessment, especially if an interpreter is required.

**Working in teams**

An important part of the assessment is gathering information from various team members who work with the client or resident as well as from the client and their family. Research demonstrates that there are better outcomes for clients and residents when teams work well together.

Let us consider the types of teams working in aged care.

Various models of teams – including the multidisciplinary and interdisciplinary team models – have been developed and researched as to their effectiveness. The model in place will impact on the process for gathering the information for an assessment of a client.

In **multidisciplinary teams**, each health professional will conduct an assessment according to their specialised area of expertise and this information will be documented either as a specialised care plan and report, or in case/progress notes and will be available to other members in the team to inform their thinking and planning.

An **interdisciplinary team** is made up of health professionals with different areas of expertise who collaborate together to create a plan with, or for, the client which incorporates the whole team’s assessment.
In residential aged care we also have the **care teams** of workers on each shift that share a care/nursing focus and are dedicated to delivering the care prescribed in the care plan. However, these teams can also work either as independent members, getting their jobs done as efficiently as possible, or as a collaborative group, with the residents’ wellbeing, rather than their own work role, at the centre of their thinking.

**Activity 2.2  Assessment for depression or anxiety: how does your team work?**

It is most likely that you work in a team based on a multidisciplinary model. In this activity you will be creating a visual representation to show how members of your team work together in the assessment of a client. You can work in pairs or small groups to complete the activity.

This activity has three parts.

**Part A**

Take some time to consider the role of team members shown in the list below and indicate (with a tick or highlight) if they are likely to contribute to the assessment of a client for depression and/or anxiety. You might use your own organisation as a guide.

The multidisciplinary team:

- The client
- Family
- Direct care staff
- Volunteers and visitors
- Activities/lifestyle staff
- GPs
- Allied health professionals
- Senior members of staff (may be a care manager or a nurse or clinician)
- Enrolled nurses
- Others

**Part B**

Using the blank template on the following page, record on each shape:

1. a member of the team (which you ticked or highlighted)
2. what information they would contribute to the assessment of a client
3. how you, as the enrolled nurse, can access this information – including details about where it’s located.

Make sure you include your role and what you are likely to know about a resident or client.
We have filled in one shape to help you get started. You may wish to add more information to our example.

1. Family/significant other
2. Significant life changes
   - Asking the family (they may have already reported this)

Assessment of a client for depression or anxiety – a team approach
Part C
Now we would like you to compare your completed chart with others in your group. Note any significant differences between your responses.

As you can see many team members hold some ‘pieces’ of information about clients or residents that contribute to their assessment. Bringing all of that information together is a crucial component of an assessment and enhances outcomes for the client and care staff.

You work as part of a care team and many members of that team may hold information that will contribute to comprehensive assessments.

WORKSHEET 10 – Working in teams in aged care
You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.

Other factors that can inform an assessment for depression and anxiety
When assessing for depression and anxiety in a client or resident, you also need to determine what other factors might be having an impact on a person’s mental health, such as pain, chronic illnesses, side effects from medication, UTIs or disrupted sleeping patterns.

Imagine, for a moment, what it would be like to be in pain and not be able to communicate that you are in pain – this would contribute strongly to the presence of depressive symptoms. These depressive symptoms may be identified in a depression screening tool – but these symptoms are present because of pain, not depression.

Many different pain assessment tools can be used to assess a client’s pain. Other elements that will contribute to a pain assessment include:

- whether the client is able to report their pain
- information from staff directly working with that client
- the frequency and the impact of pain medications and other treatments.

REMEMBER...
If we manage our client’s pain their depressive symptoms may be reduced.

In addition to pain assessment, other assessments may be conducted to provide important information about your clients. For example, an assessment of the client’s weight could be important in the assessment of depression in an older person.

We need to collect other pieces of the puzzle and look at other contributing factors as well as health assessments. Importantly, we need to examine the person’s strengths or protective factors that can be used to help or assist them overcome some of the contributing factors. As a team we may need to perform psychosocial assessments, for example:

- looking for evidence of grief over the loss of people, roles and body image
- examining social isolation which may be a lifestyle choice, or may be driven by economic factors, other mental conditions, by living in rural and remote conditions or losing a driving licence
- looking at neglect or abuse as a contributing factor or a supportive, loving and close family as a protective factor
- assessing lifestyle factors such as alcohol consumption that can contribute to depression, or a history of an interest in a hobby or physical fitness which may be protective
• examining the living environment, which may be a contributing or a protective factor.

In most instances, tools or screens exist that can guide our assessments and good gerontological nursing texts can assist.

Assessing for depression or anxiety is a team effort – it involves every member of the team observing, listening, reporting and documenting changes in their clients and responses to interventions.

WORKSHEET 11 – Reflecting on the experience and outcomes of assessment

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
Let us begin with a question: “Why do we screen?”

We screen as part of an assessment to identify risk or as part of an evaluation of the outcomes of interventions we have chosen (or which have been prescribed by a medical practitioner) for our clients. Screening helps to inform the enrolled nurse’s role in reducing the impact of depression and anxiety on the person and their family.

In Chapter 1 we learned that older people in residential care and those frail older adults in the community are particularly at risk for developing depression and anxiety; and we know that depression and anxiety can present differently in older people.

It can be easy to dismiss some of the symptoms of depression and anxiety in older people because of the similarity and overlap with other chronic illnesses. This is why specific screening tools have been developed for older people, whether they are living in residential care or in the community.

**What is screening?**

Screening identifies the symptoms of depression and/or anxiety in those clients and residents at risk of developing these conditions. Working as an enrolled nurse, you may notice changes in a client’s or resident’s behaviour or demeanour that could be an early sign of depression or anxiety. Other members of the care team might also be noticing changes and be reporting these observations to you. This might contribute to building a picture of a client at risk.

But we need firm data to confirm our concerns and to share these with the rest of the team as clearly and objectively as possible; screening can assist that process. Screening data also provides a common language we can use to communicate with other health professionals who may become involved in this person’s care or in our referral to other services.

*Screening does not equal diagnosing.*

Screening is not like a chest x-ray – a diagnostic tool – which identifies whether a person has pneumonia or not. Screening simply informs the health care team of the potential for, or degree of, risk – in this case the risk of depression or anxiety. If the symptoms of depression exist, the diagnosis needs to be made by a GP or psychiatrist.

However screening tools have another important function in nursing. We focus on the overall result or score when we are using screening to identify the risk of illness and report that. However, when we use the screening to plan care, each question and answer in the tools has potentially useful information about the person’s strengths, preferences and particular issues. For example, several of the screening tools ask questions about whether the person feels fatigued. While this contributes to the older person’s overall score it also gives us important information about their energy levels and what impact this may have on their ability to attend activities of daily living or their interest in joining activity groups.
Screening is only one of a number of tools you may use to help identify depression and anxiety in your clients. It is equally important to observe the client and to interview them and significant others. Actions must follow from screening and assessment – these will be care planning or referral. From an ethical and legal point of view we are obliged to act on the information we collect.

Sometimes, however, the use of the Cornell depression screen in residential aged care is associated with the Aged Care Funding Instrument (ACFI) funding tool rather than care planning and the information obtained from using it is not always then applied to care planning.

WORKSHEET 12 – Identifying screening tools used in your organisation
You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
Activity 2.3  Comparing a screening tool for adults and a screening tool specifically developed for older adults

In this activity you will compare two screening tools:

1. The Beck Depression Inventory (BDI), which is commonly used for adults and which can be administered by individuals themselves.

2. The Geriatric Depression Scale (GDS), which is a screening tool specifically developed for older adults and which can also be administered by individuals themselves.

We suggest you work in pairs or small groups to complete this activity.

This activity has two parts.

Analyse and interpret

Part A

Please turn to page 111 of this workbook for copies of the two screening tools.

Analyse each screening tool and identify the similarities and differences. Consider the following question and record your response.

Q1) How effective would either tool be in identifying those older adults at risk of depression? Support your answer with examples from the tools.

Make some notes about your findings.

<table>
<thead>
<tr>
<th>Similarities</th>
<th>Differences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Think critically

Part B

Now discuss the following questions with members of the group and record your responses.

Q2) What are the similarities and differences between the two screening tools?
Q3) Do you think the GDS adequately reflects the presentation of depression in older people provided earlier? Please give your reasons.

Q4) Could there be risks for screening for depression in older people by using the BDI? Please give your reasons.

Q5) Do you think any other specific questions should be included in the GDS to reflect the experience of depression in older people? Yes/No

Provide an explanation to support your response.

Q6) In reviewing the GDS, what information beyond the total score have you learned about this person that could inform their care plan?
Common screening tools for depression and anxiety in older people

In this section we will be looking at screening tools commonly used for detecting depression or anxiety in older age. The following screening tools are considered valid and reliable.

1. Geriatric Depression Scale (GDS)

The GDS is the most commonly used tool in the assessment of depression in older age. It is available in two forms – an original 30-question tool and a modified 15-question short form.

2. Cornell Scale for Depression in Dementia (CSDD)

The CSDD is a purpose-designed tool for identifying depression in people with dementia.

3. Brief Assessment Schedule Depression Cards (BASDC)

The BASDC was designed to screen for depression in medically ill older adults in hospitals. Patients respond to a series of statements via cards labelled ‘true’, ‘false’ or ‘don’t know’.

Specific screening tools for anxiety in older adults have only recently been developed and used.

The Geriatric Anxiety Inventory (GAI) was developed in 2007 in Queensland and is modelled on the GDS. Limited research has been conducted on it due to its relatively recent development, however what has been done has indicated that it is a reliable and valid tool.

In the following online task you will have the opportunity to critically analyse three of these screening tools.

WORKSHEET 13 – Comparative analysis of three common screening tools for depression in older people

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
Culturally inclusive screening tools

There has been limited research into screening tools with older people from culturally and linguistically diverse (CALD) backgrounds. Existing tools such as the GDS and the GAI have been translated into languages other than English but that does not ensure these tools are particularly appropriate for other languages and cultures.

*A direct translation of a screening tool does not consider particular language or cultural subtleties to identify if the tool is appropriate for people who use that language or identify with that culture.*

For instance, in some languages the word ‘depression’ may not be a widely known term, so a direct translation may be inappropriate for those cultures and languages.

Not having culturally inclusive screening tools means older CALD clients may not be adequately screened for depression or anxiety.

Note: beyondblue has recently commissioned research to adapt and validate the GDS and the GAI for older Chinese people. Updates, and the tools themselves, are expected to be available on the beyondblue website in 2014.

Communication in the screening process

As an enrolled nurse involved in the screening process for your clients and residents you will be using a range of communication skills including observing, listening, questioning, recording and reporting. You may also have members of the care team reporting to you about their concerns and you will need to respond to those reports.

**Activity 2.4 Applying communication skills to your role in screening for depression or anxiety**

Apply knowledge to practice

Take some time to reflect on what you have learned about using screening tools to recognise depression or anxiety in older people and the key communication skills required to ensure the screening process and outcomes are effective.

Now consider the questions in the table on the next page and decide how you might apply effective communication skills to your role.
<table>
<thead>
<tr>
<th><strong>Observation</strong></th>
<th>What would you be observing?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What might members of the care team be observing?</td>
</tr>
<tr>
<td></td>
<td>What actions will you take in response to your observation and staff reports?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Listening</strong></th>
<th>Who would you be listening to?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Who would members of the care team be listening to?</td>
</tr>
<tr>
<td></td>
<td>What actions will you take in response to the oral information you receive?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Questioning</strong></th>
<th>Who would you be questioning?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What questions might you ask to help you clarify your thinking and come to some conclusions about what you have observed?</td>
</tr>
<tr>
<td></td>
<td>What further actions might you need to take?</td>
</tr>
</tbody>
</table>
**Recording**

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>What information would you be recording?</td>
</tr>
<tr>
<td>What information would members of the care team be recording?</td>
</tr>
<tr>
<td>Where would this information be recorded?</td>
</tr>
<tr>
<td>What actions will you take in response to the information recorded?</td>
</tr>
</tbody>
</table>

**Reporting**

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who are you reporting to?</td>
</tr>
<tr>
<td>Are members of the care team reporting their observations and concerns to you?</td>
</tr>
<tr>
<td>What are your actions in response to their reports?</td>
</tr>
</tbody>
</table>

By observing and documenting what you notice in relation to your clients and residents and by clarifying information through thoughtful questioning, you assist in building a picture of what is happening to each person.

The CSDD screening tool was designed to gather information from a number of sources including from members of the care team working directly with that client or resident.
Depending on your role, you may be interviewed about your observations in relation to a client or resident, or you may be interviewing members of the care team to contribute to the screening process.

Ensuring all written records are clear, accurate and comprehensive is an important part of the screening process because your notes, and those of your team, may be reviewed as part of your client’s or resident’s assessment for depression or anxiety.

**Outcomes from screening**

*Gathering detailed information from a range of sources contributes to better outcomes for your clients and residents.*

With screening tools, often the higher the score the greater number of symptoms present – and the greater the likelihood that the person has depression or anxiety.

Screening gives us important information about a client or resident. However, unless this information is used in a proactive way to guide and evaluate care, it is of little use.

For example, the score on a screening tool may be high, and at that score the protocol in your organisation may be to inform the client’s or resident’s General Practitioner (GP).

So, actions have to follow in response to screening.

**WORKSHEET 14 – Protocols following screening for a client or resident**

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
STEP 3 UNDERSTANDING AND RESPONDING TO THE NEEDS OF OLDER PEOPLE AT RISK OF SUICIDE

Talking, learning and reading about suicide can be confronting for many people, particularly if you (or close friends or family members) have been affected by suicide.

As you work through this topic, you might find that it brings up strong emotions or uncomfortable feelings. We suggest you talk with your facilitator if you require support. If you would like further information or need additional support we encourage you to contact any of the following services:

- Lifeline – 13 11 14 or www.lifeline.org.au (web chat 8pm–12am)
- Suicide Call Back Service – 1300 659 467 or www.suicidecallbackservice.org.au
- beyondblue Support Service – 1300 22 4636 or www.beyondblue.org.au/getsupport (web chat 3pm–12am)

What is suicide?

Although most of us would have a common understanding of what suicide is, we may not be aware of the way we ‘talk’ about suicide. Words are powerful. Sometimes how we respond and behave towards a person and how that person responds to us is influenced by the language we use. As enrolled nurses, it is important that we use the appropriate terminology and language relating to suicide in order to communicate our concerns to other health professionals and ensure our clients and residents are treated with dignity and respect.

Talking about suicide

Suicide is defined as the act of purposely ending one’s life. The Australian Psychological Society (APS) has provided guidance on the use of terms relating to suicide – see the table below. Stigmatising terminology is often language that was used in the past but is now regarded as detrimental to people who have attempted suicide.

beyondblue uses the preferred terminology (shown in the right hand column). We encourage you to also use this preferred terminology in your care of older adults.

<table>
<thead>
<tr>
<th>TALKING ABOUT SUICIDE¹⁵</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigmatising terminology</td>
<td>Appropriate terminology</td>
</tr>
<tr>
<td>Committed suicide</td>
<td>Died by suicide</td>
</tr>
<tr>
<td>Successful suicide</td>
<td>Suicided</td>
</tr>
<tr>
<td>Completed suicide</td>
<td>Ended their life</td>
</tr>
<tr>
<td></td>
<td>Took their own life</td>
</tr>
<tr>
<td>Failed attempt at suicide</td>
<td>Non-fatal attempt at suicide</td>
</tr>
<tr>
<td>Unsuccessful suicide</td>
<td>Attempt to end his/her life</td>
</tr>
</tbody>
</table>

¹⁵ APS website – www.psychology.org.au
What other terms should you know?

You may hear several of the following terms used in connection with suicide:16

- Postvention – interventions to support and assist the bereaved after a suicide has occurred.
- Self-injury – deliberate damage of body tissue, often in response to psychosocial distress, without the intent to die. Sometimes called self-inflicted injuries or self-harm.
- Suicidal ideation – thoughts about suicide.
- Suicide attempt – an attempt to die by suicide.

Some people with depression and anxiety can experience changes in their thinking patterns. Sometimes their thought patterns can become overwhelmingly negative and may include themes of hopelessness and helplessness.

This negative thinking can be like a whirlpool and it can lead to more and more negative thoughts and, in some people, this can lead to thoughts about being better off dead and thoughts about how to end their life. The latter two thoughts are called ‘suicidal ideation’. There is a strong link between the hopelessness associated with depression and suicidal ideation and suicide.

The facts about suicide in older people

To get to the facts about suicide in older people, we will analyse the data contained in the following chart from the Australian Bureau of Statistics, which looks at suicide rates across the population in 2012.

AGE-SPECIFIC SUICIDE RATES, 2012

*Rate is /100 000 of the estimated resident population of the same age group. Please note: The rate does not refer to the actual number of suicides but how often suicide occurs within a defined population group.

Suicide data and definitions are different in each state and territory, but the process includes:

- a police and/or coronial investigation (in some cases of reportable deaths)
- certification of the cause of death by the coroner
- registration with births, deaths and marriages
- data provided to the Australian Bureau of Statistics.

Because of this process, it can take some time for suicide data to be gathered and there will always be a lag in the reporting of suicide attempts.

Suicide in older people is often under-reported due to a number of factors including:

- stigma
- lack of national standards – different practices ruling what is or is not a suicide in each state and territory
- risk of insurance claims not being met if the cause of death is suicide.

WORKSHEET 15 – Suicide rates in Australia: Analysing data and drawing conclusions

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
Activity 2.5  “What is the point of going on” – A suggested response to a client or resident with suicidal ideation

This activity has two parts.

Think critically

Here you have an opportunity to analyse a hypothetical conversation between an older client at risk of suicide and the enrolled nurse.

The client's situation

Mr Davis is a 79-year-old man receiving community aged care services and Helen is the enrolled nurse who is his care manager. Helen knows Mr Davis well as she has been his care manager for nearly 12 months. He has multiple medical problems, limited family supports, requires support with his medications and has a history of depression. Helen is visiting Mr Davis for his regular review.

The conversation

Mr Davis:  What is the point of going on?
Helen:  Are you having a bad day?
Mr Davis:  Well I think this is as bad as it gets, don’t you … to be stuck here like this?
Helen:  Do you just feel like this today or do you feel like this a lot of the time?
Mr Davis:  Nowadays, I feel like this all the time.
Helen:  Have you ever felt so low, so bad, that you felt like life was not worth living?
Mr Davis:  Yes, I am not much longer for this world.
Helen:  Have you ever had thoughts about harming yourself, or taking your own life?
Mr Davis:  Yes, I have had thoughts about that.
Helen:  Have those thoughts been to the extent that you have made plans about how you would do something like that?
Mr Davis:  What, like swallow a whole bottle of pills?

The activity asks you to analyse the messages conveyed in the conversation and evaluate the suggested responses.

Part A
Summarise the critical messages or key moments in the conversation between Mr Davis and Helen.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Part B

Now we will analyse how Helen determined the level of risk for this client. In the conversation, Helen:

- asked questions about the depths of his feelings (does he feel like this all the time?)
- probed further by asking a couple of questions to clarify if he was always feeling like this or just having a bad day
- asked a critical question about whether he felt life was worth living – this identified whether the client was feeling hopeless
- introduced the subject of suicide in two ‘stages’, first by asking Mr Davis if he had ever thought of harming himself, then by asking – in a direct question – whether he had considered suicide
- asked if he had a plan as to how he might self-harm or suicide – this provided information about how critical the situation was.

Critical reflection

Why is it important to ask these questions?

Asking these questions helps you – the enrolled nurse – to understand and assess the level of risk to your client. In this case the risk is high. Mr Davis is referring to suicide and has also thought of a plan. You will need to act quickly.

Now we would like you to revisit the conversation between Mr Davis and Helen, and write your response to the following question. We encourage you to share your thoughts with fellow students.

Q1) *What other signs might have encouraged Helen to have this conversation?*

As nurses, we might feel uncomfortable about having this type of conversation with one of our clients or residents, fearful that just by asking we might plant the idea of suicide and we might not feel able to handle that conversation.

There is no evidence that asking these sorts of questions will make a person think about suicide, in fact the opposite is true. Frequently, the client or resident will appreciate the opportunity to talk openly and will be reassured that you took the time to discuss their feelings and concerns. If you are unable to have this conversation with a client or resident, it is very important that you pass on your concerns immediately to your supervisor.

*Giving the person the opportunity to disclose these intense feelings is important and can reduce the risk of suicide. These conversations also provide further opportunities to help the client or resident.*
Responding appropriately: organisational principles and protocols

Every organisation, whether in residential or community care, will have developed protocols and common principles to guide responses to situations with older clients such as Mr Davis. Also, as other staff may be reporting their concerns to you, it is important that you know your organisation’s policies and procedures in relation to clients at risk of suicide.

WORKSHEET 16 – Your organisation’s protocols for clients and residents at risk of suicide

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.

We will now study suggested responses for clients in two different situations.

Situation A – Responding to a client or resident with suicidal thoughts and a plan and the means to carry out that plan

Actions that need to be considered include:

1. Remain with the client or resident (or until another member of the health team arrives)
2. Inform the client or resident that you are going to contact your supervisor
3. Report immediately to your supervisor who will in turn:
   - ask you to remain with the client until other help arrives
   - contact local mental health services or the client’s or resident’s GP or psychiatrist
   - contact the client’s or resident’s family
   - contact emergency services (such as police), if necessary
   - possibly ask you to remove any items such as knives, medication, glass etc. in the client’s or resident’s environment that may be used to harm them.

You will recall in the conversation with Mr Davis, that he said he could swallow a bottle of pills. In that situation you would need to make sure the client or resident does not have access to ‘a bottle of pills’.

Reflect and discuss

Consider the following questions and record your responses. Share your thoughts with fellow students.

Q1) Describe how these actions would work in your residential or community service.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Q2) Identify the barriers to implementing these actions.

________________________________________________________________________

________________________________________________________________________
Situation B – The client has suicidal thoughts but no plans

If the client has suicidal thoughts but no plan, the risk is not as high but it is still important to assist this person to get help.

Again, common actions will include:

• reporting to your supervisor (you may need to contact the client’s care manager) as soon as possible so the client or resident can be followed up by their GP, psychiatrist or care manager
• following your supervisor’s advice and the protocols of your organisation
• informing the client or resident that you will contact, or have contacted, their family
• frequently checking on the client or resident
• putting a safety plan in place and ensuring all staff are aware of it.

_In these situations the client’s or resident’s misery remains and even though they don’t have the means they still wish their life to end._

Safety plans

Every client or resident who has expressed suicidal thoughts should have their own safety plan. In your role as an enrolled nurse you might contribute to the safety plan. It provides you with important information about what actions are helpful in these types of situations.

The client or resident, their family and all care staff should know where the safety plan is located.

**Reflect and discuss**

Critically review the following example of a safety plan and make notes of key points or issues. Discuss your ideas with fellow students.
SAFETY PLAN

Make a ‘safety plan’ for crisis situations that you have experienced in the past and/or may experience in the future. Write this plan when you are feeling well.

Step 1: Warning signs
1. 
2. 
3. 

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person
1. 
2. 
3. 

Step 3: People and social settings that provide distraction
1. Name Phone 
2. Name Phone 
3. Place Place 

Step 4: People who I can ask for help
1. Name Phone 
2. Name Phone 
3. Place Place 

Step 5: Professionals or organisations I can contact during a crisis
1. Clinician Name Phone 
   Clinician Emergency Contact # 
2. Clinician Name Phone 
   Clinician Emergency Contact # 
3. Emergency Services – Ambulance – 000 
4. Local Hospital Emergency Department 
   Local Hospital ED Address 
   Local Hospital ED Phone 
5. Lifeline Phone: 13-11-14 www.lifeline.org.au
   Suicide Call Back Service 1300 659 467 www.suicidecallbackservice.org.au

Step 6: Making the environment safe
1. 
2. 

WORKSHEET 17 – Analysing safety plans in your organisation

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.

Think critically

Compare your organisation’s safety plans with the example provided and determine whether the safety plans your organisation uses could be improved.

Identify any changes you would recommend and explain how the changes could be incorporated into your organisation’s protocols.
Activity 2.6  Reflecting on your experience in responding to suicidal ideation

Critical reflection

Please take some time to think about the following questions and write your responses.

Q1) Has there been a time when one of your clients or residents has expressed suicidal thoughts? Briefly describe the situation.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Q2) a) How did you and/or other members of the care team respond?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

b) Did you have protocols or procedures to follow? Were you able to access the protocols or procedures?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

c) Did the client’s or resident’s care plan include advice on how to respond to suicidal ideation?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Q3) On reflection, was the response appropriate? Please give your reasons. You might also describe the client’s or resident’s experience.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Q4) What would you do differently in a similar situation now?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Q5) In what ways do your organisation’s policy and procedures support care staff and respond to the needs of clients?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Q6) Was the client or resident prescribed any prn (as needed) anti-anxiety or sedative medications? If so, what was the client’s response to this medication?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Q7) What non-pharmacological interventions might be appropriate in these situations?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Feeling hopeless about a client’s or resident’s situation can be contagious and will impact upon staff’s ability to support this person.

Reporting and documentation

Assessment of an older person’s mental health must be ongoing. If in doubt screen, report and/or refer. Every suspicion or every conversation you have with a client or resident around suicide should be reported to your supervisor and documented in the client’s or resident’s notes.

As we have discussed in previous topics, there are essential communication procedures that all care staff must follow. In the case of clients or residents at risk of suicide it is vital that all members of the care team who are involved directly or indirectly in their care observe, listen, ask questions, and report and document conversations, actions, or changes in behaviour that may indicate a client or resident is at risk.
Activity 2.7  Analysing a scenario: A conversation with your client – Clem’s story

For this activity we would like you to put yourself in the role of Clem’s nurse.

Important note: You are about to watch a DVD which introduces you to Clem. Clem talks about his experiences of being in residential care. You may find that you have a strong emotional response to this footage. Please speak with your facilitator if you require particular support with your thoughts and feelings.

This activity has three parts. We encourage you to discuss your responses to each part with fellow students.

Apply knowledge to practice

Part A

Q1) As you watch the DVD, ‘tune in’ to the words Clem uses to describe how he is feeling. Make notes of your observations.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Q2) What makes you think Clem is at risk of suicide? What evidence do you have to support your response?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Q3) If Clem is at risk of suicide, what would or could you do within your role to respond to this risk?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Apply knowledge and professional judgment

Part B

Take time to consider words that Clem might use as part of this ongoing conversation. Please provide at least four lines of conversation between you and Clem that would follow on from the last line of the DVD.

Clem’s last line: “I’ve got no interest ...”

Your response:  

Clem’s response:  

Clem’s response:  

Clem’s response:  

Apply knowledge to practice

Part C

Q4) What would you record in Clem’s notes? Use your exact wording.

Q5) Aside from recording in his notes, what other actions might you undertake after this conversation with Clem? Please list your follow-up actions.
Critical reflection

As the enrolled nurse, staff may be reporting to you their concerns about a client.

Imagine that a member of staff reported to you their conversation (as outlined above) with Clem. What will be your responsibilities as their supervisor?

Getting support for yourself and families

Having conversations with clients or residents about suicidal thoughts and/or feelings is not easy and nurses need to be supported by their organisation. It is essential that you talk through what happened with your supervisor and/or get more help. Every organisation will have different protocols for supporting staff.

You should access the support available in your organisation as you might not realise the full impact of these difficult situations. Also, you may be in a role where you are supporting staff and it is important for you to find out what support is available and ensure that other staff members have access to that support.
Investigate and record

What happens in your organisation?

Take some time to think about the following question then record your response in the space provided. You might be able to base your response on personal experience or you may need to access the information from your supervisor or other care team members.

Q1) How does your organisation support members of the care team in these situations?

__________________________________________________________________________________________

__________________________________________________________________________________________

It is important to recognise that discussing suicide with a client or resident can be a tough conversation to have; however it is equally important to know you are not on your own and help can be close by.

Getting support for families

It is also important that families are supported through this process. The impact on family members may not be fully understood, especially if there are limited opportunities for them to talk through their experience.

The stress of living with someone who is depressed, and at risk of suicide, is enormous and can create health issues for the family members concerned. As the enrolled nurse, you need to be aware of, and respond empathically to, these situations, as well as the potential grief and loss if the family member has ended their life.

An unwell individual may often mean an unwell family. Include them in your assessment and care, or refer them for help and support. Again, each organisation will have different protocols and different services for supporting families.
Investigate and record

Support for families – what happens in your organisation?
Please outline the protocols and services available in your organisation for families. You might need to consult your supervisor or other team members.

________________________________________

________________________________________

________________________________________

________________________________________

Reflect and discuss

Supporting Clem’s family
Take some time to reflect on Clem’s story and consider the following questions. We encourage you to share your reflections with fellow students.

Q1) Describe what you could do, within the scope of your role, to support Clem’s family members – during and after his disclosure.

________________________________________

________________________________________

________________________________________

________________________________________

Q2) Describe two strategies an aged care service could put in place to ensure families are supported in such situations.

________________________________________

________________________________________

________________________________________

________________________________________

Note: You will look more closely at working with families in Chapter 3.

Online reading
You can read the National Suicide Prevention Strategy produced by the Department of Health and Ageing which lists a number of resources including the LIFE booklet available at www.livingisforeveryone.com.au
**STEP 4 EVIDENCE BASE FOR CURRENT APPROACHES TO TREATMENT AND EVALUATING OUTCOMES**

**Depression can be treated**

“**Depression is a health problem for which effective treatments are available, regardless of a person’s age. Although it’s a mental health problem, it shouldn’t be thought of any differently from a physical health problem – and there’s no stigma or shame in getting help for arthritis or asthma! It should be the same for depression.”** – The Hon. Jeff Kennett AC, Chairman, beyondblue

Some might think there are limited treatment options available for depression and anxiety in older people. In this section we will explore different approaches to treating depression and anxiety in older adults.

**Individualised treatment options**

Just as no two people with depression or anxiety present in exactly the same way, treatments need to be tailored for each client or resident. There are a range of treatment options available and it is often a combination of treatments that proves most effective.

We will begin by looking at treatment options that are effective for older people.

**Psychological therapy**

Psychological treatments (also known as talking therapies) help to improve people’s coping skills so the person feels more able to deal with life’s stresses and conflicts. Research indicates that there are two psychological approaches that are particularly effective for people with depression and anxiety.

<table>
<thead>
<tr>
<th>Psychological therapy</th>
<th>Outcomes for older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive behaviour therapy (CBT) helps to correct negative thought patterns. How we think affects the way we feel, and CBT helps to identify and challenge unhelpful thought patterns. CBT is particularly effective in the treatment of depression and anxiety.</td>
<td>We may think that psychological interventions are less effective in older adults and also that older adults may prefer medications over psychological approaches. However, research demonstrates that in older adults, psychological interventions can be as effective as medications.17</td>
</tr>
<tr>
<td>Interpersonal therapy (IPT) helps to improve relationships and/or the ability to cope with grief. IPT is particularly effective in the treatment of depression in adults.</td>
<td>In a large primary care base study where a treatment choice of either medication or talking therapies was offered to older patients with depression, 50 per cent expressed a preference for psychological therapy over drugs.</td>
</tr>
</tbody>
</table>

## Medical interventions

<table>
<thead>
<tr>
<th>Medications</th>
<th>Outcomes for older people</th>
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</thead>
</table>
| Antidepressant medications have been extensively researched and have proven effective for moderate to severe depression and also for many types of anxiety. | Antidepressants can be an effective treatment option for older adults but generally they will commence on lower doses that are gradually increased. In older adults, there can be specific side-effects such as gastrointestinal disturbances, agitation and confusion (medications can impact on sodium levels).  

It is important to note that individuals will have individual responses to antidepressant medications. According to NPS Medicine Wise (www.nps.org.au), the full effect of antidepressant medication should be felt within six to eight weeks of commencing treatment.  

If the medications have not been effective in that time, the person might be moved to another medication by their GP or psychiatrist.  

*Your role will be to evaluate the effect of the medication and to carefully observe and report the person’s response to the medication especially in the period up to full efficacy.* |
| Anti-anxiety medications have also proven effective as a short-term intervention for some types of anxiety. | Anti-anxiety medications can be effective for anxiety, however because of side-effects they are recommended for short-term use only. The side-effects of some anti-anxiety medications include sedation, which can impact on gait (manner of walking) and increase risk of falls.  

Also, these medications can be highly addictive so can create issues of dependence and therefore are only recommended for short-term use.  

Often anti-anxiety medications (and sedatives) can be prescribed as prn (as needed) medication in case there are times when the client or resident requires these additional medications. It will be important for the enrolled nurse to report the trigger and impact of these medications. |
| Antipsychotic medications can also be used for particular types of depression that may not have responded to antidepressants. | According to beyondblue’s publication, *A guide to what works for anxiety*, antipsychotic medications are effective for psychotic depression and some types of anxiety.  

Antipsychotic medications can cause a number of side-effects including weight gain and dry mouth and they can also cause extrapyramidal side-effects (Parkinson-like movements). |

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18 *A guide to what works for anxiety*, beyondblue publication.
A note of caution: Recent studies have revealed that the highest rates of use of antipsychotic, antidepressant, anti-anxiety and sedative/hypnotic drugs occurs in people aged 80 to 95 and are nurse initiated. This is of concern for two reasons:

1. Older adults are particularly vulnerable to the side-effects of these medications because of an ageing metabolism and, in the worst case, the side-effect will be premature death.

2. These medications may adversely interact with other medications the older person is prescribed.

Medications can be potentially harmful and should be used with caution.

<table>
<thead>
<tr>
<th>Electroconvulsive therapy (ECT)</th>
<th>Outcomes for older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>According to the beyondblue publication, <em>A guide to what works for depression</em>, ECT is normally used for severe depression that has not responded to other treatments. Modern ECT is a safe, effective procedure, which is used to rapidly treat depression.</td>
<td>ECT can also be used effectively in older adults. One of the main side-effects of ECT is memory loss which normally resolves after a few weeks but can last longer.</td>
</tr>
</tbody>
</table>

**Lifestyle interventions**

<table>
<thead>
<tr>
<th>Lifestyle interventions</th>
<th>Outcomes for older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is solid evidence to demonstrate that exercise is an effective treatment option for mild to moderate depression in adults.</td>
<td>In older adults, the research continues to support the findings that lifestyle factors, particularly exercise, are effective in older adults with depression. Also, there are fewer negative side-effects from these lifestyle interventions and one positive side-effect – better health!</td>
</tr>
</tbody>
</table>

“The evidence shows that for both treatment and prevention of relapse for depression, the combination of a psychological intervention and a biological one, medication, is far more effective than either alone.” – Assoc. Professor Gerard Byrne Psychiatrist, Head of Psychiatry, The University of Queensland

**Your role in evaluating treatment options**

As the enrolled nurse, your role is to evaluate and report the effectiveness of treatment options. How will you know whether the medications and/or treatments are effective?

You will need to consider several factors if the client or resident has commenced a new treatment such as antidepressant medication. These include:

- judging whether the treatment has been effective
- observing side-effects of the medication or treatment
- reporting those observations and/or evaluation to the prescribing doctor.

It may be that the client or resident is rescreened (using whatever tool was used as part of their initial assessment) to identify the impact of this new treatment. Enrolled nurses need to be alert and report changes in mood or behaviour which may be evidence of the person’s response (or lack of response) to the treatment.

Older people can be at risk of polypharmacy – drug interactions associated with the number of medications they are prescribed – as well as being more susceptible to the side-effects of medications.

It is important to monitor the side-effects of medications and not conclude that the person is experiencing another age-related condition; the cause may be their new medication. It will be essential to report your evaluation and observation to the prescribing doctor in person or via client notes.

Online reading

For more information, go to www.nps.org.au/topics/ages-life-stages/for-individuals/older-people-and-medicines/for-health-professionals/medicines-management/prescribing-principles

beyondblue has produced two free resources that review and rate the available evidence of many treatment approaches for depression and anxiety. They are not specific to older people, but adults in general. The resources are:

- A guide to what works for depression
- A guide to what works for anxiety

Both resources are available from www.beyondblue.org.au/resources. Or, for a physical copy of the booklets, visit www.beyondblue.org.au/order or call 1300 22 4636.

Information for aged care staff about psychosocial interventions for the prevention and treatment of depression or anxiety in older clients is in a new beyondblue booklet, What works to promote emotional wellbeing in older people. The booklet has been developed to guide evidence-based practice. It lists interventions for the prevention and treatment of depression and anxiety in older people and includes a review of the evidence on each intervention.

The booklet, released in 2014, will be available from www.beyondblue.org.au/resources

WORKSHEET 18 – Treatments for your clients and residents with depression or anxiety

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
Emerging treatment options

There are emerging treatment options that are being shown to be effective for older adults with depression.

Reminiscence

One of the emerging treatment options for older people with depression is reminiscence. Reminiscence is an enjoyable activity that we all like to do. For older people, reminiscence can boost mental health. Different components of reminiscence which have been studied in research include:

- Simple reminiscence – involving autobiographic storytelling that activates the process of reminiscence. This can be triggered through particular items or through the senses and can be incidental. It is the type of reminiscence that will be most familiar to you.
- Life review – a structured process for recalling past events in their order, and evaluating these experiences in light of the person’s current situation.
- Life review therapy – this guides the person to reflect on positive experiences to replace negative thoughts about themselves and their past.

Recent evidence demonstrates that reminiscence – specifically life review and life review therapy – can be therapeutic for depressed older adults. Simple reminiscence – something all of us can do when working with clients and residents – boosts mental health, therefore it can be an important consideration when we are looking for effective treatment options for older adults with depression.

Life review and life review therapy is generally conducted by a clinician, whereas we can all use simple reminiscence with our clients or residents.

We should keep in mind that although clients and residents with dementia may have difficulty with their short-term memory, their long-term memory can be intact and you can get to know the client or resident by accessing these preserved memories through reminiscence.

Activity 2.8 Exploring the benefits of reminiscence for your clients and residents

This activity has two parts.

Reflect and discuss

This activity should be done in pairs. It is important to remember that we all reminisce. In this activity you will have a brief experience of reminiscence and gain insight into the benefits of reminiscence for your clients or residents.

Part A

Think back to your childhood and remember something that was precious to you. It may be a pet, favourite toy, blanket, cooking bowl, plant or something else.

Allow yourself time to reflect on that special item.

Next, turn to the person beside you and describe that object, explain why it was precious and how it made you feel.

Now ask your partner to tell you about their favourite thing.

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20 Based on Activity 9, beyondblue training program: Making a difference: Understanding depression and anxiety disorders in older people, p. 38.
Part B

Take some time to reflect on the following questions. You may wish to make some notes. We also encourage you to share your thoughts with your partner and members of the group.

- How was that experience?
- How did you feel at the beginning?
- Did you find that starting to talk about your favourite thing led to other treasured memories, things you haven’t thought of for a long time?
- Did it make you feel good?

Your reflections:

This is how reminiscing can benefit your clients and residents.

________________________________________________________________________

________________________________________________________________________

Applying knowledge to practice

Reminiscence as part of the treatment option

If your aged care service already conducts reminiscence with your clients and residents who have depression, please answer questions 1–6 below.

Q1) Briefly describe how reminiscence is provided.

________________________________________________________________________

________________________________________________________________________

Q2) Please indicate the type of reminiscence provided. You can use a circle or tick.

☐ Simple reminiscence ☐ Life review ☐ Life review therapy

Q3) Identify who provides the reminiscence. If you are involved in this activity, please describe your role.

________________________________________________________________________

________________________________________________________________________

Q4) Describe some of the effects of reminiscence you have observed in clients and residents.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Q5) a) What evidence will you look for to confirm if the reminiscence is effective?

___________________________________________________________________________________________________________________________________________________________

___________________________________________________________________________________________________________________________________________________________

b) Describe any outcomes that are measured from this activity or therapy.

___________________________________________________________________________________________________________________________________________________________

___________________________________________________________________________________________________________________________________________________________

Q6) If there is an evaluation of this activity, explain what happens to the information.

___________________________________________________________________________________________________________________________________________________________

___________________________________________________________________________________________________________________________________________________________

Think creatively

If your organisation does not provide reminiscence for clients or residents, think about what you could do (within the scope of your role) to encourage your aged care service to provide reminiscence therapy to boost clients’ and residents’ mental health.

Describe two ideas or actions you could put forward for consideration. You might also think about who you would need to influence to realise your ideas.

1. __________________________________________________________________________

__________________________________________________________________________________________________________

2. __________________________________________________________________________

__________________________________________________________________________________________________________

A non-pharmaceutical treatment option: the benefits of socialisation

Social isolation – the loss of social networks, friends and family – has many negative health outcomes for older people, including increasing the risk of developing depression. Research indicates that increasing socialisation and pleasant events is an important element in the treatment of depression in older adults.

Sometimes engaging isolated older people into social programs can be a challenge for community care staff. Have you found this to be true?

Some clients or residents may refuse to participate in social programs and therefore maybe at greater risk of depression. If an older person has depression it can be particularly overwhelming for them to join a social group.
**Activity 2.9  Stories from the field: Creative strategies to meet clients’ and residents’ social needs**

You are about to view a DVD, *Stories from the field*, where Brotherhood of St Laurence Care Manager, Carolyn McAlister, reflects on several clients and discusses how you need to be creative when working with socially isolated clients, or those who have depression, to meet their social needs.

As you watch, you might think about how you could introduce some of the examples the Care Manager describes into your practice or organisation.

**Think critically**

Consider the following questions and record your responses in the space provided.

**Q1) Describe some of the practical barriers that might prevent a community care client participating in a social activity.**

**Q2) What actions can you take in your role as an enrolled nurse to overcome some of these practical barriers?**

Take some time to reflect on a client or resident in your care who has been reluctant to engage in social activities.

**Q3) Describe what you might now do differently.**

**Apply knowledge to practice**

Based on what you know about your clients’ interests, describe one or two social activities that could be introduced to meet their social needs. Give two indicators that you could use to show in your evaluation that these have been successful for the client.
Making a difference: Implementing person-centred practice to promote older people's mental health and wellbeing

Older people with dementia and depression

In Chapter 1 we discussed the overlap between depression and dementia. We know that dementia can contribute to depression through the slow erosion of confidence and self-esteem, as the person's ability to manage their physical and social environment is affected.

Although depression affects mood, it can also lead to poor memory and difficulties making decisions and organising and initiating activities. Thus, for a person with dementia, depression not only affects their mood but may also worsen their symptoms of dementia. Additionally they can have problems communicating and may not be able to describe their symptoms very well.

REMEMBER...

It is often incorrectly assumed that it is ‘normal’ for older adults to be depressed, especially those with dementia.

Recognising depression in the presence of dementia involves more than simply identifying a client’s symptoms. Other factors will need to be taken into account, including:

- the number of symptoms present
- the type of symptoms – particularly feelings of hopelessness, guilt or worthlessness
- the length of time the symptoms have been present
- the fact that the person with severe dementia may not be able to communicate verbally but may communicate mood with body language, actions and tone of voice.

Depression can be difficult to diagnose in the presence of dementia and in all instances, the diagnosis should be made by a doctor.

Treating depression and dementia: What options are available?

Treatment options for older people who have a diagnosis of depression and dementia may be similar to those we discussed earlier. These include medication and ‘talking therapies’ such as counselling, cognitive therapy and behavioural interventions.

However in this situation, it is important to identify and understand the cause of the depression in order to determine the most appropriate treatment. Depression with a physiological basis (what is happening in the human body) may not respond to counselling and psychosocial interventions alone, and may require medication.

<table>
<thead>
<tr>
<th>Social activity</th>
<th>Indicators of success</th>
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<td></td>
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<tr>
<td>WORKSHEET 19 - Person-centred care to support older people living with mental illness: Analysing two case studies</td>
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<td>You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.</td>
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</table>
Depression in which the primary cause is psychological or environmental (external factors), may be more responsive to psychosocial treatments and strategies to improve the environment rather than medication.

In some instances, depression may have both physiological and psychosocial causes and appropriate treatment may include both medication and therapy.

The table below shows the outcomes of different treatment options for older adults with dementia.

<table>
<thead>
<tr>
<th>Treatment interventions</th>
<th>Outcomes for older people with dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td>Older people with dementia often have the most significant depression but unfortunately they also have the poorest response to medications owing to their impaired cognition (thinking skills). This does not mean that older people with dementia will never be given medication, as we know that individuals will have individual responses to medications. Rather we need to monitor closely each person’s response to these medications.</td>
</tr>
<tr>
<td>ECT</td>
<td>ECT is generally not used with older people who have dementia because of their existing impaired cognition.</td>
</tr>
<tr>
<td>Psychological therapy</td>
<td>It may be difficult for older people with dementia to benefit from psychological support unless they are in the very early stages of their dementia.</td>
</tr>
<tr>
<td>Lifestyle interventions</td>
<td>Exercise is one of the treatment options that can be used with people with dementia.</td>
</tr>
</tbody>
</table>

What can we do to reduce the risk of depression in dementia?

In addition to medical treatment, there are many things we can do to reduce the risk of depression, especially when it may be caused by external factors, and to maintain and/or improve the quality of life of our clients who have dementia.

It is important, though, as enrolled nurses to be mindful of matching the intervention to the person so that we do no harm with inappropriate ‘knee jerk’ interventions that do not target the cause of the client’s or resident’s problem. We do not suggest that you would implement all of the interventions below – you would need to tailor the intervention to the client’s or resident’s identified needs.

So let us consider the following interventions through the prism of person-centred, evidence-based care practice.

**Think critically**

We suggest you work in pairs or small groups for this exercise.

For each intervention, think of a situation where it would/could meet the needs of a client or resident in your care. You might also identify interventions that could not be implemented in your organisation. In each situation please explain your rationale.

- Adapt the person’s home and immediate environment to make it more manageable.
- Minimise change and keep to a predictable routine.
- Minimise stress and anxiety by simplifying or eliminating tasks or activities that have become too difficult.
- Reduce exposure to overstimulating or threatening situations.

---

• Provide support for the person so they can carry out normal activities for as long as possible.
• Ensure that healthy meals with lots of fresh fruit and vegetables are available every day.
• Provide Vitamin B supplements if deficiency is present.
• Encourage regular exercise.
• Make sure a small amount of time is spent in the sun each day.
• Make sure that something enjoyable is done every day.
• Make sure that there is regular social contact.
• Get a pet if appropriate care is available.
• Encourage a period of relaxation or meditation every day.
• Use simple reminiscence.

Activity 2.10 Reducing the risk of depression in dementia: Three interventions that can be implemented in your organisation

This activity has two parts.

Think critically

Part A
Take some time to consider each intervention described above and identify three which could be introduced in your organisation. For example, there could be changes to protocols or procedures, or new care practices. You may select options that you could implement to enhance your own role and practice. Your aim is to choose options that will most appropriately respond to your clients’ and residents’ needs.

Apply knowledge and professional judgement

Part B
For each intervention, please give a brief explanation for your choice and how you think it could be implemented. You can include examples of the way you think clients and residents will benefit from the intervention and you might also note who would be involved in the intervention.
### Three interventions that can be implemented in my organisation

<table>
<thead>
<tr>
<th>Intervention 1</th>
<th>Why I chose this intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The resident or client need the intervention addresses</td>
</tr>
<tr>
<td></td>
<td>How it could be implemented</td>
</tr>
<tr>
<td></td>
<td>Who would be involved</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention 2</th>
<th>Why I chose this intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The resident or client need the intervention addresses</td>
</tr>
<tr>
<td></td>
<td>How it could be implemented</td>
</tr>
<tr>
<td></td>
<td>Who would be involved</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention 3</th>
<th>Why I chose this intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The resident or client need the intervention addresses</td>
</tr>
<tr>
<td></td>
<td>How it could be implemented</td>
</tr>
<tr>
<td></td>
<td>Who would be involved</td>
</tr>
</tbody>
</table>
Accessing treatment options

An important part of your role as an enrolled nurse is to know about, and understand, how treatment options can be accessed by aged care services, by older adults themselves and by their families.

Understanding access to, and funding for, psychological therapies

Here we will examine how some of the treatment options you have studied can be accessed, and importantly, how they are funded.

This first online task will focus on the support for psychological therapy. Older people in the community can access Medicare-funded psychological support.

**WORKSHEET 20 – Accessing psychological support for older people in the community**

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.

Options for older people living in the community or in residential care

Commonwealth-funded residents of residential aged care facilities can access psychological support through the Chronic Disease Management funding which allows for up to five individual allied health services (Medicare Benefits Schedule (MBS) items 10950–10970), one of which can be a psychologist.

In the past, older people in residential care may have also been able to access psychological support through funding provided to Medicare Locals. However, this support was not a mandated service, but may have been provided by Medicare Locals based on their local area’s needs and priorities. Funding and needs are always changing but your Medicare Local may provide this support for your residents.
Making psychological support more accessible: What is available online for clients or residents and their carers?

Here you will explore a new initiative that makes psychological support more accessible for older people who have depression or who are experiencing anxiety. E-therapies are online programs that provide structured courses and contact with a psychologist for people experiencing depression or anxiety.


Wellbeing Plus Course is one of the online courses established for people over the age of 60. It provides participants with a structured course as well as email and telephone support from a psychologist. beyondblue was involved in building and evaluating the course. The program has been trialled with older adults and benefits were sustained up to three months after the course.

It may be that clients in community care and/or some older people in residential care comfortable with the technology may access and benefit from these e-therapies.

**Reflect and discuss**

Take some time to think about the following questions then discuss your thoughts with members of your group. We encourage you to make notes from the discussion.

**Q1) Who might benefit from an online course, like the Wellbeing Plus Course?**

**Q2) Identify one of the constraints in using e-therapies.**

**Medical interventions**

- General practitioners (GPs), psychiatrists or psychogeriatricians will prescribe medication for people with depression or anxiety.
- A psychiatrist will prescribe and administer ECT. As previously mentioned, ECT is generally not a first treatment option for someone with depression.

*If one of your clients has commenced treatment for depression or anxiety, your role is to monitor, observe, report and document all positive and negative effects of the treatment.*
Activity 2.11  Analysing your role in a client’s treatment

There are two parts in this activity.

Apply knowledge to practice

This case study presents a scenario which you may see in your day-to-day practice. You will be preparing to introduce one of your clients, Mr Jones, to another enrolled nurse who is providing support to Mr Jones as you go on long service leave.

The activity asks you to:
- write up the client’s history
- analyse the client’s current situation
- take note of key points – particularly relating to medical and other interventions
- identify impacts and outcome measures for the client
- record your observations.

Your notes could be used to inform future decisions about the client’s ongoing treatment.

Part A

Read Mr Jones’ story, making note of information relevant to the points outlined above.

You are the case manager for Mr Jones, who is 87 and who lives alone. You have been supporting him for the past 18 months.

He has several chronic illnesses and his wife of 55 years, Enid, died suddenly two years ago.

Normally Mr Jones is reluctant to engage in any social activities and when he speaks about his wife he becomes emotional. He does have good family support and his daughter, Ellen, visits regularly (but he doesn’t go out with his family members). Some of his neighbours also keep an eye on him.

Mr Jones has recently been diagnosed with depression by his general practitioner and six weeks ago started low-dose antidepressants.

You have spoken to Ellen about her father’s low mood and whether increasing his socialisation could boost his feelings of wellbeing. Ellen has indicated she will try and take him out when visiting. You asked about her father’s social interests and she said that he used to love bush walking and hiking, joining hiking groups and so on.

When you visit Mr Jones, you try to interest him in some social programs but he is reluctant to get involved. You tell him about a local older person’s walking group and ask if he is interested in joining. He does eventually agree to going only if Mary, his community worker who helps him, can go too.

You request, and provide, permission for the community care worker to take Mr Jones to the walking group that meets at his local park. The group often have a cup of tea in the park after the walk.

Mary reports that while reluctant initially, after some encouragement, he did go to the park and meet the group but did not talk about his wife while he was there and seemed to enjoy himself.
Apply knowledge and professional judgment

Part B

In this part you will be documenting relevant information as part of your briefing to your team member, using the headings below.

- Mr Jones’ history

- His risk factors for depression

- Your role in his care

- Actions by other team members

- Medical and other interventions that are part of Mr Jones’ treatment plan

- The reports of Mr Jones’ response to his outing to the park.
In Chapter 3 you will look in greater detail at recording and reporting your observations as part of care planning.

Understanding referral

In this section we will explore the process of referral and its potential benefits for older people who have depression, anxiety and/or dementia. Knowing what services are available when clients or residents need to access other support services, which services will be most appropriate and who makes the referral will contribute to clients and residents’ wellbeing and enhance your care practice.

Clients can be referred to other health practitioners and supports such as:

- allied health practitioners – including physiotherapists, dieticians, occupational therapists and psychologists
- General Practitioners
- specialist services, such as psychiatrists
- mental health services for older adults, for example the Dementia Behaviour Management Advisory Service (DBMAS) provides clinical support for people caring for a person with dementia
- Alzheimer’s Australia which offer counselling, information and support for people and their families affected by dementia
- Aged Psychiatry Assessment and Treatment Team (APATT).

Aged care organisations will have different protocols for referral, but all will include:

- who is responsible for referring clients to other services
- what information is to be sent with the referral
- what consent needs to be provided.

WORKSHEET 21 – Understanding referral protocols in your organisation

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.

Successful interventions for older people with dementia and depression: analysing research findings

In the final section of this chapter, we will analyse several research projects that have investigated alternative interventions for people with dementia and depression. We will focus on people with dementia and depression as there has been more research with this group than with people with dementia and anxiety.

We know that older people with dementia can have very significant depression. However, if the treatment options described previously are not effective, then what other treatment options exist for this group?
Emerging research has indicated that non-pharmaceutical (non-drug) management of people with depression and dementia can be an effective treatment option – these interventions have been called psychosocial (psychological and social) interventions.

Researchers have investigated several psychosocial research projects which demonstrated a clear improvement in depression in people with dementia.

**WORKSHEET 22 – Evaluating a psychosocial intervention: A successful research project on exercise and behavioural management**
You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.

**Features of successful research projects**
Research projects that had successful outcomes shared several common features, such as:

- a focus on increasing pleasant social events
- providing structured individualised activity
- they may have included an exercise component
- improved communication skills and problem-solving strategies for the care-giver through training
- a focus on one-on-one treatments and working closely with families.

**WORKSHEET 23 – What will work for your clients and residents? Developing a proposal to implement interventions for prevention and treatment of depression and anxiety**
You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.

**WORKSHEET 24 – Quiz – Learning reflections**
You are now ready to check your learning from this chapter by completing a short online quiz. Your facilitator will explain how to record your answers and when to submit your completed worksheet.

**WORKSHEET 25 – Final reflections**
In the last online task for this chapter we ask you to reflect on your learning and consider how you can share your new knowledge with members of the care team. Your facilitator will explain how to complete the task and when to submit your worksheet.
Information and references

There are many sources of information and useful references available to you. Here are some suggestions relevant to the information discussed in this chapter to help you on your learning journey.

Visit [www.beyondblue.org.au/resources](http://www.beyondblue.org.au/resources) for access to many free fact sheets and resources, including:

- A guide to what works for depression – Booklet
- A guide to what works for anxiety – Booklet
- Getting help – How much does it cost? – Fact sheet
- Depression and dementia – Fact sheet
- Depression and anxiety disorders in older people – Fact sheet
- Depression and anxiety: an information booklet – Booklet
- Grief, loss and depression – Fact sheet
- Anxiety and depression in older people – Booklet
- Over Bloody Eighty (OBE) Stories – a marvellous collection of personal stories from older Australians – Booklet

**Alzheimer’s Australia Help Sheets**

Alzheimer’s Australia provides Help Sheets and many other resources about dementia that you will find useful. To access them, go to: [www.fightdementia.org.au/understanding-dementia/help-sheets-and-update-sheets.aspx](http://www.fightdementia.org.au/understanding-dementia/help-sheets-and-update-sheets.aspx)

This Help Sheet is a useful reference for reminiscence: [www.fightdementia.org.au/common/files/NAT/2012_NAT_HS_CSD_02_TherapiesAndCommunication.pdf](http://www.fightdementia.org.au/common/files/NAT/2012_NAT_HS_CSD_02_TherapiesAndCommunication.pdf)


The ABS is Australia’s official statistical organisation. This data is then freely available to everyone and informs planning of services. We all contribute data by completing the census every five years.

**Australian Psychological Society (APS) [www.psychology.org.au](http://www.psychology.org.au)**

The APS is the largest professional association for psychologists in Australia. The APS provides resources on a range of topics including suicide and depression. You can also search for a psychologist who specialises in particular mental health issues and for specific population groups.


LIFE Communications is a National Suicide Prevention Strategy project by the Department of Health and Ageing. The project aims to improve access to suicide and self-harm prevention activities in Australia through the promotion of the LIFE resources and the LIFE website.

**National Ageing Research Institute (NARI) and The Benevolent Society** produced a briefing paper: Supporting older people experiencing mental distress or living with mental illness Research to Practice Briefing No 7, August 2012. To access this document, visit: [www.benevolent.org.au](http://www.benevolent.org.au)


**Challenge Depression (DVD), Challenge Depression Kit, Hammond Care and Department of Health and Ageing. (2001).** Featuring Clem from Activity 2.9.
**Resources for Activity 2.3** Comparing a screening tool for adults and a screening tool specifically developed for older adults

**Beck Depression Inventory (BDI)**

Choose the one statement from among the group of four statements in each question that best describes how you have been feeling during the past few days. Circle the number beside your choice.

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<thead>
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<tbody>
<tr>
<td><strong>1.</strong></td>
<td>0</td>
<td>I do not feel bad.</td>
<td>1</td>
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<tr>
<td></td>
<td>1</td>
<td>I feel sad.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I am sad all the time and I can’t snap out of it.</td>
<td></td>
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<tr>
<td></td>
<td>3</td>
<td>I am so sad or unhappy that I cannot stand it.</td>
<td></td>
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<tr>
<td><strong>2.</strong></td>
<td>0</td>
<td>I am not particularly discouraged about the future.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I feel discouraged about the future.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I feel I have nothing to look forward to.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I feel that the future is hopeless and that things cannot improve.</td>
<td></td>
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<tr>
<td><strong>3.</strong></td>
<td>0</td>
<td>I do not feel like a failure.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I feel I have failed more than the average person.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>As I look back on my life, all I can see is a lot of failure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I feel I am a complete failure as a person.</td>
<td></td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>0</td>
<td>I get as much satisfaction out of things as I used to.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I don’t enjoy things the way I used to.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I don’t get any real satisfaction out of anything anymore.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I am dissatisfied or bored with everything.</td>
<td></td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>0</td>
<td>I don’t feel particularly guilty.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I feel guilty a good part of the time.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I feel guilty most of the time.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I feel guilty all of the time.</td>
<td></td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>0</td>
<td>I don’t feel that I am being punished.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I feel I may be punished.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I expect to be punished.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I feel I am being punished.</td>
<td></td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td>0</td>
<td>I don’t feel disappointed in myself.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I am disappointed in myself.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I am disgusted with myself.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I hate myself.</td>
<td></td>
</tr>
<tr>
<td><strong>8.</strong></td>
<td>0</td>
<td>I don’t feel I am worse than anybody else.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I am critical of myself for my weaknesses or mistakes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I blame myself all the time for faults.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I blame myself for everything bad that happens.</td>
<td></td>
</tr>
<tr>
<td><strong>9.</strong></td>
<td>0</td>
<td>I don’t have any thoughts of killing myself.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I have thoughts of killing myself but I would not carry them out.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I would like to kill myself.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I would kill myself if I had the chance.</td>
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</table>
**10.**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don’t cry any more than usual.</td>
</tr>
<tr>
<td>1</td>
<td>I cry more now than I used to.</td>
</tr>
<tr>
<td>2</td>
<td>I cry all the time now.</td>
</tr>
<tr>
<td>3</td>
<td>I would kill myself if I had the chance.</td>
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</table>

**11.**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>I am not more irritated by things than I ever am.</td>
</tr>
<tr>
<td>1</td>
<td>I am slightly more irritated now than usual.</td>
</tr>
<tr>
<td>2</td>
<td>I am quite annoyed or irritated a good deal of the time.</td>
</tr>
<tr>
<td>3</td>
<td>I feel irritated all the time now.</td>
</tr>
</tbody>
</table>

**12.**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I have not lost interest in other people.</td>
</tr>
<tr>
<td>1</td>
<td>I am less interested in other people than I used to be.</td>
</tr>
<tr>
<td>2</td>
<td>I have lost most of my interest in other people.</td>
</tr>
<tr>
<td>3</td>
<td>I have lost all my interest in other people.</td>
</tr>
</tbody>
</table>

**13.**

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<thead>
<tr>
<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>I make decisions about as well as I ever could.</td>
</tr>
<tr>
<td>1</td>
<td>I put off making decisions more than I used to.</td>
</tr>
<tr>
<td>2</td>
<td>I have a greater difficulty in making decisions than before.</td>
</tr>
<tr>
<td>3</td>
<td>I can’t make decisions at all anymore.</td>
</tr>
</tbody>
</table>

**14.**

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<thead>
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<th>Score</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>I don’t feel I look any worse than I used to.</td>
</tr>
<tr>
<td>1</td>
<td>I am worried that I am looking old or unattractive.</td>
</tr>
<tr>
<td>2</td>
<td>I feel that there are permanent changes in my appearance that make me look unattractive.</td>
</tr>
<tr>
<td>3</td>
<td>I believe that I look ugly.</td>
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**15.**

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<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>I can work about as well as before.</td>
</tr>
<tr>
<td>1</td>
<td>It takes an extra effort to get started at doing something.</td>
</tr>
<tr>
<td>2</td>
<td>I have to push myself very hard to do anything.</td>
</tr>
<tr>
<td>3</td>
<td>I can’t do any work at all.</td>
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</table>

**16.**

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<th>Score</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>I can sleep as well as usual.</td>
</tr>
<tr>
<td>1</td>
<td>I don’t sleep as well as I used to.</td>
</tr>
<tr>
<td>2</td>
<td>I wake up 1–2 hours earlier than usual and find it hard to get back to sleep.</td>
</tr>
<tr>
<td>3</td>
<td>I wake up several hours earlier than I used to and cannot get back to sleep.</td>
</tr>
</tbody>
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**17.**

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<thead>
<tr>
<th>Score</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>I don’t get more tired than usual.</td>
</tr>
<tr>
<td>1</td>
<td>I get tired more easily than I used to.</td>
</tr>
<tr>
<td>2</td>
<td>I get tired from doing almost anything.</td>
</tr>
<tr>
<td>3</td>
<td>I am too tired to do anything.</td>
</tr>
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</table>

**18.**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>My appetite is no worse than usual.</td>
</tr>
<tr>
<td>1</td>
<td>My appetite is not as good as it used to be.</td>
</tr>
<tr>
<td>2</td>
<td>My appetite is much worse now.</td>
</tr>
<tr>
<td>3</td>
<td>I have no appetite at all anymore.</td>
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</table>

**19.**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I haven’t lost much weight, if any, lately.</td>
</tr>
<tr>
<td>1</td>
<td>I have lost more than five pounds (2 kilos).</td>
</tr>
<tr>
<td>2</td>
<td>I have lost more than ten pounds (4.5 kilos).</td>
</tr>
<tr>
<td>3</td>
<td>I have lost more than fifteen pounds (6.8 kilos) trying to lose weight.</td>
</tr>
</tbody>
</table>

Score 0 if you have *been purposely trying to lose weight*. 

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**Making a difference**: Implementing person-centred practice to promote older people’s mental health and wellbeing
<table>
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<th></th>
<th>20.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I am no more worried about my health than usual.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>I am worried about my physical problems such as aches and pains or upset stomach.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I am very worried about physical problems and it’s hard to think of much else.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I am so worried about my physical problems that I cannot think about anything else.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>21.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I have not noticed any recent change in my interest in sex.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>I am less interested in sex.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I am much less interested in sex.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I have lost interest in sex completely.</td>
<td></td>
</tr>
</tbody>
</table>

Source: nsand.ca/media/forms/EHNMC-BeckDepressionInventory_DSM-IV.doc
GDS long form

<table>
<thead>
<tr>
<th>No</th>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are you basically satisfied with your life?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>2</td>
<td>Have you dropped many of your activities and interests?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>3</td>
<td>Do you feel that your life is empty?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>4</td>
<td>Do you often get bored?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>5</td>
<td>Are you hopeful about the future?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>6</td>
<td>Are you bothered by thoughts you can’t get out of your head?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>7</td>
<td>Are you in good spirits most of the time?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>8</td>
<td>Are you afraid that something bad is going to happen to you?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>9</td>
<td>Do you feel happy most of the time?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>10</td>
<td>Do you often feel helpless?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>11</td>
<td>Do you often get restless and fidgety?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>12</td>
<td>Do you prefer to stay at home, rather than going out and doing new things?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>13</td>
<td>Do you frequently worry about the future?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>14</td>
<td>Do you feel you have more problems with memory than most?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>15</td>
<td>Do you think it is wonderful to be alive now?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>16</td>
<td>Do you often feel downhearted and blue?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>17</td>
<td>Do you feel pretty worthless the way you are now?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>18</td>
<td>Do you worry a lot about the past?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>19</td>
<td>Do you find life very exciting?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>20</td>
<td>Is it hard for you to get started on new projects?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>21</td>
<td>Do you feel full of energy?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>22</td>
<td>Do you feel that your situation is hopeless</td>
<td>YES / NO</td>
</tr>
<tr>
<td>23</td>
<td>Do you think that most people are better off than you are?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>24</td>
<td>Do you frequently get upset over little things</td>
<td>YES / NO</td>
</tr>
<tr>
<td>25</td>
<td>Do you frequently feel like crying?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>26</td>
<td>Do you have trouble concentrating?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>27</td>
<td>Do you enjoy getting up in the morning</td>
<td>YES / NO</td>
</tr>
<tr>
<td>28</td>
<td>Do you prefer to avoid social gatherings</td>
<td>YES / NO</td>
</tr>
<tr>
<td>29</td>
<td>Is it easy for you to make decisions?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>30</td>
<td>Is your mind as clear as it used to be?</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>

Source: www.neurosciencecme.com/library/rating_scales/depression_geriatric_long.pdf
Enhancing the enrolled nurse’s role in care planning and person-centred practice to promote older people’s mental health and wellbeing
Introduction

In this chapter you will build on your knowledge and experience of care planning by examining the essential components of person-centred, strengths-based care plans. You will explore ways you can, within the scope of your role, lead your team in implementing a person-centred model of care and critically analyse three important areas of practice that contribute to your clients’ and residents’ health, wellbeing and independence. Throughout the chapter you will be encouraged to reflect on your role as an enrolled nurse and identify how you can promote positive outcomes for older people experiencing depression, anxiety or other mental health conditions.

This chapter explores the following topics:

1. Developing a person-centred, strengths-based care plan – a team effort
   - Your role as part of the care team
   - Purpose and structure of a care plan and its importance to client care
   - Components of a care plan
   - Supporting team evaluation of the care plan
   - Care plans as legal documents

2. Your role and practice – implementing person-centred care
   - Person-centred care – three important areas of practice
     - Highly effective communication
     - Working constructively with families
     - Culturally sensitive care
   - What does person-centred care look like?
   - Your leadership role – modelling person-centred practice

3. Highly effective communication
   - Elements of communication
   - Communication techniques to enhance your practice
   - Barriers to effective communication

4. Working constructively with families
   - Establishing positive partnerships with families
   - How we can respond to carer needs

5. Culturally sensitive care
   - Culturally appropriate communication
   - Culturally sensitive care is embedded in person-centred practice
As you work through this chapter you will be:

- gaining greater understanding of the accountability of enrolled nurses for care planning
- developing your knowledge and skills in care planning and care evaluation as part of a multidisciplinary team
- extending your range of communication skills to enable you to respond effectively to complex care situations and promote and plan person-centred care
- gaining insight into the needs of families and the importance of informing and supporting family carers to make decisions about care
- critically reviewing current literature on person-centred care to evaluate your organisation’s current policies and practices and contribute to evidence-based continuous improvement decisions
- developing the ability to translate ideas into action and to think creatively to achieve positive outcomes for your clients and residents.

Learning outcomes

Learning outcomes are important for you as the student. As you progress through the information and activities in this chapter, take a moment to record your knowledge and skills. These can also be used to show an employer and are often referred to as employability skills.

<table>
<thead>
<tr>
<th>Read each statement and record your ‘yes’ or ‘no’ response in the next column.</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can identify the common components of a care plan.</td>
<td></td>
</tr>
<tr>
<td>I can develop a strengths-based person-centred care plan in collaboration with the care team.</td>
<td></td>
</tr>
<tr>
<td>I am able to evaluate care outcomes and assist others to do so.</td>
<td></td>
</tr>
<tr>
<td>I have increased my understanding of the relevance of using the care plan effectively to guide care.</td>
<td></td>
</tr>
<tr>
<td>I can explain how a care plan can become a legal document.</td>
<td></td>
</tr>
<tr>
<td>I have increased my understanding of the principles and impacts of person-centred care.</td>
<td></td>
</tr>
<tr>
<td>I am able to, within the scope of my role, assist the care team to implement person-centred practice.</td>
<td></td>
</tr>
<tr>
<td>I can identify essential elements of effective communication about care planning with clients, staff and families.</td>
<td></td>
</tr>
<tr>
<td>I can select and use a range of communication strategies and techniques that are required in my workplace role and responsibilities.</td>
<td></td>
</tr>
<tr>
<td>I can provide support and guidance to families and carers.</td>
<td></td>
</tr>
<tr>
<td>I have increased my understanding of the relationship between culturally sensitive care and person-centred practice.</td>
<td></td>
</tr>
<tr>
<td>I am able to participate in research, contribute to the analysis and interpretation of results, and apply findings to promote quality living for clients and residents in my care.</td>
<td></td>
</tr>
</tbody>
</table>
Activities in this chapter

As you work through this chapter you will complete different types of activities such as critically analysing case studies, accessing and interpreting research data, applying knowledge and professional judgment, completing quizzes and answering questions that encourage you to reflect and apply skills in the workplace. Some of these activities will take place in class and some will be completed online. You will also have the opportunity to extend your learning by exchanging ideas and experiences with fellow students.

In-class activities

Your facilitator will lead you through each activity. You might like to keep a record of your progress using the table below.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Roles and responsibilities in care planning for clients with depression or anxiety – What happens in your organisation?</td>
<td>123</td>
</tr>
<tr>
<td>3.2 Case study: Identifying common components of a care plan – Harry’s story</td>
<td>126</td>
</tr>
<tr>
<td>3.3 Reading the client’s case history and writing problem statements</td>
<td>129</td>
</tr>
<tr>
<td>3.4 Identifying person-centred goals for your client, based on problem statements</td>
<td>130</td>
</tr>
<tr>
<td>3.5 Developing person-centred interventions as a team</td>
<td>131</td>
</tr>
<tr>
<td>3.6 Team evaluations of care plans</td>
<td>136</td>
</tr>
<tr>
<td>3.7 Charting the changes on the continuum to a person-centred model of care</td>
<td>142</td>
</tr>
<tr>
<td>3.8 Analysing person-centred care: two case studies</td>
<td>145</td>
</tr>
<tr>
<td>3.9 Looking through a daughter’s eyes</td>
<td>159</td>
</tr>
<tr>
<td>3.10 Identifying supportive responses to carer needs</td>
<td>162</td>
</tr>
<tr>
<td>3.11 Case study: An holistic approach to client care – person-centred practices that work at Samarinda Lodge</td>
<td>165</td>
</tr>
<tr>
<td>3.12 Implementing person-centred practice: identifying and responding to the needs of older people from CALD backgrounds – four case studies</td>
<td>168</td>
</tr>
</tbody>
</table>
Online components in this chapter

There are several ways to participate in the online components of this chapter.

1. Worksheets

The online tasks in this chapter are designed to build on the concepts you learn in-class and further develop your understanding of depression and anxiety in older people. These online tasks will be provided as worksheets that you need to complete. You will see references to these online worksheets in your student workbook. As with your in-class program, your facilitator will guide you through each task and provide feedback on your responses.

2. Online discussion forums

There are several opportunities throughout the chapter where your facilitator may choose to further explore topics by establishing an online discussion forum with members of your group. These forums may be part of a worksheet and are designed to help you engage in the online environment by sharing your ideas and experiences. Your facilitator will lead you through these forums.

3. Online reading

Another way you can learn more about the topics covered in this chapter is by accessing relevant information sheets online. Links to these publications are included in your workbook. You may wish to discuss your reading with other members of your online group.
Getting started...

Online pre-reading for this chapter

To enable you to fully understand some of the concepts presented in this chapter, we suggest you undertake the following online pre-reading.

<table>
<thead>
<tr>
<th>Title</th>
<th>Related to...</th>
</tr>
</thead>
</table>

This chapter has five steps. When you have completed them, you are encouraged to reflect on your learning.

**STEP 1**

In this step you will learn about your role, as part of the care team, in developing a person-centred, strengths-based care plan.

*Complete in-class activities and online tasks.*

**STEP 2**

In this step you will analyse the purpose and elements of a care plan as well as its importance to client care.

*Complete in-class activities and online tasks.*

**STEP 3**

You will then consider how, as a team, the care plan can be evaluated to determine its effectiveness in meeting client outcomes and the quality and appropriateness of the care delivered by the team.

*Complete in-class activities.*

**STEP 4**

In this step you will explore how care plans can become a legal document.

*Complete in-class activities and online tasks.*

**STEP 5**

In this final step you will focus on skills and strategies to enable you, within the scope of your role, to lead a team in implementing person-centred care to promote the mental health and wellbeing of clients and residents.

*Complete in-class activities and online tasks.*

**LEARNING REFLECTIONS**

In learning reflections you have the opportunity to complete a short online quiz.

**FINAL REFLECTIONS**

In final reflections you are encouraged to reflect on your learning experience and then participate in online activities.
STEP 1 DEVELOPING A PERSON-CENTRED, STRENGTHS-BASED CARE PLAN – A TEAM EFFORT

Our role as enrolled nurses – whether in community or residential care – is complex:

1. Advocate for, and facilitate the involvement of, individuals, their families and significant others, including care staff, in planning and evaluating care and progress made toward health outcomes or goals.

2. Contribute to the planning of person-centred care to promote health, wellbeing and independence.

3. Communicate the client’s and resident’s responses to care clearly and accurately in case and progress notes.

4. Evaluate the outcomes of care and be responsible for seeking assistance by reporting and referring to, or liaising with, other health care providers (such as the RN or medical practitioner) when the client’s and resident’s needs or goals are not met.

5. Maintain the confidentiality of care records.

6. Communicate the content of the care plan and explain care provision, within the nurse’s scope of practice, to clients and residents, families and staff.

7. Where the existing client or resident care plan or care provision is not understood, or is outside the nurse’s and/or the organisation’s scope of practice, to report or refer to the supervisor or the interdisciplinary care team.

While one person may write up the care plan, developing one is a team effort. The composition of the team will depend on the context of care. The team will be composed of direct care staff and any other people involved in care provision. The client or their representative also should be considered part of the team and included in care planning, goal-setting and in developing relevant, person-centred interventions.

Sometimes, clients are frail-aged or have a cognitive impairment that will prevent them from participating directly in the team. In this case it is important to learn as much as possible about them from their significant others.

Who has information about a client?

If a client cannot participate, families, staff and others will all hold different pieces of information about that client. For example:

- Family and direct care workers are likely to have a lot of information that is not documented about the person’s culture and life story, their personal preferences and their goals.
- The GP, RN and EN will know about the client’s health, treatments and responses to care.
- Physiotherapists, occupational therapists and lifestyle personnel will all be able to tell us something different about people they know and work with, their preferences and strengths as well as their problems.
Putting the pieces of the puzzle together

These bits of information we all possess about our clients are like pieces of a jigsaw puzzle which, when put together, can provide us with the big picture – one that puts the client at the centre of the picture and our thinking. It is the role of the nurse to encourage all team members to contribute to an assessment and then to participate in analysing the data that is collected, identifying issues for the client but, importantly, also client strengths and preferences.

This analysis of what we know can enable us to look with empathy at the world through the eyes of the client, allowing us to be person-centred even when the person themselves may not be able to directly contribute to their care plan. It requires us to think critically about the impact on the client of that world in combination with their health issues. We then work with the client or their significant others to identify and meet their needs.

Identifying personal strengths and preferences is of particular value. We will encourage the client or resident to use these to overcome their difficulties. For example, knowing whether a person is an extrovert or introvert can help us to make use of that preference in establishing person-centred goals. Knowing that they have always enjoyed music and are strongly spiritual can give us ideas about how to tailor psychosocial interventions to those strengths and abilities to help them overcome their issues and problems.
Activity 3.1  Roles and responsibilities in care planning for clients with depression or anxiety – What happens in your organisation?

This activity has four parts.

Part A

Investigate and record

Reflect on the different roles and responsibilities of staff members in the care team and the different pieces of information they are likely to have about clients. Please write your responses in the relevant spaces below.

<table>
<thead>
<tr>
<th>Member of care team</th>
<th>Role and responsibility</th>
<th>What information about the client will each team member be likely to know?</th>
</tr>
</thead>
</table>
Part B

Apply knowledge to practice

How might you include the family, client or resident, and relevant staff members in the process of planning care?


Part C

Think critically

Identify what may stop the family from taking part in care planning or communicating what they know about the story, preferences and issues for their family member.


Part D

Think creatively

In this part, you have the opportunity to make recommendations for improvement. Please identify two changes to policy or procedures that would ensure all staff – and clients’ families – are included in the care planning process.

1. 

2.
STEP 2 THE PURPOSE AND STRUCTURE OF A CARE PLAN

The care plan is a document that identifies what the care team will set out to achieve with, or for, the client and resident, how it will be achieved, by whom, and how and by when we will be able to identify success or failure.

Once we have explored or assessed the person’s preferences, needs, strengths and clearly identified the problems as a team, we can decide on strategies that help promote health and minimise the impact of illness. This is care planning. The client or resident is always considered part of the team and we must be proactive in including them in planning where possible.

Care plans are developed by a variety of multidisciplinary and interdisciplinary health care teams and plans can have a variety of names in different contexts and work environments.

They may be called ‘service delivery plans’, ‘action plans’, ‘care coordination plans’, ‘lifestyle plans’, ‘management plans’, ‘treatment plans’, ‘nursing care plans’ or ‘support plans’. They will come in various formats, from tabular, to computer-driven, to freehand.

Components of a care plan

A care plan, however termed, must contain:

- a statement of the problem
- a goal or expected outcome for the client
- a plan of action that will enable the team to achieve the goal
- evaluation criteria, or a requirement for some form of evidence, that can prove that the goal has been met or is being worked towards.
Activity 3.2  Case study: Identifying common components of a care plan – Harry’s story

Analyse and interpret

Imagine Harry is one of your clients (either in a residential or community care setting). Your multidisciplinary care team members are working together to develop a care plan for Harry.

As you work through the activity you will:

- apply the steps of care planning
- explore how they are developed for an individual client.

To begin, read Harry’s story below, keeping in mind what you have learned about the components of a care plan. We suggest you highlight key points to discuss with your group, and to guide your responses to the next activity.

**Team assessment**

Harry is described as an extrovert who has mild depression and anxiety related to the death of his close friend and life companion, Joan. He states he is coping on a day-to-day basis but is unable to manage some of the social situations which he routinely shared with Joan – such as going to church and the bowling club. When he attends he is reminded vividly of his loss and becomes very anxious and restless and wants to leave. As an extrovert he will generally benefit from social interactions but is beginning to avoid going out and is withdrawing from friends and family, becoming isolated, in order to avoid distress.

**The problem**

Harry’s withdrawal is caused by grief and aggravated by a reminder of his loss when attending social events. If his need for support in social situations is not managed, his grief may be compounded by social isolation.

**The goal**

Harry will again find pleasure in social activities and re-establish social connections.

**The action plan**

Harry will be accompanied to social events by a person he trusts, either a staff member that he knows well, such as the lifestyle coordinator or a volunteer. They will acknowledge his difficulty and provide moral support and encouragement, or assistance to withdraw if necessary. It is hoped that this may give him the confidence to allow him to continue to engage in, and learn to enjoy again, his normal social interactions as well as give his friends an opportunity to support him and monitor his wellbeing.

**The evaluation**

We observe that the client is attending more social events and is initiating interaction with others. He reports that he is coping better and feels sad less often.
Reflect and discuss

In pairs or small groups, discuss Harry’s case study.

Make note of how the assessment data underpins, and is summarised by, the problem statement and discuss whether Harry’s withdrawal could have been caused by anything other than grief and loss.

Can you suggest any other actions that should be included in the plan that would help Harry find pleasure in social activities?

Is there any further information you would need before the team developed a plan?

Care plans – short-term or long-term

Care plans can be short or long-term. A short-term plan will include a date by which the goal is expected to be met and a long-term plan will include a date for a review of the progress being made towards the goal. Whether short or long-term, the care plan is a working document that ‘lives and breathes’.

In most cases plans are formally reviewed monthly or quarterly, but the care team will need to maintain an ongoing awareness and record of the client’s response to their care so assistance can be provided if another problem arises or if the care plan is not working.

Apply knowledge to practice

Please take some time to reflect on what you have learned about the steps of care planning.

Now consider the various components of a care plan, how they are developed for clients within your service and who is involved. Describe two changes that could enhance any component of the care planning process in your organisation.

1. 

2.
Action learning – Developing a care plan for James

In Step 1 we looked at the common components of a care plan. Now you will work through each component of the planning process to achieve a person-centred, strengths-based care plan for a particular client.

You will be completing a number of different activities as you develop your care plan for James, so we have provided a template for you to insert details into as you work through the care plan activities.

Turn to the care plan template on page 172 to record details for James.

Component 1 The problem statement

The problem statement is a summary of the observations and/or assessment of the client. If we do not correctly identify and target the problem, the care plan will not be helpful or effective.

The importance of asking ‘why’

Too often we will identify only what is observable as the problem – for example, withdrawal from social interactions or disturbed sleep. But if we ask why we are seeing this, we may find that the real problem is the cause behind the withdrawal or disturbed sleep. It may be that the person is withdrawing because they are missing a companion who passed away, or because they had to give up their driver’s licence and lost their means of transport – that is the heart of the problem.

The heart of the problem might be difficult to observe, but the flow-on effects of the problem are more visible. Finding the underlying cause is important to defining the problem accurately.

If your documentation templates at work do not allow you to relate what you have observed to a probable underlying cause as a complete sentence then make sure the probable cause is what you document as the problem. For example, withdrawal or aggression should never be cited as problems because these are most likely to be simply symptoms of, or an attempt to communicate, distress.

However, the care plan that should say: ‘Withdrawal, related to loneliness and grief’ may sometimes be shortened to simply ‘grief about partner’s death’. ‘Withdrawal, related to loss of independent transport’ may just be stated as ‘loss of independent transport’.

Nonetheless, we should always have in our mind the symptoms we have noted of withdrawal or aggression in our assessment, because these are what we want to stop or change.

One way to think about it is this: If the person was asked what the problem is, they will rarely say “I am withdrawn”, or “I am aggressive”. They are more likely to tell you the underlying reason that is causing them to withdraw or become aggressive.

Having identified the cause of the problem we can be specific and person-focused with our goals and actions which will be very different in each case. In the first instance we will try to help the person cope with their loneliness and grief using psychosocial interactions; in the second we will find alternative means of transportation.
Activity 3.3  Reading the client’s case history and writing problem statements

This activity has two parts.

Part A

Analyse and interpret

Please take time to read about James.

James is 75. He was a career soldier and Vietnam Veteran. He retired from the Army in 1981. In 1980 he began to experience flashbacks of his experiences in Vietnam as well as disturbed sleep and aggression, which disrupted family relationships. At that time, he felt his post-traumatic stress disorder (PTSD) was manageable and he took on a job as a car salesman before retiring completely in 1990.

Whilst in the Army, James had frequent postings around Australia and he still talks about the places he went and the people he met with great pleasure. He has lots of photographs around his home. He has an interest in cars and gardening. He was a full-time carer for his wife (who had Alzheimer’s disease) before she died at home 18 months ago.

James had an active social life before becoming a carer and now has little contact with friends. He appears to want to chat when his home carer and care manager visit, but seems to have no one else to talk to about his wife and his grief. He has one son who lives interstate and phones regularly, but the son states they “were never close”.

James has rheumatoid arthritis which has severely affected his mobility; he receives help with his personal care and with housework. His GP diagnosed him with depression six months ago and prescribed medication which James says is helping.

However, he recently began to complain about lack of sleep and has been drinking more than the recommended daily intake of alcohol. James has become increasingly irritable with his home care worker who has asked to be reassigned. Last week, a neighbour complained to James that he had his TV on too loud. James lost his temper, swore and hit out at the man. The police were called, primarily because the neighbour was concerned about James’ state of mind and safety. The police found that James was under the influence of alcohol.

Part B

Apply knowledge to practice

We suggest you work in pairs or small groups to complete this part.

Q1) Discuss the key points you identified in James’ story, then summarise the issues as problem statements. Make sure that each statement contains an issue linked to the probable cause.
Component 2  The goal

**Goals are the end results that we are working towards. Goals need to have a time frame attached to them for either completion or re-evaluation.**

*Team goals in care planning are clear, achievable and measurable.*

Research tells us that we work better individually, and as team, if we have clear, achievable, measurable and common goals. In the earlier example of withdrawal as an outcome of either grief or loss of independent transport, what we have observed or assessed as happening is ‘withdrawal’. Our goal would be to change that to promote or create what are reasonably normal levels of socialisation acceptable to that person. Our plan for achieving our goals is to target the causes of the problem with actions or interventions that will prevent or manage them.

**A person-centred approach to goal setting**

Our goals must reflect a person-centred approach to care. They must be the client’s goals – not our goals, or the organisation’s goals.

For example, to gain compliance with care strategies will be a staff goal, and an organisational goal may be to demonstrate engagement in the group activities that are provided.

The client’s goal, on the other hand, may be to enjoy going out and participating in social activities. Therefore, the goal may be stated as “client attended agreed activities and stated he enjoyed them”.

**Activity 3.4  Identifying person-centred goals for your client, based on problem statements**

We suggest you continue to work with your partner or in your group to complete this activity.

**Q1)** Review the problem statements you wrote for James. Now consider an appropriate goal for James, based on one of your problem statements.

**Q2)** To record your goals for James, turn to page 172 and fill in the appropriate space.
Component 3  Action plan

The action plan comprises the interventions and the actions we use, as a team, to either prevent or manage the underlying causes of the problem.

Using verbs in action planning

A care plan is a document that directs staff to provide care in the way that will best help the person and prevent staff making individual choices about care that, in the best case, may not be well thought out or appropriate and, in the worst case, may cause harm. For this reason we need to use directive language and strong statements, using verbs such as ‘refer’, ‘provide’, ‘engage’, ‘give’ or ‘observe’

Using evidence to support action planning

Interventions should be evidence-based; they are actions that we know from evidence are worthwhile for managing the causes of our client’s specific problems.

Evidence can come from the research literature or recommendations from peak bodies and organisations such as beyondblue. Evidence may also come from a client’s case or progress notes, as the team tries strategies and records how they are working.

Activity 3.5  Developing person-centred interventions as a team

This activity has two parts.

Part A

Think critically

We suggest you continue to work with your partner or in your group to complete this activity.

Q1) Review the problem statements and the goal you identified for James. Now consider some interventions for James aimed at preventing or managing the cause of his problem. Remember to use ‘action’ words or verbs.

<table>
<thead>
<tr>
<th>What is observed?</th>
<th>What is the probable underlying cause/s?</th>
<th>What are the goals for James?</th>
<th>What interventions will be used to manage the underlying cause and achieve goals?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part B

Q2) To record your interventions for James, turn to page 172 and fill in the appropriate space.
Component 4  Evaluation

*We need to be able to provide evidence that the actions documented in the care plan are making a positive difference, that by using them we are progressing towards our client’s goals.*

It is not good enough to simply sign off on the plan intermittently – we need to ask ourselves:

- “How do we know we are doing good, not harm?”
- “What evidence could we provide to someone who asked that question?”
STEP 3 SUPPORTING TEAM EVALUATION OF THE CARE PLAN

The term ‘evaluation’ refers to measuring the worth or merits of something – in this case our care plan and, therefore, our care provision.

Do you recall the important elements of team goals in care planning?

✔ Clear
✔ Achievable
✔ Measurable

Measuring progress towards our client’s goals

We measure the worth or merit of the plan by reviewing and measuring our progression towards (or achievement of) the client goals we have set.

This process needs to be a team process and it needs to be ongoing.

Informing the team of the importance of evaluation and assisting them to record and report their observations is an important, but sometimes neglected, part of nursing. If we find we have not succeeded or progressed towards the client’s goals, we need to go back and review the plan, or reassess the client.

The methods for evaluation are the same as those you have covered in assessment: use of formal assessment tools combined with observation and interview of the client and significant others. In assessment you are trying to establish the client’s issues; in your evaluation you are trying to see if either the changes you expected or predicted as goals have occurred, or the client has improved and remains stable.

Gathering evidence over time

The observations of one team member are not strong enough evidence to prove that we have either achieved, or not achieved, our goals. We need all the team to be engaged in observing and reporting on how that client is responding to the care provided over time, as we expect the client to have good days and not-so-good days.

The team needs to understand the importance of the evidence their documentation provides, and we need to be aware that they may not document all they know. We should regularly give team members an opportunity to talk about their experiences of care in order to capture all they know.

As enrolled nurses we may be ultimately responsible for acting on the information they give us and we need to know it is accurate.

Team members will be better able to evaluate care outcomes if they are given the clear evaluation criteria or goals to work with from the care plan. For example, a vague instruction to report any change to mood is likely to be overlooked if change happens slowly over time or is erratic.

If a team member is told that the goal is that this person ‘initiates conversation on contact’ or ‘does not express a desire to die’ then they must report the exceptions, i.e. that the person is no longer interacting with carers or that they have stated they wish to die.

Privacy and confidentiality of data

As our evaluation will sometimes consist of the collection of data relating to our client’s interactions with other people, whether they are staff, families or friends or other residents, privacy can become an issue.
The laws about privacy and confidentiality of data relating to health care can vary from state to state and it is recommended to check your state government websites for more information.

However, what all states have in common is that we can document information about individuals other than our clients, without their consent, if the information is necessary to provide a health service to our clients and the information is collected:

- as required or authorised by or under law; or
- in accordance with rules established by competent health or medical bodies that deal with obligations of professional confidentiality which bind the organisation.

This simply means that we are obliged to document as accurately and objectively as possible what we know about the client and their relationships to others if it impacts on the care we are providing.

The key words are to ‘collect and document’ ‘relevant’ data.

The organisations we work for then have an obligation to make sure that the protocols and templates we use are within the law and that the information we collect is protected and remains available only to those involved in providing the care or service.

Please consider this example

We have observed that Mrs Brown – who has dementia and suffers from paranoia – begins to shout at Mr Jones whenever she sees him at her table “…get that bastard out of here. Help, help!”

We could simply write that Mrs Brown was verbally abusive to another resident but that information would not necessarily help staff to help her. We need to document what happened, quoting her words accurately as they tell exactly how she feels, and name Mr Jones because his presence is a risk to her health and wellbeing.

Having provided the evidence for our opinion we can then summarise that opinion by saying that Mrs Brown’s anxiety appears to be made worse by proximity to Mr Jones. Conversely, a statement that Mrs Brown appears to be made anxious by Mr Jones could, by itself, be labelled as subjective and possibly judgmental.

We need to present both the facts and our conclusion to be accurate and objective and at a diploma level of thinking it is expected that we report the facts accurately and objectively; then we draw conclusions from those facts in our assessment or evaluation and document that thinking.
Remember the medication chart

As an enrolled nurse we must remember that the medication chart is also a care plan.

We need to be observing behavioural changes in the person or any signs of the effects and side-effects of medications, especially the prn medications we are responsible for giving, or if there has been a recent change in medication.

In most cases, changes to medications for depression or anxiety may need three to six weeks to become fully effective.

Assisting the team to document exceptions to the plan

Exceptions that we report could be:

- failures of the strategies in the care plan
- strategies that are not in the plan but which have been trialled and documented over time in the progress or case notes and which are working well for the client.

*If an intervention is used and found not to work, that is an exception.*

If the team tries something that is not in the plan but which works, or does not work, both are exceptions from normal practices and both the intervention and the outcomes need to be reported.

Other exceptions could be:

- if the client (or significant others) tells us something or requests something that is not documented elsewhere
- if we see something happen which is not part of the ‘normal’ routine of the day, such as the client really enjoying something or having a disagreement with someone.

The idea of documenting ‘by exception’ is that if you have a care plan it should have identified the problem – for example, lowered mood related to a particular cause such as loneliness or grief; the cause of the problem is managed by interventions and the goal or outcome will be that there is evidence that ‘mood is stable or improved’.

If everything is going according to plan, care staff should be seeing evidence of improved mood on a daily basis and there will be no need to record that because you are acting in accordance with the care plan.

What you do not see...

If, however, you do not see evidence of stable or improved mood when this is our goal then this is an exception, and it may mean:

- the interventions are not working any more
- the cause of the problem has been incorrectly identified and, consequently, the wrong interventions are being applied

or

- the goal is no longer realistic and achievable (for example, medication needs to be reviewed).

If such reports appear in the progress notes the next step will be an investigation with a reassessment.

There are many exceptions in our day-to-day lives which may have potential importance and it is better to focus on them rather than record the same story or events, such as ‘showered today, dressing attended’ when it’s all been documented in the care plan.
This is a critical part of our ongoing evaluation of the plan and evidence of our response to the changing needs of our client as well as evidence of our general quality management of care.

**Activity 3.6  Team evaluation of care plans**

Q1) *Record what evidence or evaluation criteria you will use to show you are achieving your goal for James. Turn to page 172 and fill in the appropriate space.*

Q2) *Record how you can help the team to collect the evidence:*
- tools you will use
- directions you may give the team about what to look for
- questions you will ask them and James.

Q3) *What documenting of exceptions would you expect to see by the team that will show whether the plan is working or not?*
STEP 4 CARE PLANS AS LEGAL DOCUMENTS

To protect yourself, make sure you know what is in the care plan!

Care plans can be used in legal situations such as coroner’s cases, civil suits and when staff competency is challenged.

Protecting ourselves and providing evidence of quality care

If we are involved in a coroner’s case or civil suit and found to have contributed to harm by not acting in accordance with the plan, or reporting concerns about the plan if it is inappropriate, the consequences may be a review of our right to practice by the Australian Nursing and Midwifery Council.

For an enrolled nurse, ignorance of the care plan or not having enough time to read it, is no defence.

Nurses also have a responsibility to make sure personal care workers know what is in the care plan and are working with the care plan or collecting evidence that may lead to a change in the care plan if the existing plan is not working.

Care plans as evidence of quality of care

Care plans will be referred to when an organisation’s or individual staff member’s competence is in question or if there is a formal complaint against the organisation by the client or the client’s family. Care plans need to be kept for at least three years – in some states seven years – after the death or discharge of a client.

Incomplete information circulated to staff

In both community and residential settings, direct care staff members are often given a handover sheet or abbreviated care plan from which to work.

There is a risk associated with this practice as the handover sheets or abbreviated care plans may not be truly representative of the full care plan when both are compared. To protect ourselves we need to know what is in the full care plan, even if a handover sheet is used, especially if we are a team leader on a shift.

Challenging the care plan

As members of the care team we have a responsibility to challenge the plan if we believe it is not working for the client or is putting staff at risk. WorkSafe Victoria* states that:

“All workers have a duty of care to ensure that they work in a manner that is not harmful to their own health and safety and the health and safety of others”.

If you are not complying with the formal care plan then full compensation may be difficult to obtain if you are injured.

Risk management in care planning

If the care plan is not working, it needs to be formally evaluated or changed, especially if strategies from the plan are putting you or the client at risk, or there has been a ‘near miss’.

The health status of frail-aged clients may change rapidly or slowly over time. Therefore strategies that have worked in the past may no longer be appropriate and may create a risk for the client, other clients and workers.

*Please note that workplace safety laws and legislations have local jurisdictions but are similar in nature in each state or territory.
Please consider this example

If a client’s or resident’s dementia advances over time, the recommended psychosocial intervention may eventually become too difficult for the client or resident to accommodate. For example you may have been giving the person a variety of choices of clothing to wear, but choice has become difficult and may annoy the client, provoking their anxiety and aggression towards staff.

What do you think would be the enrolled nurse’s responsibility in this particular case?

Several things need to be considered; this intervention, as dictated by the care plan, is no longer effective. The exception needs to be reported, the resident or client reassessed and the care plan evaluated and updated to reflect this change.

WORKSHEET 26 – Critique the quality of a care plan

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
STEP 5 YOUR ROLE AND PRACTICE: IMPLEMENTING PERSON-CENTRED CARE TO MAKE A DIFFERENCE

In this step we will focus on how you can, within the scope of your role, lead your team in implementing the principles of person-centred care.

To enable this you will critically analyse three important areas of practice that underpin a person-centred approach as represented in the following diagram:

![Diagram of person-centred care](image)

You will have a significant and positive impact on the quality of life of the clients and residents in your care and be recognised as a leader within your care team and aged care service when you develop knowledge and skills in these aspects of your role.

In this section we will identify essential features of person-centred care and examine the potential benefits of it to staff and clients, and the issues involved in applying the approach to your role and practice. We will also investigate ways you can, as a team leader, introduce some of the enabling principles of person-centred care within a multidisciplinary care team.

Let us begin with a key question:
What does person-centred care look like?

Edvardsson and colleagues identified the features of a person-centred service and concluded that person-centred care needed to:

- acknowledge the individual as a person ‘experiencing’ life
- offer and respect clients’ and residents’ choices
- know and understand the person’s history/biography and its impact on their care
- focus on abilities rather than disabilities
- have a positive regard for the resident or client
- understand that all behaviour has meaning
- maximise each client’s and resident’s potential
- share the decision making with the client and resident, and their family
- support clients’ and residents’ rights, values and beliefs

Please reflect on the following statement (previously included at the beginning of the chapter). It focuses on one of the critical aspects of your role and places person-centred care in context:

… Advocate for, and facilitate the involvement of, clients and residents, their families and significant others, including care staff, in planning and evaluating care, and progress made toward health outcomes or goals.

Person-centred care – principles and practice

Person-centred care principles shape best care practices. Person-centred care means knowing each client and resident as an individual, appreciating what makes them unique, and understanding what is important to them. It means delivering care that puts the person first and is meaningful to the person, not to a group or a collective sharing the same environment.

Beyond the individual – the organisational framework for person-centred practice

Although the impact of the individual on a client’s experience and outcomes of care can be significant, a recurrent theme in literature about person-centred care is that the team caring for residents’ and clients’ needs to be equally valued and respected.

In aiming for a person-centred model of care we need to remember that one staff member alone cannot implement change – it needs a team. We also need to be aware that unless the organisation’s leaders are supportive and person-centred – to both staff and clients – the team will not be able to function.

The aged care service is responsible for creating the systems, policies and protocols that support person-centred care in practice. For example, shared decision making involves establishing processes and systems to ensure that this can happen. It may include family meetings, structured staff development such as in-service, staff empowerment and continuous improvement strategies. Your policies and procedure manual will contain information about how your organisation works with residents or clients and their families.

Despite the research findings and our professional experience, translating the concept of person-centred care into tangible actions, can be difficult to pin down. Sometimes it is easier to identify what is person-centred care is not.

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23 Alzheimer’s Australia. (2007). Quality Dementia Care: Practice in Residential Aged Care Facilities for all Staff. p. 4.
Comparing old and new care models

Historically, aged care services did not provide person-centred care; models of care were more like doctor-led care with aged care services being run like mini hospitals.

Residential aged care facilities have been viewed as places of long-term treatment and therapy dominated by a biomedical model that values efficiency, consistency and hierarchical decision-making.24

The situation now is that most aged care services do not encompass all the principles of person-centred care, nor are they solely based on the old system; rather they fall somewhere in between. Most services, however, will be actively working towards a person-centred model of care.

If we think of the transition from the old to the new system as a continuum, it could look something like this.

![Diagram comparing old and new care models](image)

<table>
<thead>
<tr>
<th>Old system</th>
<th>Person-centred care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client or resident is expected to be compliant with care or treatments prescribed for their own good</td>
<td>Client or resident choices are at the centre of the team’s thinking about care provision</td>
</tr>
<tr>
<td>Doctor-led medical model focusing on the disease process or condition</td>
<td>A team approach is used and the team includes the client or resident or their representative</td>
</tr>
<tr>
<td>When errors occur the individual staff member is blamed</td>
<td>When errors in care occur, rather than blame, questions are asked to understand why, so that the team can do better</td>
</tr>
<tr>
<td>Staff are just expected to do as they are told</td>
<td>Staff are listened to, feel safe to speak up about care provision if they think it needs changing, and are supported to change things when necessary</td>
</tr>
</tbody>
</table>

**Activity 3.7**  Charting the changes on the continuum to a person-centred model of care

This activity has two parts.

**Part A**

Reflect and discuss

Working in pairs or small groups, use your knowledge and professional experience to record your ideas of the old and new systems under the following headings. We have provided an example to get you started.

<table>
<thead>
<tr>
<th>Looks like an institution</th>
<th>Environment</th>
<th>Looks like a person's home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse's role and empowerment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication processes between staff, management, residents and families</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family involvement</td>
<td></td>
</tr>
</tbody>
</table>

*Making a difference: Implementing person-centred practice to promote older people’s mental health and wellbeing*
Part B

Think critically

Think about the aged care service you work in and suggest where it might be on the continuum to person-centred care. Provide five examples that support your choice.

1. ___________________________________________________________
2. ___________________________________________________________
3. ___________________________________________________________
4. ___________________________________________________________
5. ___________________________________________________________

Reflect and discuss

Share your analysis of where your aged care service is located on the continuum with your partner or group members.

Did you learn some additional person-centred care practices from fellow students? If so, we encourage you to make notes for future reference.

Why focus on person-centred care?

The reason we focus on person-centred care is because it is effective and contributes to best care practice.

It is difficult to quantify the benefits and impact of person-centred practice as it is not one single intervention with one outcome which can be easily researched. In their recent study, Brownie and Nancarrow (2013) “...found that person-centred culture change interventions are not homogenous or single-element interventions. Instead, they incorporate several features including:

• Environmental enhancement (e.g. plants and animals)
• Opportunities for social stimulation and fulfilling relationships (visits by children and increased interaction with other residents and staff)
• Continuity of resident care by assigning residents to the same care staff
Changes in management and leadership approaches (often devolved) with the introduction of democratised approaches to decision-making that involve residents and staff.

Changes to staffing models focused on staff empowerment.

Individualised (rather than institutionalised) humanistic philosophy of care.  

Person-centred practice can range from an articulated framework incorporating all the above features such as the Eden Alternative, through to facility-specific interventions that focus on one or two features such as changes in management and leadership or continuity of resident care.

There has been significant research into person-centred care with some of the positive outcomes being shown to include:

- improved client and resident wellbeing
- improved staff engagement and confidence
- improved social interactions among residents
- increased communication between staff and residents.

We can conclude that there are improved outcomes for clients and residents, their families and for staff by providing a person-centred approach to care practice.

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Activity 3.8 Analysing person-centred care: two case studies

This activity has four parts. Parts A and B relate to the first case study; Parts C and D apply to the second study.

Part A

Analyse and interpret

What person-centred care is not – analysing a practice example

Below is a case study of George Smythe who is a resident of Tall Trees aged care service. In this first example, your aim is to detect what is not person-centred in the care being provided by Helen, his enrolled nurse.

Background

Helen, the enrolled nurse, is providing an orientation for care worker, Judy, a new member of the team in their residential facility. Before Helen introduces Judy to the residents, she provides a history of each client including Mr Smythe. This is how Helen introduces Mr Smythe:

“Georgie is one of the dementias and he’s also got depression, diabetes and arthritis. He is really hard to get going in the morning and is resistive to assistance with his hygiene, his care plan says to prompt him but it’s easier for him if you shower him.

He is a falls risk and needs constant reminding about using his frame when he mobilises, sometimes I put him in the wheelchair to take him down to the day room – it’s kinder really than having him struggle and fall.

He is inclined to become verbally aggressive with staff. He has not hit anyone yet but he waves his fists so be careful and document it – we want to keep a record of his difficult behaviour for ACFI. His family say he was never violent but they don’t understand that things change.

You will find in each resident’s room there are memory boards with photos of them when they were younger, but most of them don’t even know who is in the photos – mind you most of them can’t see them clearly! I have gotten into some arguments with Georgie insisting that it is him!! Silly duffer, he really is past it so I wouldn’t waste your time using it. So let’s meet Georgie.”
Record of Helen’s interaction with Mr Smythe

Helen enters Mr Smythe’s room: ‘Hi Georgie – remember me?’

Mr Smythe – (looks at Helen for some time) – ‘No, never met you.’

Helen – ‘Oh you are a duffer (teasing), you met me when you first came to Tall Trees.’

Mr Smythe – (getting angry) ‘I already told you I don’t know you.’

Helen – ‘Well it doesn’t matter if you don’t remember me, I am just showing Judy around (waves to Judy). Judy is going to come back later and shower you.’

Mr Smythe – just looks confused at both Helen and Judy. He starts to get out of bed and tries to go out to the shower.

Helen – (putting George’s leg back in the bed) ‘No, not now. Judy will come back later. You will just end up hurting yourself – you will have to wait till Judy comes back later for your shower.’

Mr Smythe – (getting angrier) ‘I don’t need your’s … or her help. I will have my shower.’

Part B

Apply knowledge and professional judgment

Review this vignette and identify examples of Helen’s care that is not person-centred. Explain why you have chosen each example.

Now consider the following questions. Support your responses with examples from the case study.

Q1) What impact did Helen’s communication and approach have on Mr Smythe?

Q2) What impact could Helen’s approach have on Judy, the new member of the care team?
Think critically

Person-centred care practice: a comparative analysis

In this part of the activity we present Mr Smythe’s case study from a very different perspective. As you read, identify how Helen, the enrolled nurse, is providing person-centred care in her practice. Make notes or highlight examples.

Background

Helen, an enrolled nurse, is providing an orientation to Judy, a new care worker at their residential facility. Before Helen introduces Judy to the residents, she provides an introduction to each resident (away from the resident’s room). This is how Helen introduces Mr Smythe:

“George Smythe is an 82 year old gentleman who has vascular dementia, depression diabetes and arthritis. His gait and balance are slightly impaired but he is able to mobilise independently if he uses his wheelie frame. He can be forgetful due to his dementia but is fine with a visual prompt. If you show him the frame he will use it, and if you set up the bathroom and give him the odd verbal prompt as well as asking his permission to wash his back and legs he can manage and accept assistance.

Remember his low mood can make him a bit resistive to social interaction sometimes and to having his shower first thing in the morning. If this happens leave him, give him time and try again.

Let me know if he complains of pain or seems short-tempered as his arthritis flares up from time to time; I will give him some pain relief. We can also use heat packs which have been approved for use on his lower back by the physio.

You will find in each resident’s room there are memory boards which are a great way to get to know each resident. My Smythe’s board includes photos of him as a younger man, when he was a farmer (he used to like to get up early and have his shower), with his large extended family and his interests and hobbies which included fly fishing. He enjoys reminiscing over these pictures as well. So let’s meet Mr Smythe.”
Record of Helen's interaction with Mr Smythe

Helen knocks – ‘Good morning Mr Smythe, its Helen the nurse. How are you this morning?’

Mr Smythe – (looks at Helen for some time) – ‘Oh the same.’

Helen – ‘Mr Smythe I would like to introduce you to Judy, she is new here at Tall Trees and we are working together today.’

Mr Smythe nods.

Helen – ‘I was just telling Judy about your large family.’

Mr Smythe – ‘Yep... four boys and four girls,’ he says proudly.

Helen – ‘And grandchildren?’

Mr Smythe – ‘Too many to count.’

Helen to Judy – ‘Mr Smythe is always having visitors – children, grandchildren and sometimes even great grandchildren, aren’t you?’

Mr Smythe smiles.

Helen – ‘We were just wondering if it would suit you to shower first thing this morning and then you will be ready for whoever visits today.’

Mr Smythe – ‘Yes that sounds good.’

Helen – ‘If you’re ready, I will grab the wheelie and you can walk out to the shower.’
## Part D

### Apply knowledge and professional judgment

Please review the features of person-centred care listed in the following table. Provide an example from the case study that reflects each feature and record it in the appropriate space.

<table>
<thead>
<tr>
<th>Features of person-centred care</th>
<th>Examples from case study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledge the individual as a person ‘experiencing’ life</td>
<td></td>
</tr>
<tr>
<td>Offering clients choice and respecting clients’ choices</td>
<td></td>
</tr>
<tr>
<td>Knowing and understanding the person’s history/biography and its impact on their care</td>
<td></td>
</tr>
<tr>
<td>Focusing on abilities rather than disabilities</td>
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<tr>
<td>Having a positive regard for the resident or client</td>
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<tr>
<td>Understanding that all behaviour has meaning</td>
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<tr>
<td>Maximising the client’s potential</td>
<td></td>
</tr>
<tr>
<td>Sharing the decision making with the client (and family)</td>
<td></td>
</tr>
<tr>
<td>Supporting the clients’ rights, values and beliefs</td>
<td></td>
</tr>
</tbody>
</table>

Now consider the following questions. Support your responses with examples from the case study.

**Q3)** *What impact did Helen’s care have on Mr Smythe?*
Q4) What impact could Helen’s approach have on Judy, the new member of the care team?

Your leadership role: modelling person-centred practice

In the two versions of Mr. Smythe’s case study, we saw the influence the enrolled nurse can have on care workers and their understanding of person-centred practice. This influence can be a positive or a negative one, as we identified. The enrolled nurse contributes to the culture and tone of the organisation and as a more senior member of staff also impacts upon new or junior members of the team.

Critical reflection

Take some time to reflect on your role within your aged care service and the influence you have on other staff. Consider the following questions and record your responses.

Q5) In what ways do you model person-centred care in your practice?

Q6) Describe how you contribute to, and/or prompt others to contribute to, the person-centred culture of your organisation?

WORKSHEET 27 – Person-centred care: moving from principles to practice

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
Person-centred care can be thought of as a protective factor for older people’s mental health.

Highly effective communication

Communication is the foundation of every relationship and interaction.

Through communication we reach some understanding of each other, learn to respect, influence and trust each other. This is important to us not only on a personal level but also in our working lives. We communicate to express our needs or wants, our feelings, thoughts and ideas. And we use a variety of ways to ‘get our message across’.

As enrolled nurses, our daily activities revolve around our communication and interactions with our clients and residents, their families and significant others, and members of the multidisciplinary care team. Thinking back to the earlier steps in this chapter, we saw how much of our care planning role involves communication – written, oral and interpersonal. Effective communication is integral to person-centred care and getting our communication ‘right’ is essential if we are to make a positive difference in the lives of our clients and residents and their families.

In this section we will summarise the concepts and techniques that are the foundation of effective workplace communication.

Elements of communication

There are three broad elements involved in communication – verbal, vocal and non-verbal/visual. The impact of each element on the communication process is quite different as the diagram below shows.

As you can see, vocal and non-verbal elements account for 93% of the impact of our message. That is why our non-verbal messages play such a crucial role in the communication process.
Non-verbal communication

We can use non-verbal communication to reinforce our verbal messages or to simply convey meaning by using body language and other visual or vocal messages. Here are some examples of non-verbal communication that you might use or observe in your role as an enrolled nurse:

- Gestures such as pointing or demonstrating can be used where language differences prevent or limit verbal communication.
- Facial expressions such as smiles or frowns can take the place of, or emphasise, our words.
- A gentle touch can calm or soothe; holding someone’s hand can guide or reassure.
- Showing someone an object such as a piece of clothing, can help them understand what you are going to do or what is expected of them.
- Our dress and appearance can indicate our work role if we wear a uniform; it can also indicate our personal preference and style.

**REMEMBER...**

*Always consider the appropriateness of your non-verbal messages, especially when touching your older clients.*

**WORKSHEET 28 – Observing and recording non-verbal communication in your workplace**

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
Communication techniques to enhance your practice

Here we will focus on three essential communication techniques. Each technique is an important component of your communication with clients and residents experiencing depression or anxiety. Put simply, not understanding or feeling understood can increase a person’s anxiety and depression and will impact upon a person’s willingness to communicate. By strengthening your skills in these techniques you will not only enhance your ability to communicate effectively but also contribute to positive outcomes for your clients.

1. Questioning – integral to your role and practice

Questioning is one of the most important skills in your care role. You can use questions to:

- gain an understanding of your client’s or resident’s background – open questions are best for this
- see if you are right about the person’s needs – closed questions can be best for this
- involve the client or resident and their family members in discussions that directly affect them
- check that your client or resident or their family member understands what is being said
- clarify your understanding of the messages being communicated
- encourage clients and residents who seem less enthusiastic
- elicit additional information from the care team, clients or residents and family members that can influence care decisions
- direct or redirect the focus of communication exchanges
- encourage interaction and information sharing among members of the care team
- slow down or speed up the pace of a communication or interaction
- have direct follow-up on information from different sources.

Apply knowledge to practice

Now we would like you to identify one or two key situations where effective questioning can enhance care decisions for your clients and residents. Draw on experiences from your practice. Please include a rationale for each example.

<table>
<thead>
<tr>
<th>Example</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
</tbody>
</table>

2. Listening – an essential skill

We spend most of our communication time engaged in listening, yet many of us are relatively poor listeners. However, we can make our listening behaviour more effective – and given the amount of time we engage in listening, it’s well worth the effort.
Effective or active listening is not easy; it takes time, energy and practice.

Contrary to popular belief, listening is an active rather than a passive process. Listening is not the same as hearing. Hearing involves only the aural sense – our ears; listening involves the brain.

Listening to help

The ‘helping’ function of listening is a crucial one which we turn to repeatedly in our role as enrolled nurses. When we listen to a client or resident, family member or team member talk about their problems, express a complaint, or attempt to make a decision, we are often listening with a view to helping.

Perhaps the help will come simply from being a receptive and supportive listener. Just being there, ready to listen and willing to help, is often a great comfort. At other times, the help we give can be more direct such as making a suggestion or offering advice.

When working with older people, it is important to allow them time to process and respond; they might take longer than people from other groups you communicate with.

Please take some time to study the following characteristics of good and poor listeners.

<table>
<thead>
<tr>
<th>Characteristics of listeners(^27)</th>
<th>Good listeners</th>
<th>Poor listeners</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Make eye contact</td>
<td></td>
<td>X Interrupt</td>
</tr>
<tr>
<td>✔ Ask questions</td>
<td></td>
<td>X Jump to conclusions</td>
</tr>
<tr>
<td>✔ Summarise frequently</td>
<td></td>
<td>X Finish other people’s sentences</td>
</tr>
<tr>
<td>✔ Check for understanding</td>
<td></td>
<td>X Change the subject</td>
</tr>
<tr>
<td>✔ Give feedback</td>
<td></td>
<td>X Have inattentive non-verbals</td>
</tr>
<tr>
<td>✔ Give the speaker time to gather their thoughts</td>
<td></td>
<td>X Don’t respond</td>
</tr>
<tr>
<td>✔ Remain poised, calm and in control</td>
<td></td>
<td>X Don’t ask questions</td>
</tr>
<tr>
<td>✔ Appear interested</td>
<td></td>
<td>X Don’t give feedback</td>
</tr>
<tr>
<td>✔ Let the speaker finish and then speak</td>
<td></td>
<td>X Don’t check for understanding</td>
</tr>
<tr>
<td>✔ Paraphrase before disagreeing</td>
<td></td>
<td>X Are easily distracted</td>
</tr>
<tr>
<td>✔ Use vocal feedback such as ‘uh-hums’</td>
<td></td>
<td>X Fidget</td>
</tr>
<tr>
<td>✔ Remain aware and engaged</td>
<td></td>
<td>X Allow communication barriers</td>
</tr>
</tbody>
</table>

\(^{27}\) Rural Health Education Foundation, Facilitating Groups of Learners, p. 20.
Critical reflection

Now you can assess your ability to listen actively by ticking the characteristics of ‘good’ and ‘poor’ listeners that describe your listening habits in the table on the previous page.

If you have some ‘poor’ habits you might think of some strategies to improve those listening skills. Make notes in the space provided in the table below.

You might also reflect on how much time you give your clients or residents to respond before ‘jumping in’.

<table>
<thead>
<tr>
<th>‘Poor’ listening habit</th>
<th>Strategies for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REMEMBER...
It takes older people more time to process and respond to questions and people with dementia need more time. When communicating with your clients and residents, allow 15 seconds of silence before ‘jumping in’.
3. Feedback – a vital component in the communication process

In the communication process, feedback can be:

- Connecting
- Completing
- Continuing

Feedback is the response you give to a speaker’s message, both intentionally and unintentionally. It also helps your own understanding. It is fundamental to the communication process and incorporates skills in questioning, listening and reading non-verbal cues.

Helpful, non-threatening feedback focuses on:

- staying positive and calm
- descriptions and examples rather than judgments
- the person’s behaviour, not their personality
- a specific situation rather than on abstract (or general) behaviour
- the ‘here and now’ not the ‘there and then’
- sharing your perceptions and feelings rather than giving advice
- collaborating on actions that the person can change.

Barriers to effective communication

Communication works best when the message is received and understood as the sender intended. Sometimes, perhaps more often than we realise, barriers occur that can disrupt, confuse or silence the message. Recognising potential barriers is an essential step in making sure your communication is effective.
Reflect and discuss

Take some time to reflect on the following examples of barriers that can impede effective communication. You might also note other barriers you have experienced or observed in your daily practice.

Share your reflections and examples with fellow students.

- Inappropriate language, such as jargon, terminology
- Perceptions, prejudices, stereotyping
- Inattentive or passive listening
- Unintended non-verbal and vocal messages
- Lack of feedback
- Mixed signals
- Unnecessary message complexity
- Lack of observation – missing the ‘cues’
- Environmental factors, such as noise
- Lack of time
- Inappropriate time and timing
- Cognitive and physical impairments
- Cultural differences

WORKSHEET 29 – Strategies to overcome communication barriers that impact on care practice

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
Relying on verbal communication: what are the risks?

Reflect and discuss

According to a recent Australian study, enrolled nurses spend nearly 38% of their time communicating orally about a person’s care requirements rather than referring to written information in the resident’s or client’s notes.28

Take some time to think about the implications of this finding for the quality and effectiveness of care processes and outcomes. You might wish to revisit Step 4 of this chapter – Care plans as legal documents. Discuss your thoughts with fellow students.

Think critically

Now identify potential risks when care information is exchanged verbally and explain the likely impact for clients and residents. Also consider the potential consequences for care staff and yourself, as the enrolled nurse, when information is not documented, particularly in case notes and care plans. Record your responses in the appropriate spaces.

<table>
<thead>
<tr>
<th>Potential risks</th>
<th>Likely impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
</tbody>
</table>

WORKSHEET 30 – ResearcHing and writing a life history for a client or resident

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.

Working constructively with family members

An important component of the person-centred model of care involves working constructively with the families of our clients and residents.

Sometimes it can be challenging working with families. In this section we are going to explore why families might respond the way they do and how we can develop more constructive relationships with them.

It is natural that we are comfortable in an aged care environment and because of this we may not realise the impact on families and friends of seeing loved ones in an aged care setting.

---

Activity 3.9  Looking through a daughter’s eyes

This activity has three parts.

Part A

Reflect and discuss

The following quote is from a family member who was supporting her mother in residential care.

“I entered the code into the facility to visit my Mum and just burst into tears. It was something that had to be endured – you had to be tough to withstand it. Some days I just was not tough enough.” – Interview with blueVoices member 2012.

Imagine you are this daughter. Take some time to reflect on her situation.

Think about the words she used to describe her feelings and consider the following questions:

Q1) Why was this experience “something to be endured”?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Q2) Why did she, “… [have] to be tough to withstand it”?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Share your thoughts with fellow students.

Part B

Think critically

Now, imagine this is your aged care facility. Look at the situation from your role as an enrolled nurse and record your responses to the following questions:

Q3) How can the needs of this family member be explored with them?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Q4) In what ways can you ensure the family member feels valued and respected?

Q5) What are the issues for this family member and, potentially, members of other families?

Q6) What considerations should be included in policies and procedures to support family members?

Part C

Think creatively

As a team leader, and within the scope of your role, identify two changes you could make to improve the experience of family members who are visiting your facility. Explain how the changes will enhance person-centred practice.

1. 

2. 

Establishing positive partnerships with families

Unless we have had personal experience of a family member accessing either residential or community aged care we can be unaware of the impact on families witnessing the deterioration of a family member – especially when we are caught up in the busyness of day-to-day work.

There are significant benefits to client and resident wellbeing if their relationships with family members are maintained once they are accessing aged care. Research has demonstrated that resident or client wellbeing is improved when families are involved in their care.²⁹

Often staff might not see the benefits of family involvement – they may only see the negatives. There can be conflict or tension between aged care staff and families. In such situations your leadership and communication skills can help to diffuse these tensions and you can encourage empathy from staff by modelling thoughtful and sensitive responses to families’ concerns.

As the enrolled nurse, you can play a leadership role by supporting and encouraging family members to continue their relationship with their family member whilst sharing the care with staff.

One way of boosting our clients and residents’ mental health and wellbeing is to form meaningful and trusting relationships with family carers.

Reflect and discuss

Working in pairs or small groups, take some time to reflect on the ‘helpful hints’ identified below.

**How families assist aged care staff**

Families provide:

- background information to help with problem-solving
- the words, routines, stories, history, interests and more that contribute to the picture of our clients
- helpful hints on previous routines for personal care
- a knowledge of what the person would traditionally do to help themselves to feel better or what made things worse for them.

Please add to this list with examples from your experience.

---

**What families need us to do**

As aged care staff, we should:

- communicate openly, factually and honestly
- recognise their knowledge and expertise and try to continue to inform and educate
- provide support, respite and self-care skills
- enable them to be involved in care management to the extent they would like to be involved.

Now add to this list with examples from your experience.

---

**How can we respond to carers’ needs?**

It is important to understand that the caring journey is different for everyone. As enrolled nurses, we should aim to be responsive and person-centred to each family carer’s individual experiences and needs. As we have learned this is an essential component of a person-centred model of care.
**Activity 3.10** Identifying supportive responses to carer needs

You might wish to work in pairs or small groups for this activity.

Take time to consider the following diagram showing four broad areas of carer needs.

![Diagram showing four broad areas of carer needs: Emotional support, Time out and self-care skills, Knowledge about mental health conditions and caring, Information and practical support.]

We encourage you to reflect on what you have learned about person-centred care, effective communication and developing constructive relationships. Think critically about how you can use these skills to provide support to families and carers.

This activity has three parts.

Record your responses in the blank templates on the following pages.

---

Part A

Critical reflection

Identify at least one example of each type of family carer need that you have experienced in your role. Record your examples in the relevant space in the left hand column.

<table>
<thead>
<tr>
<th>Family carer need and example/s I have experienced</th>
<th>Examples of supportive response/s I offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional support</td>
<td></td>
</tr>
<tr>
<td>Your example</td>
<td></td>
</tr>
<tr>
<td>Knowledge about mental health conditions and caring</td>
<td></td>
</tr>
<tr>
<td>Your example</td>
<td></td>
</tr>
<tr>
<td>Time out and self-care skills</td>
<td></td>
</tr>
<tr>
<td>Your example</td>
<td></td>
</tr>
<tr>
<td>Information and practical support</td>
<td></td>
</tr>
<tr>
<td>Your example</td>
<td></td>
</tr>
</tbody>
</table>

Part B

Apply knowledge to practice

For each carer need you identified, describe one or more supportive response/s you offered. Record your examples in the relevant spaces in the right hand column of the table above.
Part C

Think creatively

Think about how you could play a leadership role to affect more constructive, person-centred relationships with families and carers. Describe one innovation or new practice for each carer need. Briefly explain how you could encourage your team to implement this supportive response. Record your ideas in the relevant spaces.

<table>
<thead>
<tr>
<th>Family carer need and responsive innovation or new practice</th>
<th>How I could encourage my team to implement this innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional support</td>
<td></td>
</tr>
<tr>
<td>Your example</td>
<td></td>
</tr>
<tr>
<td>Knowledge about mental health conditions and caring</td>
<td></td>
</tr>
<tr>
<td>Your example</td>
<td></td>
</tr>
<tr>
<td>Time out and self-care skills</td>
<td></td>
</tr>
<tr>
<td>Your example</td>
<td></td>
</tr>
<tr>
<td>Information and practical support</td>
<td></td>
</tr>
<tr>
<td>Your example</td>
<td></td>
</tr>
</tbody>
</table>

Supporting families when a client also has dementia

In many ways, the impact on families who are living with dementia\(^1\) is similar to those whose family member has depression or anxiety. However, there are some additional factors around dementia that family carers must confront.

Sometimes families and friends become puzzled, upset, frustrated and/or exasperated because of the actions and behaviours of a person with dementia. They may have difficulty understanding why the person with dementia constantly repeats the same story over and over, or why they talk about their life as it was many years ago.

If the person's first language is not English, they may revert to speaking in their first language, or they may speak a confused mixture of languages that makes it difficult for their family to understand them. A family member may tell you that in difficult situations, no amount of cajoling or reasoning will change the situation.

As a result of this frustration and anxiety, and the constant demands of caring, families and friends may show signs of carer stress. It is helpful to provide these people with information about dementia, to create a better understanding of why such changes might be occurring.

\(^1\) Aged Care Standards and Accreditation Agency Ltd. Participant Guide Module 3: Communicating effectively, pp. 21 and 23.
As well as providing information about the condition and sharing strategies that work, it may be useful to give suggestions about where to obtain additional support and services to make the task of caring an easier one. Some organisations provide support groups and counselling to family and friends of people with dementia.

For example, Alzheimer’s Australia provides a range of information and services to support families. You can find more information at their website www.fightdementia.org.au

You will also find helpful information about depression (including depression and dementia) at www.beyondblue.org.au

**REMEMBER**…

*A person has the condition of dementia but the family or significant others are ‘living’ with dementia.*

A valuable resource for family carers is *The beyondblue guide for carers*. We encourage you to familiarise yourself with this booklet and recommend it or pass it on to family members. Sharing information in this way can be a positive contribution to the partnership with family carers.

**Activity 3.11** Case study: An holistic approach to client care – person-centred practices that work at Samarinda Lodge

This activity focuses on four features of client care in a residential aged care facility.

It provides an opportunity to observe how the understanding, skills and knowledge you have been developing throughout this program come together in the daily care practices of a multidisciplinary care team.

**Investigate and record**

As you watch the DVD we encourage you to closely observe how the manager, staff and family members work together to promote the health and wellbeing of the residents. Record your observations.

Identify examples of:

- person-centred care
- effective communication
- non-verbal messages and body language
- family involvement and support
- leadership.

Please record your examples in the following table.
### Aspects of practice

<table>
<thead>
<tr>
<th>Aspects of practice</th>
<th>Examples from the DVD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-centred care</td>
<td></td>
</tr>
<tr>
<td>Effective communication</td>
<td></td>
</tr>
<tr>
<td>Non-verbal messages and body language</td>
<td></td>
</tr>
<tr>
<td>Family involvement and support</td>
<td></td>
</tr>
<tr>
<td>Leadership (Who displays this skill?)</td>
<td></td>
</tr>
</tbody>
</table>

**WORKSHEET 31 – Finding inspiration for your care role: Introducing practices to make a difference**
You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.

**WORKSHEET 32 – Supporting family members: Taking a leadership role**
You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.

#### Culturally sensitive care

“Can I share my experiences and interact with you?”

“Can I communicate some of my most basic needs or wants with you?”

What do you hear when you reflect on these questions? What are the underlying messages being conveyed? Could they be expressions of anxiety?

Because they can be interpreted in different ways, such messages may not always be understood by care staff.
Reflect and discuss

Take some time to reflect on the following questions then discuss your responses with fellow students. Make notes of issues and key points.

Q1) How would you respond if one of your CALD clients asked these questions?

Q2) Would a CALD client be able to engage with you in a meaningful way?

The role of culture in the context of person-centred care

Culture is not a mere ‘add on’, but rather it informs the whole experience of all our clients. Person-centred practice depends on fostering a sense of belonging in whatever care setting CALD older people choose to live. For this to occur the person’s sense of self and cultural history must inform individual care plans and a variety of strategies need to be directed to their care.\(^{32}\)

We understand that person-centred practice is responsive and sensitive to our clients or residents and their family members or carers. Such practice shows consideration of our clients’ and residents’ wishes and preferences and is offered but not forced. It respects the customs, beliefs, emotions and values of our clients and residents and recognises them as individuals in their own right.

Respectful care practice uses creative problem solving to identify what is needed. This involves you, in your leadership role, members of your care team, the client or resident and their family, in a partnership of communication, action and change. It requires flexibility and the willingness to try new ideas and to modify or abandon practices that are no longer suitable.

Recognising the difficulties and barriers facing clients or residents and families from CALD backgrounds is an important first step in meeting their needs.

Culturally appropriate communication

Accurate and appropriate communication between care staff, clients or residents and family members is crucial at key moments such as conducting assessments and developing and reviewing care plans. Where interpreters are required, care staff and interpreters need to be aware of the range of issues that might arise (for example, the use of dialect) and the need to convey complex matters in ways that are appropriate to the backgrounds of CALD clients.\(^{33}\)

WORKSHEET 33 – Applying effective cross-cultural communication in your role and practice

You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.


\(^{33}\) Ibid p. 7.
Culturally sensitive care is embedded in person-centred care

Culture is patterned, it is not arbitrary. It involves rituals, actions, shared understandings and expectations. Cultural rules govern the most ordinary actions, including those actions which we take for granted and that affect our health: how we eat, rest and recreate. We are all of and within culture.\(^34\)

A culturally sensitive model of care:

- provides for the whole person and does not see them simply as a composite of ‘needs’
- focuses on the individual and their specific care needs
- places culture at the centre of service planning for CALD older people
- engages the client or resident in decision making about where and how their needs will be met
- engages family members and ethnic communities in the provision of appropriate care
- is focused on reducing social isolation and cultural dislocation
- seeks to achieve circumstances in which clients and residents can effectively exercise their rights and experience positive health outcomes.

**Activity 3.12** Implementing person-centred practice: identifying and responding to the needs of older people from CALD backgrounds – four case studies

This task has three parts.

**Part A**

Investigate and record

The DVD you are about to watch, *Ageing in Australia – The immigrant experience* presents the stories of four older people from culturally and linguistically diverse (CALD) backgrounds. Cengiz, Nhung, Uga and Irene share their stories of migrating to Australia, their attitudes to ageing and their expectations for the future.

As you watch make notes of key points – as if you were taking a life history.

---

\(^34\) Ibid p10
Part B
Analyse and interpret

Please consider the following questions and record your responses in the relevant spaces.

<table>
<thead>
<tr>
<th>Question</th>
<th>Cengiz</th>
<th>Nhung</th>
<th>Ugo</th>
<th>Irene</th>
</tr>
</thead>
<tbody>
<tr>
<td>What were some of the protective factors you observed for each person?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What were each person’s expectations for the future?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was each person’s expectation of their family to support them as they age?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was each person’s attitude to aged care services?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part C
Think critically

Here we would like you to select two of the older people featured in the film and imagine they are being admitted to your aged care service. They are likely to have a range of risk factors for depression or anxiety and might also have developed specific protective factors to promote their wellbeing and independence.

Now think about implications for their care:

Q1) What actions would your organisation take to provide culturally sensitive care for each client/resident?

List the actions and explain how they would contribute to meeting the needs of each person.
Q2) How can these clients continue to engage in their protective factors now they are no longer fully independent and are accessing your aged care service? 

Record your ideas for maintaining these client’s protective factors.

Q3) What strategies would you consider if your service is unable to support one or all of these protective factors?

Apply knowledge to practice

As an enrolled nurse, you would have a leadership role in ensuring each CALD client or resident receives culturally sensitive care.

Describe how you would implement a person-centred model of care responsive to each client’s/resident’s specific needs.

Now record your responses to the following questions:

Q4) How would you involve members of your care team?

Q5) What additional skills and knowledge might care staff need?
Q6) How could you ensure constructive and supportive relationships with their family members or carers?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Critical reflection
Take some time to reflect on the following questions and record your responses.

Q7) In what ways does knowing more about the biography of a CALD client or resident contribute to person-centred care planning?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Q8) How would this biographical information be communicated to other staff likely to be involved in their care?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Q9) What implications does this have for meeting their care needs?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

REMEMBER...
Person-centred care is a practical way to enhance the protective factors for your CALD clients.

WORKSHEET 34 – Critical analysis of a research study: applying findings to your role and practice
You are now ready to extend your learning by completing this online task. Your facilitator will explain how to complete the task and when to submit your completed worksheet.
<table>
<thead>
<tr>
<th>Care plan for James</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem statement</strong></td>
</tr>
<tr>
<td><strong>What is observed?</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>What are the goals for James?</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Evaluation criteria</strong></td>
</tr>
</tbody>
</table>
WORKSHEET 35 – Learning reflections
You are now ready to check your learning from this chapter by completing a short online quiz. Your facilitator will explain how to record your answers and when to submit your completed worksheet.

WORKSHEET 36 – Final reflection
In the last online task for this chapter, we ask you to reflect on your learning and consider how you can apply your new knowledge to your care role and share it with the rest of the team. Your facilitator will explain how to complete the task and when to submit your worksheet.
Information and references

There are many sources of information and useful references available to you. Here are some suggestions relevant to the information discussed in this chapter to help you on your learning journey.

**beyondblue publications** – When you log onto [www.beyondblue.org.au/resources](http://www.beyondblue.org.au/resources) you will have access to many free fact sheets and resources, including:

- **The beyondblue guide for carers** – Booklet
- **Fact sheet – Reducing stress**
- **Anxiety and depression in older people** – Booklet
- **Over Bloody Eighty (OBE) Stories – a marvellous collection of personal stories from older Australians** – Booklet

**Alzheimer’s Australia** Help Sheets – Alzheimer’s Australia provides Help Sheets and many other resources about dementia that you will find useful. Log on to: [www.fightdementia.org.au/understanding-dementia/help-sheets-and-update-sheets.aspx](http://www.fightdementia.org.au/understanding-dementia/help-sheets-and-update-sheets.aspx) and open the tab, ‘About dementia’.

**Alzheimer’s Australia Quality Dementia Care** publications:

- **Practice for Managers in Residential Aged Care Facilities**
- **Practice in Residential Aged Care Facilities for all Staff**

**beyondblue** audio-visual resources including **Person-centred care in action**


**Reference for care plan audit tool:**

Aberdeen, S. 2010. Concept Mapping To Improve Victorian Residential Aged Care Team Learning And Problem-Solving For Clients With The Behavioural And Psychological Symptoms Of Dementia: unpublished doctoral thesis, School of Public Health, La Trobe University.

Other references provided:


Readings


Community Care Common Standards Guide EO 2.3: Care Plan Development and Delivery


*Demystifying dementia care* is a set of resources produced by the Aged Care Standards and Accreditation Agency and freely available.

These comprehensive resources will equip staff working in aged care residential (homes) and community services with the skills and knowledge needed to provide support for people with dementia in a range of service settings. The resources are available at:

www.accreditation.org.au
Congratulations! You have now completed the program *Making a difference: implementing person-centred practice to promote older people’s mental health and wellbeing.*

This is a good time to critically reflect on what you have learned about depression, anxiety and other mental health conditions experienced by older people. You can also look back on the range of skills and strategies you have developed to enhance your role and practice in aged care.

To conclude your learning journey we would like you to reflect on the goal of the program – implementing person-centred practice to promote older people’s mental health and wellbeing.

Now identify five practice innovations or changes to current procedures you will introduce in your role as team leader. Describe how these innovations or changes will contribute to achieving the goal for your clients and residents. It may be helpful to go over your notes in each chapter, as well as the activities, final reflections and research tasks you have completed.

I will contribute to achieving this goal in my aged care practice by introducing these innovations or changes:

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