

## Well for Life

Improving emotional wellbeing  
for older people

*In residential aged care*



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March 2011

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# Acknowledgements

National Ageing Research Institute, HDG Consulting Group, Well for Life participants and project workers, Reference Group members, Dr Catherine Barrett and Department of Health staff.

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Published by Wellbeing, Integrated Care and Ageing Division, Victorian Government  
Department of Health, Melbourne, Victoria.

This document is also available in PDF format on the internet at:  
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March 2011 (1012021)

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# About this resource

Well for Life started with a focus on improving the nutrition and physical activity of older people in a range of settings. The Department of Health has further enhanced Well for Life by including a focus on improving emotional wellbeing. Emotional wellbeing is essential to a happy and healthy life. Activities to enhance emotional wellbeing strengthen an individual's capacity to maintain their independence, autonomy and general wellness.

A combined focus on the three elements of **physical activity**, **nutrition and emotional wellbeing** supports the Victorian Department of Health's priority of promoting physical and mental health and wellbeing among older people. Well for Life is an integrated health promotion approach. Agencies use a range of interventions and partnerships to achieve positive outcomes for individuals and the community.

This information resource aims to promote Well for Life goals with a focus on **emotional wellbeing** for **older people living in residential care**. It provides a framework to assist and facilitate discussion and staff development about improving older people's emotional wellbeing. It is aimed at staff and managers for the practical application of identifying barriers and challenges to people's emotional wellbeing and to identify actions to overcome them.

Physical  
activity  
and  
nutrition

The information resource complements the physical activity and nutrition sections of the *Well for Life: Improving nutrition and physical activity for residents of aged care facilities* resource kit (Department of Human Services, 2003). The resource has been reviewed and tested by Well for Life projects funded to implement physical activity, nutrition and emotional wellbeing strategies.

This information resource includes:

- practical guidelines for identifying barriers to people's emotional wellbeing
- suggestions about how to recognise opportunities to encourage emotional wellbeing
- a series of help sheets with practical strategies
- an education package.

Service providers are encouraged to make full use of the information resource as an easy-to-use, practical and effective tool for supporting the emotional wellbeing of older people living in residential aged care.

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# Section 1: Introduction

## 1.1 Purpose

Used in conjunction with *Well for Life: Improving nutrition and physical activity in residential aged care facilities*, this information resource will assist managers and staff to promote nutrition, physical activity and emotional wellbeing opportunities for older people in their care.

The intention of the information resource is to generate discussion about emotional wellbeing and focus on ways in which the emotional wellbeing of older people can be actively enhanced through service provision.

The information resource provides a self-assessment and continuous improvement process to enable service provider staff and managers to:

- recognise the benefits of engaging in discussion about emotional wellbeing
- better understand the benefits of emotional wellbeing
- identify and consider current emotional wellbeing practice
- gain experience in applying self-assessment and continual improvement tools and checklists
- generate ideas and action to improve opportunities for emotional wellbeing
- develop and implement strategies to enhance the emotional wellbeing of older people.

## 1.2 Resources

This document contains the following resources:

- An introduction and overview of the **principles** of emotional health and wellbeing for older people living in residential aged care.
- A **facilitator's guide** to use in leading discussion about emotional wellbeing for older people living in residential aged care. The facilitator's guide includes: **case studies** to illustrate key issues; a **good practice checklist** for physical activity, nutrition and emotional wellbeing for self-assessment and planning; and an **action plan** template for recording agreed actions.
- A series of **help sheets** outlining key issues and practical considerations for the emotional wellbeing of older people living in residential aged care, which can be used in conjunction with the facilitator's guide and educational resources. All or some of the help sheets can be selected for use depending on the service setting and context.
- **Educational resources** including a session format, PowerPoint presentation, handouts and speakers notes. **Module one** provides an overview of emotional wellbeing of older people, its principles and practice, and **module two** explores the issue of ageism.

This document is complimentary to other residential aged care services resources requirements already in existence, such as *Strengthening care outcomes for residents with evidence* and quality indicators. See <<http://www.health.vic.gov.au/agedcare/services/score>>



# Section 2: Emotional wellbeing concepts and principles

## 2.1 Concepts and definitions

Well for Life defines emotional wellbeing in the same way the World Health Organization and VicHealth define mental health.

**World Health Organization** 'Mental health is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.'

**VicHealth** 'Mental health is the embodiment of social, emotional and spiritual wellbeing. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just.'

Social, emotional and spiritual wellbeing for Aboriginal people recognises the importance of connection to land, culture, spirituality, ancestry, family and community that serve as sources of strength and resilience. Social and emotional wellbeing problems cover a broad range of issues that can result from, for example, unresolved grief and loss and removal from family (Cooperative Research Centre for Aboriginal Health 2009).

The adoption of the concepts of active ageing and positive ageing by service providers and the wider community can counteract some risks to an older person's emotional health.

### Active ageing

**Active ageing** is a term used by the World Health Organization (2002) and relates to 'the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age.' In a practical sense, active ageing is about recognising and supporting older people to realise their potential, and continue to engage with families, peers and the wider community in a social, economic, cultural, and spiritual way. Therefore a key goal for service providers is supporting independence and autonomy for all older people no matter how frail, disabled or in need of care.

### Positive ageing

**Positive ageing** is about being valued by and contributing to the community as we age, which benefits both individuals and society (Office of Senior Victorians 2005). Well for Life seeks to enable active and positive ageing through promoting physical activity, nutrition and emotional wellbeing.

The information and help sheets included in this information resource provide strategies to assist staff in their day to day work with older people. They are based on research evidence and expert opinion and reflect the concepts of active ageing and positive ageing.

## 2.2 Guiding principles for emotional wellbeing

The guiding principles are based on a range of approaches that uphold active ageing and positive ageing including person-centred care, an active service model approach and health promotion. These principles underpin the information contained in the help sheets.

Service providers can use these principles in their day-to-day work. For example:

- when communicating with older people
- in considering the key messages conveyed to older people, including through written, verbal and non-verbal communication
- as part of a practice review
- in planning or thinking about how to enhance services provided to older people
- in updates of organisational policy and procedures
- including emotional wellbeing information in workforce development and training activities
- families, carers and guardians will need to be included as appropriate, especially with residents who have diminished ability to make informed decisions.

### Emotional wellbeing guiding principles for staff

- 1 Support **autonomy** and **independence** recognising that frail older people continue to have relationships with friends and family that are interdependent.
- 2 Encourage and foster social connections within and external to the service.
- 3 Focus on **strengths, abilities** and **improving capacity**, rather than disabilities.
- 4 Promote **personal responsibility** for activities of daily living and engagement in activities of personal interest.
- 5 Provide **person-centred services** that are **flexible and responsive** to changes in an older person's health and wellbeing, and based on their goals.
- 6 Create **relationships** with the older person to explore their interests and strengths and to develop their goals.
- 7 **Respect** an older person's decision-making ability and incorporate their wants in decisions about care they receive and types of services provided, whilst recognising some residents may have diminished ability to make informed decisions and there is the need to balance risk taking, activity and choice.
- 8 Work in **partnership** with other local services and agencies, and with the person's carers and family, but recognise that in some cases a person may not want other parties consulted if making decisions about their future.
- 9 Respect **privacy and dignity** in relation to consulting friends, families, neighbours, relatives and service providers when making decisions about a person's future.

Principles

## 2.3 Understanding diversity

The *Victorian Charter of Human Rights and Responsibilities* (2008) represents a commitment that all Victorians are treated with equality, fairness and respect. It encompasses the diversity of the Victorian community and acknowledges that barriers to accessing services are experienced by many individuals and groups who are marginalised or disadvantaged.

The Charter prompts services to plan for and address the needs of all people, taking into account diversity in age; gender and sexual identity; physical and cognitive ability; emotional, spiritual, religious and cultural background and beliefs; ethnicity; Aboriginality; refugee status; language; and socio-economic circumstances and needs. The Charter encourages us to recognise the commonality between people as well as the difference within groups, and respond to this difference.

### Aboriginal people

For the purposes of this document Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or as both Aboriginal and Torres Strait Islander. An Aboriginal person is defined as a person who is a descendant of an Indigenous inhabitant of Australia, identifies as an Aboriginal, and/or is recognised as Aboriginal by Aboriginal members of the community in which they live.

Each Aboriginal community is unique. Aboriginal people conceptualise good health as inclusive of social, spiritual, emotional and physical wellbeing. Cultural identity, self determination, and connection to land, family and community is critical to the emotional wellbeing of Aboriginal people.

### People of culturally and linguistically diverse backgrounds

The interplay between culture and health is significant for many Victorians from culturally and linguistically diverse (CALD) backgrounds. Health and wellbeing issues for CALD Victorians differ depending on factors including gender, age, cultural background, health and wellbeing prior to their arrival in Australia, settlement experiences, family reunification and length of time settled in Victoria.

The various traditions practiced by CALD Victorians may impact on their experience of health and wellbeing, and also on the way in which they access the human services system. Sometimes these traditions are successfully recognised through mainstream practice but at other times they may be in conflict. Furthermore the interplay between culture and health may continue for subsequent generations and can result in intergenerational conflict. Research also clearly shows the ill-health effects of discrimination and social exclusion.

Being culturally informed and providing sensitive support is an integral component of service provision. It is important that health and human service workers provide support with an understanding of culture beyond their country of origin.

A lack of spoken English and/or literacy skills also impacts on some CALD Victorian's access to human services. Additionally, it is recognised that as people age, it is not unusual to lose proficiency in speaking a second language. As a result older people with conditions affecting memory tend to revert to speaking their first language. When working with people from a CALD background who do not speak English well, workers should use a professionally qualified interpreter to help overcome these issues.

## Gay, lesbian, bisexual, transgender and intersex people

It is important that aged care service providers support the sexuality of clients, whether they are heterosexual, gay, lesbian, bisexual, transgender or intersex. Many older people grew up in an era when homosexuality, other non-mainstream sexualities and transgender identities may have been considered criminal, unnatural, deviant or the basis for societal discrimination. This can mean that older people might not feel comfortable or safe to 'come out', or talk about their needs. This may have a range of impacts from limited expression of their sexuality or gender identity to social isolation that, in turn, can have negative consequences on emotional wellbeing.

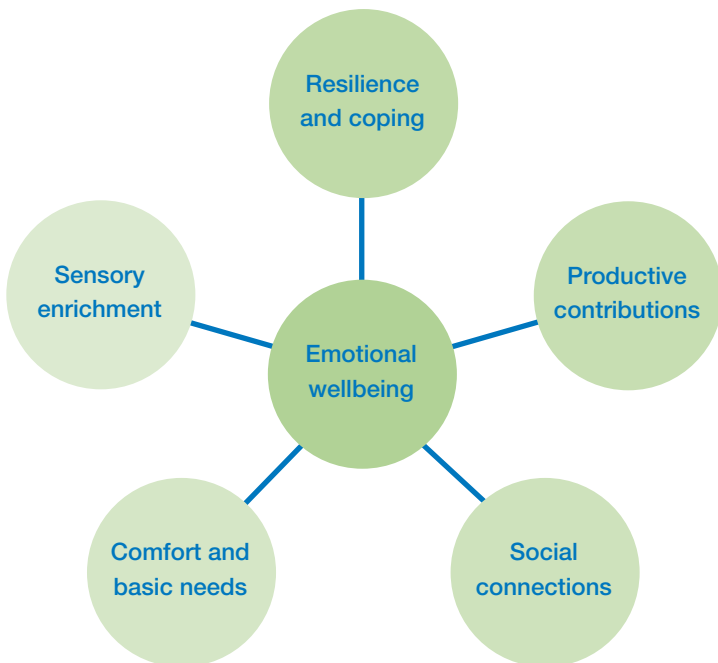
Gay, lesbian, bisexual, transgender and intersex (GLBTI) older people want understanding, empathy, non judgement, acceptance, sensitivity and awareness. Cultural competency training, advocacy and respect by service providers are important in providing safe, high-quality services appropriate to their needs.

## 2.4 Individual emotional wellbeing

Well for Life identifies five elements crucial to maintaining an individual's emotional wellbeing:

- 1 Resilience and coping
- 2 Being productive and making a contribution
- 3 Social connections
- 4 Basic needs and comfort
- 5 Enjoying sensory enrichment.

Figure 1: Five elements of emotional wellbeing



Element	Description	How organisations and staff can support this
Resilience and coping	This is the ability to cope with life events and stresses associated with changes in circumstances. Effective coping skills give people better control over their lives and adds to their sense of emotional wellbeing.	Develop an awareness of when the person is not managing and what is important to them, which will assist them in developing practical solutions. Positive communication is required.
Being productive, making a contribution	Staying active and happy and enjoying what life has to offer. Maintaining self-esteem, feeling productive and having a meaningful role in daily affairs.	We can challenge ageism. Get to know the person, their interests and respect their roles in life, past and present. Show respect and incorporate their wishes in their care. Encourage independence and autonomy and participation in purposeful activities.
Social connections	Having meaningful relationships with family, friends, peers, and the wider community, staff/workers. Receiving and giving affection.	Encourage individuals to be involved in positive social activities. Support individuals to engage with social and cultural networks and the local community, their peers, families and friends.
Being comfortable	Fulfilment of basic physical needs and the absence of health problems. Having a sense of privacy, security and safety. Being comfortable in your environment.	Encourage nutritious enjoyable meals, good healthcare, appropriate lighting, temperature control and a safe environment. Provide assessments and equipment to support independent living. Implement HACCC Active Service Model principles and goal setting.
Sensory enrichment	Having one's senses stimulated and enjoying habitat ambience. Having a pleasant amount of activity and arousal to convey emotional support, affection and respect.	Be aware and inventive in finding sources of sensory enrichment for individuals whose emotional wellbeing is at risk. Resources for this include group activities catering for individual tastes and interests. Ensure noise, lighting and access to sunshine are appropriate and do not irritate. If appropriate, offer hand and hair treatments or massages.

The help sheets contained in section 4 provide strategies and suggestions for implementing these elements in practice. Addressing these elements will need to be adapted to individual residents' circumstances and health status.





# Section 3: Facilitator's guide

## 3.1 Responsibilities

Facilitators or nominated change leaders can use this guide to plan and conduct a productive group discussion about emotional wellbeing.

To effectively implement and sustain increased opportunities for emotional wellbeing for older people at home and their carers, **service providers** must be committed to delivering best practice and continuous improvement.

**Facilitators or nominated change leaders** need to ensure that:

- the process and tools for assessing the organisation's practices in promoting emotional wellbeing are related to existing organisational systems for improving the quality of services
- clear explanations are provided to staff about how to use the good practice checklist and help sheets
- ongoing opportunities are provided for participants to read, engage with and discuss the emotional wellbeing information
- there are opportunities for reinforcement and practice.

**Participants** in discussions may range from very experienced to inexperienced and/or from highly qualified to having minimal formal education. Inform yourself of the background of the group before the session. Participants could include:

- Division 1 and 2 nurses
- personal care attendants
- activities coordinators and assistants
- therapy staff
- kitchen staff
- administrative staff
- any staff member who works in a direct care role
- health promotion nurse/coordinator
- quality care staff/management.

## 3.2 The process

### The key steps

- 1 Plan and convene a staff meeting to discuss the emotional wellbeing of older people.
- 2 Explain your role and the aims of the discussion.
- 3 Discuss a range of emotional wellbeing topics, issues or areas of interest to participants. The help sheets and educational resources can be used to inform and stimulate discussion.
- 4 Discuss and self-assess current practice in relation to supporting emotional wellbeing. The good practice checklist and program standards can be used.
- 5 Define an area or topic for further investigation and continual improvement.
- 6 Discuss and generate possible ideas, approaches and solutions.
- 7 Agree on action to be taken and timelines.
- 8 Conclude the discussion.
- 9 Reflect.

Further information about each step is provided below.

## **Step 1: Plan and convene a staff meeting to discuss the emotional wellbeing of older people**

Discuss with your manager the desire to focus on emotional wellbeing of older people. Suggest that a staff meeting is convened to discuss the topic. The discussion may occur at regular staff meetings or at meetings convened specifically for the purpose. Allow two hours for the meeting if possible.

Schedule the meeting and discussion to occur over two or more sessions. This allows time for participants to reflect, review their work practices and develop enhanced problem-solving skills.

Prepare for the meeting and familiarise yourself with relevant resources:

- the help sheets contained in this information resource
- the education package, PowerPoint presentation and speakers notes contained in this information resource
- *Well for Life: Improving nutrition and physical activity for older people in residential aged care*, including the checklist and help sheets.

Make enough copies of the help sheets and other resources to use during or following the discussion. Before commencing the group discussion, make sure that:

- management supports the meeting—consider having invitations endorsed by management to encourage participation
- participants are able to take time off from their regular duties
- management will be interested and supportive of ideas generated by participants
- a room that is comfortable and free of interruptions is available for the meeting
- seating can be arranged around a table or in a circle to encourage interaction
- there is adequate advance notice and promotion of the meeting
- someone has been organised to record and write up the results of the discussion and the plans
- the resources and equipment needed for the discussion are readily available
- refreshments have been arranged for participants.

## **Step 2: Explain your role and the aims of the discussion**

Commence the meeting and explain your role to the group, which is to help them identify, discuss and work through issues about emotional wellbeing. Inform the group that your role is to facilitate the discussion, ask questions, provide access to information and resources, and generate ideas and solutions to the issues they identify.

Introduce participants to the concept of emotional wellbeing. Explain the aims of the discussion and the outcomes that will be achieved, that is: to identify improvements to current organisational practice and outcomes to enhance older people's emotional wellbeing.

## **Step 3: Discuss a range of issues or areas of interest to the group**

After setting the scene, begin a free-ranging discussion of aspects of current practice relating to the emotional wellbeing of older people. Ask the group to think about how they define and understand emotional wellbeing.

Use workplace examples to highlight the concept of emotional wellbeing, such as an incident that has occurred, discussions a staff member has had with a colleague, or something staff would like to do better. The following prompts may be useful:

- A person's behaviour has changed quite abruptly
- A person seems sad, withdrawn or anxious
- A person is not communicating with others when their usual behaviour is to do so
- A person wants to speak about their emotional wellbeing
- A person expresses a sense of hopelessness or is negative towards others
- A person's confidence and self esteem appears to be declining
- A person is having trouble sleeping, or is sleeping during the day
- A person is losing weight or leaving large amounts of food on their plate at mealtimes
- A carer or relative expresses concern about an older person's change in behaviour.

You can communicate to the group information you have read in current literature or industry journals in relation to the emotional wellbeing needs of older people. Prompting questions can be asked such as:

- Is that an approach our organisation could adopt or something our program could be doing?
- Is that a possible solution to an issue we have been experiencing and discussing?
- The literature does not seem to address [x] ...could we look at that problem in our agency and come up with some answers?

#### **Step 4: Self-assess against the good practice checklist**

With the group, assess the agency's strengths and opportunities for improvement in supporting the emotional wellbeing of older people. For example, using:

- the good practice checklist in this information resource
- other relevant program standards applicable to your agency.

#### **Step 5: Define an area for further investigation and continual improvement**

Based on your assessment of current practice, identify an area for further discussion and investigation. In selecting this area, consider the following issues:

- Has a broad range of issues been raised?
- Did the group reach consensus on the primary area for further discussion and investigation?
- Is the issue relevant for the needs of the group and the agency?
- Is the identified area of practice improvement achievable?

#### **Step 6: Discuss and generate ideas, approaches and solutions**

Ask questions to assist the group to identify strategies to address any gaps in emotional wellbeing knowledge or practice that could be changed. For example:

- In your experience, how often does this issue occur?
- How many older people, their carers or staff members are affected?
- What would you need to help explore and address the issue or bring about quality improvement?
- Could you use help sheets in this process?
- Would an education session help?
- Which people within or external to the agency could help to address the issue?
- Is the strategy or action achievable and realistic?

Ensure that for each question posed, the group is able to agree on an appropriate course of action, if the question is applicable for their situation.

- Help participants generate the solution that will work for them.
- Use the help sheets to explore possible actions in more detail.
- Document the outcomes of the discussion and proposed actions, take notes on a whiteboard or butchers paper. This will be useful for later reference to review progress and outcomes.

Below are some examples of issues, questions and possible interventions. It is important that appropriately qualified staff are utilised in the assessments and interventions suggested.

### Example 1

Issue/topic	Questions/considerations	Possible interventions
Sleep (difficulty sleeping, or change in sleep patterns for example sleeping during the day)	<b>Psychological state</b> <ul style="list-style-type: none"> <li>• Is the person showing signs of boredom, unhappiness?</li> <li>• Is the person having trouble coping?</li> <li>• Is the person interacting socially with others (older people, family, friends, staff)?</li> <li>• Has the person exhibited changes in cognitive function?</li> </ul>	<ul style="list-style-type: none"> <li>• Find out if and why the person is unhappy and explore what could be done to address this.</li> <li>• Engage them in purposeful and enjoyable activities.</li> <li>• Arrange medical review (discuss management plan with the doctor).</li> </ul>
	<b>Health/nutrition status</b> <ul style="list-style-type: none"> <li>• Has there been a change in the person's health status?</li> <li>• Does the person seem more dependent?</li> <li>• Is the person in pain?</li> <li>• Is the person disinterested in food?</li> </ul>	<ul style="list-style-type: none"> <li>• Arrange medical review (discuss a management plan with the doctor).</li> <li>• Arrange a review by an accredited practising dietitian or speech pathologist.</li> <li>• Find out what food the person enjoys.</li> </ul>
	<b>Physical/social activity</b> <ul style="list-style-type: none"> <li>• Is the person participating in some sort of physical exercise?</li> <li>• Are the resident's preferences considered?</li> <li>• Is the person socialising with the other residents, for example chatting at meal times, spending time with others in activities.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and implement a strategy to obtain resident feedback about enjoyable physical activities.</li> <li>• Consult with the resident and his/her relatives or friends about preferences for activities.</li> <li>• Implement a strategy to engage the person in purposeful and enjoyable activities.</li> </ul>
	<b>Medication</b> <ul style="list-style-type: none"> <li>• Has the person's medication recently been changed?</li> <li>• Is the person's medication the type that is likely to affect sleep?</li> </ul>	<ul style="list-style-type: none"> <li>• Discuss with GP or request medical review if necessary.</li> <li>• Consult with appropriate health professionals.</li> <li>• Consider staff training to ensure awareness of medication and nutrition issues.</li> </ul>

## Example 2

Issue/topic	Questions/considerations	Possible interventions
Appetite (a loss of, or change in appetite or food intake)	<b>Psychological state</b> <ul style="list-style-type: none"> <li>• Is the resident showing signs of depression or general unhappiness?</li> <li>• Has the resident exhibited changes in cognitive function?</li> </ul>	<ul style="list-style-type: none"> <li>• Find out if and why the person is unhappy and explore what could be done to address this.</li> <li>• Engage them in purposeful and enjoyable activities.</li> <li>• Arrange medical review (discuss management plan with the doctor).</li> </ul>
	<b>Health/nutrition status</b> <ul style="list-style-type: none"> <li>• Has there been a change in the resident's health status?</li> <li>• Does the resident have swallowing difficulties?</li> </ul>	<ul style="list-style-type: none"> <li>• Arrange medical review (discuss management plan with the doctor).</li> <li>• Arrange a review by an accredited practising dietitian or speech pathologist.</li> </ul>
	<b>Satisfaction with meals</b> <ul style="list-style-type: none"> <li>• Does the resident have a choice at mealtimes?</li> <li>• Are the resident's preferences considered?</li> <li>• Is the resident's cultural background reflected in the menu?</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and implement a strategy to obtain resident feedback about meals.</li> <li>• Consult with the resident and their relatives or friends.</li> <li>• Arrange a menu review by an accredited practising dietitian.</li> </ul>
	<b>Medication</b> <ul style="list-style-type: none"> <li>• Has the resident's medication recently been changed?</li> <li>• Is the resident's medication the type that is likely to affect appetite?</li> <li>• Is the resident's medication the type that may affect bowel function?</li> </ul>	<ul style="list-style-type: none"> <li>• Discuss with GP or request medical review if necessary.</li> <li>• Consult with appropriate health professionals.</li> <li>• Consider staff training to ensure awareness of medication and nutrition issues.</li> <li>• Review bowel management plan.</li> <li>• Consider staff training to ensure awareness of medication and nutrition issues.</li> </ul>

## Step 7: Agree on action to be taken and timelines

Discussion participants need to know that some action will be taken as a result of the meeting. Therefore, it is important for the group to agree on the next steps. Participants should be able to contribute ideas about the actions to be taken. This could be to arrange another meeting, circulate help sheets, invite a guest speaker, trial a new practice, or draft an organisational policy.

**Actions** arising from the agency's self-assessment of their practice using the good practice checklist can be formally recorded using a format similar to the *Action plan template* in education module 2. Record the action you intend to take, when this will occur and who is responsible.

**Ensure management support for the action.** *The integrated health promotion resource kit* (Department of Human Services, 2003) provides examples of strategies that reflect management support and commitment to integrated health promotion. This provides a useful framework for considering ways you can engage management support for group discussions and, potentially, ideas generated by participants. Suggestions include to:

- incorporate specific health promotion tasks, such as improving emotional wellbeing into performance plans
- seek opportunities to promote and showcase achievements to senior management and board members.

## Step 8: Conclude the discussion

As facilitator, you will have guided the discussion through a series of stages:

- discussion of general issues related to emotional wellbeing
- deciding on a particular area of concern or issue on which to focus
- working through a series of questions to highlight gaps in knowledge or areas where changes in practice may be required
- reaching agreement about what should happen next.

End the discussion at a point that is agreed by the group, ensuring that you have taken the group through these discussion stages. Reinforce and summarise the agreed action, timeframe and responsibilities.

## Step 9: Reflect

Following the meeting reflect on your skills and performance as a facilitator. As a skilled facilitator, you will have:

- ensured that the group members know each other and their roles prior to commencing the discussion
- facilitated, rather than directed, the discussion
- encouraged the group to find the answers to their own questions and issues
- encouraged the group to use the good practice checklist and help sheets to assist them to work through issues
- ensured that the group has developed an achievable plan for continuing to broaden their knowledge on their selected topic or issue. This does not have to be formal; it can be an agreement to continue the discussion at another meeting. Alternatively, you can use the Action plan template included in the educational resources section of the manual.

### 3.3 Good practice checklist for emotional wellbeing

The following is a good practice checklist for emotional wellbeing which has been informed by the HACCC Active Service Model practice review and planning tool. It complements the existing Physical activity and nutrition Well for Life checklist and is designed for self-reflection, to prompt team discussion or for individual supervision discussions.

#### Good practice checklist for emotional wellbeing

This checklist can be used for self-reflection, to prompt team discussion or for individual supervision discussions.

##### Rating system

Not met: Those aspects you do not currently do.

Partially met: Those aspects you sometimes do well, but there is scope for improvement.

Fully met: Those aspects you currently and consistently do well.

## Good practice checklist for emotional wellbeing

Element of good practice	Not met	Partially met	Fully met
I/we offer an integrated approach combining the three Well for Life elements of physical activity, nutrition and emotional wellbeing in care plans and activities.			
I/we are aware of and able to recognise, observe, monitor and discuss aspects of emotional wellbeing for older people through training, discussion, observation or surveys.			
I/we use a person-centred approach to consider the five key dimensions of emotional wellbeing for older people: productive contributions; social connections; comfort/basic needs; sensory enrichment; resilience and coping. This includes talking supportively with the older person and together identifying goals and interventions to enhance emotional wellbeing (in care plans and activities).			
I/we acknowledge, understand and respect the diversity of older people including: gender and sexual identity; physical and cognitive ability; spiritual, religious and cultural background and beliefs; ethnicity; Aboriginality; language; and socio-economic circumstances.			
I/we promote <b>autonomy and independence</b> with the older person. (See Help sheet 37)			
I/we actively support an older person's <b>social connections</b> and facilitate interaction with family members and friends. (See Help sheets 39 and 40)			
I/we actively support the older person to access a range of community facilities and events and develop new <b>friendships</b> . (See Help sheet 39)			
I/we acknowledge and respect the older person's <b>past roles</b> and support them to feel productive and accomplished. (See Help sheet 37)			
I/we are aware of the connection of <b>physical activity</b> to emotional wellbeing and use the Well for Life physical activity recommendations to inform care plans and activities. (See Help sheet 36)			
I/we are aware of the connection of <b>nutrition</b> and <b>hydration</b> to emotional wellbeing and support the older person to ensure they are well nourished and hydrated. (See Help sheets 34 and 35)			
I/we assess aspects of the physical <b>environment</b> and how they suit the older person. (See Help sheet 46)			
I/we provide opportunities for the older person to engage in <b>sensory</b> activities which they enjoy. (See Help sheet 47)			
I/we acknowledge and support the person's <b>sexuality, sexual and gender identity</b> as essential aspects of emotional wellbeing. (See Help sheets 42)			
I/we observe and support the <b>resilience</b> and <b>coping</b> skills of the older person, including how they look and the quality of communication with others. (See Help sheet 41)			
I/we acknowledge and support the person's <b>spiritual, cultural or religious</b> beliefs. (See Help sheet 43)			
I/we actively support a person through <b>grief or bereavement</b> . (See Help sheet 44)			
I/we use positive and respectful <b>communication</b> and actively address communication barriers. (See Help sheets 25 and 33)			

See also the *Good practice checklist for physical activity and nutrition in Well for Life: Improving physical activity for older people in residential aged care facilities* (Department of Human Services, 2003)



## Section 4: Help sheets

A series of 24 help sheets are included in the existing *Well for Life: Improving nutrition and physical activity for older people in residential aged care facilities* resource kit. The additional help sheets included in this information resource focus specifically on emotional wellbeing. Organisational and resident-related factors that influence emotional wellbeing are covered. All or some of the help sheets can be selected for use depending on the service setting and context.

### Organisational-related factors

Help sheet number	Topic
25	Strategies to combat ageism
26	How staff benefit from Well for Life
27	Staff communication strategies
28	Emotional wellbeing of staff
29	Accessing health professionals
30	Volunteers in aged care services
31	Introducing change within residential facilities
32	Workplace learning

### Resident-related factors

Help sheet number	Topic
33	Communication and emotional wellbeing
34	Hydration
35	Food and emotional wellbeing
36	Physical activity and emotional wellbeing
37	Promoting independence and autonomy
38	Purposeful activities
39	Social relationships and connections
40	Involving family members, carers and friends
41	Resilience and coping skills
42	Sexual expression
43	Spirituality and wellbeing
44	Loss and grief
45	Health, hygiene and comfort
46	Understanding sensory changes and the impact of the environment
47	Using sensory stimulation
48	Light – seasonal affective disorder
49	Privacy and confidentiality



## Help sheet 25: Strategies to combat ageism

### Ageism

Ageism is about age and prejudice. It can apply to any age, but it most frequently has negative results for vulnerable older people. Stereotyping of older people creates prejudices and misconceptions which frequently result in ageist practice. Ageism impacts on social participation and the involvement of older people in the workplace and in health service delivery.

Ageism in health service delivery and its negative effects on the physical and emotional wellbeing of older people are often unchallenged. People who have negative stereotypes of older people are often unaware of these views. This can impact on care.

It is especially important not to apply ageist assumptions to people in residential care.

Common ageist assumptions	Common incorrect assumptions
<ul style="list-style-type: none"><li>• Older people are all the same</li><li>• Older people are like children</li><li>• Physical and mental decline is an inevitable consequence of ageing</li><li>• Older people do not have the same social needs as other age groups</li><li>• Older people do not communicate as well as younger people</li><li>• Older people do not have diverse sexual needs</li><li>• It is normal for older people to be withdrawn or sedentary</li></ul>	<ul style="list-style-type: none"><li>• A physical disability indicates a cognitive disability</li><li>• Loss of speech indicates loss of hearing and/or cognition</li><li>• Older people do not have the same privacy/modesty/confidentiality concerns as others</li><li>• Inappropriate responses to questions or comments indicate poor cognition or failure to cooperate rather than failure to hear</li><li>• Conversation with an older person is boring</li><li>• All older Aboriginal people are Elders</li><li>• Being kind is the same thing as showing respect</li><li>• It is acceptable to talk about older people in their presence without including them directly in the conversation.</li></ul>

To combat stereotypes of ageing, **staff training and mentoring** need to reinforce commitment to *active* and *positive ageing*, and person-centred care, and raise awareness of ageist beliefs, attitudes and practices.

- Do assume physical and cognitive competence to reinforce confidence and self esteem.
- Do provide care that increases independence to promote personal strengths and abilities.

### Strategies to combat ageism in the wider community

Ageist stereotypes can impact adversely on older people's behaviour as well as their self-perceptions. Self-presentation is the monitoring and control of how one is seen by others.

Community strategies to address ageism and promote healthy living can include media campaigns and intergenerational programs. These programs should aim to raise awareness of the value and ongoing contribution of older people to the community. Social inclusion and engagement of older people has many benefits. See the **Count Us In!** website for further information.

[www.health.vic.gov.au/agedcare/maintaining/countusin](http://www.health.vic.gov.au/agedcare/maintaining/countusin)

## Organisational level strategies to combat ageism

There are many strategies that organisations can use to combat ageist attitudes and practices.

- Include the topic in staff orientation, in-services and training.
- Establish a mentor system.
- Invite expert speakers to present models of healthy active ageing from Council on the Ageing (COTA) and the wider community.
- Discuss positive role models.
- Encourage staff to talk about healthy older people they know or have heard of—they are not all exceptions!
- Use role plays to simulate sensory and physical losses of ageing as part of staff training.
- Conduct a ‘challenge your senses’ learning session. Discuss the impact of the environment on the senses. Simulate vision and hearing loss and reduced functional ability by wearing distorting glasses to blur vision, stuff cotton balls in ears to reduce hearing and in the nose to dampen smell, wear latex gloves with adhesive bands around the knuckles to impede manual dexterity. Ask participants to read, write, answer the phone, tie shoe laces, pick up coins.
- Establish a resource library to provide staff with access to training videos and DVDs, for example:
  - *The Heart has no Wrinkles* (Health Media, New South Wales Health) about sexuality
  - *Effective Communication with people with dementia*, (Alzheimer’s Australia, [www.alzheimers.org.au](http://www.alzheimers.org.au))
  - *Side by Side*, DVD available from Moyne Health Service.
- Encourage senior staff to model non-ageist practice.
- Monitor language used in care plans.
- Maintain positive expectations in relation to the needs and capabilities of older people.

## The built environment and ageism

The built environment refers to the buildings, structures and spaces in which we live, work and play. The built environment impacts on mobility, independence, autonomy and quality of life in old age and can also facilitate or impede a healthy lifestyle. In its submission to the Second World Assembly on Ageing in 2002, the World Health Organization observed that age-friendly built environments can make the:

‘...difference between independence and dependence for all individuals but are of particular importance for those growing older. For example, older people who live in an unsafe environment or areas with multiple physical barriers are less likely to get out and therefore more prone to isolation, depression, reduced fitness and increased mobility problems.’

An age friendly built environment means having safe footpaths, easy access to transport, toilet facilities, shopping centres, a mix of housing choices, nearby health centres and recreational facilities. These factors can positively affect the ageing experience. Government, industry and community support to change and promote good age friendly urban design allows seniors to age and remain active, both physically and in their local communities.

Look at ways your organisation can improve the environment for older people: put away unused chairs, provide better storage options, de-clutter the visual environment, and provide outdoor seating.

**Refer to:** Residential aged care services built environment audit tool <[www.accreditation.org.au/accreditation/accredonsiteassessmentandreports/](http://www.accreditation.org.au/accreditation/accredonsiteassessmentandreports/)>

## Help sheet 26: How staff benefit from Well for Life

Most of the suggestions in the help sheets focus on the benefits of promoting exercise, nutrition and emotional wellbeing for residents. These suggestions, however, may be viewed by some staff as 'yet more work!'. This sheet points out the benefits that staff receive when using the approaches recommended in the help sheets.

### Not enough time!

Time constraints are usually cited as the most significant barrier to promoting any change to practice within residential facilities. Initially, new programs or practices may be more time consuming. However, in the long term, time can be saved.

- Residents who are more mobile generally require less assistance with showering, dressing and going to the toilet.
- Residents who can walk independently to the dining room may save staff the time it takes to get wheelchairs out and assist residents to the table. This is a long-term goal and something in which staff need to persevere.
- Residents who are more mobile, active and better nourished are generally happier and more interactive. This can promote socialising between residents and less need for staff to provide all social contact.
- Residents who are well nourished are likely to be stronger and require less assistance.
- Residents who are emotionally healthy may take more initiative, be more social with other residents and require less assistance.
- Involving families in activities and meal assistance may assist staff.
- Well nourished residents have fewer health problems, for example, pressure ulcers and infections, which may result in lower demands on nursing time.
- Improving communication between staff may minimise time wasting. Good communication strategies enable staff to keep up to date on new procedures and avoid duplication and performing tasks that are no longer necessary.
- Reviewing current practices may highlight areas where time is not managed well.

As well as saving time, promoting nutrition and activity can provide physical benefits to staff. Residents who are able to weight-bear place fewer physical demands on staff during transfers and other personal care tasks. Staff may notice less back strain when residents are able to perform tasks more independently.

Happier residents generally require less staff time. This may also promote a happier working environment where residents can be respected and staff can find more satisfaction in their work.

In summary, improving the nutrition, activity levels and emotional wellbeing of residents can promote independence, bringing a likely increase in resident self-esteem.

For staff, it can save time, be less physically demanding, and make work more rewarding. Relationships with residents built on mutual respect, trust and an appreciation of diversity are likely to provide a higher level of engagement and meaning for all involved.

Importantly, the principles of good practice and good quality care underpin the information presented in the help sheets.



## Help sheet 27: Staff communication strategies

Effective communication is critical to a well-functioning organisation. Consider the following.

### In groups

- Regular staff meetings including different levels of staff to promote discussion, sharing information and ideas, reflecting on practice and jointly deciding on action.
- Try creating action statements during these meetings as an alternative to minutes. This motivates staff to achieve new goals. These statements can also be provided to staff unable to attend the meeting so that they are kept informed.
- Conduct education programs that use current approaches to adult learning, for example, experiential learning. Try role swapping or role playing to break down barriers between staff and to help staff understand limitations that others face.
- One method that has promoted self-esteem involved staff forming a circle and each telling one other staff member one thing they valued about working with them. If sensitively managed, this technique enables people to see that others value them and it also develops communication skills.
- Recognition of staff achievement on a regular basis.

### One-on-one

- Staff appraisal to encourage communication between staff and supervisors, linked to annual performance development review. Appraisal enables staff to determine how they are valued and how they can improve. It also increases supervisors' knowledge of staff satisfaction and ways to promote staff development.

### Sharing information

- Place coloured posters with important messages around the facility.
- Satisfaction surveys for staff, residents and their families or 'opportunity for improvement' forms allow staff to report things that could be improved. Management has responsibility to keep a record of these reports and to discuss possible solutions with staff and then act on the best approach.
- Foster communication between different work groups.
- Encourage staff social activities and celebration of days of significance.
- Use a whiteboard to communicate information to other staff – remember confidentiality issues.
- Create regular newsletters.

### Newsletters

Finding someone who has the time to write newsletters may pose a problem. Despite this, they are an excellent method for communication between staff, residents and families. Consider the option of family members contributing to the compilation of a newsletter. Ideas to include in a newsletter:

- Message from the manager
- Occupational health and safety updates
- Birthdays
- Recipes
- Forthcoming events and meetings
- Fundraising and donations
- In-service information or 'best practice' tips

- Competitions, trivia questions and puzzles
- Welcoming new staff/residents
- Changes in policy and new procedures.

## Listening

Listening is a critical part of communicating. Ask yourself:

- Do I really listen?
- Do I fully concentrate and block out other distractions?
- Do I make an effort to be interested in what others say?
- Do I try and put myself in other's shoes?
- Do I listen 'between the lines' to the meaning behind the words?
- Do I listen patiently or have a 'waiting to pounce' tendency?
- Is my mind made up on an answer before the other person has finished or do I listen with an open mind?
- Am I aware of non-verbal communication?
- Do I have time and do I appear hurried?
- Do I treat what is shared with me as privileged information?

## Handover

- Handover time is an important communication opportunity that allows staff to improve resident care.
- It is vital that staff all have the same goals for handover time. Goals need to be discussed.
- It is ideal to have a staff meeting to discuss what information is to be shared during handover. Sometimes information about what happened during the previous shift is not pertinent to staff during the following shift.
- What really needs to be shared? Use communication books to record notes so that staff in following shifts can refer back to them.

## Case study

The importance of using handover effectively was demonstrated during a staff discussion group. The morning staff member stated she regularly supervised Mr D walking to the shower. The afternoon staff member said in surprise, 'I didn't know he could walk!' As a result she had never given him the opportunity to walk during the afternoon.

## Source

Adapted from material obtained through a HACC Certificate IV Course held at Barton Institute of TAFE, 1998; and C Barrett, Melbourne Extended Care and Rehabilitation Service.



## Help sheet 28: Emotional wellbeing of staff

### Job stress

Aged care staff experience stress in their workplace, for example, exposure to psychosocial stressors such as time pressure and to physical stressors such as noise. Exposure to stressors can lead to elevated blood pressure and tension and behavioural responses such as smoking. These can lead to long-term health problems such as coronary heart disease, anxiety, or addiction to nicotine or to alcohol.

It is common for people to have 'down days' and feelings of anxiety, particularly at times of life transitions. However, if these symptoms are out of the ordinary or persist, discuss them with your doctor for advice and assistance.

### Strategies for improving staff emotional wellbeing

- Regular staff meetings including different levels of staff to promote discussion, sharing information and ideas, reflecting on practice and jointly deciding on action.
- Place coloured posters with important messages around the facility.
- Role-swapping or role-playing to help break down barriers between staff and help staff understand limitations that others face.
- Education programs that use experiential learning approaches.
- Staff appraisal to encourage communication between staff and their supervisors.
- Satisfaction surveys for staff, residents and their families
- 'Opportunity for improvement' forms allow staff to report things which could be improved.
- Use a whiteboard to communicate information to other staff – remember confidentiality issues.
- Regular newsletters are an excellent means of communicating between staff, residents and families. Consider involving family members and residents in contributing to newsletters.
- Foster communication between different work groups.

### Dealing with grief

Unlike other workers, aged care staff frequently experience grief in the workplace. The WorkCover NSW Report *Managing loss and grief in the aged-care industry* noted that unresolved grief was a significant stressor for aged care staff. Strategies to address this form of stress include:

- The provision of a debriefing opportunity following a stressful event or death of a resident offers an avenue of possible closure for a staff member.
- A memorial service can be a means for staff to show respect for the deceased resident, express loss, deal with grief and to ameliorate burnout. Mourning rituals are helpful for bereaved workers who often do not get the opportunity to mourn because they are busy with the next resident's admission.
- Consult professionals and other trained bereavement workers.



## Help sheet 29: Accessing health professionals

Health professionals can assist residents by providing specialist assessment, advice and therapy to meet individual needs. Their advice should be sought during initial assessment and through ongoing reviews. The key is to contact health professionals as a preventative measure, rather than when a situation becomes too difficult to improve.

Not all health professionals, however, have the expertise required for working in a residential aged care setting. Do not be afraid to ask specific questions of dietitians, counsellors, physiotherapists, occupational therapists and others about their experience before deciding to engage them in your facility.

### Engaging allied health services

As part of the funding arrangements in residential aged care approved providers must make arrangements for health practitioners to visit residents at the service, or arrange for them to visit a health practitioner if the practitioner is unable to visit the service. This includes physiotherapy, podiatry, dietetics, speech therapy, as well as access to medical and psychiatric services. These services must be provided as appropriate to the individually assessed needs of residents.

### Effectively using allied health professionals time

It is important that residents have access to individual assessment and advice of an allied health professional when required. The allied health professional can provide detailed clinical assessment and the most appropriate advice for optimum care. This is particularly so for residents who often have complex health issues and needs.

However, allied health professionals are usually only available for a limited time, for example, on a sessional basis.

Allied health staff may be employed as staff of the facility or may be brought in on a sessional basis. They can make a significant contribution to assessment, review and care planning for individual residents. They may also provide individual therapy or treatment.

To maximise the input of allied health staff, given budget concerns, it is also possible to engage them to train staff in the facility.

For organisations that regularly access health professionals, it is not always necessary to increase therapy hours to improve outcomes for residents. The same hours can be used from time to time.

## Contacts

The following lists some relevant allied health associations and professional organisations.

Australian Physiotherapy Association (Victorian)  
Suite 2, 1175 Toorak Road, Camberwell VIC 3124  
Ph: (03) 9092 0866 Fax: (03) 9092 0877  
Email: vic.branch@physiotherapy.asn.au

Dietitians Association of Australia (Victoria)  
1/8 Phipps Close  
Deakin, ACT 2600  
Ph: (02) 6282 9798 or  
Accredited Practising Dietitians  
hotline 1800 812 942  
Email: vic@daa.asn.au  
www.daa.asn.au

Australian Association of Occupational Therapists (Victoria)  
PO Box 1286  
Nth Fitzroy 3068  
Ph: (03) 9481 6866  
Fax: (03) 9481 6844  
www.otausvic.com.au

Speech Pathology Australia  
2nd floor  
11–19 Bank Place  
Melbourne 3000  
Ph: (03) 9642 4899  
Fax: (03) 9642 4922  
<http://www.speechpathologyaustralia.org.au/>  
VIC Branch Office  
Email: office@speechpathologyaustralia.org.au

Australasian Podiatry Association (Victoria)  
Suite 26  
456 St Kilda Road  
Melbourne 3004  
Ph: (03) 9866 5906  
Fax: (03) 9866 2094  
www.podiatryvic.com.au

## Help sheet 30: Volunteers in aged care services

Many residential aged care services benefit from using volunteers. Volunteers are people who provide a service that benefits the community, of their own free will and without financial payment.

Volunteers can contribute in a number of ways to the emotional wellbeing of older people:

- Gardening
- Teaching art or craft
- Driving residents
- Reading the paper, letters, other information of interest
- Chatting
- Sharing a meal
- Going out with residents (to the library, movie, shops, café)
- Playing music or games.

Remember to:

- recognise volunteers as valuable team members
- provide mechanisms to acknowledge the value of contributions made by volunteers, such as certificates or an annual volunteer event.

### Developing a volunteer policy

A volunteer policy should reflect and state the philosophy and mission of the organisation and its commitment to volunteer involvement. Your volunteer policy should also include:

- principles of volunteering
- a code of practice
- a statement of volunteer rights and responsibilities
- volunteer checks (proof of identity, qualifications, referee checks, work history, police checks)
- a procedure manual which should contain such things as reimbursement of expenses, insurance, grievance procedures, health and safety regulations
- task descriptions for volunteers.

### Task descriptions for volunteer positions

Activities should be written into a clear and concise task to minimise misinterpretation between the agency and volunteer. It should include the following basic elements:

- a description of the position
- skills or qualifications—mandatory and desirable
- key areas of responsibility—a list of duties.

It should also clarify organisational relationships, answering questions such as:

- who is the volunteer supervised by or accountable to?
- does the volunteer supervise other volunteers?
- does the volunteer liaise with others in the organisation?

The task description should also spell out the conditions of the position, that is: days and time required and any training requirements.

## Training volunteers

Training is an important part of a volunteer program. It can be divided into four categories:

- 1 Orientation
- 2 Pre-placement training
- 3 Continuing education
- 4 On-the-job training.

Training should be ongoing, not just at the start of the volunteer's service. Regular review discussions should be scheduled.

## Recruitment of volunteers

Methods of recruitment can include:

- enquiring among family and friends of older people
- staff members presenting talks at local community groups to invite participation
- hosting an open day morning tea
- listing your service with Volunteering Victoria.

Depending on a person's circumstances a volunteer may be eligible for Centrelink support payments.

## Arranging insurance

Appropriate and comprehensive cover is vital for any organisation involving volunteers.

Types of insurance to consider are:

- professional indemnity
- personal accident for volunteers
- directors' and officers' liability
- public liability
- burglary
- money
- contents/special inclusions
- fire.

While volunteers are not covered by WorkCover, organisations are still required to report serious incidents involving volunteers.

## Police checks

Volunteers can obtain a National Police Certificate at a reduced fee. Often the organisation will pay. A valid Community Volunteer Fee (CVF) number must be provided by an organisation registered with Victoria Police to claim the reduced fee. For further information visit the Victoria Police website: [www.police.vic.gov.au/content.asp?Document\\_ID=274](http://www.police.vic.gov.au/content.asp?Document_ID=274)

## Help sheet 31: Introducing change within residential facilities

The structure of an organisation impacts on the satisfaction of staff and the quality of resident care. Many studies considering quality of life for people in residential aged care focus on perceptions of control in decision making, from the staff members' perspective and residents' perspective.

### What staff value

Understanding what is important to staff in a residential setting can help improve staff satisfaction and outcomes for residents. Atchison (1998), in a US study, found that staff valued:

- personal growth and development
- job security
- job challenge
- fair treatment and respect.

Other areas identified as being important to staff include discussion, sharing information and ideas, reflecting on practice and jointly deciding on action.

### What residents value

The structure of an organisation usually determines the level of control a resident has in day-to-day activities. For quality care, determine what residents place value on and what decisions they want to have control over. Most residents would value their family having input into their care. A study by Kane et al. (1997) found that residents attached most importance to having control over:

- bed times
- rising times
- meals
- room mates
- care routines
- use of money and telephone
- trips away from the facility
- initiating physician contact.

### Staff satisfaction

When considering staff satisfaction the issue of control inevitably arises. What do staff consider an ideal level of control in decision making and at what point does higher staff control reduce resident control? A study by Kruzich (1995) found a positive relationship between the head nurse's perception of control over decision making with nursing assistants' perception of control. The more control the head nurse believed she had, the greater the control the assistants believed they had. It is important to develop an optimal balance of control over decision making between different staff positions and residents.

Responses of nursing assistants from the same nursing homes found that they believed residents would place greater value on visitors and formal activities. It is difficult for staff to effectively promote residents' level of control if they do not have a clear understanding of what each resident values most.

## Effective ways to introduce change

With a clear understanding of what staff and residents value, change can be more effectively introduced into a facility. The need for change is often linked to a problem or a need for improvement. Explore the problem or need for improvement by asking questions and looking beneath the surface:

- Why do we need to change this practice?
- Why has the problem arisen?
- What do staff believe the problem is?
- How many different solutions are there?
- Which solutions do staff believe to be most appropriate?
- What do staff perceive as the practical implications for a particular solution?
- How will these changes impact on staff?
- Which solutions provide the best outcomes for residents?

Involve staff in the process so that they can own the solutions and understand why change needs to occur. Staff may offer suggestions and limitations that management have not considered.

Generally, effective change management requires:

- leadership
- a focus on the benefits
- involvement of all levels of staff
- ongoing communication and discussion
- adequate time to discuss and adjust to the planned change
- adequate time to implement the change
- use of a range of strategies across the stages of change
- monitoring and reviewing progress
- celebrating outcomes.



## Help sheet 32: Workplace learning

Learning 'on the job' makes an important contribution to best practice. Staff can learn more from opportunities that exist or can be created in their day-to-day work. Workplace learning can be more readily incorporated into behaviour and practice because it is likely to be more directly relevant and more immediately available. To maximise the learning, the focus is on the learner.

### Creating learning sessions

Try setting aside a 20 minute session once per week, for example, after handover each Wednesday, for planned learning. Decide to have a topic, a resident or an issue as the focus for the session. Identify the topic each week for the following week and have a different staff member volunteer to prepare an 8–10 minute talk. Another staff member can be the facilitator of the session. All staff should be involved in these different roles.

Once the talk is delivered, questions, comments and queries will be encouraged by asking open-ended questions that invite participation and problem-solving. Maybe you do not need to have a formal presentation; work from staff knowledge and experience.

Complete a round of six sessions and then review how it is going. Ensure all participants contribute their views to this evaluation and plan for continuing in the same or modified form. Remember, there is no need to have the sessions all year. Give everyone a breather and keep the sessions stimulating.

### Presenting to a group—a few pointers

- People learn best when their needs have been assessed; consider what people need to know or are interested in.
- Help people focus on your topic by asking them to think about a recent experience of it, for example: 'What have you found to work best for this resident?' A question helps participants tune into the meaning in your talk.
- Plan to say about 100 words per minute; prepare only 800 words for an eight-minute talk. Try to 'speak' rather than 'read'.
- Design your talk in manageable chunks of information and ideas, and emphasise 'headings' to help keep people in touch with the different sections of your talk.
- Consider using handouts, posters/charts to display some visual information. It does not need to be flashy information to make it easier to understand and remember.
- Give out a copy of an article, encourage others to read it.
- Ensure staff members are given opportunities to think and talk about the information and ideas you have presented.

## Individuals learn differently

Tips for designing activities to facilitate effective learning:

- While some of us like to think before trying something out or speaking to others about it, others may like to talk in a group to explore the topic before being left with it on their own. Others may like to listen or read and then take time to reflect and draw their conclusions. We need to allow for these different preferences.
- Some people prefer words and diagrams, others like listening or trying things out or working in discussion groups.
- Some people like to know the whole picture to understand what we are learning and why. Others prefer to build the picture by knowing the details first.
- Some educators talk about a learning cycle: act, reflect, theorise (find meaning) and try it in practical ways. While we may have a preference for one of these steps, if we are to make the learning complete, we need to take all steps to complete the 'cycle'.

## Helping staff learn at work

Processes to help staff learn at work could include creating a project group to work on an organisational issue, for example, dealing with families or implementing new regulations. This is a good way of staff being involved in acknowledging and solving the problem.

If a staff member attends a seminar, or conference or is undertaking formal studies, their learning can be enhanced if their workplace is involved. If it is appropriate and the staff member is willing, the following techniques can be used:

- Have regular chats about the course.
- Invite the staff member to present on a topic from the course/seminar to others in the facility.
- Help the staff member write down learning objectives for the seminar/conference they are attending.
- Ensure the staff member reflects on the learning activity; for example, provides a short written report or feedback to colleagues.

## Information is not the same as learning

We need to do something with information to make it meaningful. A good learning session has discussion, questions, exercises and activities that help each individual interact with the information and ideas.

Finally, remember RRR and E: learning needs to be REPEATED, REINFORCED, REWARDED and ENJOYABLE!

## Help sheet 33: Communication and emotional wellbeing

### Positive communication

Communication plays an essential role in maintaining a person's autonomy and sense of self, and ultimately affects mental and physical wellbeing. Following the loss of former social partners and social roles, many older people have little opportunity to talk about themselves or past events and achievements. Their status in the family may have changed, often becoming progressively isolated.

Consider the following statements that are common reflections of the loneliness felt by those who have lost all the people who knew them when they were young:

*'I never wanted to be alone'*

*'They all went away and left me'*

*'I still miss the fun and the good times we had together'*

*'They do not love me'*

*'I really miss my gay community'.*

### Patronising communication and negative expectations

Patronising or 'ageing talk' highlights perceived incapacity or powerlessness of older people and can reinforce dependent behaviour, as can 'talking down' or using directive parental language. Patronising speech is an adjusted communication style arising from negative expectations of recipients' communicative capacity.

Patronising communication can include:

- over simplified vocabulary and grammar
- continuous repetition
- over-familiarity
- disapproval
- non-listening
- inappropriately changing the subject
- altered body language
- inappropriately altered speech pace
- inappropriately altered volume or intonation
- assuming heterosexuality.

Old age 'cues' such as grey hair, wrinkled skin, voice changes, a shuffling gait, walking or hearing aids often activate stereotypes that prompt negative expectations of an older person's competence. These can be self-fulfilling. Older people's self-esteem and confidence in their capacity to communicate often diminishes, as does their performance, if they are made to feel less competent or less worthy of being engaged with on adult terms.

## Strategies to enhance positive communication

### The foundations of positive communication

- Be aware of the influence of old age cues, and assess each person's needs on an individualised basis. Assume competence rather than incompetence as a starting point.
- Be aware and sensitive to older people who have speech difficulties. Inability to speak clearly does not indicate lack of cognitive capacity.
- Avoid speaking over or about older people in their presence. Direct comments and questions to them, and include them in any conversation about themselves. Avoid making disparaging comments about other older people.
- There are multiple communication techniques, aids and equipment that can enhance communication. Identify each individual's preferred method of communication. Provide support for staff, volunteers and group members in using the preferred method.
- Minimise background noise such as loud television or radio, vacuum cleaners, leaf blowers or dishwashers.
- Check that hearing aids have batteries and are properly fitted and turned on, and that people with dentures or glasses are wearing them. Ensure people access annual checks for hearing and vision.
- Attract the person's attention, either by speaking or touching if appropriate. Greet the person by name, repeat your own name and speak clearly, keeping your face in view. Avoid speaking from behind the person's back.

### Speech

- Avoid using jargon
- Modify your style of speech only when you have taken time to assess competence, and try to match the demonstrated need. For example, slower speech, shorter sentences, and re-phrasing of groups of words may be necessary for people with hearing difficulties.
- Speak clearly and slowly if the person has a hearing impairment. You may need to raise your voice, but avoid shouting. It is more important to speak clearly and slowly, keep sentences short, and use predictable words as far as possible (avoid modern slang unless you know it will be familiar to the older person).

### Listening

- Use active and sensitive listening, encouraging the older person to communicate freely and demonstrate communication skills.
- Provide opportunities for older people to talk about their past lives and achievements and express their views. Strategies could include keeping life books, reminiscence therapy and encouraging residents to discuss photos and life experiences. Genuine interest confirms the value of the storyteller.
- Signal to older people that they are welcome to discuss their sexual orientation, gender identity and relationship status, and that heterosexuality is not presumed. Use open and inclusive questions that are gender neutral and demonstrate acceptance, for example, 'Do you have a partner?'
- Respond positively when gay, lesbian, bisexual, transgender and intersex (GLBTI) older people are open about their sexual orientation, gender identity and intersex condition.

- Address transgender older people using their preferred name, title and gender pronoun on forms and in conversation.
- Use active listening, reflect back what a person has said and check that you have understood correctly.

### Culturally appropriate communication

- Be aware that a considerable number of older people from CALD backgrounds have specific cultural preferences and limited English language. Ethnic and multicultural organisation staff with specialist expertise may be able to provide cultural competency briefings or workshops, advice on cultural backgrounds and perceptions or practical translation advice and guidelines.
- At all times use language that respects the adult or Elder status of older people.
- For people with a preferred language other than English, you may need to ensure access to interpreters to facilitate the conversation. Use resources that are acceptable to the older person: smiles, touch, gestures, pictures, photos, objects or a dictionary, and consult family members where appropriate. Try to learn a few everyday words in the preferred language of each person, such as hello, goodbye, please and thank you, to demonstrate your interest and willingness to communicate.

### Examples for use in everyday practice

- Provide staff, volunteers and carers training and use active listening techniques
- At intake find out a person's preferred method of communication and how they wish to be addressed (preferred name, title/sex pronoun)
- If a person uses an assisted communication device, make sure they carry it with them, and provide information and training to staff
- Allow time for listening
- Reinforce positive examples of good communication practice
- Acknowledge the emotions people are expressing in their communication and respond to them
- Provide opportunities for verbal and non-verbal expression, such as visual and expressive arts.



## Help sheet 34: Hydration

The most vital substance for a healthy mind and body is water. Older people have been identified as particularly susceptible to dehydration. Sense of thirst seems to decrease even for healthy older people. Decreased mobility, the effect of the ageing process, memory loss and medication can all impact on the body's ability to function adequately, causing fluid and electrolyte imbalances. It is important for people to drink before they feel thirsty.

### How dehydration affects older people

Some people have a false concept that if they drink more they will need to use the toilet more often. Failing to drink causes the urine to be more concentrated and the bladder becomes irritated, in turn increasing a feeling of urgency. A person with dementia may forget to drink and therefore needs prompting.

Dehydration makes a person tired, cranky, and stiff-jointed. Being dehydrated can bring on headaches, nausea, aches and cramps and other, more serious physical ailments. Dehydration can make it more difficult for people to be patient with each other. Severe dehydration can cause seizures, coma or even death.

### Signs of dehydration

	Signs	Action
<b>Mild dehydration</b>	Thirst, dry lips, dry mouth, flushed skin, fatigue, irritability, headache, urine begins to darken in colour, urine output decreases.	Increase fluid intake, discuss with supervisor
<b>Moderate dehydration</b>	All of the signs of mild dehydration, plus: skin does not bounce back quickly when pressed, very dry mouth, sunken eyes, output of urine will be limited and colour of urine will be dark yellow, cramps, stiff and/or painful joints, severe irritability, fatigue, severe headache.	Call a medical professional
<b>Severe dehydration</b>	All of the signs of mild and moderate dehydration, plus: blue lips, blotchy skin, confusion, lethargy, cold hands and feet, rapid breathing, rapid and weak pulse, low blood pressure, dizziness, fainting, high fever, inability to urinate or cry tears, disinterest in drinking fluid.	Call emergency services

## Strategies for increasing hydration

- Offer drinks with meals and after exercise.
- Offer a variety of drinks such as juice and water.
- Install a fresh water fountain away from eating tables yet close to activities, with easy access for people in wheelchairs and with walking frames.
- Encourage staff to increase their intake of water, modelling and reminding residents to do likewise.
- Use visual cues to encourage residents to help themselves, for example, leave small jugs of water with slices of lemon on tables.
- Include soups, jellies, custards and ice-cream in menus.
- Give residents information so they can make informed choices.
- Provide reassurance for residents if on an outing, about proximity of toilets and plan for regular toilet stops.
- Invite guest speakers such as a nurse or physiotherapist to discuss pelvic floor exercises and hydration issues.



## Help sheet 35: Food and emotional wellbeing

The *Well for Life: Improving nutrition and physical activity for older people in residential aged care facilities* resource kit contains extensive information and help sheets about nutrition for older people in residential aged care.

In residential aged care settings it is essential to involve dietitians and catering in any discussions and activities related to food and wellbeing.

It is generally accepted that how we feel can influence what we choose to eat or drink (mood to food). What is less well known is how what we eat can affect our mental functioning (food to mood). There are many explanations for the cause-and-effect relationship between food and mood. The following are some examples:

- **Avoid the highs and lows** of mood and energy associated with fluctuating blood sugar levels by choosing foods that are digested slowly. These foods have a low glycaemic index (GI) and include wholegrain rye bread, oats and basmati rice. High GI foods, which are best avoided, include white bread and instant white rice. Brain chemicals (neurotransmitters, such as serotonin, dopamine and acetylcholine) influence the way we think, feel and behave. They can be affected by what is eaten. Low levels of vitamins, minerals and essential fatty acids can affect mental health.
- **Vitamin B6, vitamin C, folic acid (folate) and zinc** are all essential good mood nutrients and support the immune system. They are needed to make the feel-good brain chemical serotonin from the tryptophan protein fragment found in foods such as meat, fish, beans and lentils.
- **Turkey and chicken** contain a good source of mood enhancing tryptophan, an essential amino acid which is converted into serotonin.
- **Contrary to popular belief, tinned tuna** is not a good source of omega-3 essential fatty acids as the canning process reduces the tuna's fat content.
- **Carbohydrate cravings** (for bread, cakes and biscuits for example) may be a subconscious attempt to raise serotonin levels. Serotonin is the neurotransmitter, or brain chemical, responsible for mood, sleep and appetite control.
- **Caffeine** increases mental alertness and concentration and can improve performance. However, too much caffeine (a different amount for each person) has been found to be associated with: anxiety, cravings, depression, emotional instability, insomnia, mood swings and nervousness.
- The romantic associations we have with **chocolate** may be due to the effects on the brain of a naturally occurring substance called phenyl ethylamine (PEA). PEA can enhance endorphin levels, increase libido and act as a natural antidepressant.

Significant improvement to a wide range of mental health problems can result from making changes to what we eat. There have been reports of improvements in the following: mood swings, anxiety, panic attacks, cravings or food 'addictions', depression and seasonal affective disorder (see Help sheet 49).

## Foods to feel well

- The most vital substance for a healthy mind and body is water.
- Five portions, daily, of fresh fruit and vegetables provide the nutrients needed to nourish mind and body (one portion equals about a handful).
- It is best not to skip breakfast and to keep regular meal times.
- Eat foods that release energy slowly, such as oats and unrefined whole grains.
- Eat some protein foods, such as meat, fish, beans, eggs, cheese, nuts or seeds, every day.
- Essential fatty acids, particularly the omega-3 type in oil-rich fish, such as mackerel and sardines, linseeds (flax), hemp seeds and their oils, are vital for the formation and healthy functioning of the brain.
- Other seeds and nuts, such as sunflower seeds, pumpkin seeds, brazil nuts and walnuts, also contain important 'good mood' nutrients.

## Food from different cultures and favourite foods

The best way to find out about a person's cultural or religious beliefs and practices related to food is to ask them, or their friends or relatives. There may be dietary preferences and restrictions, fasting, styles of serving or special foods for celebrations. Ethnic and multicultural organisation staff with specialist expertise and may be able to provide advice on culturally appropriate foods. Further information is available in the Well for Life Nutrition help sheets. A multidisciplinary approach and consultation with the catering department and dietitian can support the provision of culturally appropriate foods.

Favourite foods can lift spirits and remind people of good times. Assumptions about generational favourites based on a person's age can be wrong! Finger food or food presented in bite size portions can be considered special or bring back memories.

### Examples for use in everyday practice

- Talk about favourite recipes; develop a booklet or calendar with participants favourite recipes.
- Use photos of food to stimulate discussion.
- Choose an international cuisine day for each month.
- Share food from different cultures, for example Mediterranean or South-East Asian foods.
- Collect seasonal fruits and make preserves.
- Prepare food for festivals such as Easter, Christmas and religious days.
- Ask people to think about the most memorable meal they have ever had.
- Try local restaurants with carers, family members and friends.
- Introduce new foods by making own wraps (flat breads) and combination juices (fruit and vegetables).
- Host a morning tea and invite special guests or other group members.
- Borrow recipe books from the local library.
- Recognise that comfort food on occasions is an enjoyable experience.

## Help sheet 36: Physical activity and emotional wellbeing

The *Well for Life* resource kit *Improving nutrition and physical activity for older people in residential aged care facilities* contains extensive information and help sheets about physical activity for older people in residential aged care.

Physical activity has many positive benefits for physical and mental health. As we age there is a change in our physical ability. This can include loss of bone density, loss of muscle tone and joint problems. The extent of these changes differs from person to person. Medical evidence suggests that much physical decline is not the inevitable result of ageing but of long-term sedentary living. Such physical decline can be halted and even reversed by regularly exercising.

The best reason for being physically active is that it helps to maintain an individual's independence and ability to do the same things through life. It can also be fun, and a way of reducing the stresses and strains of everyday life. Whatever physical activities are chosen, including those for people in wheelchairs or with limited mobility or cognition, and whether they are in a group or individual, indoors or out, there is likely to be a psychological benefit and an increased sense of emotional wellbeing.

For example, in relation to emotional wellbeing, regular physical activity can:

- lift mood
- improve confidence and self-esteem
- help deal with negative feelings
- bring a sense of mental wellbeing
- improve sleep which can in turn improve emotional wellbeing
- reduce tension levels and feelings of stress or fatigue
- increase energy
- in a group, foster supportive relationships and friendships between participants.

Studies by Morris, ME & Schoo, AM (2004) and Bauman A, et al (2002) have shown that people feel better about themselves once they start some sort of physical activity.

- Changes to body shape through weight loss or improved muscle tone may result in a more positive self image.
- Learning a new skill or achieving a goal, however minor, boosts self-esteem and motivation.
- Physical activity can be an ideal way to enjoy the company of other people as it gives people a common interest and something to talk about.
- Aerobic activity and resistance activity have been shown to help people who experience moderate or more severe depression, and also seem to have potential for reducing anxiety. Physical activity may even reduce the chances of someone developing such problems.

Physical activities may require the services of an appropriate allied health practitioner, such as a physiotherapist or occupational therapist, or a trained physical fitness educator who has the skills to communicate effectively and can recognise an individual's ability to achieve to their optimal level, and adapt the pace during the session as required.

For further information refer to the website

<<http://www.health.vic.gov.au/agedcare/maintaining/wellforlife.htm>> for:

- *Well for Life: Improving nutrition and physical activity for older people in residential aged care facilities resource kit including the help sheets*
- Well for Life evaluation report
- Well for Life stories.

### Case snapshot

One residential care service worked with residents to involve them in the planning and direction of an exercise program. Previously attendance had been low and silence preceded the start of the class. Now while waiting, residents hold animated conversations and discuss the day's activities. The session is longer, residents require less encouragement from staff, and now encourage each other. As one person stated:

*'Participating in the exercise program takes away my stiffness and relaxes me. I like it and I'm pleased to be in it. ...It's a good chance to socialise'.*

## Help sheet 37: Promoting independence and autonomy

Older people typically wish to retain and improve their independence and autonomy. This means keeping or improving physical and cognitive function to fulfil the tasks of independent living, maintaining social connections, and making decisions about their care.

Traditionally, support services have been delivered in a task-oriented way that comes from a 'do to or for' approach rather than a 'support to do' or 'do with' approach. Service delivery has often focused on a person's weaknesses and what they are unable to do, rather than using a strengths-based approach focused on capacity building and restorative care.

The **HACC Active Service Model** is a quality improvement initiative which explicitly focuses on promoting capacity building and restorative care in service delivery. It is important to note that capacity building in this context does not only relate to physical function but includes social and psychological wellbeing. The core components of an active service approach that can also be applied within a residential care setting include:

- capacity building, restorative care and social inclusion
- a holistic person-centred approach to care that promotes wellness and active participation in goal setting and decisions about care
- timely and flexible services that respond to the person's goals and maximise their independence
- collaborative relationships between service providers.

Emerging research suggests that service delivery models with a health promoting, capacity building approach can have positive and long reaching benefits. This means focusing service delivery on optimising an individual's functional and psychosocial independence.

Strategies for supporting independence and autonomy include to:

- do with and provide support to do, rather than doing to or for
- acknowledge the role, both past and present, of the older person
- find out about what the person values in their lifestyle and what they would like to change if they could 'turn back the clock' or 'get back on their feet' (metaphorically speaking)
- identify client abilities using strengths-based assessment practice
- acknowledge that the complexity of a person's needs will impact on their level of autonomy
- provide opportunities for the person to practice and enjoy their skills
- encourage people to learn new skills, including problem-solving skills
- ask the person what they think the best way to solve a problem may be to support their emotional wellbeing
- provide opportunities for valued roles, such as volunteering or organising, and thank the person for their contribution
- encourage self-management of health by involving the person in care decisions and activities of daily living
- develop a goal orientated support plan with the person that reflects their goals, desires and preferences
- design and implement service delivery options that support independence, autonomy and a sense of wellbeing for the person
- provide a user-friendly environment, for example easy to open windows and doors and ramps instead of steps.

### Examples for use in everyday practice

- Access equipment to enable the person to do their own personal care.
- Introduce aids and appliances, such as hearing aids and walking frames.
- Ask about the fear of falling (which can limit independence) and how to reduce it.
- Consider devices that facilitate calling for help, such as an telephone alarm button or personal alarm, which may restore self-confidence.
- Provide programs to help people connect with other members of their local community and community of interest (for example, CALD communities, GLBTI communities, Count us in!).
- Use environmental modifications.
- Involve participants in planning and leading activities.
- Share roles (depending on capacity) usually carried out by staff, such as making cups of tea, setting up craft materials, cooking and serving meals, welcoming new people, taking photos, writing newsletters, or sending cards to group members who are unwell.

## Help sheet 38: Purposeful activities

The way older people think about quality of life and mental or emotional health is not much different from the way younger people think. Most people need to feel like a useful member of society and connected to their community. Being able to contribute to family and community—whatever this means for an individual—can be important to emotional wellbeing.

### Acknowledging roles, skills and interests

Find out about the interests, roles and responsibilities the person had when they were younger, or they still have. These can include both formal paid roles as well as informal or voluntary roles. These roles may have been in Australia or in other countries. For example:

Aboriginal Elder	Entertainer	Parent/grandparent
Accountant	Farmer	Passing on cultural traditions
Aunt/uncle	Home maintenance	Public servant
Builder	Home management	Shop keeper
Chef	Local business person	Sports coach
Council member	Musician	Writer, journalist
Driver	Nurse or teacher	Volunteer

Listen to the person and consider what they most often reflect about. You may hear statements such as:

- ‘When I used to do [x]’
- ‘I do miss the excitement and responsibility of [x]’
- ‘We used to have so much fun when we [x]’
- ‘Times have changed and we don’t seem to do [x] as much anymore’
- ‘At home in [name of country] we used to [x].’

Comments such as these can prompt a conversation where you can find out more and think about activities that could provide the person with a sense of connection to their current or previous roles and responsibilities. With older people from CALD backgrounds you may need to ensure access to interpreters to facilitate the conversation. With older gay, lesbian, bisexual, transgender or intersex (GLBTI) people you may need to create a safe, non-judgemental and affirming environment for disclosure of sexual and preferred gender identity, recognising that not everyone doing so will be comfortable being ‘out’. Activities linked to previous roles can provide a sense of being productive and contributing to society and community and therefore enhance emotional wellbeing.

Introducing new interests can also provide a sense of achievement, productivity and contribution. Think about new activities that build on the person’s strengths and interests.

When running activities in residential aged care facilities, consideration should be given to residents’ capabilities, length of activity, time of day, seating arrangements and so forth.

## What new interests could be introduced?

- Gardening, picking produce and raising seedlings
- Link into *Count us in!* project initiatives
- Discussing food choices and finding recipes
- Keeping chickens for eggs for use in facilities or for selling at local markets
- Being involved in local groups, committees, book clubs, University of the 3rd Age courses, Men's Shed, football, bowls, social service, music festivals, dining out, libraries or Tai Chi
- Internet café and pen pal program
- On-line learning and computer skills
- Family tree research
- Maintenance opportunities, painting, being around builders
- Folding laundry and clothes
- Participating in shopping, going to the local shop for newspapers or magazines, coffee and morning/afternoon teas
- Intergenerational activities—connections with local schools and child care centres to develop learning opportunities for children and older people (for example computers, reading, local history)
- Reconnect with communities of interest (for example GLBTI celebrations and media)
- Use virtual visiting technology or SKYPE to stay in touch with family and friends regardless of their geographic location.

Refer to: *Count us in!* <[www.health.vic.gov.au/agedcare/maintaining/countusin](http://www.health.vic.gov.au/agedcare/maintaining/countusin)>

## Case study

When a new resident was admitted to the residential facility activity staff focused on the roles he had in life and how they could accommodate them now that he was in the facility. His role as a home maintenance man was important for him. The activity staff worked with management and provided necessary resources for him to engage in minor maintenance within the facility, for example maintaining the fish pond and managing his own garden bed. This opportunity provided the resident with the ability to engage in self-directed activities, with a sense of purpose and achievement, whilst contributing to the facility's outdoor maintenance.

## Case study

*Count Us In:* Participation in a range of meaningful and purposeful social inclusion programs had positive impacts for staff, residents and community members. Staff reported that residents were stimulated by new interests, skills and knowledge through using the internet and social connection applications such as SKYPE or Facebook to keep in touch with family members, relatives and friends. Some residents developed good relationships with volunteers and students from local community schools through their participation in community gardens and intergenerational programs. Residents felt valued by their communities in passing on their life stories, local knowledge and skills to their community. There were benefits for all participants including staff and community organisations.



## Help sheet 39: Social relationships and connections

Having meaningful relationships with family, friends, peers and the wider community is a key factor in achieving and maintaining quality of life. Social isolation can impact on both physical and mental health. It is not simply the amount of contact that influences health. The perceived quality of contacts is most important. Meaningful social connections and having people to do things with and talk about things to, helps people cope with worries and motivates them to get up and about.

Older people who have participated in Well for Life physical activity and nutrition activities often report socialising and connecting with other people as reasons for joining in, and benefits of, group activities. Social interaction not only promotes emotional wellbeing, it can also help in the maintenance of cognitive functioning and physical health. Challenges for an older person to maintain or create social relationships and connections include:

- public transport—frailty or vision impairment may restrict use
- financial restraints—limited money to spend on activities
- attitude—reluctance due to frailty or disability, lack of motivation, fear of falling, an entrenched pattern of isolation
- the effort required to communicate if hearing or speech is impaired
- assumptions made by family members or staff, which can be varied and include concerns about time, resources, health issues, frailty, sexual orientation or gender identity, special needs or knowledge of community resources.

### Strategies for supporting social relationships and connections

#### Acknowledge diverse interests

- Explore a person's interests, strengths and abilities to encourage involvement in meaningful social relationships and connections.
- Acknowledge that for some people, the health benefits of a nutrition activity or physical activity, rather than socialising, may be appealing.
- Aboriginal Elders often have a range of community and family responsibilities and are often the main carers for their grandchildren and their relatives' children and grandchildren. Always consider the importance of connection to family, community, the land and place to the spiritual and emotional wellbeing of older Aboriginal people. Fifty years and over is considered 'aged' for Aboriginal people and respect for Elders is highly valued.
- Use the expertise of staff in multicultural organisations to develop strategies and support connections for people from CALD backgrounds.

#### Effective communication

- Show respect in communication with older people.
- Provide direct care staff, volunteers and interested clients and carers with training in active listening skills.
- Identify a person's preferred method of communication and support staff and group members to adapt their communications.

## Overcoming barriers

- Provide opportunities for enjoyable social activities
- Challenge barriers to social inclusion by supporting engagement with the local community, community of interest, individuals, peers, family members and friends.
- Offer emotional support to people at appropriate times.

### Examples for use in everyday practice

- Find a specific common interest between two or more individuals and provide information, resources and activities to support that interest.
- Develop or access community activities that include a mix of age groups.
- Use community facilities such as the library, local clubs or attend community events such as a school fete or street fair.
- Assist a person to attend a community group (for example, by asking a family member, friend or volunteer to provide support).
- Assist an Aboriginal person to record their storyline.
- Assist GLBTI older people to access GLBTI media, including radio.
- Ask an individual if they are interested in doing a project about their favourite topic or hobby; help them research and prepare their project and present it to a group.
- Help people reconnect with past friends by writing letters or email.

Below is an example of a program of activities to stimulate memory and cognitive activity. Inviting new people to join such a group can be a means of integrating them into a new environment and help them make new friends. Staff should use their judgment about the use of this activity with residents when inviting them to participate.

### Information exchange/gathering

- Name, nickname, birthplace, favourite things, number of children/grandchildren, most positive memory.

**Memory activity**, depending on level of cognitive function:

- Easiest: recognition (for example, Which of these places was H born in?)
- Cued recall (for example, What town was H born in?)
- Most difficult: free recall (for example, What do you know about H's childhood?).

### Formats

- Pairs based on interests and cognitive function
- Family days to facilitate new connections
- Name tags, photographic displays of residents
- Resident ambassadors to facilitate networking
- Groups doing word puzzles, or book clubs
- Memory games, displays of old photographs.

*Activities to promote cognitive function and social networking* (source: Winningham & Pike 2007)

## Help sheet 40: Involving family members, carers and friends

Involving families, carers and friends in the care of older people can provide multiple benefits. Liaison with families around care planning and involvement in activities, for example, helps create a shared understanding about the older person and positive relationships between all parties. Families, carers and friends can help to make the transition to residential aged care a smooth one for the older person, and may also help themselves adjust to the change.

There are many possible ongoing benefits for the older person from the involvement of family, carers, community and friends, including improved nutrition, promotion of physical activity and improved emotional wellbeing.

Benefits to **older people** include that families, communities, carers and friends:

- provide an understanding about the person that can take many years to develop
- continue important relationships and friendships
- provide visibility and acceptance of cultural, sexual and gender identity
- provide information, interest, variety and increase socialising
- maintain social community connections for the resident
- can act as an advocate.

Benefits to **families, carers and friends** of ongoing involvement with the older person include:

- reinforcement and acknowledgment of caring relationships which help people feel valued and needed
- the opportunity for social connection
- spending quality time together
- the ability to share memories, stories, views and opinions
- Aboriginal Elders have a role in teaching the story lines to their communities
- older CALD people reinforce cultural values
- reassurance that the person is receiving appropriate care and support.

Benefits to **staff** of involving family, carers and friends include:

- learning more about the older person's background, interests, aspirations and preferences
- learning of useful strategies for communicating with the person and ways of encouraging them to perform tasks and other activities from families, carers and friends who may have been providing care for many months or years
- gaining information about cultural norms, customs and the person's religion or spirituality
- additional resources and help to organise special activities.

Where a person is very socially isolated, increased efforts to partner with community organisations and volunteer groups to support their emotional wellbeing is important. Seek ways to connect the person with other residents within the aged care facility with similar interests, backgrounds, personalities and so forth.

## Examples for use in everyday practice

- Involve carers in developing and reviewing care plans. Carers can provide information about resident meal preferences and recreation interests, particularly where residents have cognitive deficits and memory problems. Encourage the carer to sign the care plan to indicate they accept it. Ensure you comply with privacy legislation, and the person is legally able.
- Conduct ongoing reviews of the care plan with the family. Regularly inform the nominated relative or advocate of changes in a resident's mood and encourage them to read the day-to-day notes or communication book.
- Let carers know that they should make themselves feel at home with residents and not feel that they are visiting a patient in hospital.
- Encourage families and friends to help make a person's room as home-like as possible, for example bringing in objects such as ornaments, photos, religious figures.
- Acknowledge the arrival and departure of family and friends with a warm greeting or farewell
- Hold activity planning sessions, inviting staff, residents, carers, family members and volunteers.
- Encourage the families and carers of people from diverse backgrounds to share information on culturally appropriate care.
- Involve carers in activities and special events, for example helping to organise a BBQ or celebrate a religious event.
- Encourage family members to participate or lead activities.
- Encourage family members, carers and friends to take residents on outings.
- Provide families, carers and friends with the opportunity to make complaints or suggest possible improvements for the program.
- Invite families and friends to attend planning meetings or to carry out a satisfaction survey inviting feedback. Act on any recommendations and schedule a review.
- The Internet can help keep older people connected. It serves a wide range of purposes, from contacting distant friends and family, liaising with people with similar interests, obtaining health information, and managing finances.
- Familiarise all staff with guidelines in relation to visits in the facility, transferring and assisting walking, food regulations in relation to families bringing food in.
- Relatives' committees hold regular meetings and make an important contribution to a facility. For example, one committee organised activities and outings including a Melbourne Cup BBQ for residents and families to enjoy and get to know others as well as provide support for each other.

The Department of Health's 'Count us in!' initiative, launched in 2006, sought to promote and develop social inclusion opportunities for people living in residential aged care facilities.

Further information can be found at:

[www.health.vic.gov.au/agedcare/maintaining/countusin](http://www.health.vic.gov.au/agedcare/maintaining/countusin)

## Help sheet 41: Resilience and coping skills

Across our lifetime, we make changes to adapt to our circumstances and learn how to cope with life changes. Older people are vulnerable to the experience of loss, be it in terms of health, finance, independence or social connection. The maintenance of emotional wellbeing in the face of such losses can be considered a function of resilience. Older people moving into residential aged care often experience loss and grief in conjunction with mental and/or physical illness.

### Resilience and coping in the context of emotional wellbeing

Resilience is the capacity to recover from and adapt to life events. Effective coping skills give people better control over their lives and add to their achievement of emotional wellbeing. The use of appropriate coping mechanisms contributes to resilience and has a protective effect when dealing with ill health or age-related life changes.

People have different ways of coping which they develop over a lifetime, so older people will have a range of skills in this area. Some will be more resilient than others depending on their background, experience of discrimination and resources.

Coping mechanisms may be internal or external or a combination of both.

Internal factors	External factors
<ul style="list-style-type: none"><li>• Physical health and medications.</li><li>• Thinking patterns and self-talk</li><li>• Beliefs and fears</li><li>• Stress management techniques</li><li>• Sense of control and influence over the situation</li></ul>	<ul style="list-style-type: none"><li>• Friends, family and community members to talk to</li><li>• Practical support</li><li>• Physical environment and connection to land</li><li>• Demands from others</li><li>• Sense of control by others</li><li>• Cultural differences</li></ul>

In being confronted with a changed situation, an older person may:

- actively try to change an unsatisfactory situation
- change their approach and thinking to adapt to the changed circumstances
- seek help or support
- try to ignore it and hope it will go away.

To help people cope well, there may be ways to support, strengthen or introduce new coping mechanisms.

## What can staff do to find out if someone is not coping?

- Get to know the person. Many of the older generation have experienced the hardships of war, abuse, discrimination, racism, economic depression, immigration or removal from family. The resilience that saw them through these crises may be reduced by their current health and living conditions.
- Developing trust will help when encouraging a person to expand their boundaries.
- Be consistent in your behaviour so the person knows what to expect, enhancing a feeling of confidence.
- Identify if the person has just suffered an acute illness or experienced the onset of a disability. This can result in a profound sense of discontinuity giving rise to depression.
- Knowing the person, their background, their culture and community, previous life roles, strengths and abilities will help you understand when the person is not managing and help to support them to develop appropriate solutions. This may mean multiple discussions with the person to build rapport.
- Be aware that the coping strategies older people use to sustain their sense of wellbeing may limit their opportunities to enjoy life to the full. For example, comments such as 'exercise makes me tired' or 'I might fall if I walk in the garden' can be addressed.

Help the person to extend their coping repertoire to promote their emotional wellbeing. Although a person may appear resilient, assistance should still be offered. If necessary seek the assistance of a social worker or other forms of support.

## How to respond to a situation where an older person appears to be not coping

- Discuss the situation and your concerns with the person.
- Acknowledge what has changed and the person's response.
- Ask the person how they have dealt with difficult times in the past.
- Provide emotional support and encouragement.
- Re-assess the person's support needs.
- Consider whether family, friends or other support people can provide emotional support.
- Develop supportive strategies and positive experiences.
- For Aboriginal people and people from CALD backgrounds always liaise with the appropriate Aboriginal or CALD organisation, with the client's consent.
- Consider referral to a relevant service, support group or specialist.

## Help sheet 42: Sexual expression

Sexual activity and the expressions of sexual identity is a basic human right and important for emotional wellbeing. Sexual identity includes concepts of body image, self-esteem, self-perception, sexuality, intimacy and sexual preferences.

In residential aged care sexual expression can be challenging for a number of reasons. Firstly, it may challenge staff members who don't expect older people to be sexual. Consequently, staff may be shocked and uncomfortable when residents express themselves sexually. Staff may not have been taught how to respond when sexual expression occurs, or when they find out someone they are caring for is gay, lesbian or bisexual. These challenges can be intensified when cognitively impaired residents express themselves inappropriately.

Positively acknowledging the way a person expresses their sexuality can enhance emotional wellbeing. For example, a positive response to the disclosure of sexual identity can mean that older gay, lesbian or bisexual people feel understood, valued and safe.

### Myths and facts about sexual expression and older people

Myths	Facts
<p>All older people are —</p> <ul style="list-style-type: none"><li>• asexual</li><li>• physically incapable of sex</li><li>• uninterested in sex</li><li>• unattractive</li><li>• heterosexual</li><li>• monogamous</li><li>• do not want to discuss their sexual health</li><li>• perverted if they think about sex.</li></ul>	<p>All older people may —</p> <ul style="list-style-type: none"><li>• think sex is important</li><li>• be sexually active—a recent study of sexual health in older adults reported that 53 per cent of people aged 65 to 74 years were sexually active (Stacy Tessler Lindau et al 2007)</li><li>• have more than one partner</li><li>• masturbate</li><li>• have same sex partners</li><li>• hide being gay, lesbian or bisexual for fear of discrimination and judgement</li><li>• require opportunities to express their sexuality in an appropriate way</li><li>• become depressed or lose their will to live if their sexuality identity is suppressed.</li></ul>

The following strategies may assist staff to respond to sexual expression and to understand the importance of sexual expression to emotional wellbeing.

### Organisational strategies

#### Give staff permission to talk about what they see, think and feel

Giving staff permission to talk about sexual expression can be a simple and effective way of promoting the emotional wellbeing of residents. It can help staff to understand the importance of sexual expression, reduce their discomfort and enable them to understand how to respond. Staff who are able to talk about sexual expression are more likely to communicate with residents in a positive way. Some strategies to give staff permission to talk about sexual expression include the following:

- Facilitate regular forums for staff to:
  - discuss case studies or experiences in relation to sexual expression
  - raise awareness of the needs of gay, lesbian and bisexual residents people and learn about their historical experiences of discrimination
  - understand sexual expression as a person's right.
- Talk about sexual expression at handover.
- Invite staff to discuss what they think about sexual expression in order to:
  - acknowledge values, beliefs and staff discomfort
  - address myths
  - understand the impact of discriminatory responses
  - enable staff to differentiate between their needs and the resident's needs
  - identify inappropriate sexual expression
  - simplify discussion around consent, vulnerability and duty of care
  - enable staff to feel supported.
- Identify staff boundaries and clarify limits of professional responsibility.
- Differentiate between inappropriate sexual expression and staff discomfort with sexual expression.

#### Ensure staff responses to sexual expression are consistent

- When sexual expression is not discussed staff responses can vary.
- Residents who have cognitive impairment may have difficulty understanding what is required of them if staff responses are inconsistent.
- Consistent responses from staff can send a clear message to residents about what is acceptable and what is not.
- Consistency can assist individual team members to feel supported.

#### Develop a written policy that supports the above and includes, but is not limited to:

- identifying the responsibilities of staff in relation to homophobia and how to protect residents from this form of discrimination
- strategies to support sexual expression and diverse sexual identity
- a description of appropriate and inappropriate sexual activities
- consistent strategies to respond to inappropriate sexual expression
- documentation that protects resident privacy and dignity
- the prescription of medications for inappropriate sexual expression only considered after all reasonable alternatives have been explored, and are not used for treating staff embarrassment or lack of resources.

#### Care planning

- Discuss sexuality with each individual during the assessment process to better understand how they express their sexuality—ask the resident *Would you like to discuss your sexuality? How can we acknowledge and support your sexual identity?*
- Be sympathetic to changes in sexual function or activity that might result from illness, health treatments or partner loss or separation.



- Consider that many diseases like stroke and dementia affect brain function and therefore how a resident expresses their sexuality. Residents who are gay, lesbian or bisexual may have difficulty protecting themselves from discrimination by staff, residents or visitors. Understanding why and how sexual expression has changed can assist staff to plan a response that is effective.
- Identify patterns of sexual expression.
- Where appropriate ask family about a resident's previous relationships.
- Acknowledge that families and residents may have different needs and that children may not be comfortable with sexual expression from a parent.
- Document the referral pathway for specialist sexual health assessment.
- Connect older gay, lesbian and bisexual clients to community supports through Gay and Lesbian Health Victoria or Val's Café (for information, advice or education sessions for staff and residents).

### Individual expression

- Guarantee a private environment for sexual expression, for example, a 'do not disturb' sign on resident doors, or knocking and waiting for permission to enter a resident's room, and facilitating overnight stays
- Some residents may need cuing to understand the difference between public and private spaces.
- Support the continued expression of sexuality for people dealing with disabilities or age-related changes (for example, consider referral to an occupational therapist).

### Case study 1: creating privacy for sexual expression

At handover a female staff member reported that Alan masturbated when she was assisting him to shower that day. The staff member was embarrassed and tearful. Later she described she felt angry that Alan had masturbated in front of her. Several other staff members added that Alan had masturbated while they were assisting him to shower, but reported that they were too embarrassed to talk about what happened. Another female staff member described how, if she was caring for Alan, she would ask a male colleague to shower him because she felt threatened when he masturbated. Other staff described their concerns about being exposed to body fluids. Most staff reported that when they asked Alan to stop he refused.

The team discussed Alan's right to masturbate and acknowledged that because of his brain injury he had difficulty understanding when and where it was appropriate to masturbate. The team agreed that it was important for Alan and for staff that he was able to masturbate in private. The staff discussion revealed Alan wore a large continence pad that prevented him from touching his genitals. Alan's cognitive function meant he could not remove the pad himself and showering was the only time he could masturbate. For two weeks the team trialled night staff removing Alan's pad at 6 am to enable him to masturbate in the privacy of his room. The strategy was successful. Alan's dignity was restored when he was provided with privacy to masturbate. The discussion gave staff permission to speak about several other situations where sexual expression occurred and they were unsure how to respond. It normalised sexual expression as a part of residents' lives.

## Case study 2: caring for a gay resident

Edward had been in a relationship with Bob for 45 years. After Bob died Edward was admitted to a high care facility with dementia. Staff in the facility raised concerns when Edward was found holding hands with John, another male resident. This was discussed with Edward's brother who disclosed that Edward was gay and that John looked a lot like Bob. Staff were unaware that Edward was gay and wanted him tested for HIV. A staff education session was facilitated in which staff members were invited to discuss their values and beliefs regarding homosexuality and their concerns about Edward's care. The education session provided staff with an update on universal precautions and a reminder that caring for a gay resident was not a prerequisite for additional infection control precautions. The education session addressed staff myths about gay people and invited staff to consider Edward's grief at the loss of his long-term partner. The staff were also invited to identify strategies to respond to Edward's grief and mistaken belief that John was his partner.

## Help sheet 43: Spirituality and wellbeing

### Introduction

Spirituality and beliefs may be described as experiencing a deep sense of meaning and purpose in life, together with a sense of belonging. It is about acceptance, integration and wholeness. It applies to everyone, including those who do not believe in God or a 'higher being'. For an individual, their spiritual, religious or personal beliefs may be particularly important in times of emotional stress, physical and mental illness, loss and bereavement. People's beliefs and experiences of spiritual or religious matters can change through the course of their lives and may differ from that of their family of origin.

Religions offer community-based worship, each faith having its own set of beliefs and sacred traditions. It is possible to find advice about spiritual practices and traditions through the resources of a wide range of religious organisations. Secular spiritual activities (separate from religion) are increasingly available and popular. For example, many complementary therapies have a spiritual or holistic element that is not defined by any particular religion. The internet, especially internet bookshops, the local yellow pages, health food shops and bookstores are all good places to look. Spiritual practices span a wide range, from the religious to secular and include:

- belonging to a faith tradition, participating in associated community-based activities
- ritual and symbolic practices and other forms of worship
- pilgrimage and retreats
- meditation and prayer
- reading scripture
- sacred music (listening to, singing and playing) including songs, hymns, psalms and devotional chants
- acts of compassion (including work, especially teamwork)
- deep reflection (contemplation)
- yoga, Tai Chi and similar disciplined practices
- astrology
- engaging with and enjoying nature
- contemplative reading (of literature, poetry, philosophy and so forth)
- appreciation of the arts and engaging in creative activities, including artistic pursuits, cookery or gardening
- maintaining stable family relationships and friendships (especially those involving high levels of trust and intimacy)
- group or team sports, recreational or other activity involving a special quality of fellowship.

## Coping through religion and spirituality

Religious involvement and spirituality can yield positive health outcomes. Religion is a common coping mechanism for older people. Effective coping mechanisms can reduce the psychological morbidity associated with chronic and terminal illness.

Mental health patients have identified the following benefits of good quality spiritual care: (Royal College of Psychiatrists)

- improved self-control, self-esteem and confidence
- faster and easier recovery, achieved through both promoting the healthy grieving of loss and maximising personal potential
- improved relationships—with self, others and with God, creation and nature
- a new sense of meaning, resulting in reawakening of hope and peace of mind, enabling people to accept and live with problems not yet resolved.

Spirituality is an important predictor of quality of life. An international study (WHO 2005) in 18 countries to observe how spirituality, religion and personal beliefs relate to quality of life suggested that it should be more routinely addressed in assessment of quality of life, as it can make a substantial difference in a person's quality of life particularly for those who report very poor health or are at the end of their life.

Maintaining the spiritual, physical and emotional connection to the land is intrinsic to Aboriginal culture and many Aboriginal peoples' beliefs.

## Recognising and supporting the religious and spiritual aspects of a person's life

Staff members need to be aware of whether an older person holds particular beliefs. People are usually receptive to carefully worded inquiries about their spiritual and religious beliefs and practises. A helpful way to begin is simply to ask 'what keeps you going in difficult times?' With older people from CALD backgrounds you may need to ensure access to interpreters to facilitate the conversation. A person's answer to such questions usually indicates his or her main spiritual concerns and pursuits. There are three aspects to look at:

- 1 What helpful inner personal resources can be encouraged?
- 2 What external supports from the community and/or faith tradition are available?
- 3 How does this impact on the way services are provided or the way the person's beliefs can be respected within service delivery and group activities?

This discussion should take place in a trusting environment by someone whose interpersonal skills enable them to obtain information using a conversational style rather than via a 'fact finding interrogation'. Value the role, knowledge and understanding about cultural beliefs that staff from multicultural or Aboriginal organisations can offer. Be aware that an Aboriginal person may only feel comfortable meeting with a worker of the same sex (Men's and Women's Business).

Spirituality is a deeply personal matter however an individual's spiritual and religious practices can be supported in the home, group or residential setting by the use of everyday strategies.

### Examples for use in everyday practice

- Ensure there is space on intake forms for information about a person's spiritual and religious needs.
- Recognise the need for, and ensure regular quiet time and place, such as for prayer, reflection or meditation.
- Organise appropriate cultural, religious or spiritual material to be available.
- Support the person to develop and maintain friendships with others sharing similar spiritual or religious aims and aspirations.
- Provide opportunities for the person to discuss their beliefs and religious practises in a non-judgemental environment.
- Support people to attend religious/cultural services or events.
- Outings to temples, cathedrals, mosques, synagogues or sacred sites.
- Provide information and community resources such as pamphlets, books, radio and television programs and DVDs.
- Provide access to chaplaincy or pastoral care services.
- Celebrate religious festivals matching the religion of group members.
- Celebrate the seasons.
- Be mindful of the choice of music.
- Incorporate simple rituals into programs.



## Help sheet 44: Loss and grief

Stressful life events and the loss of a partner, family, community member and friends can adversely affect an older person's emotional wellbeing. Organisations have a duty of care to both staff and clients to have systems in place to accommodate and support the grieving process.

People with dementia and their families and carers are likely to experience feelings of grief from diagnosis and throughout the journey of dementia. Grief is a process that helps us adjust and cope with loss. Everyone has a different, individual experience with dementia and grief. However, there are some common feelings that people may share, including denial, anger, resentment, sadness, loss, and acceptance. It is normal to have conflicting emotions, or emotions that make one feel guilty.

There is significant grief and loss in Aboriginal communities in Victoria from Stolen Generation policies and preventable deaths of infants, children and young adults. Rituals, ceremonies and sorry business are intrinsic to Aboriginal culture.

Gay, lesbian, bisexual, transgender and intersex (GLBTI) older people who may have passed as heterosexual or concealed their same-sex relationships from family and society may not feel safe to publicly grieve for the death of a partner or homosexual/transgendered friend.

Religious involvement and spirituality is a common coping mechanism for older people. Many older people facing stress, loss or bereavement report that their religious beliefs help them to cope.

### What can you do to support an older person who is grieving?

- Acknowledge the person's grief.
- Be aware of an older person's beliefs and practices—see the Spirituality and wellbeing Help sheet 43.
- Talk to the person sensitively and respectfully.
- Ensure staff understand grief processes and have skills in this area.
- Respect the privacy of those who publicly or privately grieve and practise their beliefs.
- Ensure there is a private space for families and friends.
- Chaplains and pastoral care workers with experience and knowledge about spiritual issues can be a useful resource.
- Be aware that the attendance at funerals and the mourning period is a high priority for all Aboriginal community members.
- Assist the person to relax and do activities they feel comfortable doing.
- Support the person in social/cultural rituals such as memorial services as appropriate.
- Consider referral to specialist services such as counsellors.

### Points to consider in preparing for end of life in residential aged care

- Provide a high level of spiritual care for dying residents if appropriate. Many facilities have services from religious providers and other visiting personnel.
- Staff play a significant role in the satisfaction levels of residents, and the close attachment of staff to residents can enhance end of life care.
- Providing staff with the confidence and skills to be able to discuss these issues with residents.

## Case example

Members of a craft group in a residential service talked about how difficult it was to cope with people in the group dying. They had a psychologist conduct a session with group members, staff, volunteers and carers to learn more about grief and loss and talk openly about it. They decided that each time someone died they would have a ritual. The ritual they planned included sitting around in a circle with a candle and photo of the person in the middle. Sometimes family members would come and talk about what the group had meant to the person. Everyone had a chance to say something about the person who had died and a local minister gave some readings and prayers. They completed the ritual by enjoying a shared morning tea. People who wanted to talk more were provided with individual counselling or pastoral care.

## Case study

Frank had been admitted to a residential aged care service on discharge from hospital. His condition deteriorated rapidly, and the staff contacted the local palliative service for support. As Frank had limited family support, Frank agreed that he would like Andrew, a volunteer from the palliative service, to sit with him. On his last visit, Andrew found that Frank was no longer responsive, but appeared agitated and restless. Andrew sat with Frank for several hours, playing his guitar. 'I don't know if it was any help, but he seemed calmer while I was there,' said Andrew. The staff reported that Frank did in fact settle while Andrew was with him. Frank died peacefully several hours later.

(Department of Health and Ageing, 2006)

## Case example

Susan, a lesbian, supported her partner Mary of 30 years moving into residential care.

They met with the residential care staff and explained that they would like to be recognised as a couple. They requested that no male nurses would provide personal care and to be respected for their lifestyle, ideas and preferences. Mary's usual GP continued to attend her in residential care.

Susan and Mary felt an enormous sense of loss as a result of the changes. They discussed how they felt with the residential care staff and developed a range of strategies, one of which was to support them to continue to attend activities within the lesbian community.



## Help sheet 45: Health, hygiene and comfort

Preventing the effects of poor hygiene and health are important for comfort and good mental health.

Achieving and maintaining physical health in older people is an active process. Good physical health for older people will enhance good mental health and emotional wellbeing, and relies on nutrition, physical activity and social participation.

### Constipation

Many older adults can have constipation which can be painful and difficult, and affect their sense of wellbeing. To prevent constipation older people should be encouraged to:

- keep a regular bathroom routine
- drink 6–8 cups of liquid a day
- eat foods with fibre each day
- be active
- avoid too many laxatives.

### Pain management

Consequences of chronic pain in older people include increased confusion, sleep disturbance, nutritional alterations, impaired mobility, depression, social isolation, worsening pain, slowed rehabilitation, and increased risk of falls.

Good practice in assessment, care planning and medication for pain management is required to ensure people are as comfortable as possible.

Non-medication and complementary therapies (such as aromatherapy or acupuncture) may be used by themselves or in conjunction with medication. Emotional support for people in pain can be therapeutic when offered by their GP, staff and relatives/carers. Diversion therapies may help, as well as offering nutrition and fluids, ensuring the resident is warm and comfortable, and reducing lighting and surrounding noise.

### Personal hygiene

Good hygiene contributes to physical comfort and emotional wellbeing. Older people may need assistance with personal hygiene. However, continuing to do as much as possible and practicable themselves can maintain a sense of independence for frail older people. Staff members should avoid the temptation to do something for a resident simply because it is faster for the staff member to do it. Individual preferences for hygiene products, aromas, tactile sensations may be sought to enhance personal hygiene practices and experiences. Ensure residents are able to have choice about the gender of the personal carer attending to their personal hygiene.

### Bathrooms

Bathrooms in modern western style homes provide privacy, warmth, comfort and even luxury while undertaking our daily personal hygiene routines. How does a residential facility bathroom compare? For most adults and older people with motor disabilities it means stressful experiences. How can the bathroom environment and routine be made as pleasurable as possible for a frail older person, while maintaining function and safety?

Consider privacy, warmth, aroma, reduced glare and noise. The use of colour and soft furnishings can make the environment seem less clinical and sparse.

Poor bathroom hygiene can present a health risk to users. When not cleaned properly a bathroom becomes a risk due to bacteria and spread of disease.

- All bathroom surfaces should be cleaned regularly: door handle, taps, toilet, sink, floor, shower and bathtub.
- All toilet parts should be cleaned regularly including the seat, rim, lid, bowl and flushing handle. Always wipe the toilet seat before and after using.
- Shake water from the curtain after showering to prevent buildup of mould and mildew. Always leave the curtain open so water evaporates.
- Occasionally removing showerheads and soaking them overnight in vinegar or a commercial cleanser removes dirt that clogs the head and contaminates the shower water.

### Oral health

Old age, illness, and dentures don't diminish the need for oral hygiene and regular dental checkups. The amount of saliva (which cleans teeth) decreases with age, leaving the mouth more vulnerable to tooth decay and infection. Decreased saliva flow combined with the inability to brush and floss, increases the risk of oral disease.

Older people may need assistance with brushing teeth, and dentures should be checked regularly for proper fit. Some older people are also at high risk for oral cancer, another reason for regular dental visits.

## Help sheet 46: Understanding sensory changes and the impact of the environment

Senses are the primary interface with the environment. Sensory changes occur with ageing. As hearing and vision deteriorate with age it is important to ensure that older people have access to annual tests and updated aids.

Sensory changes can be complicated with the symptoms of dementia. Sensory losses or impairments (aggravated by incorrect or malfunctioning visual and hearing aids) together with cognitive deficits make it difficult for people with dementia to interpret and understand the environment. People with dementia have an increased sensitivity to environmental conditions, stemming from the reduction of the individual's ability to understand the implications of sensory experiences. Gay, lesbian, bisexual, transgender and intersex (GLBTI) older people may lose the capacity to assess when it is safe to disclose their sexual or gender identity.

### Temperature

In principle, older adults do not perceive thermal comfort differently from younger adults. The effects of gender and age can be accounted for by activity and clothing level. On average, older adults have a lower activity level, and thus metabolic rate, than younger persons which is the main reason they require higher ambient temperature. The ability to regulate body temperature tends to decrease with age.

### Smell

Smell interacts closely with taste. A decreased sensitivity to odours may be dangerous, for example, not being able to smell gas, smoke or spoiled food. It can also have social implications. People may be unaware of their own body odour. People may be unaware of the smell of urine that accompanies them. Unpleasant smells (urine, strong cleaning products) are known to cause over stimulation and should be removed as much as possible. Pleasant odours can have positive effects, such as:

- the smell of nice soap or bathwater with fragrance
- smells from an adjacent kitchen improve appetite
- enhanced enjoyment of food and social interaction.

### Taste

The senses of taste and smell interact closely. We detect certain dangers, such as spoiled food, noxious gases, and smoke with taste and smell. A delicious meal or pleasant aroma can improve social interaction and enjoyment of life.

The number of taste buds decrease beginning at about age 40 to 50 in women and at age 50 to 60 in men. Each remaining taste bud also begins to atrophy (lose mass). The sensitivity to the four taste sensations does not seem to decrease until after age 60, if at all. If taste sensation is lost, usually salty and sweet tastes are lost first, with bitter and sour tastes lasting slightly longer.

### Vision

After the age of 50, glare and low levels of light become increasingly problematic. People require more contrast for proper vision and have difficulty perceiving patterns. After the age of 70, fine details become harder to see, and colour and depth perception may be affected.

Older people who experience vision impairment may experience a range of feelings including grief, confusion, anger, fear, loss of control and loss of self-esteem.

## Hearing

The sense of hearing begins to be affected by the age of 40 years. High frequency pitches are the first to become less audible, with reduced sensitivity to lower frequency pitches. The ability to understand normal conversation is usually not disturbed at first, but when combined with the presence of background noise understanding may be affected.

### Considerations for a positive sensory environment

A positive sensory environment can contribute to a person's sense of emotional wellbeing. Consider these sensory items when choosing venues or environments or planning activities, outings or functions.

Sense	Examples
Temperature	<ul style="list-style-type: none"><li>• Ensure a comfortable temperature by asking people how they feel and making sure they are warm and comfortable.</li></ul>
Smell	<ul style="list-style-type: none"><li>• Minimise offensive smells.</li><li>• Find out what smells evoke positive memories for people.</li><li>• Create pleasurable smells, such as through foods or use of fragrances.</li></ul>
Taste	<ul style="list-style-type: none"><li>• Ask people about their favourite tastes and flavours.</li><li>• Provide additional seasoning for people to add to a meal.</li></ul>
Vision	<ul style="list-style-type: none"><li>• Ensure good lighting.</li><li>• Avoid surface glare.</li><li>• Use contrasting colours.</li></ul>
Hearing	<ul style="list-style-type: none"><li>• Eliminate background noise as much as possible as hearing aids magnify background noise.</li><li>• Remember that for older people the bathroom can cause stress, partly because of sounds and acoustics.</li><li>• Minimise sounds that may be confusing or irritating, including rushing water, toilet flushing, exhaust fans and outside noises such as traffic or people.</li><li>• Limit reverberation, for example by using textile floor coverings, provided they are not a falls risk or hinder wheelchair movement.</li><li>• Limit excessive background noise during meals as it can be distracting to social interaction and communication.</li><li>• A silent bedroom is crucial to good sleep.</li></ul>

## Help sheet 47: Using sensory stimulation

Sensory stimulation is an important aspect of overall emotional wellbeing. It can convey emotional support, affection, and respect. Along with opportunities for sexual and gender expression, it enhances quality of life and wellbeing.

Sensory stimulation plays a major part in activating the potential for communication in people with dementia, as demonstrated through programs such as Sonas aPc.<sup>1</sup> At the same time, it contributes to the reduction of agitation, sleep disturbances and behavioural issues in people with dementia.

### General strategies to promote sensory stimulation

Endeavour to create a balanced amount of stimulation – enough to keep the older person from becoming bored but not so much that they become agitated. Too much noise, activity, people and visual stimulation may create overload for some older people and those with dementia. It is important to assess the need for sensory stimulation and observe for over stimulation.

There are many ways of incorporating sensory stimulation and enrichment into group activities and programs to enhance emotional wellbeing. Some considerations include to:

- have a coordinated focus on sensory enrichment and include it as a component in staff training
- be aware and creative in finding sources of sensory enrichment
- offer a range of group activities and outings to cater for individual tastes and interests (for example games, quizzes, craft groups, gardening, pottery, outings, concerts, exercise programs, cooking, food tasting, singing) to contribute to sensory stimulation
- be conscious of the impact of lighting, flowers, décor, access to gardens and sunshine
- be aware that music has the potential to stimulate in a beneficial way, but also to irritate and pose communication barriers
- reduce competing noise sources and control volume
- facilitate hand and hair treatment and hand, neck, back, shoulder and foot massage.

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<sup>1</sup> Sonas aPc—<http://www.sonasapc.ie/approach.html> This program, designed to activate potential for communication in people with dementia, offers gentle stimulation of all the five senses. The DVD has old familiar music, songs and simple instructions for each stage of the program. Activities include gentle exercise, singing, massage, music-making, tasting, smelling and cued speech (completion of proverbs and poems). The visual element is provided by the faces and movement of the diversional therapists and other participants, and bright banners and balloons.

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## Specific strategies for the five senses

Providing choice and understanding of what a person does and does not like should underpin approaches to sensory stimulation.

Sense	Examples
Touch	<ul style="list-style-type: none"><li>• Manicures, pedicures</li><li>• Hair care</li><li>• Hand, head, back, shoulder and foot massage</li><li>• Different tactile opportunities such as rugs and throws, cushions, clothing</li><li>• Activities such as gardening or handling food</li><li>• Animal therapy such as hens on site or visitors with pets</li><li>• Sunshine in moderate amounts</li><li>• Clothing, jewellery and makeup</li><li>• Feel the sand at the beach.</li></ul>
Sight	<ul style="list-style-type: none"><li>• Appropriate lighting and views to outside</li><li>• Bright colours in activity rooms</li><li>• Restful colours in lounge or dining areas</li><li>• Food presentation, such as contrasting colours on the plate</li><li>• Indoor plants and flowers</li><li>• Non-abstract paintings</li><li>• Use magnifying glasses and binoculars.</li></ul>
Taste	<ul style="list-style-type: none"><li>• Interesting and varied meals</li><li>• Introduction to new and varied tastes</li><li>• Finding out people's likes and dislikes and different cultural dishes</li><li>• Tasting activities (bitter, sour, sweet, salty, spicy)</li><li>• See Help sheet 35 on food and emotional wellbeing.</li></ul>
Hearing	<ul style="list-style-type: none"><li>• Music activities such as dancing, listening, singing, clapping, and playing musical instruments</li><li>• Sharing favourite music and songs</li><li>• Conversation (see communication help sheet)</li><li>• Games, debates, quizzes, karaoke and concerts</li><li>• Attend a free jazz concert</li><li>• Invite local musical groups to perform.</li></ul>
Smell	<ul style="list-style-type: none"><li>• Flowers—ask people to bring flowers from their garden</li><li>• Perfumed massage creams and oils</li><li>• Food smells—coffee, fresh herbs, lemon</li><li>• Sensory gardens or herb gardens</li><li>• Have a smelling quiz</li><li>• Use aromatherapy oils or incense</li><li>• Use real Christmas trees or bring in eucalypt branches with aromatic leaves.</li></ul>

## Help sheet 48: Light—seasonal affective disorder

Seasonal affective disorder (SAD), or ‘winter depression’, may affect as many as a third of us, but the problem often goes undiagnosed.

### What causes SAD?

There are several different theories as to what causes SAD. They mostly centre on the way light hits the back of the eye (the retina) and triggers messages to the hypothalamus, which controls sleep, mood and appetite. These messages are conveyed by brain chemicals (neurotransmitters), in particular serotonin and melatonin, which may be lower during winter when daylight hours are less. Changes in the levels of these chemicals may cause SAD symptoms in people who are genetically predisposed. Some people need more light than others. Bereavement and serious illness can also trigger SAD.

As well as the impact of seasonal differences on emotional health, older people living in residential care may be at risk of low vitamin D, particularly during the winter months. Exposure to sunshine is essential for the manufacture of vitamin D as only 10-25 per cent is available through diet. Guidelines to reduce risk are available from the Victorian Chief Health Officer, December 2009.

### What are the effects of SAD?

For some, changes in mood and behaviour are severe, and happen regularly, each winter, following a seasonal pattern. Symptoms go away in spring, either suddenly or gradually, depending on the amount of sunlight in spring and early summer.

### Symptoms

The symptoms are many and varied, and people may experience any of the following:

- lethargy or fatigue – no energy for everyday tasks
- a lowered immune system during the winter, and are more likely to get constant colds, infections and other illnesses
- sleep problems – oversleeping, disturbed sleep, waking too early in the morning, unable to stay awake during the day
- depression – feeling sad, low, weepy, guilty, a failure; sometimes hopeless and despairing, sometimes apathetic and feeling nothing
- mood changes – in some people, bursts of overactivity and cheerfulness (known as hypomania) in spring and autumn
- anxiety – tenseness and inability to cope with everyday stresses; panic attacks
- social problems
- concentration problems – difficulty ‘thinking straight’ or making decisions
- overeating – craving carbohydrates and putting on weight (which may increase negative feelings)
- bulimia – eating large amounts of food and then vomiting
- loss of libido – not being interested in sex or physical contact
- alcohol and drug abuse.

### What sort of treatment is there?

Any treatment (including light treatment) should be medically supervised, either by a GP or a SAD clinic. Bright light is the most effective treatment for most people. Talking treatments, such as counselling, psychotherapy or cognitive behaviour therapy can be extremely useful in helping people to cope with symptoms.

### Practical ways to avoid/treat SAD

- Assist residents to be outdoors in natural daylight for an hour each day, especially at midday and on bright days. Inside, place chairs near windows. Ensure minimum light exposure meets government health recommendations.
- Monitor diets – balance the SAD craving for carbohydrates, such as pasta and potatoes, with plenty of fresh fruit and vegetables.
- Some people find that taking extra vitamin B12 is helpful.
- Pamper residents with a massage or relaxation exercises.
- Consider complementary medicine.



## Help sheet 49: Privacy and confidentiality

Privacy and confidentiality are important to the maintenance of a person's dignity and wellbeing. It is vital that staff safeguard the privacy and confidentiality of the older person as far as possible. This includes physical privacy (respect for bodily privacy, personal space and property) as well as confidentiality and privacy of information.

### Maintaining privacy in a residential aged care setting

- Ensure the older person is appropriately covered by clothing.
- Respect the older person's dignity by maintaining bodily privacy during care tasks.
- Provide sufficient toilets and have toilets out of public view.
- Ensure that staff and other residents knock and ask permission before entering a resident's personal space (room).
- Permit residents to maintain a private lifestyle in their own rooms.
- Provide opportunities to fulfil religious practices and respect privacy for those who publicly or privately practise their beliefs (refer to Help sheet 44).
- Develop high quality, culturally sensitive practices.
- When nursing staff pay attention to the residents' need to talk, and show respect, the residents feel in control of their lives and may ultimately become more satisfied.

### Confidentiality

Safeguarding confidentiality of information can be difficult when family members demand to know private information pertaining to their relative. Staff need to have an understanding of the relevant Commonwealth and State legislation, regulations and instruments concerning privacy to inform them of their legal responsibility to ensure that the resident's information remains private and confidential.

### Informed consent

- In Australia, medical services cannot be provided without an individual's consent.
- This consent is considered 'informed consent' when the person assents to a treatment without duress, consent is voluntarily given after a reasonable time, and adequate information has been provided to the person.
- The only exception is when the person's capacity to consent is impaired by a serious mental illness, in which case the relevant state Mental Health Act can be invoked.

### Family members

- If a family member has been granted a legal right to make decisions for an older person, appropriate documentation must be sighted by a staff member, and its power and limitations noted on the older person's record.
- Staff can then be directed by this document as to how much information they are able to share regarding the older person.
- The legislation can vary concerning the responsibilities of those authorised 'in advance' by the older person's 'enduring power of attorney' or 'enduring power of guardianship', so it is incumbent on each facility/service provider to check legal requirements.



# Section 5: Well for life emotional wellbeing – education package

## 5.1 Aims and objectives

The educational resources contained in this section have been developed to assist staff members to facilitate a meeting or workshop to raise awareness of the emotional wellbeing of older people living in residential aged care. It adds to the nutrition and physical education modules included in the *Well for Life: Improving nutrition and physical activity for people in a residential aged care facilities* resource.

The **aim** is to provide staff with information and education so they can understand, encourage and support positive emotional wellbeing, along with nutrition and physical activity strategies, among diverse older people, as an integral part of service delivery.

The **guiding principles** outlined below have been used to provide a context for the education package. They reflect active ageing and positive ageing and are based on a range of approaches including person-centred care, the HACC Active Service Model and health promotion.

- 1 Support **autonomy** and **independence** recognising that frail older people continue to have relationships with friends and family that are interdependent.
- 2 Encourage and foster social connections within and external to the service.
- 3 Focus on **strengths, abilities** and **improving capacity**, rather than disabilities.
- 4 Promote **personal responsibility** for activities of daily living and engagement in activities of personal interest.
- 5 Provide **person-centred services** that are **flexible and responsive** to changes in an older person's health and wellbeing, and based on their goals.
- 6 Create **relationships** with the older person to explore their interests and strengths and to develop their goals.
- 7 **Respect** an older person's decision-making ability and incorporate their wants in decisions about care they receive and types of services provided.
- 8 Work in **partnership** with other local services and organisations, and with the person's carers and family, but recognise that in some cases a person may not want other parties consulted if making decisions about their future.
- 9 Respect **privacy and dignity** in relation to consulting friends, families, neighbours, relatives and service providers when making decisions about a person's future.

At the end of the program, participants should be able to:

- discuss the benefits of emotional wellbeing for older people
- apply knowledge to individual case examples
- propose strategies to increase emotional wellbeing among older people in their workplace and as part of everyday service delivery
- understand the links between the three health promotion aspects of the Well for Life approach: physical activity, nutrition and emotional wellbeing.

Learning objectives

## 5.2 How to use the education package

The package is designed to be used by staff members without a formal background in education or training, but with knowledge of working with older people. Older people, their carers and families should be supported and involved in planning and implementing the program.

The educational program is intended to be delivered as a seminar, workshop or meeting. It is divided into **two modules** that can be delivered as a single session or delivered as two sessions:

Module one: Understanding emotional wellbeing

Module two: Understanding ageism/action planning

The facilitator may choose to select some components of the package and exclude others depending on the learning needs and interests of the participants.

The **session plan** provides the session facilitator with a clear and logical program to follow and aims to limit the amount of additional preparation required to deliver the session.

A **PowerPoint presentation** for each module is supported by facilitator's notes, including additional references.

**Handouts** and the **help sheets** are used throughout the session to support the learning objectives.

## 5.3 Participants

The program is designed for anyone with an interest in the emotional wellbeing of diverse older people living in residential care as an integral part of service delivery. This includes people with little, through to extensive work experience, or with varying levels of formal education.

Participants could include:

- community/district/Division 1 or 2 nurses
- home care and personal care attendants
- activities coordinators and assistants
- social support workers
- managers and team leaders
- allied health or therapy staff
- health promotion coordinators
- quality care managers
- any staff member who works in a direct care role
- volunteers
- carers, family members and resident's representatives.

At the beginning of the session, ask participants about their background and understanding of the topic, to tailor the session pitch and examples to participant's level of experience and interest.

## 5.4 Preparation

Prior to conducting the session, ensure that:

- there is management support to run the session
- session participants are able to take time off from their regular duties
- there is a follow-up process for management to consider and provide feedback about ideas generated by participants.

Equipment requirements:

- An overhead projector/data projector and screen for the PowerPoint presentation (or sufficient photocopies of the slides as handouts).
- A room large enough to hold the group seated in a circle and with provision for small group work.
- Tea/coffee facilities and morning or afternoon tea.
- Butchers paper or whiteboards and marker pens (for each small group).



# Module one: Understanding emotional wellbeing

## Contents

- Session plan
- Facilitator's notes
- Handouts: *Guiding principles for emotional wellbeing* and *Maintaining an individual's emotional wellbeing*
- PowerPoint presentation slides (or used as handouts)
- Case studies and guide to intervention.

## Module one session plan Time: 1.5 hours

Module 1	Content (What will be taught)	Method (How it will be taught)	Resources
Introduction (10 minutes)	Explain seminar aims, learning objectives, why this is an important topic and why the seminar is being offered.	Use of brief explanatory comments	PowerPoint presentation of aims and objectives: Slides 1–4
Group discussion (20 minutes)	Facilitated group discussion on: <ul style="list-style-type: none"> <li>• definitions of emotional wellbeing</li> <li>• aspects of emotional wellbeing (and what contributes to it.)</li> </ul>	Group activity. Participants break into small groups to discuss their understanding of their own emotional wellbeing and factors that detract from or enhance it.  Participants record key points on butcher's paper and then report back to whole group.	
Presentation (20 minutes)	Overview of current trends and key research findings in relation to emotional wellbeing: <ul style="list-style-type: none"> <li>• definitions of mental health from WHO and VicHealth</li> <li>• benefits</li> <li>• guiding principles</li> <li>• understanding diversity</li> <li>• 5 key elements</li> <li>• influencing factors</li> </ul>	Use the prepared overheads and/or handouts: <ul style="list-style-type: none"> <li>• Session overview/refer to handout of principles</li> <li>• Definitions and principles</li> <li>• Definitions focusing on: Quality of life, social connections</li> <li>• Principles focusing on: older people usually want to maintain their independence, continue participating in activities they have always been interested in, and maintain their privacy and dignity</li> <li>• Understanding diversity—cultural, sexual, gender</li> <li>• Aspects of emotional wellbeing.</li> </ul>	PowerPoint presentation of definitions and aspects with/without handouts of slides: Slides 5–22  Handout of principles
Case study, role play and feedback (30 minutes)	Discuss and role play case studies demonstrating older people at risk of diminished emotional wellbeing.	Discuss case studies in small groups; volunteers to act out role play in large group, group to suggest interventions and facilitator to record on whiteboard.	Case studies. Facilitator to refer to 'guide to interventions' sheet.
Summary (10 minutes)	Summarise session and introduce next session.	Recap aim, aspects of emotional wellbeing and outcomes of session.	PowerPoint presentation of aims, objectives and/or handout as per first session of this module: Slides 2 and 3, 23

## Module one: Presentation and notes

**Introduction** (10 minutes)

### Notes for slide 1

- Welcome and introductions

### Notes for slide 2

Describe the aims:

- Raising awareness of benefits of emotional wellbeing for all age groups, including older people in residential aged care.
- Applying this knowledge to case examples of individuals.
- Proposing opportunities to increase emotional wellbeing among older people in their own environments.

### Notes for slide 3

- Describe the learning objectives

### Notes for slide 4

- Describe the structure and style (interactive, practical) of the session.
- Comment on the outcome of an action plan (in module two).

**Well for Life including  
emotional wellbeing  
for older people**

**Module 1**

1

Slide 1

**Aims**

- To raise awareness of the importance of emotional wellbeing of older people
- To integrate emotional wellbeing with nutrition and physical activity
- To identify opportunities for improving emotional wellbeing in service delivery practice

Well for Life Emotional Wellbeing: Module 1

2

Slide 2

**Learning objectives**

At the end of the program participants will be able to:

- Identify and discuss the key elements, enablers and barriers to emotional wellbeing of older people
- Be familiar with the help sheets
- Apply knowledge to settings, services and individual cases to facilitate the emotional wellbeing of older people

Well for Life Emotional Wellbeing: Module 1

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Slide 3

**Session structure**

- Introduction, aims and objectives
- Discussion
- Presentation: definitions, principles and elements of emotional wellbeing
- Case study and discussion
- Summary and close

Well for Life Emotional Wellbeing: Module 1

4

Slide 4



### Activity 1: Group discussion (20 minutes)

The purpose of this warm-up exercise is to ask participants to start thinking about emotional wellbeing. Do not provide information about emotional wellbeing at this stage. Definitions of and factors that enhance and detract from emotional wellbeing will be discussed in the following section.

Begin by eliciting staff perceptions of emotional wellbeing by asking the participants to break into small groups or pairs to discuss:

- their understanding of their own emotional wellbeing
- factors that contribute to their own emotional wellbeing.

Encourage all participants to consider these questions, to share their views, and to listen to and respond to other people's ideas.

Record the group's answers on the whiteboard or butchers paper. Summarise the outcomes by emphasising the range and diversity of factors that both detract from and enhance emotional wellbeing for individuals.

### Presentation (20 minutes)

#### Notes for slide 5

Present the current trends and key research findings including:

- WHO and VicHealth definitions noting that there is no single definition of emotional wellbeing
- other terms such as 'quality of life', 'thriving' and 'social connections' often used to describe emotional wellbeing. What is becoming increasingly understood is that the concepts of mental health or ideas about quality of life held by older people do not differ substantially from those of younger people.
- That most differences in behaviour are the result of physical or mental disease or social disadvantage rather than the ageing process itself.

Other misconceptions include that the elderly choose to 'disengage' socially, that depression is natural, that intellectual decline is a normal feature of ageing and that older people are not distressed by the death of contemporaries or their own disabilities. These attitudes are either in response to disability or are simply not valid assumptions. Dementia has also been confused with the ageing process.

As with the other stages of the life-cycle, the older person's values regarding their mental health should be respected and they should be encouraged to make their own decisions regarding their lifestyle rather than having others decide for them. There will be individual and cultural differences, but the principle remains the same. Efforts to maximise their options through improved physical health, supportive social conditions and opportunities for personal growth and expression will promote improved mental health.

Findings on daily living practice among older people suggest the importance to their physical and mental health of good food habits, regular exercise, seeking knowledge about health, religious activity involvement, good relationships with others and well-planned management of income and expenses.

## Notes for slide 6

The WHO (1993) Quality of Life Group defined quality of life as:

*'An individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns. It is a broad-ranging concept, incorporating in a complex way, the person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features of the environment'*

(World Health Organization Quality of Life Group, 1993).

Lawton defines quality of life in frail older people as:

*'The multidimensional evaluation, by both intra-personal and social-normative criteria, of the person-environment system of an individual in the time past, current and anticipated'*

(Lawton, 1991).

When someone is 'thriving' we generally mean they are doing well given their circumstances.

The concept of thriving encompasses several perspectives: thriving as an outcome of growth and development; thriving as a psychological state; and thriving as an expression of physical health state (Bergland & Kirkevold, 2001).

### Definitions: mental health

- ... is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. **WHO 2001**
- ... is the embodiment of social, emotional and spiritual wellbeing. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just. **VicHealth 2005**

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Slide 5

### Definitions of related terms

- Quality of life
- Thriving
- Social connection

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Slide 6

### Notes for slide 7

Present and discuss the key principles for emotional wellbeing (using the handout if desired) to elicit the key points:

- Older people usually want to maintain their independence
- Older people want to continue participating in activities they have always been interested in, and continue to learn new things.
- Older people want to maintain their privacy and dignity.
- Active ageing is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. It allows people to realise their potential for physical, social, and mental wellbeing and to participate in society according to their needs, desires and capacities while providing them with protection, security and care when they require assistance.
- The HACC Active Service Model is based on the following principles: people want to remain autonomous; people have the potential to improve their capacity; people's needs should be viewed in a holistic way; person-centred care; and that a person's needs are best met when there are collaborative working relationships between service providers, the person and their family members.
- Person-centred practice means respect for a person's desire to make their own decisions with a focus on self-determination and empowerment

### Notes for slide 8

Present and discuss the diversity of older people. Ensure the group considers all of these factors: age; gender and sexual identity; physical and cognitive ability; emotional, spiritual, religious and cultural background and beliefs; ethnicity; Aboriginality; refugee status; language; and socio-economic circumstances.

The *Victorian Charter of Human Rights and Responsibilities* (2008) states that all Victorians should be treated with equality, fairness and respect.

The Charter encourages us to recognise the commonality between people as well as the difference within groups, and respond to this difference.

## Guiding principles

- Promoting emotional wellbeing is aligned with the concepts of *active* and *positive ageing*, including person-centred care, the Active Service Model and health promotion. The guiding principles are to:
  - Support **autonomy** and **independence**
  - Encourage and foster **social connections**
  - Focus on **abilities** and **improving capacity**
  - Promote **personal responsibility**
  - Provide **person-centred services** that are **flexible and responsive**
  - Create **relationships**
  - **Respect** an older person's decision making ability
  - Work in **partnership**
  - Respect **privacy and dignity**

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Slide 7

## Understanding diversity

- recognise the commonality between people as well as the difference within groups, and **respond to this difference**
- age; gender and sexual identity; physical and cognitive ability; emotional, spiritual, religious and cultural background and beliefs; ethnicity; Aboriginality; refugee status; language; and socio-economic circumstances.

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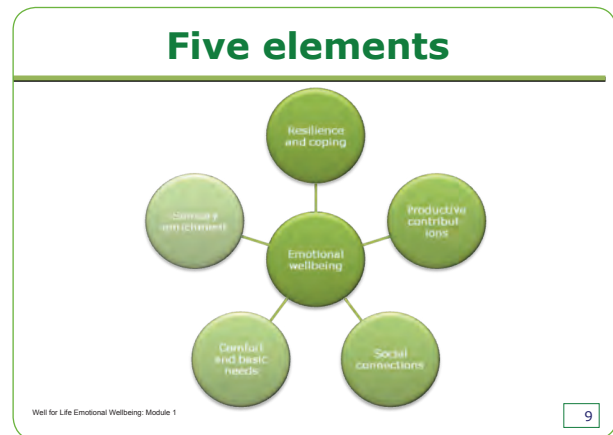
Slide 8

### Notes for slide 9

Present the Well for Life five key elements to emotional wellbeing.

Using the handout and ask participants to expand on each element.

- 1 Resilience and coping
- 2 Being productive and making a contribution
- 3 Social connections
- 4 Basic needs and comfort
- 5 Enjoying sensory enrichment



Slide 9

### Notes for slide 10

Present and discuss the factors that contribute to emotional wellbeing.

#### Physical activity

- Exercise has many benefits for physical and mental health.

#### Nutrition, including hydration

- It is generally accepted that how we feel can influence what we choose to eat or drink.
- What is less well known is how what we eat can affect our mental functioning and wellbeing.
- Ethnic and multicultural organisation staff with specialist expertise may be able to provide advice on culturally appropriate foods.

#### Purposeful activities

- Being able to contribute to community, whatever 'community' is for an individual, can be important to emotional wellbeing.

#### Sensory changes

- Changes to the senses occur with age.
- The environment interacts with our senses.
- Modifying the environment, assessing and treating sensory change are important to promote emotional wellbeing.

#### Respect, dignity and privacy

- Respect an older person's decision-making ability and incorporate their wants in decisions about care they receive and types of services provided, whilst recognising some residents may have diminished ability to make informed decisions and there is the need to balance risk taking, activity and choice.

#### Social connections

- Most people need to feel like a useful member of society and connected to their community.
- Being able to contribute to family and community, whatever this means for an individual, can be important to emotional wellbeing.
- The expertise of GLBTI staff or staff in Aboriginal and multicultural organisations can be used to support connections for people from diverse backgrounds.

### Spirituality

- For an individual, their spiritual, religious or personal beliefs may be particularly important in times of emotional stress, physical and mental illness, loss and bereavement.

### Resilience and coping skills

- Older people are vulnerable to the experience of loss, be it in terms of health, identity, finances, independence and social connections.
- The maintenance of emotional wellbeing in the face of such losses can be considered a function of resilience.
- The use of appropriate coping mechanisms or skills contributes to resilience and has a protective effect.

### Sexuality

- Sexual and sensual expression enhances wellbeing.
- It can be viewed as a broad concept that encompasses not only sexual behaviour but also body image, self-esteem, physical intimacy (cuddling, touch), romance, social relationships, same-sex attraction and behaviour.

### Gender identity

- Gender identity is independent of a person's sexual identity.
- Wearing clothing that expresses preferred gender enhances emotional wellbeing.

### Communication

- Empathic and respectful communication involves interest in and recognition of the value of the older person.

### Grief and bereavement

- Stressful life events and losses can adversely affect a person's emotional wellbeing.
- Older people face the loss of partners, family and friends, as well as familiar environments.

### Built environment

- The built environment impacts on mobility, independence, autonomy and quality of life in old age
- It can also facilitate or impede a healthy lifestyle.

## Contributing factors

- Physical activity
- Nutrition (including hydration)
- Purposeful activities
- Sensory changes
- Respect, dignity and privacy
- Social connections
- Spirituality
- Resilience and coping skills
- Sexuality, sexual and gender identity
- Communication
- Grief and bereavement

Well for Life Emotional Wellbeing: Module 1

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## Notes for slide 11 – 22

The following slides provide additional information about these factors.

Refer to the help sheets or use them as handouts or for discussion.

### Physical activity

Regular exercise can:

- Lift mood
- Help deal with negative feelings
- Bring a sense of mental wellbeing
- Improve sleep
- Reduce tension levels
- Reduce feelings of stress or fatigue
- Increase energy
- Improve confidence and self esteem

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#### Slide 11

### Nutrition and hydration

- Water vital for healthy mind and body
- Eat at least 5 portions of fresh fruit and vegetables every day
- Eat breakfast and have regular meal times
- Eat foods that release energy slowly, such as oats and unrefined wholegrains
- Eat some protein foods, such as meat, fish, beans, eggs, cheese, nuts or seeds, every day
- Eat oil-rich fish (eg. mackerel and sardines) and linseeds. They contain oils that are vital for a healthy functioning brain
- Eat sunflower seeds, pumpkin seeds, brazil nuts and walnuts which contain important 'good mood' nutrients

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#### Slide 12

### Purposeful activities

- ...the concepts of mental health or ideas held about quality of life held by older people do not differ substantially from those of younger people
- Continue roles and contributions to family, friends, community and society
- Have a meaningful role in daily affairs

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#### Slide 13

### Sensory changes

- Senses are the primary interface with the environment
- Sensory changes occur with ageing
- Ensure regular assessing and prescribing for vision and hearing

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#### Slide 14

### Respect, dignity, privacy

- Dignity is about having a sense of control in your life (autonomy)
- To find out what dignity means for an individual – ask them!
- Privacy and confidentiality are important to maintaining a person's dignity
- We demonstrate respect when people have choices and are enabled to participate in decisions that affect them

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#### Slide 15

### Social connection

- Being connected to 'community', within and external to the family
- Changes to social networks can affect physical and emotional well being
- Social interaction promotes emotional health and can help maintain good cognition
- Social support need not be wholly face-to-face (e.g. telephone, email, Skype, Facebook)
- Even in a caring environment, older people may still be at risk of social isolation

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#### Slide 16

## Spirituality

- Spirituality is an important predictor of quality of life
- Spiritual needs should be assessed as people enter aged care facilities or community care programs
- Research suggests that people are receptive to carefully worded inquiries about their spiritual and religious beliefs

Well for Life Emotional Wellbeing: Module 1

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Slide 17

## Resilience and coping

- The ability to cope with life events and stresses associated with changes in circumstances.
- Effective coping skills gives people better control over their lives and adds to their sense of emotional wellbeing.

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Slide 18

## Sexuality & sexual identity

- Sexual expression and sensual experiences enhance quality of life and wellbeing
- There are many, diverse ways people express their sexuality
- Sexuality and sexual identity is a normal part of older people's health
- Sexuality can be viewed as a broad concept that encompasses not only sexual behavior but also body image, self esteem, physical intimacy, romance and social relationships

Well for Life Emotional Wellbeing: Module 1

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Slide 19

## Gender identity

- Gender identity is a person's own sense of identification of male or female.
- Gender identity is independent of a person's sexual identity.
- Gay, lesbian, bisexual, transgender and intersex people may hide their sexual /gender identity for fear of discrimination
- A positive response to the disclosure of sexual/gender identity can mean an older person feels understood, valued and safe

Well for Life Emotional Wellbeing: Module 1

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Slide 20

## Communication

- Demonstrate empathic and respectful communication
- Use language that respects the adult and Elder status of older people
- Assess each person's needs on an individualised basis
- Assume competence rather than incompetence as a starting point
- Listen to and affirm a person's history, ideas and feelings, even where the person may not be able to express these clearly

Well for Life Emotional Wellbeing: Module 1

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Slide 21

## Grief and bereavement

- Stressful life events and losses can adversely affect a person's emotional wellbeing
- Older people face the loss of partners, family and friends
- Loss of familiar surroundings, abilities and senses may lead to grief
- Those working aged care are exposed to death of those around them, making them vulnerable to bereavement of varying degrees of severity

Well for Life Emotional Wellbeing: Module 1

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Slide 22

## Case studies, role play and feedback (30 minutes)

A practical exercise should be included to provide experiential learning opportunities for the session participants.

Case studies have been prepared to be discussed initially in small groups and then 'role played' by two volunteer participants. Ask for two volunteers: one to 'play' the older person and the other to play the staff member. The case studies can be provided as handouts.

This activity provides an opportunity for participants to analyse the issues associated with emotional wellbeing for older people and to suggest interventions. This is a simple exercise and props will not be required.

At the start of the case study discussions, and for the role-play, participants will be provided with a guide to intervention to consider (attached). At the conclusion of the role-play, ask the group: 'what are the specific difficulties these older people experience and what strategies may improve their circumstances?' List suggestions from the group on the whiteboard.

## Summary (10 minutes)

### Slide 23

Summarise the main points from module one and explain what will be covered in module two.

Briefly explain how participants can start thinking about the interventions in their everyday work.

### Summary

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- Emotional wellbeing varies from person to person
- A range of factors contribute to emotional wellbeing
- Provide a range of opportunities to promote emotional well being
- Identify and minimise risk factors to emotional wellbeing
- Promote attitudes and behaviours to enhance emotional wellbeing

Well for Life Emotional Wellbeing, Module 1

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### Slide 23

## Other useful resources

Determinants of mental health

<[www.health.vic.gov.au/healthpromotion/downloads/mhr\\_determinants.pdf](http://www.health.vic.gov.au/healthpromotion/downloads/mhr_determinants.pdf)>

Approaches to promotion of mental health

<[www.health.vic.gov.au/healthpromotion/downloads/mhr\\_appb.pdf](http://www.health.vic.gov.au/healthpromotion/downloads/mhr_appb.pdf)>



## Module one: Handouts

### Handout 1: Guiding principles for emotional wellbeing

The guiding principles are based on a range of approaches that uphold *active* and *positive ageing* including person-centred care, the HACCC Active Service Model and health promotion.

- 1 Support **autonomy** and **independence** by 'doing with' rather than 'doing for' and actively involve clients in setting goals and making decisions about their care.
- 2 Encourage and foster social connections within and external to the service.
- 3 Focus on **abilities** and **improving capacity**, rather than disabilities.
- 4 Promote **personal responsibility** for activities of daily living and engagement in activities of personal interest.
- 5 Provide **person-centred services** that are **flexible and responsive** to changes in an older person's health and wellbeing, and based on their goals.
- 6 Create **relationships** with the older person to explore their interests and strengths and to develop their goals.
- 7 **Respect** an older person's decision-making ability and incorporate their wants in decisions about care they receive and types of services provided, whilst recognising some residents may have diminished ability to make informed decisions and there is the need to balance risk taking, activity and choice.
- 8 Work in **partnership** with other local services and agencies, and with the person's carers and family, but recognise that in some cases a person may not want these parties consulted if making decisions about their future.
- 9 Respect **privacy and dignity** in relation to consulting friends, families, neighbours, relatives and service providers when making decisions about a person's future.

## Module one

### Handout 2: Individual emotional wellbeing

Well for Life identifies five elements crucial to an individual's emotional wellbeing:

**1 Resilience and coping:** being able to cope with life events and stresses associated with changes in circumstances. Effective coping skills gives people better control over their lives and adds to their achievement of emotional wellbeing.

An awareness of when the person is not managing, and what is important to them, will assist in developing, with the person, practical solutions. Positive communication is required.

**2 Being productive and making a contribution:** staying active and happy and enjoying what life has to offer. Maintaining self esteem, and having a meaningful role in daily affairs.

We can challenge ageism. Get to know the person, their interests and respect their role in life, past and present. Show respect and incorporate their wishes in their care. Encourage independence and autonomy and participation in purposeful activities.

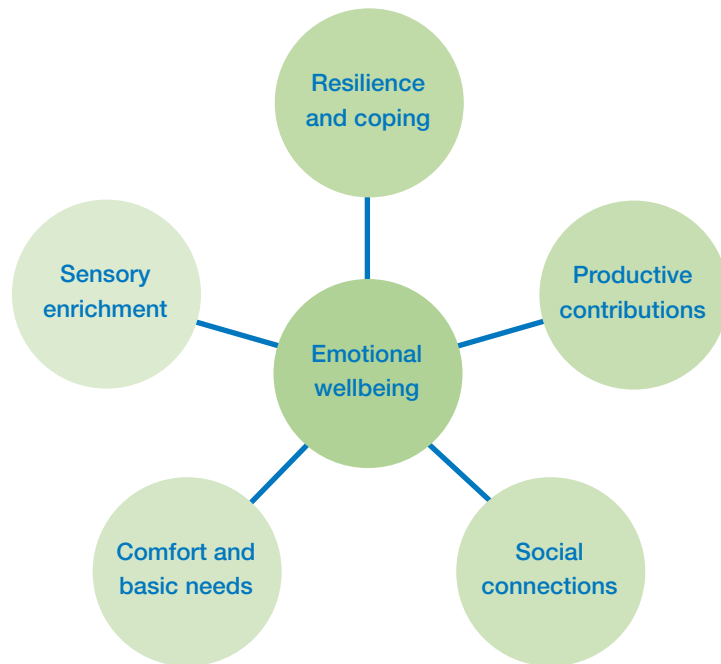
**3 Social connections:** having meaningful relationships with family, friends, peers, the wider community, and staff/workers. Receiving and giving affection.

We can provide opportunities for individuals to be involved in positive social activities, challenge barriers to social inclusion by supporting networks and engagement between the local community and individuals, and also between peers, families and friends. We can offer emotional support to individuals at appropriate times.

**4 Basic needs and comfort:** fulfilment of basic physical needs and the absence of health problems. Having a sense of privacy, security and safety. Being comfortable in your environment. Resources for this include nutritious enjoyable meals, good healthcare, appropriate lighting, temperature control, nice ambience, having sufficient funds. We can safeguard privacy, provide pain-relief, equipment and appliances, and social welfare.

**5 Enjoying sensory enrichment:** having one's senses stimulated. Having a pleasant amount of activity and arousal to convey emotional support, affection and respect.

Resources for this include group activities catering for individual tastes and interests. Ensuring noise, décor, lighting and access to sunshine are appropriate and do not irritate. Offer hand and hair treatments, spas and massages. Be aware and inventive in finding sources of enrichment for individuals whose emotional wellbeing is at risk.



## Module one: Case studies

The following case studies are intended to be used as part of group discussion and role plays. Use the case study role play discussion points to consider how the person's emotional wellbeing could be improved or supported.

### Case study 1

#### John: loss and grief, social connection

John is 89 years of age and came to live at the aged care facility following a fall. He recently lost his wife of 60 years. She had suffered a stroke ten years ago and he cared for her during that time. John has three sons who all live interstate. He is a retired school principal and was actively involved with the local primary school and volunteered with the local meals on wheels service until his wife had the stroke. During the last ten years he had been housebound and socially isolated. He is still mourning the loss of his wife and feeling lonely. John was finding it hard to connect socially with other residents during group sessions.

### Case study 2

#### Gladys: spirituality, social connection

Gladys is 92 years of age and has lived at the aged care facility for many months. She has two daughters who are both within close distance and visit her every second night. They are all busy during the day looking after their grandchildren and on weekends they have other commitments.

Gladys has been attending the resident craft group. At the group she mentioned that she enjoyed attending a church service with her neighbour every Sunday prior to coming to live in the facility. Her neighbour has now shifted to another suburb and Gladys is not able to attend church.

Staff have noticed that Gladys is withdrawn and seems concerned.

### Case study 3

#### Harry: cognitive stimulation and social connection

Harry came into residential aged care at 94. He has a number of health problems including reduced mobility (walks with a frame) and emphysema. His only other relative, a niece, lives interstate. A woman neighbour, a friend of his wife's, assists with laundry and practical shopping needs. He has a male friend who occasionally takes him out for coffee: 'I enjoy talking to him. He doesn't make me feel old.'

Harry is cognitively alert but hearing impaired. He is shy, modest, undemanding and grateful for every attention paid to him, but deafness and shyness stop him from initiating or sustaining interaction with others. Because he has few teeth he does not articulate clearly. His emphysema adds to his speech difficulties. He doesn't like wearing hearing aids. He dislikes going out to functions or events, afraid of not hearing and perhaps giving offence. He spends most of his time in his room where he falls asleep in the chair and is dissatisfied with himself for sleeping so much.

Harry is very interested in current events and values his right to vote. He is glad he has his sight and can read the newspaper, but feels he has nobody to discuss the news with. People who meet him do not realise he has full cognitive capacity or that he is very lonely. He does not complain to his son. He says he is very good to him, and that he is lucky, but then says sadly 'I did not expect to end my days like this.'

### Case study 4

#### Mira: communication and affirmation

Mira is 70 years of age and has been in a high care service for two years. She has right hemiplegia with a high degree of physical dependency as a result of two left hemisphere strokes. She has no mobility and cannot feed or wash herself. After several months on a PEG feed she is now able to eat vitamised food, which she hates both for its lack of texture and lack of taste. Mira spends her time in bed or in a tub chair.

Mira was born in Central Europe, and has lived and worked in Australia for 30 years and has an excellent knowledge of English. She has a photograph of herself in nursing uniform with a television celebrity at her side, reminding her that she was an active, useful, valued member of the community.

She was also renowned for her cooking skills and prefers stronger flavours. When an old friend visits they eat cheese pastries together.

Despite her language competence, the strokes have left her with word-finding difficulty in English. She tends to use her native language unless reminded and encouraged by a conversation partner. Mira's comprehension of English is very good, though this is not generally recognised. Her communication problems are sometimes blamed on poor cognition or poor hearing.

Mira is not linked with any multicultural organisations. She attends some group social activities and spends many hours in solitude or in silence and has gradually become increasingly isolated and depressed.

## Case study role play discussion points

Element of emotional wellbeing	Questions	Comments and suggestions
Resilience and coping	How does the person look? (for example happy, sad, tired, hesitant, anxious, withdrawn)	
	Does the person communicate willingly with others?	
	Is the person undertaking physical activity?	
	Has the person suffered a recent grief or bereavement?	
Social connections	Does the person have social connections? (for example family, friends, peers, connections in the wider community, multicultural organisations or a good relationship with staff)	
	Are there adequate opportunities to interact with family members and friends?	
	Are there any communication barriers, which you can identify? (for example language, hearing impairment or speech difficulties)	
	Are there other people with similar interests that could form the basis of a new friendship?	
	Does the person access a range of community facilities and events?	
Productive contributions	What roles has the person held in the past and how can these be respected and reflected?	
	Is there anything in the person's background, life history or case notes which might help to improve their emotional wellbeing?	
	Are there ways of knowing what the person would like to be able to do; what activities does the person like or dislike?	
	Is the person involved in planning and organising activities in some way or sharing roles?	
Comfort and basic needs	Is communication respectful and positive (non-ageist)?	
	Are there aspects to the physical environment that need to be considered to better suit the person?	
	Are the person's nutritional needs and food preferences being met?	
	Is hydration adequate?	
	Are aids correctly prescribed and fitted? (for example teeth, hearing aids or glasses)	
Sensory enrichment	Have sensory environment matters been considered?	
	Are there opportunities to engage in sensory activities that the person enjoys?	
General	Is the person's sexual identity and sexuality acknowledged and supported?	
	Are the person's spiritual or religious beliefs acknowledged and supported?	
Other comments?		



# Module two: Understanding ageism and action planning

## Contents

- Session plan
- Facilitator's notes
- Handout: *Checklist of true/false statements about older people*
- PowerPoint presentation (or handouts)
- Case studies and action plan template
- Handout: *Evaluation/feedback form*

## Module two session plan Time: 2 hours

Module 2	Content (What will be taught)	Method (How it will be taught)	Resources
Introduction (10 minutes)	Explain seminar aims and learning objectives.	Explain seminar aims and learning objectives and what will be covered in this module.	PowerPoint presentation of aims, objectives: Slides 24-27
Presentation and activity (20 minutes)	What is ageism? Myths and facts about older people Health myths and facts Ageism in practice Impacts on emotional wellbeing Challenging stereotypes.	PowerPoint presentation Awareness raising activity Discussion of the impact on emotional wellbeing of ageist attitudes and practices.	Presentation on ageism: Slides 28-33 Post-it notes
Discussion (20 minutes)	Positive communication maintaining emotional wellbeing	Large group discussion (whiteboard) about strategies to enhance positive communication and overcoming barriers.	Facilitator notes on positive communication
Break (10 minutes)			
Case study and action planning activity (40 minutes)	Review of aspects of emotional wellbeing Discuss practical issues concerned with participants' own service and develop action plan.	Small groups consider case studies based on the emotional wellbeing aspects. Handouts of case studies as provided or participants use own case studies. Each participant to record the discussion points on the handout, paper or whiteboard. Development of action plan.	Case studies Action plan template
Report back, summary and conclusion (15 minutes)	Present strategies discussed in small group sessions relating to case studies (real or provided) Facilitator to summarise session.	Member of each group to present a summary of their strategies. Facilitator to draw together main themes and record on whiteboard. [Prepare as minutes/ seminar notes for each participant]. Conclude the seminar by revisiting the learning objectives.	Learning objectives: Slide 26
Evaluation/feedback (5 minutes)	Ensure participants have an opportunity to provide feedback	Distribute the evaluation/feedback form to each participant.	Evaluation/feedback form

## Module two: Presentation and notes

### Introduction (10 minutes)

#### Notes for slide 24

- Welcome and introductions

#### Notes for slide 25

- Describe the aims

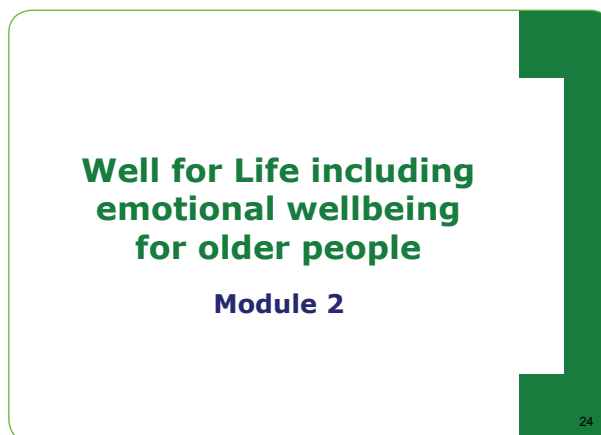
#### Notes for slide 26

By the end of this program participants will be able to:

- recognise the benefits of emotional wellbeing and identify aspects of good emotional wellbeing, as discussed in module one
- identify barriers and enablers to emotional wellbeing in older people
- apply this knowledge to individual cases
- identify target areas in your own agency for enhanced resident emotional wellbeing
- identify staff with skills to champion intervention strategies
- develop an action plan.

#### Notes for slide 27

- Present overview of session structure.

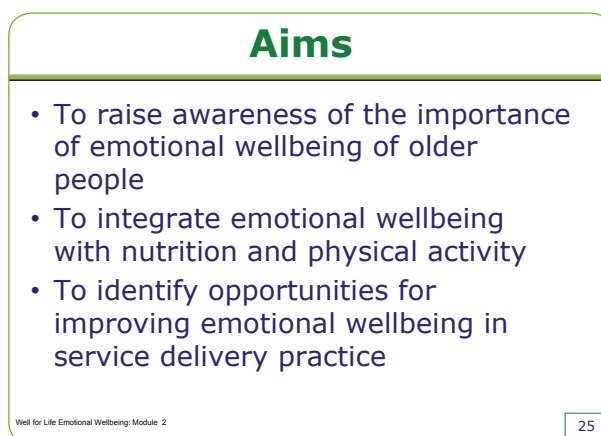


**Well for Life including  
emotional wellbeing  
for older people**

**Module 2**

24

Slide 24



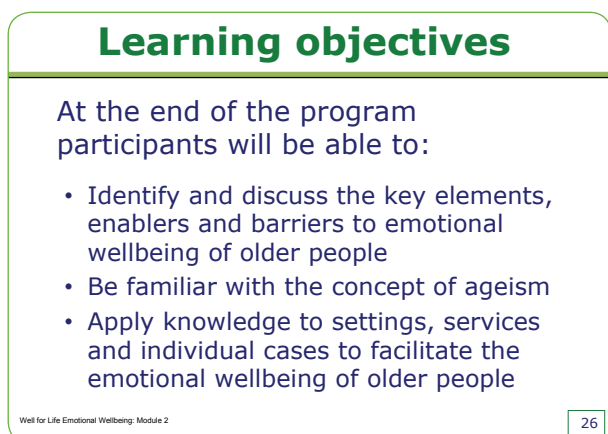
**Aims**

- To raise awareness of the importance of emotional wellbeing of older people
- To integrate emotional wellbeing with nutrition and physical activity
- To identify opportunities for improving emotional wellbeing in service delivery practice

Well for Life Emotional Wellbeing: Module 2

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Slide 25



**Learning objectives**

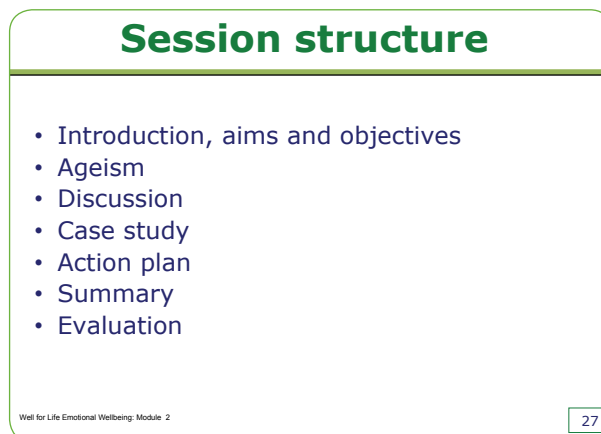
At the end of the program participants will be able to:

- Identify and discuss the key elements, enablers and barriers to emotional wellbeing of older people
- Be familiar with the concept of ageism
- Apply knowledge to settings, services and individual cases to facilitate the emotional wellbeing of older people

Well for Life Emotional Wellbeing: Module 2

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Slide 26



**Session structure**

- Introduction, aims and objectives
- Ageism
- Discussion
- Case study
- Action plan
- Summary
- Evaluation

Well for Life Emotional Wellbeing: Module 2

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Slide 27



### Workshop exercise and presentation (20 minutes)

The purpose is for participants to consider and challenge their own understanding and attitudes about older people.

Ask the group to brainstorm a range of statements about older people, including their own beliefs or the values they have heard others express, positive and negative. Ask participants to write them on post-it-notes. Collect the post-it notes, read them out and discuss them, using the facilitator's notes below. Ask the group to rephrase any negative or ageist statement into positive statements.

#### Examples of negative comments

- Older people have different social needs from other age groups.
- Older people aren't interested in talking to younger people.
- Older people do not have sexual needs.
- Older people would rather sit quietly and not have to move about.
- An older person with a physical disability is very likely to have a cognitive disability as well.
- Inappropriate responses to questions or comments indicate poor cognition.
- It is better to discuss older people with their relatives if you think they might not understand.
- Older people don't worry as much about privacy.
- The best way to show respect is by being kind.
- It is easier to do it for them.

Present the following PowerPoint slides about ageist attitudes and perceptions of older people.

#### Notes for slide 28

- Most people working in aged care, as in the rest of the community, are not consciously or deliberately ageist, but may hold ageist beliefs which they do not recognise as such.
- Sorting myth from fact is an important part of overcoming ageist stereotypes which can influence practice and have a negative impact on the emotional health and wellbeing of care recipients.
- The facilitator's role is not to suggest that participants are ageist, but begin by asking them what they think ageism is.
- 'Ageism is about age and prejudice' (Bytheway, Ward, Holland, & Peace, 2007). It can apply to any age, but it most frequently has negative results for vulnerable older people.
- Stereotyping of older people creates prejudices and misconceptions, which frequently result in ageist practice such as social and economic discrimination, and the exclusion of older people from participation in service development, research and policymaking. Institutional and personal ageism has an impact on social participation and the involvement of older people in the workplace and in health service delivery. Ageist attitudes and practices are obstacles to healthy ageing, yet ageism is often not recognised or acknowledged as such even by older people themselves (Bytheway et al., 2007; O'Shea, 2005).
- Make comparisons with other types of stereotyping.
- Ask if participants have been the target of stereotyping themselves (eg. ethnicity, religion, where they live, the car they drive, an so on).
- Equal Opportunity legislation forbids discrimination on grounds of race, gender, age and disability. Does this mean there is no discrimination?

## What is ageism?

- Holding negative attitudes or beliefs about older people i.e. stereotyping, making judgements based on prejudice
- Acting on these stereotypes to treat older people differently from other age groups

Well for Life Emotional Wellbeing Module 2

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Slide 28

## Ageism in practice

- Failure to respect and to show respect for older people
- Under-estimation of the value and capacities of older people, leading to social and financial discrimination
- Stereotyping contributes to risk of misdiagnosis or poor care decisions
- Failure to develop the strengths and preserve function in older people

Well for Life Emotional Wellbeing Module 2

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Slide 29

### Notes for slide 29

- Loneliness is exacerbated by lack of opportunities for conversation or other social interaction.
- Negative expectations of an older person's cognitive and communicative performance can lead to worse performance and loss of confidence—if expected to fail, people will fail.
- If spoken to in a childish way, an older person can feel loss of worth as well as a sense of powerlessness.

### Notes for slide 30

- **Are these true or false?** Ask participants to explain their answers.
- **Response to myth 1:** Individuals of all ages have different social needs from other individuals. Older people are not likely to have changed social needs just because they are older. If they enjoyed social interaction in their youth they are likely to enjoy it as they age.
- **Response to myth 2:** An older person's health and sensory function may affect the kind of interaction they can enjoy. People who are isolated by the loss of family and friends are likely to have even greater need for social interaction.
- **Response to myth 3:** They have all been young and many remember what it was like for them. Some may not understand the different economic and social conditions which affect young people in the 21st Century, but that doesn't mean that they don't know what it is like to be young.
- **Response to myth 4:** There is plenty of evidence to disprove this generalisation. Just like any other generation, older people have diverse sexual identities and practices.

## Myths or facts?

1. Older people do not have the same social needs as 'us'
2. Older people just want to be left alone
3. Older people do not remember what it is like to be young
4. Older people are not interested in sex

Well for Life Emotional Wellbeing Module 2

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Slide 30

### Notes for slide 31

- Discuss. Encourage participants to think about these statements. Why are they often repeated?
- Is there evidence that all older people are sick? Is there evidence that many are not? Is there evidence that being old is the same as needing care? Are all older people unhappy?
- What are the social influences which support the belief that old age is 'a miserable decline'?
- Advertisements, birthday cards, comedy routines, media (film, radio, TV), literature (Shakespeare presented old age as a return to childhood).
- What role, if any, does a focus on keeping fit and preserving youth play in stereotyping older people? Considerations: keeping fit may be depicted as the preserve of the young, especially by the fitness industry. Additionally, family and health professionals may take the attitude that 'now that you are old you should take it easy', and can shape self-perceptions.
- Many people are afraid of being unattractive, and being attractive is often equated with being young.
- People are blamed for 'letting themselves go', and may be held personally responsible for poor health.
- Fear of ageing and fear of dying contribute to avoidance of the company of older people.

### Notes for slide 32

- Evidence of lack of respect in media and in language used about old people such as 'silly old goat', 'stupid old bag'. Not taking the older client's point of view seriously, not listening, and talking over the client to family members.
- Results of under-estimation. Ask participants for examples. Suggestions: Older people are sometimes obliged to leave the workforce while they still feel able to contribute. For example, insurance policies and banks' lending practices can be discriminatory.
- Misdiagnosis. Health practitioners not listening to the client's concerns, or treating age itself as an illness can lead to misdiagnosis or failure to treat curable conditions. 'It's just old age' and 'What else do you expect at your age?'
- Assumption of incapacity. Support staff not encouraging clients to maintain function, or to be active socially in ways which would build on their strengths and heighten self-esteem.

## Health myths or facts?

1. Older people are all sick
2. People need care because they are old
3. Old age is a state of miserable decline
4. 'It's all downhill after 50'
5. 'I'd rather be a beautiful corpse'

Well for Life Emotional Wellbeing Module 2

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Slide 31

## Effects on emotional wellbeing

- Increased loneliness and isolation
- Risk of functional decline: physical, cognitive and communicative
- Loss of confidence
- Loss of self-esteem
- Increased sense of powerlessness

Well for Life Emotional Wellbeing Module 2

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Slide 32

### Notes for slide 33

- 'Old people are like children' is a common myth. There is no foundation for believing that old people are like children. Loss of function and independence mean that some older people are in need of care and protection, but even when there is severe cognitive impairment and the older person has no impulse control, the psychological condition of an older person is not like that of a child (Hockey and James 1993).
- 'All older people are frail and sick'. A little over two-thirds of people over 90 are in need of care assistance. The average age for entry into residential aged care is 82, and less than one third of people in this age group are in need of care assistance. According to the 2006 Census, 'The rates of need for assistance increased sharply around age 70–74 years, where 10% required some assistance. By age 80–84 years the rate was 29%, and among people aged 90 years and over, around 68% were in need of assistance' (ABS 2008).
- Discuss this question. Does being kind mean 'doing for' or 'doing with'. Does it involve a partnership or is it one-sided? Does it always recognise the needs and wishes of the older person? Person-centred practice places the older person at the centre and focuses on self-determination and empowerment (Dow, Haralambous, Bremner and Fearn 2006). What might this mean in practice? How can staff support the older person and build on their strengths, rather than be tempted to 'do everything for them?' What practical goals might an older person have and how can you help them achieve them?

### Challenging stereotypes

- Common myth that 'old people are like children' has no foundation
- Perception that 'old people are frail and sick' is not backed by statistics: less than one third of people aged 80-84 years need care assistance
- Person-centred care means 'doing with' rather than 'doing for'

Well for Life Emotional Wellbeing Module 2

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### Slide 33

## **Interactive discussion: positive communication and maintaining emotional wellbeing** (20 minutes)

Facilitator to speak briefly about the importance of positive communication and experiences of the older person (see following paragraphs). This will be followed by an interactive group discussion about strategies to enhance positive communication and overcome barriers.

Communication plays an essential role in supporting an older person's autonomy and sense of self, and ultimately affects mental and physical wellbeing. Empathic and respectful communication involves recognition of the other person, and ideally that recognition involves the whole person.

It also indicates, beyond the message of recognition and acceptance, willingness to engage with the history, the ideas and the feelings of a partner, even one who is unable to express these clearly. The demonstration of interest conveys a positive valuation of the person as a worthwhile conversation partner, and confirms that the story is worth telling and worth hearing.

Following the loss of former social partners and social roles, many older people have little opportunity to talk about themselves or past events and achievements. They often become progressively isolated, whether living in the community or in residential aged care.

Pay particular attention to people who might be lonely, withdrawn or depressed because of:

- loss of spouse, family, friends and previous social groups
- loss of cognitive or communicative function through illness or the ageing process (for example dementia; speech impairments caused by Parkinson's disease or stroke; hearing or vision impairment)
- loss of home, pets, privacy, and so forth.

Having people to do things with and talk about things with as an equal is important for physical and emotional wellbeing. This helps people cope with any worries, have their social needs met, and motivates them to get up and about.

Older people are all individuals and have unique, diverse needs. People who have a full social life and are satisfied with their existing circle of friends may have little need of outside intervention. People who have never been very sociable may continue to need less social interaction than those who are more outgoing. Nonetheless, it is important to get to know each older person and find out their interests.

**Communication** enables older people to engage with others and take part in social interactions, and decisions relating to their care and environment. It reinforces the older person's sense of self-worth.

**Opportunities to communicate** provide a means of remembering and talking about past experiences and achievements as well as current interests and activities. Positive communication confirms the adult status of the older person, and can help to build the confidence that supports independence.

**Patronising communication** includes simplified vocabulary and grammar, repetition, over-familiarity, disapproval, non-listening, and changing the subject.

## Activity

Discuss strategies to enhance positive communication and overcoming barriers. Begin by initiating a brainstorm for about 10 minutes. The session is intended to run as a large group brainstorm. However, the facilitator may choose to ask participants to break into small groups to discuss and/or role play ways to promote good communication with older people.

Ask the group to list strategies to enhance positive communication and overcome barriers. Generate ideas and list all suggestions for the group to see on whiteboard or butchers paper. It might be helpful to provide categories/headings to structure the brainstorm (see points below).

### Strategies for enhancing positive communication:

- Be careful not to judge by appearances. Assume competence not incompetence even if the person has a shaky voice or a hearing aid. This is not evidence that a person cannot communicate well.
- Assume that the person **can** communicate. Encourage the person to communicate freely.
- Be aware that a considerable number of older people from CALD backgrounds have cultural preferences and limited English language competence which can impact on their emotional wellbeing. Ethnic and multicultural organisation staff with specialist expertise may be able to provide cultural competency briefings or workshops, advice on cultural backgrounds and perceptions or practical translation advice and guidelines.
- Encourage participation in decisions about their care.
- Listen attentively, giving feedback (nods, sounds of interest), encouraging the older person to communicate freely.
- Always speak respectfully. The tone of your voice, facial expressions and body language should all communicate this respect. Use the person's preferred name, title and gender pronoun.
- Remember that older people are adults, and speak to them in adult language.
- Avoid talking over or about older people in their presence.
- Modify your style of speech (slower, louder, simpler sentences and instructions) only when you have taken time to assess the older person's competence.
- Be aware that speech difficulties do not indicate loss of cognitive capacity. Health and disability can affect brain function, lung capacity and throat muscles in cases of stroke, cerebral palsy or Parkinson's disease).
- Provide opportunities for older people to talk about their past lives and achievements and to express their views.
- Maximise the opportunities provided by one-to-one care tasks to talk and listen to residents.

### Overcoming barriers to communication:

- Try to minimise environmental noise, such as TV and radios, vacuum cleaners and dishwashers.
- Check that hearing aids have batteries and are properly fitted and turned on, and that people with dentures or glasses are wearing them.
- Ensure annual checks for hearing and vision.
- Attract the person's attention, either by speaking or touching if appropriate.
- Greet the person by name, repeat your own name and speak clearly, keeping your face in view. Avoid speaking from behind the person's back.
- Speak clearly and slowly if the person is hearing impaired. You may need to raise your voice, but avoid shouting.
- For the speech-impaired, allow time, and always check what you have understood. Do not say yes if you do not understand.
- Check what you think you understand by repeating it as a question.
- Use whatever resources are helpful and acceptable to the older person: smiles, touch, gestures, pictures, photos, objects or a dictionary. Use interpreters and consult family members where appropriate.
- Try to learn a few everyday words in the preferred language of the person, such as hello and goodbye, please and thank you.

### Case studies and action planning (40 minutes)

The purpose of the activity is to provide experiential learning opportunities for the session participants. The activity should result in the development of an action plan.

#### Activity

In small groups or pairs consider case studies based on aspects of emotional wellbeing. Participants can use their own case studies if they choose but these should be based on one of the following aspects:

- Physical activity and emotional wellbeing
- Nutrition, including 'mood food', and emotional wellbeing
- Purposeful activities
- Assessing and modifying sensory changes
- Communication
- Sexuality
- Grief and bereavement

Information from practitioners and recent research highlights links between nutrition, physical activity and emotional wellbeing. For example, in 2005, the American Dietetic Association reported on the pleasurable experience of food and that eating contributes to a person's quality of life and nutritional status. Some services have reported highly popular walking programs and innovations in nutrition such as a trolley of fruit mocktails.

### Action planning

Provide participants with an action plan template (below) to guide them in this task. Participants will be guided to develop action plans and consider:

- practical issues concerned with participants' own service and environment
- addressing enablers and barriers.

Each participant should record the outcomes of their group's discussion on the action plan template.

Invite a member of each small group to present a summary of their action plan.

The facilitator will integrate the main themes and record them on a whiteboard. (These can be used to prepare as minutes/seminar notes.)

### Summary and conclusion (15 minutes)

Summarise the main points from Module 2. Explain how participants can start implementing the learnings in their everyday practice.

Ask each person to identify at least one thing they intend to change or implement in their work practice as a result of the session.

### Evaluation and feedback (5 minutes)

Invite participants to provide feedback. Distribute the *Evaluation/feedback form* to each participant and thank group members for participating.



## Module two: Case studies

### Case study 1

#### Maggie: privacy, dignity, respect

Maggie was 92 years old, mobile but very frail. She was cognitively intact and capable of making her own decisions.

Because she had suffered several falls, staff were anxious for her to wear hip protectors. She felt this threatened her dignity as well as her comfort and refused to wear them. Staff consulted Maggie and her family together and agreed with a family decision to respect Maggie's choices. She did not wear the hip protectors and staff supported this. Maggie remained at her previous level of activity. Although the risk of falls had not dissipated, her emotional wellbeing was sustained.

### Case study 2

#### Evelyn: communication

Evelyn had been attending the activities group regularly for over a month since coming to live at the aged care facility and had always been considered a 'grouch' by her fellow attendees. She seemed to scowl, which deterred other members from approaching her to make conversation. Evelyn did not seem to enjoy any activities available, in particular board games and film sessions.

It seemed to everyone that Evelyn was wasting her time attending a group that she was not enjoying. Finally, another group member approached Evelyn and asked her gently why she always wore a scowl and was she not enjoying the group? 'Oh', replied Evelyn, 'I'm sorry; it's just that I don't see too well and I screw up my face to concentrate on things. I didn't know it made me look unhappy. No wonder I haven't been able to get to know people very quickly!' They laughed together and she explained her visual impairment. Other group members now understand what is happening and staff sourced large print board games. Evelyn enjoys her time at the group and has made new friends. She also has plenty of interesting things to tell her daughters and grandchildren when they visit.

### Case study 3

#### Bernard: autonomy, independence

It was time for the regular review of Bernard's care, his two sons being invited to attend. They were also anxious to discuss with the doctor what they perceived as signs of their father's depression. Bernard, aged 89, suffered the debilitating effects of Parkinson's disease, as well as cardiac problems and signs of dementia. Given the choice, he wanted to come to the meeting 'to speak for myself.' The process of asking him about his response to life in the RACF was painfully slow, because his replies were given in halting, hesitant speech. 'What do you miss most?' he was asked. 'The loss of speech' he replied, with some emotion. His older son explained that, until he was 85, Bernard had been a regular participant in an elite play-reading group, having significant skills in performing Shakespeare's characters.

Through the ensuing discussion, it became evident that more understanding was needed on the part of the aged care team when communicating with Bernard. It was also agreed that medication might help to lift his mood. His care plan was adjusted to highlight his preference for more time to be spent on verbal communication than trying to improve his mobility: 'I don't mind if I can't walk, but I do mind if I can't have a chat.' Some of the aged care team and family members had perceived his low mood as indicating a wish for death. Although severely disabled and increasingly dependent, he said with animation, 'I hope I can look forward to a few more years yet.'

Adapted from Department of Health and Ageing (2006). *Guidelines for a Palliative Approach in Residential Aged Care*. Canberra: Commonwealth of Australia. p.154

### Case study 4

#### Anna: spirituality

Anna was the only Greek speaking person at the residential aged care facility. Whilst the food was not entirely to her taste at the facility, she did not raise any issues about it. Her Greek Orthodox faith was very important to her and as Lent approached, Anna became increasingly anxious about what she would be able to eat. Staff realised that there was something wrong with Anna.

## Case study 5

### Brian: sexuality

Brian was in the residential aged care service for several years. He was always friendly and engaged with staff. He had cognitive impairment which was exacerbated by a recent hospitalisation for a mild heart attack.

Brian began touching himself inappropriately during the shower routine each morning. The second stage involved masturbating in front of any staff member who entered his room anytime during the day or night.

Many staff became unwilling to work with him and staff ceased dropping into his room to talk to him.

## Case study 6

### John: grief, bereavement and end of life issues

John had cared for his wife at home for three years until her dementia made her increasingly dependent and debilitated. As a result of John's decision to have his wife admitted to residential aged care, he felt guilty that he could not give her sufficient attention. John spent many hours of every day assisting with his wife's care and also helping out with the service's leisure activities and would assist any of the other residents whenever he could. When his wife died, the aged care team wondered how John would cope, as he had no close family. His wife, and now the RACF, had become his whole life. When he was asked, John indicated that he had no need for formal bereavement counselling. 'No, I don't want to talk to anyone, particularly a stranger'. After the funeral, the service manager asked John what he was going to do with his time and he answered that he really didn't know.

## Module two: Handouts

### Action plan template

Identify case study \_\_\_\_\_

Discuss the five elements crucial to maintaining an individual's emotional wellbeing:

- 1 Resilience and coping
- 2 Productive contributions
- 3 Social connections
- 4 Comfort and basic needs
- 5 Sensory enrichment

Refer to the help sheets as needed.

Prepare a basic plan for improving the older person's emotional wellbeing

Element of emotional wellbeing	Summary description of issue or area of support	Actions to be taken and by whom	Review date
<i>Example:</i> Productive contribution	<i>Example:</i> Identifying individual participant's interests and ways of contributing	<i>Example:</i> 1 Manager to discuss with staff using Help sheet number 31 as a resource 2 Staff to discuss previous/current roles, interests and experiences with each resident and plan ways in which the person may wish to contribute. 3 Staff to document outcomes of plan.	<i>Example:</i> Review each resident's plan in three months

# Well for Life: Understanding emotional wellbeing and ageism

## Evaluation/feedback form

**1 Was the program relevant to your work?** *(Tick one only)*

- Highly relevant
- Relevant
- Limited relevance
- No relevance

**2 How much do you think you learnt about promoting emotional wellbeing for the older person?**  
*(Tick one box only)*

- Learnt a great deal
- Learnt some new information
- Not much was new
- Learnt nothing new

**3 Have you (or will you) use any of the information from the program in your work? Please describe.**

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**4 How could the program be improved?**

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**5 Would you recommend this in-service program as a useful resource to other services?**

- Recommend highly
- Recommend
- Not recommend

**6 Do you believe that your service needs to change its practice to promote older people's emotional wellbeing? If yes, in what ways?**

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**7 Please describe any difficulties or barriers to making these changes.**

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**8 Any other comments?**

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Thank you for your time and participation in the program.

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## Section 6: Resource and contact list

### Ageing well

**Source:** The Jean Hailes Foundation for Women's Health

**Description:** Tips and information on ageing well for women.

**Advantages:** Information on a wide range of topics on one website including sexuality, nutrition, physical activity, emotional health, menopause and ageing well.

Contact for further information:

[www.ageingwell.org.au](http://www.ageingwell.org.au)

**Source:** COTA Victoria

**Description:** Council on the Ageing is an independent consumer organisation run by and for senior Australians

**Advantages:**

- COTA protects and promotes the well-being of all seniors
- Provides details of innovative activities that demonstrate new ways to defy negative stereotypes and age well
- Information on issues of importance to seniors

Contact for further information:

[www.cotavic.org.au](http://www.cotavic.org.au)

**Source:** Department of Health

**Description:** The Department of Health is a state government organisation committed to achieving the best health and wellbeing for all Victorians.

The role of the Aged Care Branch is to plan, fund and monitor services for older people, people with a disability and the carers of both target groups.

Aged Care in Victoria – Victorian Government Health Information

Provides information relating to aged care programs, policies and services for both professionals and the public.

Contact for further information:

[www.health.vic.gov.au/agedcare](http://www.health.vic.gov.au/agedcare)

## Alzheimer's disease and dementia

### Source: Alzheimer's Australia

**Description:** Alzheimer's Australia is the national peak body representing the interests of people with dementia and their families and carers. They manage a range of national programs including support, counselling, training and education for both people with dementia and their carers as well as professionals working in the area of dementia. Website includes numerous information and fact sheets.

### Advantages:

- Publications and resources
- Help sheets and update sheets
- Memory Lane cafe information
- Elder rights
- Spirituality
- Grief, bereavement and loss
- CALD information
- Information for carers

Contact for further information:

[www.alzheimers.org.au](http://www.alzheimers.org.au)

National Dementia Helpline: 1800 100 500

## Built environment

Dementia -friendly environments. A guide for residential and respite care

<http://www.health.vic.gov.au/dementia/>

Guiding design of dementia friendly environments in residential care settings:

Considering the living experiences

<http://dem.sagepub.com/cgi/content/short/8/2/185>

Residential aged care services built environment audit tool.

<http://www.accreditation.org.au/accreditation/accredonsiteassessmentandreports/>

Aged care residential services generic brief 2000, draft revised 2007

<http://www.health.vic.gov.au/agedcare/publications/genericbriefs/gen-agedresi.pdf>

Vitamin D and the built environment in Victoria A guideline for planners, engineers, architects & policy makers in local & state government

<http://www.health.vic.gov.au/chiefhealthofficer/publications/vitamind.htm>



## Carer/staff support

### Source: DVD – Away From Her

**Description:** A man coping with the institutionalisation of his wife, who has Alzheimer's disease, is devastated when she transfers her affections to a fellow patient.

**Advantages:** This is a film for carers and staff to obtain an insight into the lives of people with dementia and their carers.

Contact for further information: Your local video store

### Source: DVD – The Notebook

**Description:** *The Notebook* is an epic love story centred on an older man who reads a notebook diary about their shared youth to an invalid woman whom he regularly visits.

**Advantages:** This is a film for carers and staff to obtain an insight into enduring friendship and ways of renewing memories of youth and sustaining sense of self in a frail older person.

Contact for further information: Your local video store

### Source: DVD – The Savages

**Description:** A sister and brother face the realities of familial responsibility as they begin to care for their ailing father, despite the fact that he has been estranged from them for many years.

**Advantages:** This is a film for carers and staff to obtain an insight into the life of a person with dementia and the challenges for families in accepting unexpected responsibility and for care staff trying to provide supportive residential care.

Contact for further information: Your local video store

### Source: Stoyles & Flanagan (2002) *In their homes: caring for people as individuals.*

**Description:** A simple and informative handbook for home care workers that explains the role of the worker and the expected outcomes of their position. It was written to help all paid home care workers and registered nurses who provide personal care, care around the home, nursing care or a combination of activities to people in their own homes.

#### **Advantages:**

- A comprehensive work covering many topics relevant to home care workers, including advice on respecting older people as individuals.
- This handbook adds to the more formal training and information on safety and general work requirements provided by employers.

Contact for further information:

Aged and Community Services Australia

Level 1, 36 Albert Road

South Melbourne Vic 3205

Phone: (03) 9868 3460

Fax (03) 9686 3453

Email: [agedcare@vicnet.net.au](mailto:agedcare@vicnet.net.au)

Website: [www.agedcare.org.au](http://www.agedcare.org.au)

## Carer/staff support

**Source:** **Stoyles & Flanagan (2000) In their shoes: caring for residents as individuals.**

**Description:** A guide for all staff and students working in residential aged care. It is designed to help staff understand residents and treat them as individuals who have a lifetime of experience and history behind them.

### Advantages:

- A comprehensively referenced handbook covering many topics for people working in an aged care facility, with a primary focus is on respect for the individual person.
- By recognising each resident as an individual and understanding their background staff can improve their standard of care, quality of work and job satisfaction.

Contact for further information:

Aged and Community Services Australia

Level 1, 36 Albert Road

South Melbourne Vic 3205

Phone: (03) 9868 3460

Fax (03) 9686 3453

Email: [agedcare@vicnet.net.au](mailto:agedcare@vicnet.net.au)

Website: [www.agedcare.org.au](http://www.agedcare.org.au)

## Communication

- AUSLAN <http://www.auslan.org.au/>
- For information about when use of an interpreter is required see the Language Services Policy at <http://www.dhs.vic.gov.au/multicultural/html/langservpolicy.htm>
- Partners in Culturally Appropriate Care (PICAC) is an initiative funded by the Australian Government Department of Health and Ageing, see <http://www.culturaldiversity.com.au/Default.aspx?tabid=54#Victoria>

## Community supports

**Source:** **Yellow Pages/ Local Community Council Guide**

**Description:** Information regarding a variety of community organisations. Places to obtain information include:

- Local Council
- Senior Citizens
- Probus
- Rotary
- Community Newspapers
- Neighbourhood Houses
- Local Churches

### Advantages:

- Suggested community groups – walking groups, gardening groups, craft groups, specialist groups
- Provides a wide range of activities

Contact for further information:

[www.yellowpages.com.au](http://www.yellowpages.com.au)

## Community supports

### Count Us In!

Social inclusion for older people living in residential aged care.

[www.health.vic.gov.au/agedcare/maintaining/countusin](http://www.health.vic.gov.au/agedcare/maintaining/countusin)

## Crisis situations

### Source: Lifeline

**Description:** A website and crisis line that is available 24 hours a day, seven days a week

### Advantages:

- Lifeline's 13 11 14 service is staffed by trained volunteer telephone counsellors 24-hours a day, any day of the week from anywhere in Australia. These volunteers operate from Lifeline Centres in every State and Territory around Australia.
- The Lifeline Information Service is a nationwide service providing mental health and self-help resources. These resources are accessible by a national number 1300 13 11 14 Monday to Friday from 9 am to 5 pm or online.
- Lifeline has a variety of self-help tool kits available.
- The Lifeline National Service Finder lists details of around 20,000 services and service providers around the country

Contact for further information:

Telephone 13 11 14

[infoservice@lifeline.org.au](mailto:infoservice@lifeline.org.au)

[www.lifeline.org.au](http://www.lifeline.org.au)

## Cultural support

Centre for culture, ethnicity and health [www.ceh.org.au](http://www.ceh.org.au)

Ethnic Communities Council of Victoria [www.eccv.org.au](http://www.eccv.org.au)

Multicultural Aged Care Services Directory 2009

[www.eccv.org.au/aged-care/aged-care-resources/#1](http://www.eccv.org.au/aged-care/aged-care-resources/#1)

Centre for Cultural Diversity in Ageing the Victorian Partners in Culturally Appropriate Care (PICAC), an initiative funded by the Australian Government Department of Health and Ageing to: Improve partnerships between aged care service providers, culturally and linguistically diverse communities and the Department of Health and Ageing; and Ensure the special needs of older people from diverse cultural and linguistic backgrounds are identified and addressed.

[www.culturaldiversity.com.au](http://www.culturaldiversity.com.au)

## Dementia

**Source:** Australian Government Department of Health and Ageing

**Description:** This Australian Government website describes services and resources in the area of dementia.

**Advantages:** Provides information booklets on a broad range of topics related to dementia, such as living with dementia, family and friends, planning for the future, quality of life, and useful contacts and resources.

Contact for further information:

[www.health.gov.au](http://www.health.gov.au)

Switchboard: (02) 6289 1555

Freecall: 1800 020 103

After hours: (02) 6122 2747

Postal address:

Central Office

GPO Box 9848

Canberra ACT 2601

**Dementia friendly environments: A guide for residential care,**

[www.health.vic.gov.au/dementia](http://www.health.vic.gov.au/dementia)

**Sex and dementia: what are your needs?**

B. McCarthy, Australia

## Depression information and support

**Source:** Beyondblue

**Description:** Beyondblue is the national depression initiative. This website also includes information and resources on anxiety, bipolar, perinatal depression and other related syndromes.

**Advantages:**

- Provides the older person and their carers with information and effective treatment.
- Finds the location and contact details of a doctor or other mental health professional.
- Provides training and support for professionals to enable them to provide a better service to the older person.

Contact for further information:

[www.beyondblue.org.au](http://www.beyondblue.org.au)

Info Line Ph: 1300 22 4636

## GLBTI (Gay, Lesbian, Bisexual, Transgender and Intersex)

Ministerial Advisory Committee on GLBTI health and wellbeing, *Well Proud: a guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services (2009)*

Assists the Department of Health, the Department of Human Services and funded agencies provide quality care to their GLBTI clients. It includes additional recommendations for specific health care settings, including aged care settings. [www.health.vic.gov.au/glbtimeac](http://www.health.vic.gov.au/glbtimeac)

Gay and Lesbian Health Victoria, *Well Proud: An Audit of inclusive practice for aged care services, 2010* (in development—due June 2010)

Tool adapted from Well proud to assess how inclusive aged care services are of GLBTI clients.

Barrett, C: *My People; a project exploring the experiences of gay, lesbian, bisexual, transgender and intersex seniors in aged-care services (2008)*

This report is the result of a study conducted by the Matrix Guild and Vintage Men exploring the experiences of older non-heterosexual people as recipients of services and support for older people. [www.matrixguildvic.org.au/MyPeopleReport2008.pdf](http://www.matrixguildvic.org.au/MyPeopleReport2008.pdf)

*Positive Ageing: Older Gay Men and Lesbians. Policy Suggestions for Local Government (2008)*  
Council on the Ageing (COTA), the Municipal Association of Victoria (MAV) the ALSO Foundation and Gay and Lesbian Health Victoria have jointly produced guidelines to assist councils in engaging with people from the older GLBTI community. [www.glhv.org.au/files/glbti\\_positive\\_ageing.doc](http://www.glhv.org.au/files/glbti_positive_ageing.doc)

Gay and Lesbian Health Victoria. The role of the Unit is to 'to enhance and promote the health and well being of GLBTI people in Victoria. They do this through training health care providers and health organisations about GLBTI health needs and appropriate service delivery, developing health resources for GLBTI communities, in conjunction with mainstream services and establishing a research and information clearinghouse as a resource for health care providers, researchers and individuals to use in researching their own health issues. [www.glhv.org.au](http://www.glhv.org.au)

Birch, H, *Dementia, Lesbians and Gay Men*, Alzheimer's Australia 2009

A research paper commissioned by Alzheimer's Australia to promote an informed discussion about the issues affecting lesbians or gay men with dementia or caring for someone with dementia. [www.glhv.org.au/files/DementiaLesbiansGayMen.pdf](http://www.glhv.org.au/files/DementiaLesbiansGayMen.pdf)

Val's Café [www.also.org.au/communities/seniors/vals\\_cafe](http://www.also.org.au/communities/seniors/vals_cafe)

A support network for service providers caring and promoting the rights for older GLBTI people facilitated by Gay and Lesbian Health Victoria and the {also} Foundation. Meets four times a year.

Telephone: (03) 92855296

Email [c.barrett@latrobe.edu.au](mailto:c.barrett@latrobe.edu.au)

Matrix Guild Victoria [www.matrixguildvic.org.au/](http://www.matrixguildvic.org.au/)

Support and advocacy group committed to the support of appropriate care and accommodation choices and for older lesbians. They do this through the provision of information on care and support services, whilst at the same time promoting and liaising with government agencies and service providers to develop more appropriate lesbian friendly services.

Vintage Men [www.vintagemen.org/](http://www.vintagemen.org/)

Social and support for gay and bisexual men and their friends.

The Seahorse Club of Victoria [www.seahorsevic.com](http://www.seahorsevic.com)

Support and social group for the transgender community.

## Grief and loss

**Source:** Australian Centre for Grief and Bereavement

**Description:** Website with extensive lists of grief counselling services in Victoria

**Advantages:**

- Counselling service
- Grief and loss resource site
- Regular Newsletter
- Has a toll free bereavement information and referral service

Contact for further information:

Telephone (03) 9265 2111

Email: support@grief.org.au

The Victorian Palliative Care website [www.health.vic.gov.au/palliativecare](http://www.health.vic.gov.au/palliativecare) lists key resources and links for inpatient and community services.

Advance care planning information is available at [www.respectingpatientchoices.org.au](http://www.respectingpatientchoices.org.au) and [www.sswahs.nsw.gov.au/SSWAHS/myWishes/default.html](http://www.sswahs.nsw.gov.au/SSWAHS/myWishes/default.html)

## Health Promotion

[www.health.vic.gov.au/healthpromotion](http://www.health.vic.gov.au/healthpromotion)

Integrated health promotion resource kit;

[www.health.vic.gov.au/healthpromotion/evidence\\_res/integrated.htm](http://www.health.vic.gov.au/healthpromotion/evidence_res/integrated.htm)

## HIV and ageing

### HIV, ageing and human rights

L. Forbes, Australia; D. Menadue, Australia; R. Duffin, Australia

### Beyond the grim reaper – ageing with HIV/AIDS

D. Menadue, Australia; L. Crock, Australia; L. Craig, Australia; B. Dunn, Australia; R. Lake, Australia; R. Westacott, Australia

## Hydration

Continence Victoria help sheet 'Fluids and the older person'

<http://www.continencevictoria.org.au>

Heatwave ready resource, Department of Health

[www.health.vic.gov.au/agedcare/publications/racsheatwave/index.htm](http://www.health.vic.gov.au/agedcare/publications/racsheatwave/index.htm)

SCORE evidence based standardised care processes for nutrition and hydration

[www.health.vic.gov.au/agedcare/services/score.htm](http://www.health.vic.gov.au/agedcare/services/score.htm)

## Medical services and community health services

**Source:** Yellow Pages or your Council Community Guide

**Description:** Lists the various medical services and community health services to be found in your area.

**Advantages:** A wide range of medical and community health locations in your area.

Contact for further information: [www.yellowpages.com.au](http://www.yellowpages.com.au)

## Mental health helpline and support

Source: **SANE Australia**

**Description:** Crisis care website.

**Advantages:**

- Guidebooks, factsheets, videos and other resources on mental illness and related topics
- A national freecall telephone and online service offering information and referral
- SANE News quarterly magazine on mental health issues.

Contact for further information:

[www.sane.org](http://www.sane.org)

If you urgently need help, contact the Psychiatric Team at your nearest hospital.

Call SANE Helpline 1800 18 SANE (7263) or use Helpline Online

## Nutrition

<http://www.mind.org.uk/foodandmood>

Nutrition for older people resources at:

[http://www.healthinsite.gov.au/topics/Eating\\_Well\\_for\\_Older\\_People](http://www.healthinsite.gov.au/topics/Eating_Well_for_Older_People)

SCORE evidence based standardised care processes for nutrition and hydration

<http://www.health.vic.gov.au/agedcare/services/score.htm>

Nutrition help sheets – Well for Life

[www.health.vic.gov.au/agedcare/maintaining/wellforlife](http://www.health.vic.gov.au/agedcare/maintaining/wellforlife)

## Oral health

Better oral health in residential aged care (Department of Health and Ageing)

[www.health.gov.au/internet/main/publishing.nsf/Content/ageing-betterpractice-nursing-home-oral-dental-training.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-betterpractice-nursing-home-oral-dental-training.htm)

SCORE standardised care process on constipation, pain management, oral and dental care, see [www.health.vic.gov.au/agedcare/services/score.htm](http://www.health.vic.gov.au/agedcare/services/score.htm)

## Pain management

The Australian Pain Society

[www.apsoc.org.au](http://www.apsoc.org.au)

Pain in residential care facilities: management strategies.

SCORE standardised care process on constipation, pain management, oral and dental care, [www.health.vic.gov.au/agedcare/services/score.htm](http://www.health.vic.gov.au/agedcare/services/score.htm)

## Physical activity

Physical activity help sheets – Well for Life

[www.health.vic.gov.au/agedcare/maintaining/wellforlife](http://www.health.vic.gov.au/agedcare/maintaining/wellforlife)

## Rural and regional residential aged care

Addressing behaviours of concern in the bush: Sustainable evidence based practice in rural and regional residential aged care (Commonwealth project) [www.health.gov.au/internet/main/publishing.nsf/Content/ageing-bestpractice-program-second-round.htm#beha](http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-bestpractice-program-second-round.htm#beha)

## Sensory stimulation

Items 4.5.6 Acoustics and 4.5.7 Sensory aspects from Aged Care Residential Services Generic Brief 2000  
[www.health.vic.gov.au/agedcare/publications/genericbriefs/gen-agedresi.pdf](http://www.health.vic.gov.au/agedcare/publications/genericbriefs/gen-agedresi.pdf)

## Sexuality

Sexual expression – a person-centred approach  
J. Tinney, Australia; C. Barrett, Australia; R. Kingsbury, Australia; M. Bauer, Australia

## Social workers

**Source:** Australian Association of Social Workers

**Description:** Often you can contact an agency directly and ask to speak to a social worker or you can contact your nearest community health centre or local government office and ask for information. The Community Help and Welfare Services pages at the front of the telephone directory also list settings where social workers may be located.

**Advantages:** Direction for where to find a social worker.

Contact for further information:  
[www.aasw.asn.au](http://www.aasw.asn.au)

## Psychologists

**Source:** Australian Psychological Association

**Description:** Website contains information on initiatives, academic resources, brochures, tool-kits, articles and so forth.

**Advantages:**

- 'Find a psychologist'
- About psychologists & psychiatrists
- Psychologist specialist areas including depression, lifestyle effects on health, traumatic events and so on.
- Numerous help sheets

Contact for further information  
[www.psychology.org.au](http://www.psychology.org.au)



## Psychiatrists

**Source:** [Royal Australian and New Zealand College of Psychiatrists \(RANZCP\)](#)

**Description:** Website containing information regarding psychiatry in Australia and New Zealand as well as links to more information about mental health

### Advantages:

- How to contact a psychiatrist
- Information about psychiatry

Contact for further information:

The Royal Australian and New Zealand College of Psychiatrists

309 La Trobe Street

Melbourne Victoria 3000

Australia

Tel: +61 3 9640 0646

Toll free: 1800 337 448 (for Australian residents)

Toll free: 0800 443 827 (for New Zealand residents)

Fax: +61 3 9642 5652

Email: [ranzcp@ranzcp.org](mailto:ranzcp@ranzcp.org)

## Vitamin D

Vitamin D and the built environment in Victoria: A guideline for planners, engineers, architects and policy makers in local and state government.

[health.vic.gov.au?chiefhelthofficer/downloads/vidamin-d.pdf](http://health.vic.gov.au?chiefhelthofficer/downloads/vidamin-d.pdf)

Low vitamin D in Victoria: Key health messages for community health workers outlines at-risk population groups, safe sun exposure levels and vitamin D testing and treatment recommendations.

The resource is a joint initiative of the Victorian Department of Health, SunSmart, the University of Melbourne, General Practice Victoria, Royal Children's Hospital and other partners, and can be downloaded at [sunsmart.com.au/vitamin\\_d](http://sunsmart.com.au/vitamin_d).

Who is at risk of Vitamin D deficiency

[www.sunsmart.com.au/vitamin\\_d/who\\_is\\_at\\_risk\\_of\\_vitamin\\_d\\_deficiency](http://www.sunsmart.com.au/vitamin_d/who_is_at_risk_of_vitamin_d_deficiency)

## Volunteering

Volunteering Victoria

The Southern Gatehouse

Former Royal Mint, 280 William St Melbourne

Law Courts – P.O Box 13289 Melbourne 8010

t:+61 3 9642 5266 f:+61 3 9642 5277

[www.volunteeringvictoria.org.au](http://www.volunteeringvictoria.org.au)

The Count us in! website also has information and resources about volunteers.

[www.health.vic.gov.au/agedcare/maintaining/countusin](http://www.health.vic.gov.au/agedcare/maintaining/countusin)

## Allied health associations and professional organisations

Alzheimers Australia—Victoria

Locked Bag 3001, 98 – 104 Riversdale Road, Hawthorn Vic 3122

Phone: (03) 9815 7800 Fax: (03) 9815 7801

Email: alz@alzvic.asn.au Website [www.alzheimers.org.au](http://www.alzheimers.org.au)

Australian Centre for Grief and Bereavement

McCulloch House, Monash Medical Centre

246 Clayton Road, Clayton Vic 3168

Phone: (03) 9265 2100; 1800 642 066 (Freecall Australia wide) Fax: (03) 9265 2150

Email: [info@grief.org.au](mailto:info@grief.org.au) Website: [www.grief.org.au](http://www.grief.org.au)

Australian Physiotherapy Association—Vic Branch

6/651 Victoria Street, Abbotsford 3067

Ph: (03) 9429 1799 Fax: (03) 9429 1844

Australasian Podiatry Association—Vic Branch

Suite 26, 456 St Kilda Road, Melbourne 3004

Ph: (03) 9866 5906 Fax: (03) 9866 2094

Carers Victoria

5th floor, 130 Little Collins Street, Melbourne 3000

Ph: (03) 9650 9966 Fax: (03) 9650 8066

Careline: 1800 242 636 Website: [www.carersvic.org.au](http://www.carersvic.org.au)

Beyondblue

40 Burwood Road, Hawthorn Vic 3122

Postal address: PO Box 6100, Hawthorn West Vic 3122

Phone: (03) 9810 6100 1300 22 4636 (Info Line) Fax: (03) 9810 6111

Email: [bb@beyondblue.org.au](mailto:bb@beyondblue.org.au) Website [www.beyondblue.org.au](http://www.beyondblue.org.au)

Council on the Ageing (COTA) Victoria

Level 4, Block Arcade, 98 Elizabeth Street, Melbourne VIC 3000

Phone: (03) 9654 4443 Fax: (03) 9654 4456

Email: [cotavic@cotavic.org.au](mailto:cotavic@cotavic.org.au) Website: [www.cotavic.org.au](http://www.cotavic.org.au)

Dietitians Association of Australia (DAA) National Office:

1/8 Phipps Close, Deakin ACT 2600

Ph/Fax: (02) 6282 9798 / 1300 658 196

Victorian Office:

Ph: (03) 9642 4877

Accredited Practising Dietitian

Hotline: 1800 812 942 Email: [vic@daa.asn.au](mailto:vic@daa.asn.au)

Lifeline

PO Box 173, Deakin West ACT 2600

Phone: (02) 6215 9400 (office hours) / 13 11 14 (24 hours a day) Fax: (02) 6215 9401

Email: [infoservice@lifeline.org.au](mailto:infoservice@lifeline.org.au) Website: [www.lifeline.org.au](http://www.lifeline.org.au).

## Allied health associations and professional organisations

OT Australia—Australian Association of Occupational Therapists

OT Australia National

6 Spring Street, Fitzroy, Victoria 3065

Ph: (03) 9416 1021 Fax: (03) 9416 1421

OT Australia—Vic

PO Box 1286, Nth Fitzroy 3068

Ph: (03) 9481 6866 Fax: (03) 9481 6844

Speech Pathology Australia

2nd floor, 11–19 Bank Place, Melbourne 3000

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## References

- Alzheimer's Australia. (2007). Quality dementia care: A guide to practice in residential aged care facilities for all staff.
- Alzheimer's Australia. (2008). Caring partnerships. from <[www.alzheimers.org.au/content.cfm?infopageid=4445#car](http://www.alzheimers.org.au/content.cfm?infopageid=4445#car)>
- Andersson, I., Petersson, E., & Sidenvall, B. (2007). Daily life after moving into a care home—experience from older people, relatives and contact persons. *Journal of Clinical Nursing*, 16(9), 1712–1718.
- Atchison, J.H. (1998). Perceived job satisfaction factors of nursing assistants employed in midwest nursing homes. *Geriatric Nursing*, Vol. 19(3): 135–138.
- Australian Bureau of Statistics (2008) report: 4102.0—Australian Social Trends, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter5102008>
- Barrett, C. (2008). *My People; a project exploring the experiences of gay, lesbian, bisexual, transgender and intersex seniors in aged-care services* <[www.matrixguildvic.org.au/MyPeopleReport2008.pdf](http://www.matrixguildvic.org.au/MyPeopleReport2008.pdf)>
- Bauman A, et al (2002). *Getting Australia active: towards better practice for the promotion of physical activity*. Melbourne Australia: National Public Health Partnership
- Birch, H. (2009). *Dementia, lesbians and gay men*, Alzheimer's Australia <[www.glhv.org.au/files/DementiaLesbiansGayMen.pdf](http://www.glhv.org.au/files/DementiaLesbiansGayMen.pdf)>
- Boud, David and Griffin Virginia (1987) *Adults learning: from the learner's perspective*, Kogan Page, London.
- Brown, J., Burton, N., & Heesch, K. (2007). Physical activity and health in mid age and older Australian Women. From: By the way, B., Ward, R., Holland, C., & Peace, S. (2007). The road to an age inclusive society. In B. T & T. Scharf (Eds.), *Critical perspectives on ageing societies*. Bristol, UK: Policy Press.
- Carers Victoria (2007). Still largely on the outside: The caring experiences of relatives and friends of older people who live in aged care facilities in Victoria. Carers Victoria Melbourne.
- Cooperative Research Centre for Aboriginal Health (2009), Discussion paper series: No. 10
- de Veer, A., & Kerkstra, A. (2001). Feeling at home in nursing homes. *Journal of Advanced Nursing*, 35(3), 427–434.
- DeForge, S. (1999). In memory of loved ones who have enriched our lives: helping staff create and hold memorial services in nursing homes. *Journal of Health Care Chaplaincy*, 8(1–2), 109–116.
- Dein, S., & Stygall, J. (1997). Does being religious help or hinder coping with chronic illness? A critical literature review. *Palliative Medicine*, 11(4), 291–298.
- Department of Health and Ageing. (2006). *Guidelines for a palliative approach in residential aged care*. Canberra: Commonwealth of Australia.
- Department of Human Services. (2003). *Well for Life: Improving nutrition and physical activity for residents of aged care facilities*: Prepared by the Well for Life Working Group, National Ageing Research Institute and Dietitians Association of Australia (Victoria Branch).

- Dow, B, Haralambous, B, Bremner, F. and Fearn, M. (2006) *What is person-centred health care? A literature review*. Published by the Victorian Government Department of Human Services, Melbourne, Victoria, Australia. [http://www.mednwh.unimelb.edu.au/pchc/downloads/PCHC\\_literature\\_review.pdf](http://www.mednwh.unimelb.edu.au/pchc/downloads/PCHC_literature_review.pdf)
- Ehman, J., Ott, B., Short, T., Ciampa, R., & Hansen-Flaschen, J. (1999). Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? *Archives of Internal Medicine*, 159(15), 1803–1806.
- Elkington, J. (2000b). *Managing loss and grief in the aged-care industry* (No. 57): Workcover, NSW. Gay and Lesbian Health Victoria, *Well Proud: An Audit of inclusive practice for aged care services, 2010* (in development, due June 2010)
- Hager, Paul (1997) *Learning in the workplace: review of research*, NCVET. Adelaide.
- Hauge, S., & Kristin, H. (2008). The nursing home as a home: a field study of residents' daily life in the common living rooms. *Journal of Clinical Nursing*, 17(4), 460–467.
- Hermann, C. (2001). Spiritual needs of dying patients: a qualitative study. *Oncology Nursing Forum*, 28(1), 67–72.
- Hicks, T. J. (1999). Spirituality and the elderly: nursing implications with nursing home residents. *Geriatric Nursing*, 20(3), 144–146.
- Hockey, J and James, A. (1993) *Growing Up and Growing Old*, Sage Publications: London, Newbury Park, New Delhi.
- Honey, Peter & Mumford, A (1995) *Using your learning styles*, Peter Honey Publications, Maidenhead.
- Kane, R.A, Caplan, A.L, Urv-Wong, E.K, Freeman, I.C, Aroskar, M.A, Finch, M. (1997). Everyday matters in the lives of nursing home residents: Wish for and perception of choice and control, *JAGS*, Vol. 45 (9): 1086–1093.
- Kaplan, L. (1996). Sexual and institutional issues when one spouse resides in the community and the other lives in a nursing home. *Sexuality and Disability*, 14(4), 281–293.
- Kellehear, A. (2002). Grief and loss: past, present and future. [Editorial]. *Medical Journal of Australia*, 177(4), 176–177.
- Knowles, Malcolm (1990) *The adult learner: a neglected species*. Gulf Publishing, Houston.
- Koenig, H., Weiner, D., Peterson, B., Meador, K., & Keefe, F. (1997). Religious coping in the nursing home: a biopsychosocial model. *International Journal of psychiatry in medicine* 27(4), 365–376.
- Kruzich, J.M. (1995) Empowering organizational contexts: Patterns and predictors of perceived decision-making influence among staff in nursing homes, *The Gerontologist*, Vol.35 (2): 207–216.
- Kuzelka, J. (1986). Support system enables residents to express loss. *Provider*, 12(6), 38.
- Leland, J. (2008). 'Simulating Age 85, With Lessons on Offering Care.' from <[www.nytimes.com/2008/08/03/us/03aging.html?ex=1218513600&en=e65986484c02da61&ei=5070&emc=eta1](http://www.nytimes.com/2008/08/03/us/03aging.html?ex=1218513600&en=e65986484c02da61&ei=5070&emc=eta1)>
- Low, L., Lee, D., & Chan, A. (2007). An exploratory study of Chinese older people's perceptions of privacy in residential care homes. *Journal of Advanced Nursing*, 57(6), 605–613.

- Matsushima, T., Akabayashi, A., & Nishitatenno, K. (2002). The current status of bereavement follow-up in hospice and palliative care in Japan. *Journal of Palliative Medicine*, 16(2), 151–158.
- Ministerial Advisory Committee on GLBTI health and wellbeing, *Well Proud: a guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services* (2009) <[www.health.vic.gov.au/glbtimeac](http://www.health.vic.gov.au/glbtimeac)>
- Morris, ME & Schoo, AM (2004). *Optimizing exercise and physical activity in older people*. Oxford: Elsevier Science Limited
- National Ageing Research Institute. (2008). Dementia Resource Guide. 2008, from <[www.health.gov.au/internet/main/publishing.nsf/Content/ageing-dementia-resource-guide.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-dementia-resource-guide.htm)>
- Nazarko, L. (1997). A few home truths, *Nursing Times*, Vol. 93 (39).
- New South Wales Health. (1988). The Heart has no wrinkles [Video]. NSW: Crows Nest, NSW: Health Media, Department of Health
- Office of Senior Victorians 2005, *Positive Ageing: A strategy for current and future Senior Victorians*, Victorian State Government, Melbourne.
- Orchard, H., & Clark, D. (2001). Tending the soul as well as the body: spiritual care in nursing and residential homes. *International Journal of Palliative Nursing*, 7(11), 541–546.
- Ory, M., Kinney Hoffman, M., & et al. (2003). Challenging aging stereotypes: strategies for creating a more active society. *American Journal of Preventive Medicine*, 25((3 Suppl 2)), 164–171.
- Payne, S. (2002). Dilemmas in the use of volunteers to provide hospice bereavement support: Evidence from New Zealand. *Mortality*, 7(2), 139–154.
- Positive ageing: Older gay men and lesbians. Policy suggestions for local government* (2008) <[www.glhv.org.au/files/glbti\\_positive\\_ageing.doc](http://www.glhv.org.au/files/glbti_positive_ageing.doc)>
- Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group, Information accessed on 14/10/10 at <[www.rcpsych.ac.uk/mentalhealthinformation/therapies/spiritualityandmentalhealth.aspx](http://www.rcpsych.ac.uk/mentalhealthinformation/therapies/spiritualityandmentalhealth.aspx)>
- Sefton, Robin and Waterhouse, Peter (1995) *Workplace learning and change*, Automotive Training Australia, Melbourne.
- Sheard, T. (1990). 'In memoriam'. *Focus on Critical Care*, 17(3), 238–239.
- Sonas aPc (Activating Potential for Communication). (2008). Enhancing the lives of older people. from <[www.sonasapc.ie/approach.html](http://www.sonasapc.ie/approach.html)>
- Stacy Tessler Lindau et al (23 August, 2007), 'A Study of Sexuality and Health among Older Adults in the United States, *The New England Journal of Medicine*, Vol 357 No 8:762–774.
- Thompson, M., Rose, C., Wainwright, W., Mattar, L., & Scanlan, M. (2001). Activities of counsellors in a hospice/palliative care environment. *Journal of Palliative Care*, 17(4), 229–235.
- Tiamson, M., McArdle, R., Girolamer, T., & Horowitz, H. (1998). The institutional memorial service: a strategy to prevent burnout in HIV healthcare workers. *General Hospital Psychiatry*, 20(2), 124–126.

Touhy, T., Brown, C., & Smith, C. (2005). Spiritual caring: end of life in a nursing home. *Journal of Gerontological Nursing*, 31(9), 27–35.

Urbancek, A. (1994). Have you ever thought of a memorial service? Families and residents of a long-term care facility say good-bye. *Geriatric Nursing*, 15(2), 100–101.

Volicer, L. (1997). Hospice care for dementia patients. [Comment, Editorial]. *Journal of the American Geriatric Society*, 45(9), 1147–1149.

Weinberg, N. (1985). The health care social worker's role in facilitating grief work: an empirical study. *Social Work in Health Care*, 10(3), 107–117.

Winningham, R. G., & Pike, N. L. (2001). A cognitive intervention to enhance institutionalized older adults' social support network and decrease loneliness. *Ageing and mental health*, 11(6), 716–721.

World Health Organization, *Active ageing: A policy framework*, 2002, page 27.

World Health Organization (2002), *Active ageing: A policy framework*.

World Health Organization Quality of Life Group. (1993). Study protocol for the World Health Organization project to develop a quality of life assessment instrument. *WHO Quality of Life, Quality of Life Research*, 2, 153–159.

World Health Organization (2005) Spiritual, Religious and Personal Beliefs Group, *A cross-cultural study of spirituality, religion, and personal beliefs as components of quality of life*, World Health Organization.



