LIVING AND LOVING LATER LIFE: MARGARET’S STORY

CONTINUED PROFESSIONAL DEVELOPMENT: CONSTIPATION IN OLDER ADULTS: A SERIOUS PUBLIC HEALTH ISSUE

THE IMPACT OF NURSE-LED MEDICATION RECONCILIATION ON MEDICATION DISCREPANCY DETECTION AT OLDER ADULT CARE TRANSITIONS: A SYSTEMATIC REVIEW

GPS’ EXPERIENCES OF MANAGING ELDER ABUSE: A QUALITATIVE STUDY
When asked to write the editorial for this issue of JAIGNA, I did of course ‘jump’ at the opportunity and then thought, where do I start? It is hard to believe that it is 10 years since The All-Ireland Gerontological Nurses Association (AIGNA) was established and even harder to believe just how much has happened in those 10 years. Of course, the obvious place to start is with a celebration and to congratulate AIGNA on its 10 years of existence. The continuation of the association through this period reflects the determination of a small band of deeply committed gerontological nurses who are determined that nurses who work with older people get the recognition we deserve. AIGNA represents all that is good about gerontological nurses – passion, commitment, energy, focus, influence and strategic alignment…and the occasional funny moment!! AIGNA has brought together nurses who work with older people from all over Ireland and created spaces for conversation, creative engagement, ideas sharing and networking, as well as continuous updating on latest innovations, evidence-informed practices and engagement with international leaders. It was my pleasure to be the founding President and I am thrilled to continue my connection with the association – it is hard to get rid of a bad thing!

In thinking about the past 10 years, it is poignant to consider what has been achieved in advancing gerontological nursing practice in the context of our contribution to having a positive impact on the lives of older people, their care partners and communities. I could highlight the many nursing roles that have been developed, or the enormous work undertaken by nurses in local communities, or indeed the many excellent gerontological nurses who are advancing ground-breaking research in Ireland and beyond. However, following some reflection I have chosen to focus on two developments that particularly stand out as landmark changes in how we perceive older people, the development of a regulatory system and advances in understanding frailty.

I guess for many of us, the most significant change to older people services in Ireland over the past 10 years has been the establishment of HIQA (The Health Information and Quality Authority). Whilst being ‘critical’ of HIQA and the outcomes from inspections can be a frequently played ‘sport’, there is little doubt that the existence of a framework for inspection and regulation of residential care facilities has changed the care landscape significantly. HIQA received its powers and mandate in May 2007 under the 2007 Health Act. After the ‘Leas Cross scandal’, the demand increased for inspection of both private and public nursing homes. As a result, HIQA was given powers to register, inspect and, via application to court, close nursing homes and similar residential services delivering poor care. Whilst all of us like to believe that some of the most vulnerable (older) people in our society will always receive the most effective compassionate, dignified and person-centred care in cultures that enable staff to be ‘the best that they can be’, the reality is sometimes different. Residential care facilities are complex social environments that must balance a ‘sense of home’ with high quality health and social care services, often with constrained resources. The complexity and demands of the work, the low value often placed on such work in our society and the variation in available knowledge, skill and expertise of staff all lead to challenging and demanding contexts in which such care delivery takes place. The care provided requires the management, leadership, supervision and direct input of expert registered nurses working in partnership with care workers, families and volunteers. In partnership with Nursing Homes Ireland, AIGNA undertook research into the contributions of registered nurses to the care needs of older people in residential care services in Ireland (Phelan and McCormack 2013; 2016) and identified a wide range of expertise needed. The research concluded that nursing in residential care is complex and by making nursing expertise visible, the case for an appropriate skill-mix to provide expert person-centred care can be made more clearly. AIGNA plays an important role in making this expertise visible through its masterclasses, conferences, publications, networking and campaigning activities undertaken in partnership with AIGNA members.

The second significant development over the past 10 years has been advancements made in understanding, managing and preventing frailty among older people. Frailty is defined as “a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves” (British Geriatrics Service http://www.bgs.org.uk/frailty-explained/resources/campaigns/fit-for-frailty/frailty-what-is-it). The whole focus on frailty is an interesting one in the context of services to older people, ageing, geriatric medicine and gerontological nursing. Why do I say this? Well, whilst frailty is not the same as ‘multiple-morbidities’ it is characterised by the co-existence of multiple conditions that result in the manifestation of a complex medical picture or what has previously been referred to as ‘the giants of geriatrics’ (impairment of intellect, incontinence, immobility and instability (falls)).
These ‘giants’ have always been the core work of geriatricians and nurses working with older people, but they never had the ‘kudos’ then compared with now, when they are viewed as frailty syndromes. Is this another example of ageism, or a clear example of negative stereotyping of nursing (and medicine) with older people? It is fine to say that I am a specialist nurse working in ‘a frailty team’ but not so fine to say that I am a specialist gerontological nurse. Whilst the language of frailty is not always viewed positively by older people themselves, in the context of nursing, this development has enabled the expertise of gerontological nurses to come to the fore and be valued across all health care services. Gerontological Nurse Practitioners, Advanced Practitioners and Clinical Nurse Specialists in gerontology are providing comprehensive healthcare to older people through frailty services. Nurses are engaged in pre-frailty assessment clinics, frailty management services in acute care, community re-enablement services supporting recovery programmes and in leading innovative re-design of services so that frailty can be assessed and treated early. Expert gerontological nurses have always known the value of a ‘comprehensive geriatric assessment’ and these skills have come to the fore in frailty assessment clinics, ambulatory services and in assessment/admission units in emergency departments. However, it strikes me that we have not done enough to celebrate these developments and achievements, nor use them as platforms to demonstrate the expert role of gerontological nurses. I believe this is something that AIGNA needs to pay further attention to, as we move forward with even more integration of older people services (through the lens of frailty) and mainstream acute/sub-acute units. This is an exciting agenda and one that we can own as gerontological nurses, shape into new services and maximise our entrepreneurial potential and vision.

So, after 10 years, whilst our health and social care systems are straining under the pressures of limited resources, staff shortages and changing demographics, the opportunities available for gerontological nurses to demonstrate their value to the lives of older people are enormous. I am delighted that AIGNA has been at the forefront of these developments, supporting nurses to exercise their voices and providing a platform for connection, engagement and influencing. It is imperative that AIGNA continues to occupy this position and the support of all nurses who work with older people is essential for the work to be sustained. Now let’s celebrate!!

References


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The Impact of Nurse-Led Medication Reconciliation on Medication Discrepancy Detection at Older Adult Care Transitions. A Systematic Review.

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Abstract
Background: Improved medication reconciliation for patients at transitions between care settings is strongly advocated by many national and international organisations. Transitions are particularly vulnerable times for older adults who often have co-morbidities with a resultant increase in use of medication. The combination of medication discrepancies at care transitions and lack of consensus regarding the most ideal methods of medication reconciliation has led to calls to strengthen the evidence base. Accurate medication reconciliation can play a vital role in achieving safe transitions yet little evidence exists of the appropriate role of nurses in medication reconciliation processes.

Aim: This paper presents a review of available research studies which analysed medication reconciliation interventions performed by nurses at older adult care transitions, in order to assess the impact of the nursing role in detecting medication discrepancies.

Methods: A systematic review was conducted by two reviewers which included screening and extraction of data, strenuously endeavouring to exclude all possible bias. Quality appraisal and synthesis of all data extracted was completed. The search terms used were medication reconciliation, medication error, medication discrepancy, care transitions, older adult and nurse. PubMed, CINAHL, Cochrane Library, Web of Science and EMBASE databases were the electronic databases searched between January 1947 - January 2016.

Results: There is a dearth of research reporting nurse-led medication reconciliation interventions, and fewer studies evaluating nurse-led interventions in older adult care services. The search strategy identified four hundred and fifty-seven citations of which eight were deemed to meet the set inclusion criteria. All studies reported a reduction in medication discrepancies when medication reconciliation was carried out by nurses. However methodological weaknesses in five of the eight studies limited the ability to draw firm conclusions about the true effectiveness of the interventions.

Conclusion: Concerns regarding potential medication dangers at care transitions are well documented. Findings indicate that nurses can contribute to a reduction in medication discrepancies in care settings for older adults by performing medication reconciliation. These findings have global relevance as healthcare practitioners and safety organisations have a major interest in how to effectively manage medication reconciliation.

Relevance to Clinical Practice: Medication discrepancies pervade older adult settings. Strategies that support the prevention of medication errors need urgent consideration. Nurses are well placed to record accurate medication use and nurse-led medication reconciliation processes reduce medication errors.

Keywords: Medication reconciliation, medication error, medication discrepancy, care transitions, older adult, nurse.

Introduction
Safe healthcare is a national and international priority with one of the most worrying aspects of care being medication safety. Medication errors have been reported as the most common type of error and can have detrimental outcomes for patients (Caglar et al., 2011), yet are often preventable (World Health Organisation, 2016).

Older adults are particularly at risk from adverse medication reactions, polypharmacy (both appropriate
and inappropriate), cognitive impairments and other contextual factors. The population aged 60 or above is increasing at a rate of 3.26% per year and the number of older adults globally is expected to be 1.4 billion by 2030 (United Nations, 2015). In Ireland, the population 65 years and over saw the largest increase in population since 2011, rising by 102,174 to 637,567, a rise of 19.1% (Central Statistics Office, 2016). This demographic transformation provides healthcare policy makers with many opportunities and challenges in relation to healthcare. For example, an ageing population with an associated increase in chronic conditions has resulted in people consuming more medications (National Institute for Clinical Excellence (NICE), 2015).

Transitional care is a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care in the same location (Naylor, 2006). The aim is to improve care transitions from hospital to home and to reduce hospital readmissions. Concerns regarding potential medication dangers at care setting transitions are well documented (Ruggiero et al., 2015). Transition is a particularly vulnerable time for older adults who often have complex medication regimens, frequently amended by many different healthcare providers (Wang & Biederman, 2012). Medication reconciliation plays an integral role in securing safe transitions (Alper et al., 2015).

Medication reconciliation is concerned with compiling an accurate list of a patient’s medications and comparing that list with the prescriber’s admission, transfer and/or discharge orders. The objective is to provide the correct medications to the patient at all transitions thereby reducing errors (Chhabra et al., 2012). Recognised globally as a key component of patient safety and quality agenda (World Health Organisation, 2007; Health Information & Quality Authority (HIQA), 2014; The Joint Commission, 2015), effective medication reconciliation helps to identify any disparity between the admission/discharge medication list and the medications patients state they are actually taking at home. These disparities are often referred to as medication discrepancies. The Joint Commission in 2005 added medication reconciliation across the care continuum as a National Patient Safety Goal and recommended that organisations must carefully reconcile medications to avoid adverse drug events. Consequently, many organisations developed strategies for achieving a complete patient medication list at admission and conveying this list accurately to the next care provider (Madden 2008; HIQA, 2014).

Medication reconciliation aims to reduce the risk for adverse medication events and avoid detrimental effects on the health of patients (Fitzgibbon et al., 2013). It also aims to avoid negative effects on hospital resources post discharge (Corbett et al., 2010). For example, transition home after hospitalisation for older adults often leads to medication errors, which can consequently lead to hospital readmission (Garcia et al., 2014). One quarter of hospital admissions are related to medication discrepancies, costing the healthcare system in the USA $15 billion each year (Duran-Garcia et al., 2012). This highlights the urgent need to ensure accurate medication reconciliation processes to deliver not only safe but also cost-effective care (Hennen & Jorgenson, 2014).

Background

Despite global awareness of the positive outcomes of medication reconciliation, difficulties with this process at care transition persist (Foust et al., 2012). Moreover, it remains unclear as to the most effective process of conducting medication reconciliation (Redmond et al., 2013). This distinct lack of clarity has led to demands for services to review their medication reconciliation practices (HIQA, 2014). Guidelines recommend that facilities should ensure that medication reconciliation is performed by a nominated skilled, competent health professional (NICE, 2015). Despite this, there is little recognition of the value of nurses’ contribution even though nurse leaders are key to developing shared medication reconciliation processes among healthcare providers (Flynn & Anderson, 2012). Moreover, nurses have a key role at care transitions and are well positioned to improve the medication reconciliation process due to their prolonged contact with patients. Furthermore, current focus on nurse-led models of care results in medication reconciliation increasingly coming under the nurses’ remit.

The Review

Aim

This paper presents a review of available research studies which analysed medication reconciliation interventions performed by nurses focussing on older adults at care transitions in order to assess the impact of the nursing role in detecting medication discrepancies.

Search Methods

This systematic review adhered strictly to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement (Liberati et al., 2009). The population, intervention, comparators and outcomes (PICO) framework was used to inform the review objectives. The population included all nurses carrying out medication reconciliation interventions. Comparisons were made with medication reconciliation carried out by other professionals. The primary outcome of interest was the rate of medication discrepancies detected by nurses when performing medication reconciliation. The secondary outcome of interest was the factors which contribute to medication reconciliation.
The search was restricted to papers written in the English language which outlined nurse-led medication reconciliation processes at care transitions of older adults ≥ 50 years. No limits were placed in relation to the time of publication of the studies. Several search engines were consulted, however most pertinent results were identified from a systematic search of literature indexed in electronic databases which included PubMed, CINAHL, Cochrane Database of Systematic Reviews, Web of Science, and Embase covering the period from 1947 to 2016. The search terms used were medication reconciliation, medication error, medication discrepancy, care transitions, older adult and nurse.

Titles and abstracts were scrutinised by two reviewers for potentially relevant studies. Full text articles were obtained and screened for suitability. Relevant articles in reference lists were also considered. Eight papers were deemed appropriate to include in the final analysis. Explicit criteria explaining why papers were included or excluded was documented with the aid of the PRISMA flowchart (Refer Figure 1).

Figure 1 PRISMA 2009 Flow Diagram
Data Extraction, Analysis and Synthesis

Data were extracted from the selected studies and included author, date and design of study, research aim, geographical location, care setting, inclusion & exclusion criteria, nurse details, sample size, patient characteristics, intervention details, type of clients and discrepancies, outcomes, analysis, results and conclusions. Appraisal of quality was undertaken by two reviewers using the Evidence Based Librarianship Critical Appraisal check list (Glynn, 2006). This checklist includes a calculation for research validity scoring across four sections (i.e., population, data collection, study design, and results) in addition to an overall validity score. Results of the appraisal are interpreted as follows: if the overall validity of the study (Yes/Total) is ≥ 75% or (No + Unclear/Total) is ≤ 25% then validity is assured.

The analysis and synthesis of the extracted key characteristics of the studies retrieved was determined by the type of evidence included and the heterogeneity of the studies. As each study compared different interventions it was not feasible to carry out a meta-analysis. Dichotomous data and continuous data were analysed in terms of risk ratio (RR) and mean differences (MD) respectively and results were presented in a forest plot. Use was also made of narrative synthesis methods to integrate findings into descriptive summaries.

Results

The search strategy identified 457 citations from the searched databases. Additional records identified from study references totalled 2 in number. The full text of 53 articles was retrieved and examined by two reviewers and articles were excluded if they did not meet specified inclusion criteria. A total of 8 studies met the inclusion criteria.

Search results yielded studies with a mix of study designs and included two pre-post intervention studies (Henneman et al., 2014; Young et al., 2015); one retrospective audit (Azzi et al., 2014); one quality improvement feasibility study (Chacko et al., 2010); one action research study (Leland et al., 2012); one retrospective cohort study (Thorsteindottir et al., 2015); one randomised control trial (Corbett et al., 2010), and one cross sectional retrospective study (Hu et al., 2012). Seven of the eight studies were conducted in America and one was conducted in Australia. Nurses carried out medication reconciliation interventions in all of the eight studies with a variety of nursing roles and settings evident in all of the studies (Refer Table 1). Interventions employed included face-to-face interviews by nurses with patients, telephone interviews and use of an electronic assessment tool.

An ambulatory diabetes clinic in Australia provided the setting for the study by Azzi et al., (2014). A hospital setting was selected in two studies (Henneman et al., 2014; Young et al., 2015) and the home/community setting immediately after transition from hospital provided the setting for the remaining five studies (Chacko et al., 2010; Corbett et al., 2010; Hu et al., 2012; Leland et al., 2012; Thorsteindottir et al., 2015). The range of sample sizes varied from 37 to 474 with a mean (SD) of 181.88 (150.72).

The primary outcome of interest was the rate of medication discrepancies detected by nurses when performing medication reconciliation. In the study by Azzi et al., (2014), the objective was to identify the factors contributing to medication discrepancies for patients with Type 2 diabetes mellitus referred from GP practices to a specialist healthcare clinic. The study population was mostly male (66.6%). Of the 1218 eligible patients, a random sample of 341 (28%) records was selected. Outcome measures were types and rates of medication discrepancy investigated by analysing the structured nurse patient interview (SNPI) and comparing it with the referral letter from the GP. The SNPI involves taking a detailed drug history which includes all types of medication currently taken by the patient. It includes checking with all sources of information including the referral letter from the GP and the patient’s own actual medications or medication list if available. The SNPI was deemed the best possible method of obtaining an accurate medication history with nurses detecting at least one medication discrepancy in over 80% of the GP letters with a median of 2 medication discrepancies per letter reported. In this study the median time between clinic visit and GP referral was 28 days. There is a possibility that the patient may have accessed healthcare elsewhere during the 28 days. Patient anxiety levels while attending the clinic and poor legibility of GP handwritten prescriptions may have been contributory factors to the number of discrepancies. The use of technology such as electronic prescribing may have prevented the discrepancies due to illegible handwriting.

Similarly, use of technology, in the study by Henneman et al., (2014) showed a reduction in medication discrepancies. An electronic assessment tool to assist staff collect patients’ medication history was devised. The study evaluated the impact of a standardised approach to medication history collection, and accuracy of the list of medications at transition into hospital, using a modified version of the Eindhoven Model as the theoretical framework for the study. Evaluation of the tool was done by using student nurses in role-play scenarios with mock patients. The tool was then employed by nurses in a community hospital. Medication discrepancy rates pre and post the intervention were compared by reviewing electronic histories, orders and discharge papers. In the community hospital the number of patients without discrepancies improved significantly (pre 20% versus post 42%, p = 0.017). As a result of improved history taking by nurses, there was a decrease in drug omissions in the discharge summary (pre 0.43 (0.71) versus post 0.18 (0.44) p = 0.053) (Refer Figures 2 & 3).

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Sample Size</th>
<th>Gender</th>
<th>Technology Used</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azzi et al., 2014</td>
<td>Home/Community</td>
<td>1218</td>
<td>Male 66.6%</td>
<td>SNPI</td>
<td>Discrepancies detected in 80% of GP letters</td>
</tr>
<tr>
<td>Chacko et al., 2010</td>
<td>Hospital</td>
<td>341</td>
<td></td>
<td></td>
<td>Medication discrepancies detected in 28 days</td>
</tr>
<tr>
<td>Henneman et al., 2014</td>
<td>Ambulatory clinic</td>
<td>341</td>
<td></td>
<td>Electronic tool</td>
<td>Medication discrepancies reduced</td>
</tr>
</tbody>
</table>

Refer Figures 2 & 3.
Table 1: Types of interventions carried out and the corresponding nurses who carried them out.

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention employed</th>
<th>Nurse role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azzi et al. (2014)</td>
<td>All patients visiting a diabetic outpatient clinic received a comprehensive drug history taking.</td>
<td>Specialist diabetes nurses conducted the interviews.</td>
</tr>
<tr>
<td>Chacko et al. (2010)</td>
<td>Telephone calls were made to patients within 48-72 hours of their discharge home from hospital.</td>
<td>A specially trained Veterans Association Transitional nurse identified medication discrepancies.</td>
</tr>
<tr>
<td>Corbett et al. (2010)</td>
<td>Medication reconciliation was performed using the American Hospital Form service medication classification to categorise medication discrepancies during home visits.</td>
<td>Home visiting nurses</td>
</tr>
<tr>
<td>Henneman et al. 2014</td>
<td>Use was made of a structured assessment tool to obtain accurate medication histories</td>
<td>General Nurses</td>
</tr>
<tr>
<td>Hu et al. (2012)</td>
<td>Patients' medication histories were collected and reconciled with disparities in drugs in all hospital discharge orders and medication containers in the home.</td>
<td>Home visiting nurse</td>
</tr>
<tr>
<td>Leland et al. (2015)</td>
<td>A Registered Nurse carried out a home visit within 4 days of discharge and carried out medication reconciliation.</td>
<td>Registered General Nurses</td>
</tr>
<tr>
<td>Thorsteinsdottir et al. (2015)</td>
<td>Medication reconciliation was carried out in the patient’s home.</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>Young et al. (2015)</td>
<td>Assignment of responsibility for complete management of medication reconciliation was given to a designated nurse. Nurse was responsible for reviewing and reconciling all admission medications.</td>
<td>Advanced Practitioner Nurse</td>
</tr>
</tbody>
</table>

Figure 2: Forest plot: electronic assessment tool versus no assessment tool

Figure 3: Forest plot: decrease in drug omissions when an electronic assessment tool is used.
The use of a formal and systematic assessment tool by nurses highlighted a reduction of medication discrepancies in a community hospital and although student nurses were not the primary focus of this review, their use of the tool showed an improvement ($p = .010$) in the accuracy of medication history taking at admission. RevMan analysis was undertaken and OR was 0.41 (95% CI: 0.23 to 0.75 $p = 0.004$). This indicates that there are less odds of having a medication discrepancy when an electronic assessment tool is used and this finding was statistically significant. The study provided evidence of a decrease in drug omissions in the discharge summary. The MD is -0.25 (95% CI: -0.42 to -0.08; $p=.004$) indicating a statistically significant difference in favour of the experimental group. Levels of patient acuity were deemed to be a contributory factor to the number of discrepancies.

Interestingly this was also the case in the study by Chacko et al., (2010) which reported the workability of a nurse-based telephone transitional care programme. Patients 48-72 hours post-discharge were contacted by phone and the specially trained Veterans Affairs nurse performed medication reconciliation during the phone conversation. Medication discrepancies were experienced by 22% (8/37) of the intervention group during the first follow-up nurse phone call. Interestingly, 71% of the discrepancies were caused by unrecognised cognitive deficits or patients’ need for assistance. These specially trained nurses demonstrated the ability to recognise these deficits when protected time was given to medication history taking.

The frequency and seriousness of prescribed medication changes in frail, older adults in the first week after hospitalisation was highlighted in four studies (Corbett et al., 2010; Hu et al., 2012; Leland et al., 2012; Thorsteinsson et al., 2015). All of these studies demonstrated the effectiveness of home visits by nurses in detecting medication discrepancies.

Of particular note were the four studies, which highlighted the patient and systems factors, which can contribute to medication discrepancies developing. Medication reconciliation performed by a nurse practitioner during the first home visit resulted in medication discrepancies being detected in 150 (45%) patients (Thorsteinsson et al., 2015). A Veterans Affairs home-based transitional care programme initiated to support discharged veterans during the first month post hospital discharge resulted in nurses detecting 120 (53%) participants who had medication discrepancies within 4 days of discharge (Leland et al., 2012). In the study by Corbett et al., (2010) patients’ electronic hospital discharge medication orders were compared with the actual medications the patient reported taking at home. Participants who had ≥ 1 nurse-identified discrepancy totalled 94% in number with the mean discrepancy of 3.3 per patient. Failure to fill prescriptions and/or incomplete or inaccurate documentation was a contributory factor (Corbett et al., 2012). Hu et al., (2012) examined older Americans for the potentially inappropriate medication use and medication discrepancies. Data collection was through patient interview and chart review and 51 participants (67.1%) had at least one medication discrepancy. Of the medications at home reviewed by visiting nurses, 202 (26.9%) were inconsistent with medications at discharge. The chance of a medication discrepancy occurring was directly proportional to the number of medications the participant was prescribed. The MD odds ratio (95% CI) if ≤ 9 medications = 1 but if ≥ 10 medications the odds ratio was 2.57 (1.00-6.61). The issue of polypharmacy in addition to poor English and low levels of education were possible patient contributory factors (Hu et al., 2012).

Young et al., (2015) reported on the effectiveness of an advanced practice nurse-managed (APN) medication reconciliation in patients with a cardiac condition discharged from a community hospital. In the pre-intervention phase, the medication reconciliation process consisted of nurses in the Emergency Department conducting medication reconciliation without the guidance of any protocol or structured format. In the post-intervention phase, medication reconciliation was exclusively managed by the APN. The percentage of patients with at least one medication discrepancy decreased from 94% before the intervention to 81% post intervention ($p=.005$). This study indicated a statistically significant difference in favour of the experimental group with the OR of 0.27 (95% CI: 0.10 to 0.71: $p = 0.008$) CI of 95% is 0.27(0.10 to 0.71). Furthermore, the MD is -3.77 (95% CI: -5.50 to -2.04: (-5.50 to -2.04: $p < 0.0001$ demonstrating statistically significant mean difference in medication discrepancies in favour of the post-intervention group (Refer Figures 4 & 5).
Body of text...

Despite extensive searching, there were only a few studies that evaluated nurse-led medication reconciliation in older adult care services. As well as a lack of available quantitative research, the research was carried out by a small number of institutions. Interventions were heterogeneous and often incompletely described. Methodological weaknesses in 5 studies (Chacko et al., 2010; Young et al., 2011; Hu et al., 2012; Leland et al., 2012; Thorsteindottir et al., 2015), limited the ability to draw firm conclusions about the true effectiveness of the interventions.

Discussion

Given the significant limitations of the available evidence of this review, clearly conclusions are tentative and further research is required. However, two findings are difficult to ignore. Firstly, the scale of the problem of medication discrepancies, in some cases over 50% older adult patients have a discrepancy on transition. Corbett et al., (2010) found 69% of discrepancies occurred as a result of system related issues. These included incomplete or inaccurate communication and/or documentation and/or discharge instructions and duplication of medications. Systems within healthcare that may cause duplication can include imprecise admission medication history, absence of correct home medication reconciliation documented during the admission medication history with discharge medications, poor discharge education and changes in formularies of medication. Financial restrictions have led to the creation of strict formularies, which leads to increasing medication substitutions, with a resulting potential for more medication discrepancies (Corbett et al., 2010). In one study, 13.7% of patients needed an interpreter so this may have been a patient (as opposed to a systems error) contributing factor to miscommunications regarding medications (Azzi et al., 2014). This is a significant factor for all healthcare professionals in an era of intense globalisation.

Secondly, of note was the obvious directionality of all the eight studies in favour of nurse-led medication reconciliation interventions. This directionality was stable despite the diverse methodological approaches used in all the studies analysed here, the heterogeneity of grade and specific nursing role and location of the intervention (at home or in hospital).

Benefits of nurse-led interviews to record accurate medication reconciliation were very apparent (Leland et al., 2012; Thorsteindottir et al., 2015). Nurses who visit patients in their homes are often responsible for assessing medication in relation to patient understanding, administration and compliance with medication (Banning, 2004). Patients in their home are often better historians, for example, if unwell on admission to hospital, patients’ recall may be negatively affected. In addition, acute admissions by their very nature are unprepared for and so patients may not bring in their own medications from home and additional items purchased over the counter are often not captured (Fitzsimons et al., 2011). Use of telephone interviews by nurses in the study by Chacko et al., (2010) proved successful. However, it is noted that the mean duration time of the nurses’ calls were 80 minutes. Time limitations, including those related to staff workloads, have been described in other studies involving medication reconciliation processes (Keeyes, 2014) so this may not be the most efficient method of achieving safe medication management.

The benefits of the structured nurse-patient interview over consultation by GPs is noted (Azzi et al., 2014). The difficulties busy clinicians face is well documented. Their knowledge gaps and poor medication history taking skills have contributed to inaccurate medication histories (Chan et al., 2010). Furthermore, Hutchinson et al., (2006) demonstrated that despite patients making frequent visits to their doctor, they reported medication problems in only 50-70% of the time. Nurses are often with patients for a much longer time period than doctors and can use that time to illicit accurate medication histories. For example, the benefits of having an APN to carry out medication reconciliation was demonstrated (Young et al., 2011), however it is recognised that not every care setting will have an APN.

Consistent with other studies, (Tam et al., 2005; Forster et al., 2005) the overall results of this review showed that the higher the number of medications the patient was taking, the more likely they were to experience a discrepancy. This may be because of the increased chance of miscommunication at each occasion when a medication is prescribed. However, it is important to remember that polypharmacy may be appropriate for many older patients. Thus, it is inappropriate polypharmacy which should be the main concern and
nurses are well placed to assess medication use due to their prolonged contact with patients. The number of medications was a significant factor associated with medication discrepancies in studies by Azzi et al., (2014) and Hu et al., (2012). Multiple medications are regularly prescribed to manage the many risks and complications associated with diabetes (Kuritzky, 2010). Azzi et al., (2014) study was set in a diabetes clinic. Management of diabetes often involves multiple levels of care which includes transition between primary care, acute care services in hospitals and outpatient services. Nurses are often the first and last healthcare professional patients see, strengthening the case for nurse-led medication reconciliation practices.

The significance of prompt follow up post-discharge by nurses was a strong theme in this review. Studies have highlighted up to 67% of patients’ prescription medication histories as having ≥ 1 error and up to 46% occurring when new prescriptions were written on admission or discharge (World Health Organisation, 2007). Similarly, inaccurate discharge medication reconciliation can produce errors in medication therapy post discharge, with an increased potential for readmission. Therefore, an important aspect noted in several of the studies was the timing of the nurses’ visit in relation to the patient’s discharge. Prompt follow up visits by nurses are important in order to avoid prolonging the effect of the patient consuming incorrect medication.

Patients must be provided with legible, complete and updated discharge lists as a means of promoting patient safety and medication adherence (Keeyes, 2014). However patients themselves are often unaware of both the medication reconciliation process and the importance of having a clear understanding of their own medication (Van Sluisveld et al., 2012). Levels of patient acuity in the community hospital study (Henneman et al., 2014) may have also impacted on results as there was an inclination toward more patients from nursing homes in the pre-intervention group. Combining this with a small sample size may have impacted on the potential for bias as there were more medications per patient and increased acuity in the pre-intervention group. Given this, it is reasonable to suggest that this is a very complex problem and while nurse intervention may help, it is likely that there are broader questions that need consideration. For example, with cognitive impairment, if safe administration cannot be achieved the safety of medications must be considered. There is a need to explore services and systems including the roles of technology in helping people with cognitive problems adhere to medication regimens (Granger & Bosworth, 2011). Information technology is a central component to support the process of medication reconciliation (Wilson, et al., 2013) and use of electronic assessments (Henneman et al., 2014).

Other reported factors included patients with limited English and low education levels (Hu et al., 2012), financial burden and intolerance (Thorsteinsson et al., 2015), and failure to fill a prescription (Corbett et al., 2012). Nurses are well placed to acknowledge and manage these contextual factors through honest engagement with patients.

Limitations of the Review
The central limitation of this review is the lack of available high quality research. Some of the studies included were of limited validity and generalisability because of methodological issues, small samples and single study settings. However, the diversity of methodological approaches used and the interventions described has demonstrated efficacy during study period. The sustainability of these results and the effectiveness of these interventions are unclear.

In addition, this review consisted of searches of electronic databases only and not all studies are available through database searching. No attempt was made to contact authors or search grey literature due to time and budgetary constraints. Only published research was included which may have led to publication bias. The exclusion of non-English language papers may have resulted in language and publication bias with the real possibility of relevant studies published in other languages being overlooked.

Conclusion and Implications for Nursing Practice
The outcomes of this review have global relevance as healthcare practitioners and safety organisations have a major interest in how to effectively manage medicines reconciliation. This review suggests that nurses can contribute to reduction in medication discrepancies in care settings for older persons by performing accurate medication reconciliation. A structured approach by nurses to listing patients’ medication can deliver improved outcomes by reducing potential medication errors. High rates of medication discrepancies exist at care transition.

Healthcare delivery systems have become more complex, with hospitalisation often leading to increased and complex medication regimen for older patients (Elliot et al., 2013) and increased risk of medication errors, particularly at transitions of care (Rozich & Resar, 2011).

Recommendations
Medication discrepancies pervade settings with older adults and strategies that support the prevention of medication errors need urgent consideration. Further research is urgently needed to investigate how nurse-instigated medication reconciliation can reduce medication discrepancies and potential patient harm (Huynh et al., 2013). The focus should be on developing randomised designs to accurately evaluate medication reconciliation during care transitions. Larger population
studies are needed to accurately determine whether these observations are of significance for securing patient safety. Given that the timing of medication reconciliation is a key factor, preregistration education and training programmes for nurses and post registration professional development should incorporate medication reconciliation.

**Key Findings which should be used to Influence Policy and Practice:**

- Despite a strong focus on medication reconciliation practices over the last two decades, medication discrepancies continue to pervade older adult care transition settings. New strategies that support the prevention of medication errors need urgent consideration.

- Nurses are often best placed to contribute to a substantial reduction in medication discrepancies in care settings for older persons by performing accurate medication reconciliation. All practice settings are now required to examine or initiate formal medication reconciliation procedures. The findings from this review will assist policy makers in formulating effective medication reconciliation processes which should include nursing roles.

- Focus on the development of the nurses’ role in medication reconciliation when developing undergraduate and postgraduate nurse education programmes and policies and protocols.

**References**


Health Information & Quality Authority (2014). *Principles of good practice in Medication*


AIGNA Committee Members Present at International Aging in Society Conference California

Dr Kevin Moore, AIGNA Committee Member and Lead for the Research, Education, Publications and Strategy Sub-Group presented research findings from a major research study, which analysed the lived experiences of Irish nursing home residents, at the International Aging and Society Research Network Conference, in November 2017 in the United States.

The Minister of State with responsibility for Older People, Jim Daly TD, launched the two-year study undertaken by Ulster University researchers, at Palmerstown House, Co Kildare in September 2017. The research, commissioned by Nursing Homes Ireland, considered the context and meaning of what constitutes ‘home’ from the perspective of a nursing home resident. It evaluates and critiques the role of nursing home staff and wider healthcare providers in enabling and maximising a ‘homely’ experience for nursing home residents. Dr Kevin Moore and Professor Assumpta Ryan, Ulster University, published their research findings at a launch in September 2017 with nursing home residents, staff and Minister Daly. Professor Des O’Neill, consultant physician in geriatric and stroke medicine and Professor in Medical Gerontology, was also at the launch and he provided a response to the report suggesting that it was very timely and relevant.

The research, *The Lived Experience of Nursing Home Residents in the Context of the Nursing Home as their Home*, was undertaken arising from recommendations within previous research that suggested that the perspectives and narratives of nursing home residents be explored further to support the effectiveness of care delivery within the nursing home sector. Such research has never been undertaken previously in Ireland and there is a dearth of such research internationally. Copies of the Report and Executive Summary are available directly from Nursing Homes Ireland at www.nhi.ie or on the AIGNA web pages at www.aigna.ie or by contacting the corresponding author Dr Kevin Moore via e-mail: kd.moore@ulster.ac.uk

Mrs Marie O’Neill, AIGNA Committee Member and Member for the Research, Education, Publications and Strategy Sub-Group presented preliminary research findings from her Doctoral research study, which focuses on the analysis of the Resident’s Experiences of Moving from Home into a Care Home, at the International Aging and Society Research Network Conference, in November 2017 in the United States. Further details including a copy of the presentation are available from the corresponding author Mrs Marie O’Neill via e-mail: m.oneill@ulster.ac.uk

**Rationale for Undertaking the Study:**

- Residents in long-term care are often marginalised, and excluded from research. Moreover, there is a lack of research that takes into consideration the relocation process, incorporating residents’ experiences with the move.
- It is recognised that the transition to long-term care can be an emotional and stressful event for older people and their families.
- Research into the experiences of older people moving into a care home facility has tended to focus on the physical changes that take place, with limited research into the psychological and/or social changes that these transitions may also involve.
- Adjustment to care home life is a process that occurs over time. Part of understanding this process requires recognition of variances in the responses of older adults whose permanent move to a care home was either planned or unplanned.
Understanding of these variances will provide a foundation for developing interventions to support older adults with this process.

**Aim of Study**
To explore residents’ experiences of moving from home to a care home over a one-year period.

**Data Collection Schedule:**
Data collection involves tracking participants’ experiences of moving from home to a care home through a period of one year using a time interval approach to interviewing. Each participant will have 4 interviews with the researcher, until data saturation has been achieved. Data collection takes place initially in the Participants’ own homes or hospital ward then subsequently in the care home to which the person has moved for up to one year after the initial move.

**Preliminary Findings to Date:**
29 interviews have been undertaken to date with n=14 participants (i.e. Interview 1, n=14; Interview 2, n=9; Interview 3, n=5; Interview 4, n=1) in 8 different participating care home settings. Of the 14 participants, nine are female and five are male with an age range of 60-93 years.

An on-going analysis and interpretation of individual transcripts to date, consistent with a grounded theory approach, have revealed that for people moving into care homes relocation can be a uniquely significant and individualistic experience. Key issues identified to date are central to:

**Time Point 1 Pre-residence interview:**
- The reason for admission to care home and thoughts about the move.
- Perceptions of the validity and rescindable nature of the move.

**Time Point 2 (4-6 weeks after admission)**
- Individuals’ perceived control; degree of choice; active acceptance of the placement and how this has influenced this transition.
- What the care home means to the individual in terms of developing Identity; creating a homelike environment; developing relationships, and connectedness with others; autonomy, and caring practices.

**Time Point 3 (4-5 months)**
- Making the journey of transition, finding acceptance and adaptation.
- Maintaining and developing hope; self-perseverance.
- Maintaining personal and social identity.

**Time Point 4 (9-12 months)**
- Relationships are seen as paramount to the transition process

**Completion of Data Collection:**
It is anticipated that completion of data collection will be undertaken by December 2018.
Annual Conference

AIGNA 10th Annual Conference
‘Celebrating Advances in Older Persons Nursing’
3rd May 2018, Clayton Hotel, Monivea Road, Ballybrit, Galway, Ireland

Opening address:
Professor Brendan McCormack:
Head of the Division of Nursing/Head of QMU Graduate School. Associate Director, Centre for Person-centred Practice, Research School of Health Sciences, Queen Margaret University, Edinburgh.
Advances in Gerontological Nursing over the past 10 years

Key Note Speakers:
Ms Mary Manning: RGN, MSC, General Manager, National Dementia Office: The national dementia strategy office has the overall responsibility for implementing the national dementia strategy. Mary will present on “The National Dementia Strategy: Charting Progress and Outlining Future Plans”.

Ms Helen Rochford-Brennan: In July 2012, Helen, aged 62 was diagnosed with early onset Alzheimer’s disease. She is Chair of the Irish Dementia Working Group, which is resourced by The Alzheimer Society of Ireland. Helen has used her time with the Irish Dementia Working Group to raise awareness of dementia and raise the profile of human rights for people with dementia.

Dr. Elizabeth Weathers: PhD, BSc, PGCTLE, RGN: currently works as Lecturer in Nursing at the Royal College of Surgeons Ireland – Medical University Bahrain, where she lectures on undergraduate and postgraduate programmes. She will present on "Connectedness and Meaningful Living in Older Adulthood".

Ms Daragh Rodger: Advanced Nurse Practitioner: RGN, RNP, RANP MSc Nursing, BSc Nursing, Cert Nurse Prescribing, HDip Wound Management Tissue Viability, Dip. Gerontological Nursing. She will present on “The role of the Registered Advanced Nurse Practitioner in Gerontological Nursing”.

Other Presenters
Ms Lorraine McNamee MSc, PG Dip. Dementia, BSc Mgt, Adv Dip. Personal & Executive Coaching, Dip. Mgt., RGN: Project Officer and is based in Nursing and Midwifery Planning and Development Dublin North. She will give a short presentation on the role of AIGNA in advancing older persons nursing over the last 10 years.

Other Platform Presenters to be confirmed in due course. Applications available from website www.aigna.ie or E-mail us for an Application Form on: aignainfo@gmail.com
The annual AIGNA Masterclass took place at the Radisson Hotel, Athlone on Thursday 19th October 2017. The theme of the Masterclass was ‘Person-centred Care under the Assisted Decision Making Capacity Legislation’. Dr Amanda Phelan from UCD presented the morning Masterclass. Dr Phelan’s research and publications focus on elder abuse, abuse of vulnerable adults, person centred co-ordinated care, ageism and resilience in caregivers of people with dementia. As Subject Head for Older Persons’ Nursing and Co-Director, National Centre for the Protection of Older People at UCD, Dr Phelan was well positioned to address the topic of ‘Addressing Safeguarding: A Moral imperative’.

In her Masterclass, Dr Phelan addressed demographic issues and Ireland’s ageing population. In doing so, she set the scene for a thorough analysis of elder abuse including prevalence rates, types of abuse, risk factors and screening. Dr Phelan addressed the human rights of older people and provided the audience with an overview of the background and contextual factors which culminated in the ‘Assisted Decision Making (Capacity) Act 2015.

The afternoon Masterclass was delivered by Mary Condell, a solicitor and mediator who holds an MA in Mediation and Conflict Intervention and who is a Practitioner member of the Mediator’s Institute of Ireland. Ms Condell is also a member of the Law Society’s Task Force on Mental Capacity and Legal Advisor to Sage Advocacy where her remit includes advising on legal issues arising in advocates’ casework and educating professionals and others about the new capacity legislation and its practical application in dealing with vulnerable adults.

Ms Condell’s Masterclass addressed the issues of compliance with statutory obligations imposed by the Assisted Decision Making (Capacity) Act 2015. This included an overview of the human rights origins of the new legislation, capacity models and a review of the
current position around Wards of Court. Focusing on the new legislation, Ms Condell provided the audience with an insightful and thought provoking analysis of the new act, which included the challenges associated with defining and assessing capacity and the centrality of effective communication in doing so. The latter part of the afternoon Masterclass addressed the decision support sequence, decision support services and the practicalities of empowerment. The audience was given practical tips for assisting decision making and was left in no doubt that capacity (rather than incapacity) was to be presumed unless there is sufficient reason to doubt it.

The event was attended by over 65 delegates who reported very positively on the relevance of the content to their everyday activities in caring for older people. Delegate feedback included comments such as “a very informative day”, “excellent having it multi-disciplinary”, “really enjoyed the masterclass” and “enjoyed the opportunity to mix with other nurses”; “excellent professional development opportunity”. The key role played by AIGNA in supporting nurses caring for older people and their families across a range of health and social care settings was also acknowledged by many delegates who described the day as a “fantastic learning opportunity - AIGNA fulfilling an important role in the development of gerontological nursing and empowerment of caring for an older adult”.
The textbook entitled ‘Self-Neglect in Older Adults: A Global, Evidence-Based Resource for Nurses and Other Healthcare Providers’ was launched at The Gallery, Bishopstown Library, Wilton, Sarsfield Road, Cork on the 23rd November, 2017. The book event was launched in partnership with the Institute for Social Science in the 21st Century (ISS21) University College Cork.

The book provides nurses, geriatricians, healthcare professionals and community organisations with a comprehensive overview and analysis of self-neglect in older adults. With an aging global population, self-neglect is emerging as a complex problem that crosses multiple disciplines of health and social care. Characterised by a harmful inattention to health and hygiene, self-neglect manifests in a variety of ways across the world that healthcare professionals need to be able to recognize and manage. The only text with the latest analysis of theoretical perspectives, research, and evidence from global leaders in the field, chapters tackle the interdisciplinary problem of self-neglect to deliver current professional practice tools and clinical practice interventions. Short presentations were made by a number of contributors to the book: Emeritus Professor Geraldine McCarthy, School of Nursing and Midwifery, UCC, and Chair of the South/South West Hospital Group, Dr. Mary Rose Day, Dr. Kieran O’Connor, Clinical Director Mercy University Hospital & Consultant Physician in Geriatric Medicine, Mercy University Hospital and St Finbarr’s Hospital, Cork, Dr. Helen Mulcahy, School of Nursing and Midwifery, University College Cork, Dr. Joan McCarthy, Lecturer, Healthcare Ethics, School of Nursing and Midwifery, University College Cork, Dr. Patricia Leahy-Warren, Senior Lecturer, School of Nursing and Midwifery, University College Cork and Dr. Eleanor Bantry-White, School of Applied Social Studies, UCC.

The event was very successful and was attended by 60-70 people who came from acute, community and voluntary services, Nursing and Midwifery Planning and Development Unit HSE, South, colleagues in UCC, as well as friends and family.
AIGNA Committee Member Conferred with a Fellowship

Dr. Mary Rose Day, AIGNA Committee Member and Member of the Research, Education, Publication and Strategy Sub-group AIGNA, and Violet Hayes, previously the Director of Public Health Nursing, West Cork, HSE South, were both conferred with a Fellowship at a recent ceremony by the Faculty of Nursing & Midwifery, Royal College of Surgeons of Ireland (RCSI), Dublin, on the 11th December, 2017.

The Fellowship of the Faculty of Nursing & Midwifery RCSI (FFNMRCSI) is exclusively offered by the RCSI and is one of the most prestigious professional qualifications awarded to nurses in Ireland. Fellowships are awarded in different categories, Honorary Fellowship, Fellow Ad Eundem, and Fellow by Examination. Honorary Fellowships and Fellowship Ad Eundem are awarded to candidates in recognition of outstanding work and/or exceptional leadership in the profession of nursing/midwifery or a related science, those who have given significant service to the profession or to the Faculty of Nursing & Midwifery, and those who have positively influenced and impacted on health and society. Candidates for these awards are nominated and ratified by the Board of the Faculty of Nursing and Midwifery, prior to review and ratification by the Surgery and Postgraduate Faculties Board (SPFB), RCSI. For more information on the RCSI follow this link: http://www.rcsi.ie/fnm_fellowship

The AIGNA Management Committee would like to extend their sincere congratulations to both recipients on their Fellowships and dedication and service to the profession and their pursuit of excellence in caring, research and education.
Title: Working in a storied way: Narrative-based approaches to person-centred care and practice development in older adult residential care settings.

The authors of this participatory action research aimed to implement and evaluate a framework of narrative practice in two residential care settings (37 residents and 38 staff) in the Republic of Ireland. Action research differs from traditional research in that it is less about generalizability and more about the processes of implementing change in practice. This study was the second stage of a larger action research study. The purpose of the framework is to enable staff to work in a storied way, to identify existing culture and practices and to help develop narrative strategies to improve care. The framework was implemented over 18 months, and data collected included work group minutes, field notes, interviews, observations and reflections. The researchers found that key outcomes that emerged from the implementation of the framework of narrative practice are based on narrative knowing, being and doing. This includes themes of (i) how people responded to change (narrative being); (ii) the development of shared understandings (narrative knowing); and (iii) intentional action (narrative doing). This study has relevance to nurses working with older people in highlighting the importance that practice context is taken account of, and the importance of ensuring that narrative being, knowing and doing are clear and understandable at the outset. The researchers conclude that nurses and healthcare workers need to be aware of creating and opening communicative spaces to enable them to uncover layers of meaning and understanding that otherwise may be hidden. They suggest that the benefits of defining the leadership style of a manager prior to undertaking a development programme need further consideration and could ensure the best possible approach to implementation is adopted.

Reference

Title: The impact of life story work on person-centred care for people with dementia living in long-stay care settings in Ireland.

Much has been written about the benefits of life story work in enhancing dementia care. In this qualitative descriptive study (with overtones of grounded theory) the researchers explore whether knowing the person’s life story enhances healthcare professionals’ understanding of the person with dementia and whether this understanding impacts on the person’s care. The researchers used data from a previously undertaken grounded theory study. In-depth interviews were conducted with 11 registered nurses and 12 healthcare assistants who had used life story work with people with dementia living in long-stay care settings. The researchers found that engaging in life story work enabled staff to see the person behind the dementia. Understanding (as opposed to knowing) the person with dementia’s life story changed staff thinking on what is important when delivering care to people with dementia, with staff giving concrete examples of changes in how they delivered care to the person with dementia and what they considered important when delivering that care. The researchers concluded that life story work can facilitate a shift to person centred dementia care but they stress how it is implemented matters if this outcome is to be achieved. The researchers suggest that implications for sustaining life story work in practice should include a commitment from managers that life story work is valued and prioritised. They suggest that staff need to incorporate life story work on an ongoing basis into day-to-day practice rather than see it as a time-consuming and additional task. In addition, they suggest that life story work should be embedded into the care plan, thereby incorporating memories and life experiences and connections into day-to-day caring relationships.

Reference

Title: The care of and communication with older people from the perspective of student nurses. A mixed method study.

The focus of this descriptive study with a mixed-methods approach was third year undergraduate student nurses’ views on the care of and communication with older people. The researchers acknowledge that undergraduate nursing education needs to prepare nurses to meet the demands and to have the necessary communication skills for caring for an increasingly older population. Both quantitative and qualitative data were collected from a questionnaire completed by third-year student nurses in 2015. The quantitative data were obtained from three questions designed to elicit the student nurses’ attitudes towards and perspectives on the care of, and communication with, older persons. The qualitative data were obtained from an open-ended question. The researchers found that in the quantitative part students (n=94) responded with mostly positive attitudes towards the care of older people. The open-ended question was: “Please describe in your own words what you consider to be important for good communication and effective encounters with older people”. This question was completed by 75 students. The length
of comments varied from 1 to 15 lines. The analysis resulted in three categories and eight subcategories, which described the importance of building a relationship, techniques for communication, and external factors and prerequisites for interaction and communication with older people. Relationship building was described in terms of seeing the person, being respectful, and showing empathy and compassion. Techniques used for communication were both verbal and nonverbal, and listening to, acknowledging and supporting the older person’s participation and involvement. External factors and prerequisites were related to the interaction and communication, and included time and the environment, which were noted as important influences on the success of communication.

The authors conclude that while students reported positive attitudes about the care of, and communication with, older people overall, their views revealed a somewhat shallow understanding of the communication skills needed. They recommend that as part of communication teaching, educators should focus more on addressing older people’s emotional and existential needs.

Reference

Title: Using oral health assessment to predict aspiration pneumonia in older adults

The authors in this Japanese retrospective study investigated the significance of oral health assessment using the revised oral assessment guide (ROAG) in older adults diagnosed with pneumonia, who were at aspiration risk. Aspiration pneumonia is defined as the misdirection of oropharyngeal or gastric content into the lower respiratory tract. Aspiration pneumonia accounts for a significantly high proportion of older adults hospitalised with pneumonia. In addition, many adults in the older age group with aspiration pneumonia, such as residents in nursing homes may not be diagnosed until hospitalisation. Therefore, simple and useful tools for screening adults with aspiration pneumonia are important, as it affects both short and long-term mortality. The researchers retrospectively studied 238 older adults with pneumonia, in whom the ROAG score had been assessed between December 2014 and June 2016. The researchers found that 215 older adults (90.3%) were found to be at aspiration risk. According to the revised oral assessment guide (ROAG) score, mild to moderate and severe oral problems were noted in 38 (16.0%) and 200 (84.0%) adults, respectively. Aspiration risk was noted in 68.4% and 94.5% of adults with mild to moderate and severe oral problems, respectively (P < .0001). Furthermore, a high ROAG score was an independent predictor of aspiration risk in this study population. The researchers draw important conclusions, which may be relevant for nurses involved in oral health for older people. They suggest a comprehensive assessment of oral health is important for evaluating the risk of aspiration in older adults. The ROAG score may be a useful tool for identifying aspiration risk in clinical practice.

Reference

Title: Effectiveness of probiotics on the occurrence of infections in older people: systematic review and meta-analysis.

Infectious diseases in older people are more frequent, usually more severe, and associated with higher mortality rates and functional impairment than in younger adults and probiotics have been hypothesised to reduce the occurrence of infection. The aim of this systematic review and meta-analysis was to assess the effectiveness and safety of probiotics in the occurrence of infections in older adults in comparison to placebo. A systematic review and meta-analysis of randomised placebo-controlled trials was conducted, in December 2016 using Medline, Embase, CENTRAL, Web of Science and LILACS databases. Efficacy outcomes were: occurrence of infection, quality of life, mortality and mean duration of infection per episode. Safety outcomes were adverse events. The initial search retrieved 5,036 studies, of which, 15 randomised controlled trials were included in this review. In brief, results overall demonstrated that when compared to placebo, probiotics did not significantly reduce the occurrence of infectious diseases (ID) in older patients, with a low quality of evidence. In addition, probiotics did not seem to reduce the mean duration of an infection episode (very low quality of evidence). There were no differences in the occurrence of infection in the subgroup analyses according to age, coexistence environment and types of infection and probiotic.

Although poorly described, the effect of probiotics on general mortality did not seem to differ from that of the placebo (very low quality of evidence). This systematic review did not find differences between probiotics and placebo regarding adverse events, with a low quality of evidence. Quality of life was described by only two studies, each of which showed opposite results. Unfortunately, quality of life remains a rather neglected outcome in studies conducted with older patients. The researchers conclude that the current data on the effectiveness of probiotics in older people are insufficient.

Reference
Abstract

Background: Internationally, elder abuse is underreported. Health professionals have statutory responsibilities to intervene when action is required to safeguard older people living in the community. The GP is often the first health professional that an older person will turn to, when they want to report abuse perpetrated by a family carer. Currently, there is little research available in Ireland, the UK and internationally on GPs’ experiences of managing elder abuse perpetrated by a family carer.

Aim: To explore GPs’ experiences of management of elder abuse perpetrated by a family carer.

Design and Setting: Two focus groups were conducted, involving nine GPs in primary care in Northern Ireland.

Method: Purposive sampling was used to recruit the GPs. The focus group discussions were audio-recorded and transcribed. Data were analysed using a process of thematic analysis.

Results: The overarching theme of GPs feeling underprepared for management of elder abuse perpetrated by a family carer permeated through all the data. Three subthemes were identified. These are: ‘intervening to minimise potential for abuse’, ‘confronting challenge and isolation’, and ‘taking ownership of the responsibility to report abuse’. GPs highlighted learning needs relating to the practical application of safeguarding legislation. A number of important issues were raised by the GP participants that have implications for nursing practice. These include a sense of frustration that nurses distance themselves from GPs when elder abuse is suspected, a perception that some victims of elder abuse will encounter challenges in being believed, and the rising prevalence of medication misuse for financial gain in the community.

Conclusions: Our findings demonstrate a need for greater collaboration between GPs, nurses and social workers in the management of elder abuse. An interprofessional elder abuse training programme may have value in enhancing knowledge and clarifying the role and responsibilities of GPs, nurses, social workers, and pharmacists in the prevention, identification and management of abuse.

Keywords

Elder abuse, family caregiving, general practice, primary health care, qualitative research.

Introduction

Internationally, elder abuse is underreported and under managed (Cooper et al., 2009; Friedman et al., 2014). In light of global ageing demographics and active ageing policy, the role of specialist and district nurses in supporting community dwelling older adults and minimising the potential for elder abuse, is likely to grow. Strategies have been developed internationally to prevent and manage incidents of elder abuse, with implications for social policy, public health, human rights and protective legislation (Melchiorre et al., 2014; Elder Justice Coalition, 2014; Mental Capacity Act Northern Ireland, 2016). The estimated prevalence of elder abuse in the UK ranges from 2.6% to 4.0% (O’Keeffe et al., 2007). Adult protection policy in the UK has informed regional and local safeguarding partnership arrangements (Department of Health, Social Services and Public Safety, 2010). General practitioners (GPs), nurses and social workers are key members of local safeguarding partnerships and have statutory responsibility to intervene when action is required to protect adults from abusive situations. This paper presents a qualitative research study that explores the experiences of GPs about managing potential or suspected abuse of a community dwelling older adult, perpetrated by a family carer. For the purpose of this paper, the term ‘family carer’ represents an adult who undertakes an informal, and more often unpaid, caring role in support of an older family relative.

Background

Elder abuse has been defined by the World Health Organisation (2002, p2) as ‘a single, or repeated act,
or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person’. The typology of elder abuse includes physical, psychological and/or emotional abuse, financial exploitation, sexual maltreatment and neglect (National Centre on Elder Abuse, 2014). Historically, elder abuse has been constituted as a social and family problem. The characterisation of the older adult as highly dependent on a family carer for support, led to the tolerance of elder abuse as consequence of caregiver stress. Social exchange theory cemented the notion of the older adult as burden and generator of an imbalance in the care giving relationship (Dong, 2015). In recent years, the focus in the literature has shifted to the psychopathology of the abuser and formulation of elder abuse as intentional and systematic behaviour (Acierno et al., 2010; Brandl & Raymond, 2012; Harbinson et al., 2012).

Internationally, GPs tend to underestimate the prevalence of elder abuse (Rinker, 2009). In comparison studies, it has been found that GPs view all types of abuse scenarios less severely, than older people (Helmes & Cuevas, 2007; Hempton et al., 2010). Although training for GPs about elder abuse is limited (Almogue et al., 2009, O’Brien et al., 2014), the use of simulation in the classroom has been found to be effective for enhancing knowledge (Fisher & Walker, 2013) and recruiting older adults to teach into medical curricula has assisted in changing attitudes (Bensadon et al., 2013). Education about elder abuse is important, as research suggests that when GPs are knowledgeable, they are more likely to report it (Almogue et al., 2009).

GPs, nurses and social workers have responsibilities for supporting family carers and to report suspected abuse in the UK (General Medical Council, 2009; British Association of Social Workers, 2012; Nursing and Midwifery Council, 2015), and in the Republic of Ireland (Health Service Executive, 2014; Nursing & Midwifery Board of Ireland, 2014; Irish Medical Council, 2016). The literature identifies a number of evidenced based approaches that nurses can use to support family carers. One to one counseling interventions enhance quality of life (Visser-Meily et al., 2005), and socially supportive telephone calls (Davis et al., 2004) and home visits (Roth et al., 2005) reduce some of the distress associated with caring for an older relative. In particular, anticipatory support is highly valued (Feinberg et al., 2006).

The devolved regions of the UK have taken steps to legislate on adult safeguarding (Adult Support and Protection (Scotland) Act, 2007; Care Act (England), 2014; Social Services and Well-being Act (Wales), 2014; Mental Capacity Act (Northern Ireland), 2016). In the Republic of Ireland, policies and procedures on safeguarding (Health Service Executive, 2014) and legislation (Assisted Decision-Making (Capacity) Act, 2015) for supporting capacity have also been implemented. The context of the study is one Health and Social Care Trust in Northern Ireland. The Trust serves a population of almost 300,000 people. The geographical area has a mix of urban and rural dwelling populations. It is a common feature in the study site for the older population to have lived in the locality for most of their lives, and it is not unusual for GPs to know and treat many members of the same family. The research team therefore considered that GPs’ experiences would make a useful contribution to understandings of managing elder abuse and the translation of associated policy into practice.

Methods

A descriptive qualitative research design incorporating focus groups for data collection was utilised to meet the aim and objectives of the study. The focus of the researchers was to get up close to, and connect with GPs’ experiences of confronting and dealing with potential or suspected elder abuse perpetrated by a family carer. Informed by Walden (2012), a purposeful sample of GPs was considered sufficient to generate a quality of saturated data that could produce meaningful results. Focus groups offered an ideal medium because it was anticipated that all the GPs would be known to each other and that knowledge would be accessed through spontaneity of conversation. A flexible mix of open questions and prompts were developed to enable the researcher to generate discussion, actively listen, and be responsive to what was of value to the GPs (Walden, 2012), with potential to generate contextually embedded meaning of managing elder abuse.

The research team was inter-professional with a range of experiences and expertise. In planning and undertaking this research, the researchers took steps to ‘bracket’ and put aside predetermined notions of GPs’ experiences and moderate the potential for an overriding bias to interfere with the conduct of the focus groups and subsequent data analysis. Approval for the study was granted by the ethics filter committee of the Institute of Nursing and Health Research at Ulster University in line with regional research governance at that time. The major ethical considerations pertained to the principles of voluntariness, right to confidentiality and informed consent. Signed consent was obtained from all participants prior to commencement of the focus groups.

Participants

Two primary care practices (one urban and one rural) were purposively selected from the wider health and social care organisation. All of the GPs (n = 12) working in these two primary care practices were invited to participate in focus groups. Each of the GPs was provided
with written and verbal information about the study, and nine consented to participate. Two focus groups were undertaken. The first focus group comprised of three GPs (all men) from the smaller rural health centre, and the second comprised of six GPs (men = 2, women = 4) from the larger urban health centre.

Data Collection

An introductory open response question was developed to facilitate the sharing of experiences of managing elder abuse perpetrated by a family carer. This was ‘We are talking today about your experiences of dealing with potential or suspected elder abuse, where the perpetrator is a family carer. Take me through what this was like for you?’ Prompts were developed to generate discussion and the sharing of deeper aspects of the experience: ‘tell me more about this’, ‘what happened then’, ‘what were your thoughts’. The focus groups were conducted in the designated meeting room in each of the health centres in November 2012. Instructions about confidentiality were agreed between the researcher and participants. The focus groups were audio recorded. The duration of the focus groups ranged from 35-40 minutes. The audio tapes were then transcribed verbatim. Confidentiality was assured through the replacement of participant names with participant codes (P1, P2, P3 etc.) during the transcription process. The transcripts were then checked for accuracy with the audio recordings.

Analysis

Colaizzi’s (1978) framework of thematic analysis was used as a means to assist the extracting, organising, and analysis of the focus group data. The framework encompasses seven progressive steps. Aligned to these steps, the principle author (CMcC) and second author (EL) independently read through each transcript several times to gain an overall sense of the content and meaning. Next, they independently extracted significant statements pertaining to experiences of managing potential or suspected elder abuse perpetrated by a family carer. In the third step, CMcC and EL came together to compare and contrast the significant statements, and through a process of critical dialogue reach consensus. It was at this stage that an overarching theme of ‘feeling under prepared for management of elder abuse perpetrated by a family carer’, was discerned. Next, the significant statements were grouped into categories and clusters of themes. In the fifth step, the clusters were coded to reflect all possible meanings. Weaker structures in some clusters were discarded and in others were combined to generate stronger themes. In this process, three sub-themes that described the experience of managing elder abuse, were clarified. A summary of the results was emailed to the participants, requesting their feedback on whether the results reflected their reality. Positive responses were received validating the results. The transcripts, interpretations, analysis and results were then provided to an experienced qualitative researcher for close scrutiny, and the trustworthiness of the results was confirmed.

Results

The overarching theme was of GPs feeling under-prepared for management of elder abuse perpetrated by a family carer. A description of the experience is generated through three sub-themes. These are ‘intervening to minimise potential for abuse’, ‘confronting challenge and isolation’, and ‘taking responsibility for reporting abuse’. The themes are presented and illuminated by meaning units in Table 1. Each theme is then illustrated by quotations from participants and discussed in more detail.

Table 1: Overarching theme and sub-themes

<table>
<thead>
<tr>
<th>Overarching theme:</th>
<th>Feeling under-prepared for management of elder abuse perpetrated by a family carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning unit:</td>
<td>‘You never feel comfortable dealing with elder abuse. There is always the fear that if you say too much or give too much information, that you are going to be hauled over in court proceedings.’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Themes:</th>
<th>Intervening to minimise potential for abuse</th>
<th>Confronting challenge and isolation</th>
<th>Taking ownership of the responsibility to report abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning units:</td>
<td>‘We encourage family members to take a fair share of carer responsibilities; not to allow one person to be the absolute and total carer.’</td>
<td>‘By informing the GP, they (nurses) have distanced themselves and they leave the GP to address the case.’</td>
<td>‘You just have to take ownership and do whatever is required to care for the patient.’</td>
</tr>
</tbody>
</table>
Intervening to Minimise Potential for Abuse

The GPs were proactively intervening to minimise the potential for abuse. They placed emphasis on ‘trying to keep the family carer healthy and happy and well.’ (P7). They described experiences of intervening to prevent care-giving relationships becoming unhealthy, by bringing the whole family together in planning and sharing out the caring responsibilities.

‘We encourage family members to take a fair share of carer responsibilities; not to allow one person to be the absolute and total carer.’ (P2)

‘I’m always telling people that they will burn out if they do everything and to pull the other family members in.’ (P9)

Supporting their rationale for intervening early in care-giving relationships was the GPs construction of elder abuse perpetrated by a family carer in the form of trajectory. An increasing demand on the family carer over time, was perceived to predispose to abusive behaviour.

‘A lot of carers mean well, but the dynamics start to change as the demands on the carer evolve.’ (P7)

‘They are complacent to the abuse in the fact that they have kind of got compassion fatigue. You know they have looked after these relatives for such a long period of time.’ (P2)

The tradition for one sibling taking on the main family carer role in the region, was particularly emphasised by the GPs as predisposing to manipulative and controlling relationships.

‘The relationship can become very unhealthy, whereby the elderly person is almost like a captive of the main carer.’ (P8)

‘If one person is taking the lead (care role) in a big family, then after a few years the dynamic has developed where everyone else in the family feels excluded. Then the main carer can prohibit access to the elderly person by saying to others in the family “you’re upsetting her.”’ (P4)

Confronting Challenge and Isolation

It was highlighted that ‘GPs don’t ever go out looking for elder abuse’ (P3), and perhaps this is why physical abuse was perceived to be ‘the easiest type of abuse to recognise’. (P2) However, despite physical evidence, GPs confronted challenge in the detection of abuse. They described occasions when an injury or bruise were dismissed by the perpetrator as ‘attributed to hoists and bedrails’ (P2), and highlighted that some concerned family members are using video to capture hard evidence of the abuse.

‘The one I was involved in was videoed by a relative of the patient and it went to court and was sorted. The social workers were involved. They (relatives) contacted me to view the tape and they involved the police.’ (P1)

Another challenge confronting GPs was the financial exploitation of older people by younger relatives, which they linked to welfare reforms. Older adults with palliative care needs were perceived to be particularly vulnerable ‘due to the high street value of their medication’ (P4).

‘With current welfare changes, people have lost their own incomes and look to older relatives to create an income source. It’s often not intended to be abuse.’ (P7)

GPs experienced isolation from nurses and social workers when managing suspected abuse. They conveyed a level of frustration that nurses had a tendency to distance themselves at these times.

‘Refer them straight to the GP, the box is ticked, they (specialist nurses and community nurses) have moved on, and it has landed on your desk. By informing the GP, they have distanced themselves and they leave the GP to address the case.’ (P7)

Feelings of isolation were heightened when support from social workers was difficult to access.

‘A patient came to me and reported abuse and then did not want me to do anything about it. I felt that the backup I got from my social work colleagues was nearly non-existent.’ (P4)

Taking Ownership of the Responsibility to Report Abuse

There was consensus among the GPs that ‘you never feel comfortable dealing with elder abuse’ (P1). A principle concern related to fears regarding their competence in future court proceedings.

‘There is always the fear that if you say too much or give too much information, that you are going to be hauled over in court proceedings.’ (P6)

They highlighted that insufficient experience and training could destroy a case of elder abuse.

‘Having experience and training in elder abuse is very important in legal terms, as not having it can destroy a case, especially a case that doesn’t have physical, hard evidence.’ (P2)

Despite these concerns, the GPs stressed their professional obligations and the importance of taking ownership.

‘Ultimately, the GP is responsible for the patient.’ (P5)
‘The GP is legally responsible for the patient and would have to go to court, so you just have to take ownership and do whatever is required to care for the patient.’ (P7)

The GPs were anticipating that a ‘decreasing public tolerance for elder abuse’ (P8), together with ‘increasing numbers of older adults more aware of their rights and more willing to speak out about abuse’ (P3) would ease some of the challenges they confront in reporting and managing elder abuse in future years. However, they raised the concern that older adults living with dementia, would remain at risk of undetected abuse.

‘They can’t complain if someone is abusing them, so in essence they (abusers) are getting away with it. Unless another family member witnesses the abuse, it could continue for years.’ (P1)

‘They (persons living with dementia) rely more on others, and someone will emerge as controlling their purse strings and completing forms. That gives someone tremendous power and influence.’ (P5)

Overarching Theme

The overarching theme of ‘feeling under-prepared for management of elder abuse perpetrated by a family carer’ permeated through all the data. This in part may explain why the GPs endeavoured to clarify their learning needs, and make recommendations for practice.

‘Training should be introduced from baseline up in medical schools and placed in the context of broader ageing and dementia related issues.’ (P1)

‘There is a need to address the broader topics such as dementia, dementia care and institution care before addressing elder abuse. By virtue of increasing people’s knowledge of these broader areas you will automatically increase their knowledge of elder abuse.’ (P2)

‘We need existing legislation to be examined, clarified and disseminated to us, outlining the protocols and steps on how to apply it practically.’ (P6)

‘Specialist and community nurses with responsibilities for the management of long term conditions are in an ideal position to monitor and report changing family caregiving dynamics” (P3), and should “have a significant contribution to make in the reporting of abuse.’ (P5)

‘We need direct telephone access to the vulnerable adult’s social worker for support when we are making the referrals.’ (P6)

Discussion

This study has explored and interpreted GPs experiences of managing elder abuse perpetrated by a family carer. A total of nine GPs reflecting both rural and urban primary care practices in Northern Ireland participated in the focus groups. The overarching theme identified was ‘Feeling under-prepared for management of elder abuse perpetrated by a family carer’. Despite an acknowledged discomfort in dealing with elder abuse, the GPs were intervening early to support the development of caregiving relationships that could be sustained over time. It is important to highlight that the GPs were encountering challenges in detection of elder abuse and could feel isolated from nurses and social workers when managing the abuse. Whilst the GPs related concerns and fears in relation to their capacity to fulfil their legal obligations, it was heartening to note the emphasis they placed on their professional obligations and responsibilities to report the abuse.

Internationally, the social norm is that one member of the family, usually a woman, takes on the major informal caring responsibilities for supporting a community dwelling older relative (Yan, 2014; Dong, 2015). Whilst it was clear that GPs were endeavouring to gather the whole family together for discussions around care planning to promote the sharing of caring responsibilities, it is interesting that they did not refer to the contribution that statutory support and respite care can make to reduce carer stress and burden. It is important that health and social care professionals link caregivers to resources because the research indicates that carers are often unaware of what support services are available (Manthrote et al., 2012).

Many community-dwelling older adults have difficulty in recalling how and when to take their medications (Elliott et al., 2016), and will rely on a family carer to help them. Nurses and community pharmacists have an important contribution to make in monitoring for missed doses and adverse or toxic effects. Incidents were described by the GPs when an older adult’s prescribed medication was misused for financial gain. It is pertinent that GPs have cognisance that a number of theoretical perspectives underpin professional understandings of elder abuse, including the commonality for substance abuse and personality problems to coexist with abusive behaviour (Johannesen & Lo Giudice, 2013). The unintentional consequences of deficient understandings is the over-reliance on care giver burden as an explanation of the abuse (Dong, 2015).

Our results indicate that the vulnerable adult reporting system, did not address the sense of isolation experienced by GPs. Research supports the view that social workers are more informed than GPs about the
application of safeguarding legislation and reporting of elder abuse (Schmeidel et al., 2012). Perhaps it is not surprising therefore, that in our study the GPs were seeking direct telephone access to the older person’s social worker when making referrals relating to abuse. The GPs perceived that there is growing public intolerance for elder abuse, but highlighted their concern that older adults living with dementia and those with palliative care needs would remain at risk. The literature supports their perception that adults living with dementia are at increased risk of elder abuse (Wiglesworth et al., 2010). Manthorpe et al., (2012) have highlighted that mental capacity legislation is key to safeguarding older adults with reduced capacity. It is imperative therefore that GPs and nurses feel competent in applying the legislation in routine clinical practice.

The GPs in our study related that they ‘don’t ever go out looking for elder abuse’. However, it is recommended that all health professionals caring for older adults routinely screen for abuse (Dong, 2015). Whilst the GPs perceived that specialist and community nurses are ideally placed to assess, monitor and report on family care giving dynamics, it is pertinent to highlight that nurses will only have a limited view of care giving interactions. Dong (2015) points out that it is a common misconception among health professionals that physical evidence is required before a suspicion of abuse is reported. Training is effective at supporting GPs and health professionals to be more vigilant and skilled in the detection of elder abuse (Almogue et al., 2009). Tools are being developed (Yaffe et al., 2012; Abolfathi Momtaz et al., 2013; Moyer, 2013; Dong & Simon, 2014) and with training may support the identification of a wider range of abuse types. However, similar to the literature (Rinker, 2009; O’Brien et al., 2014), the GPs in our study related that they had received little or no training in elder abuse.

Limitations

A limitation of this study is that experiences of managing elder abuse were obtained from a relatively small number of GPs from two primary care practices. Despite this limitation, the data generated were rich and illuminating. The focus group facilitator (CMcC) has a background in psychology research and was not employed by the healthcare organisation, and these characteristics may have enabled the GPs to speak more openly.

Conclusions

This qualitative study sought to explore GPs’ experiences of managing elder abuse. The overarching theme of ‘feeling under-prepared for management of elder abuse perpetrated by a family carer’ permeated through all the data. Our results convey that GPs are proactively intervening to prevent potential for abuse. One approach they described was to bring the family together early in care-giving relationships to promote the sharing of caring roles. A number of important issues were raised in this study. These include a sense of frustration that GPs are not adequately supported by nurses when they are confronting and reporting suspected elder abuse, the rising prevalence of medication misuse for financial gain in the community, and training needs relating to the practical application of adult safeguarding legislation. We recommend an inter-professional elder abuse training strategy for GPs, social workers, specialist nurses, district nurses and pharmacists, contextualised in the broader issues of ageing, dementia and the application of safeguarding and capacity legislation. Such a strategy has potential to not only enhance knowledge about elder abuse and competence to respond effectively, but to generate the quality of collaborative team working required for safeguarding community dwelling ageing populations.

Relevance to Practice

A number of important issues were raised in this study. These have implications for nursing practice and relevance for practice for all Health and Social Care Professionals. These are:

1) A sense of frustration that GPs are not adequately supported by nurses and inadequate access to social workers when they are confronting and reporting suspected elder abuse

2) The perception that some victims of elder abuse will encounter challenge in being believed

3) Rising prevalence of misuse of older adults prescribed medication for financial gain

4) Training needs in relation to elder abuse and the application of adult safeguarding legislation.

An inter-professional elder abuse-training programme may have value in enhancing knowledge and clarifying the role and responsibilities of GPs, nurses, social workers, and pharmacists in the prevention, identification and management of abuse. Such an approach has potential to promote the quality of collaboration required for unified strategies in combating elder abuse.

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Funding

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Conflict of Interest

The authors declare that there is no conflict of interest.

Contributions

CMcC and EL conceived the study, and participated in its design, CMcC undertook data collection, CMcC and EL undertook the data analysis, BR contributed important contextual content. CMcC prepared the first draft of the manuscript. All authors read and made revisions to the final manuscript and approved it.

References


Continuing Professional Development: Constipation in Adults - A Serious Public Health Issue

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Aims and Learning Outcomes

The overall aim of this article is to assist the reader to define constipation and faecal incontinence, whilst exploring the factors that can contribute to constipation. The article will describe assessment and treatment options, to enable practitioners to work with an increasing level of professional competence in the management and prevention of constipation.

At the end of reading this article and after completing the Critical Stop Point Activities, the reader will be enabled to:

1. Describe the signs and symptoms of constipation.
2. Define constipation and faecal incontinence.
3. Outline the factors that contribute to the development of constipation.
4. Identify diagnostic criteria for both constipation and faecal incontinence.
5. Describe the assessment of a client/patient presenting with constipation.
6. Evaluate the various treatment options for the management of constipation.
7. Discuss and apply within one’s own clinical practice the empirical evidence on constipation.

Critical Stop Point 1:
Before proceeding with reading this article stop, consider and think about the title. With reference to your own area of clinical practice experience to date and your prior knowledge write down some facts that you think may support the statement that Constipation in Adults is a Serious Public Health Issue.

Background

Constipation is a functional gastrointestinal (GI) disorder and a worldwide issue. It is a symptom and not a disease, and is characterised by infrequent bowel movements or difficulty in defecation (Bardsley, 2015). It is estimated that 16% of the population have a problem with constipation and greatest prevalence is in women and people aged over 60 years. Approximately a quarter of people seek help, and 65% do not pursue immediate medical treatment (Johanson, & Kralstein, 2007). Constipation is a serious public health issue and affects people physically, psychologically and socially. It is economically burdensome for adults and health and social care services (Health and Social Care Information Centre, 2014). Episodic periods of constipation over many years can lead to chronic constipation. Many adults source over the counter medications and alternative solutions from pharmacies or herbalists (Higgins & Johanson, 2004; Johanson & Kralstein, 2007).

The causes of constipation can be primary (idiopathic) and secondary. People with constipation can be divided into two groups: those with defecation difficulties (with normal frequency) and those with transit abnormalities (infrequent defecation) (Muller-Lissner & Wald, 2010). Social taboos and stigma can surround bladder and bowel health issues. Constipation can be seen as a private matter and many individuals do not discuss or seek help from professionals (Müller-Lissner et al., 2013). It is important to highlight that assessment and timely diagnosis by nurses, and if necessary, referral to a specialist nurse led continence services, can lead to successful outcomes and improved quality of life for people affected by constipation.
Epidemiology and Prevalence

Prevalence of constipation and faecal incontinence (FI) varies widely and rests on inconsistent application of definitions, labelling and frequency of anal incontinence episodes, rendering it difficult to compare and interpret research studies. This is despite the presence of diagnostic criteria (Mostafa, 2008). A systematic review on epidemiology of constipation, reported worldwide prevalence rates ranging from 0.7% to 79% with an overall median of 16% among older adult population (Mugie et al., 2011). Prevalence and risk for constipation is higher in females (Werth et al., 2017), aged 70 years and over, and residents in nursing homes (Blekken et al., 2016a). The reported prevalence of constipation in nursing homes ranges from 23.4% and 67% in Norway (Blekken, et al., 2016b), to 38% in Ireland (Neacy, 2014). The self-reported prevalence of constipation in community dwelling adults in Australia was 21% (Werth et al., 2017).

Similarly, prevalence rates for FI vary widely due to definition and frequency classification. In Norway, FI ranges from 42·1% to 54% depending on the frequency labelling chosen (Blekken et al., 2016a). Many of those affected by constipation self-medicate daily with over the counter laxatives and herbal products. Prevalence of laxative use was 15% amongst community dwelling older adults in Australia (Werth et al., 2017), and 1% of nursing home residents use laxatives regularly (Blekken et al., 2016b; Blekken et al., 2016a). Laxative use was found to be greater in long-term care settings in Ireland, when compared with home and community settings (Cusack et al., 2012).

Critical Stop Point 2:

Before proceeding: please source a suitable Anatomy and Physiology text book within your own local hospital or University library and read up and familiarise yourself again on the normal anatomical and physiological processes related to bowel formation and elimination.

Definition of Constipation and Faecal Incontinence (FI)

Constipation is an acute or chronic condition in which bowel movement occurs less often than usual or consist of hard dry stools that are painful or difficult to pass (Medical Dictionary, 2017). Bowel habits vary but generally, an adult who has not had a bowel movement in three days is considered to be constipated (Medical Dictionary, 2017). Petersen (2014, cited in Hockenberry et al., 2015) stated bowel habits of children vary by age, and 2 year olds on average have 1.7 stools and 4 years old 1.2 stools per day, but these are not diagnostic criterion.

Faecal incontinence (FI) is the involuntary loss of liquid or solid stool that is a social or personal hygiene problem (Medical Dictionary, 2017; Norton et al., 2010). FI can be categorised into six different types: (1) Overflow incontinence (2) Urgency faecal incontinence (3) Functional incontinence (4) Comorbidity-related incontinence (5) Anorectal incontinence and (6) Dementia-related incontinence (Norton et al., 2010; Russell et al., 2017).

Effects of Constipation

Constipation can often be a debilitating condition for adults and can impact significantly on mental and physical well-being (Gallagher et al., 2008). The effects include significant economic costs and burden (cost of medication, missed work days, productivity losses), numerous physical effects (haemorrhoids, anal fissures, and rectal prolapse), psychological effects (social distress, altered interpersonal relationship, difficulty with intimacy, sexual dysfunction), and reduction and impairment in quality of life (QOL).

In the United States the national cost of constipation-related emergency department visits has increased substantially since 2006 (121.4%) and was 1.6 billion in 2011 after adjustment for inflation (Sommers et al., 2015). Approximately 17 million laxatives were prescribed in the United Kingdom (UK) in 2013 (Health and Social Care Information Centre, 2014). In Norway, with a population of 5.2 million people, a recorded spend of 18.9 million Euro was reported in 2014 on laxatives (Sakshaug, 2015). Ireland has a similar population but there is no available data on the cost of laxatives (Central Statistics Office, 2017).

Critical Stop Point 3:

Outline what is meant by slow and normal transit constipation. Write down conditions that may cause or contribute to constipation.

Causes of Constipation and Diagnostic Criteria

Constipation can be acute or chronic. Chronic constipation occurs when symptoms are present for at least three months (Gray, 2011). Symptoms of constipation can include hard stools, straining, reduced frequency of stool and digital evacuation. Rome 111 criteria is a standardized checklist to aid diagnosis of chronic constipation (Refer Table 1) (National Institute for Health and Care Excellence (NICE), 2015). The criteria must be met for the previous 3 months with symptoms onset for at least 6 months prior to diagnosis.
Table 1: Rome 111 criteria Checklist. Functional Constipation

<table>
<thead>
<tr>
<th>Diagnostic Criteria *</th>
<th>a) Straining during at least 25% of defecations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Must include two or more of the following:</td>
<td>b) Lumpy or hard stools in at least 25% of defecations</td>
</tr>
<tr>
<td></td>
<td>c) Sensation of incomplete evacuation for at least 25% of defecations</td>
</tr>
<tr>
<td></td>
<td>d) Sensation of anorectal obstruction/blockage for at least 25% of defecations</td>
</tr>
<tr>
<td></td>
<td>e) Manual manoeuvres to facilitate at least 25% of defecations e.g. digital evacuation (the removal of faeces by inserting a finger into the rectum and ‘pulling out faecal matter’)</td>
</tr>
<tr>
<td></td>
<td>f) Fewer than three defecations per week</td>
</tr>
<tr>
<td>2. Loose stools are rarely present without the use of laxatives</td>
<td></td>
</tr>
<tr>
<td>3. Insufficient criteria for irritable bowel syndrome</td>
<td></td>
</tr>
</tbody>
</table>

Constipation has a number of potential causes, and it is important to differentiate between constipation types. Most episodes of constipation are not caused by a specific condition, and sometimes the exact cause may be unknown. Primary idiopathic constipation can be categorized into three main functional causes either slow transit (prolonged delay in passage of stool through colon), normal transit constipation, and pelvic floor dysfunction (Refer Figure 1). Constipation can result as secondary to other disorders such as Parkinson’s disease, Multiple Sclerosis, and Irritable Bowel Syndrome, or as a side effect of medication (Refer Table 2). It is very important that investigation excludes any potential underlying pathology.

Figure 1: Types of constipation

<table>
<thead>
<tr>
<th>Normal Transit Constipation</th>
<th>Slow Transit Constipation</th>
<th>Pelvic Floor Dysfunction</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Most common subtype</td>
<td>• Mostly characterized by reduced phasic colonic motor activity</td>
<td>• Poor working of pelvic floor and anal sphincter</td>
</tr>
</tbody>
</table>

Table 2: Conditions that may cause or contribute to constipation

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Electrolyte disturbances: - Hypercalcemia, Hypokalemia, Hypermagnesemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel obstruction</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Irritable bowel syndrome</td>
<td>Depression</td>
</tr>
<tr>
<td>Cancer</td>
<td>Reduced mobility and balance problems</td>
</tr>
<tr>
<td>Diverticular disease</td>
<td>Urinary incontinence</td>
</tr>
<tr>
<td>Dehydration</td>
<td>Medication</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>Opioid-induced constipation (OIC)</td>
</tr>
<tr>
<td>Endocrine and metabolic disorders: - hyperparathyroidism, hypothyroidism, chronic renal disease</td>
<td></td>
</tr>
<tr>
<td>Neuromuscular disorders: – Parkinson’s disease, Multiple Sclerosis</td>
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</table>
Older people are at an increased risk of faecal incontinence (FI) if they have one or more of the following symptoms or diagnosis: urinary incontinence, diarrhoea (possibly from laxatives, antibiotics and/or diet), faecal loading, functional disability, cognitive impairment and depression (Russell et al., 2017, p. 4). A range of clinical guidelines, assessment tools and algorithms are available that provide guidance for nurses in the assessment, management and treatment of constipation (National Institute for Health and Care Excellence (NICE) 2015; NICE, 2007; National Clinical Effectiveness Committee, 2015; Royal College Nursing, 2012).

Assessment and Diagnosis

Nurses in acute community and long-term care settings have a key role in assessment of a person’s bowel habit. A structured approach to the assessment of clients with constipation needs to be adopted in line with the best available evidence (National Institute for Health and Care Excellence, 2015). Assessment firstly includes a careful history (noting any medical conditions and current medications), physical examination (weight, overall nutritional status and skin colour checked), appraisal of stool diary and food and fluid diary, in the preliminary diagnosis of constipation.

Further investigations may be required based on the clinical findings to confirm diagnosis, and to assess the severity of constipation. A Digital Rectal Examination (DRE) can only be undertaken by a skilled and competent practitioner who is trained in this specialist area (Kyle, 2011; Peate, 2016; Royal College of Nursing (RCN), 2012), and provides information on sphincter pressure, presence of dyssynergia and faecal impaction. The RCN guidance document (2012) details and describes when DRE and Digital Removal Faeces (DRF) should be conducted and the legal and professional issues around these procedures.

The food diary is important in the assessment of fibre and fluid intake, and nutrient content of meals. A history of bowel function includes size, consistency, frequency, and symptoms as reported by client/patient in conjunction with the Bristol Stool Form Scale (Refer Figure 2). The Bristol Stool Form Scale (BSFS) is a visual aid to classify stool consistencies, and provides evidence to assess how long stool has been in the bowel (Lewis & Heaton, 1997; Bladder and Bowel Foundation, 2013). The BSFS is an evidence based assessment tool that is used extensively in both clinical practice and research (Blake et al., 2016) and can assist patients in completing a bowel diary.

The Rome III diagnostic criteria are used in the identification and classification of constipation (Mostafa, 2008; NICE, 2015) [Refer Table 1]. A person-centered assessment is very important in providing an effective individualized approach to treatment. Assessment needs to identify and document all risk factors. History of laxative use, types, dose and duration is then followed with a review of client/patient medications. Correct positioning stimulates a bowel motion and is important in the prevention of constipation (Southern Health Board [SHB], 2004) [Refer Figure 3].

The presence of red flag symptoms may indicate colorectal cancer (Guérin et al., 2014; Tack et al., 2011) and will require referral to General Practitioner for further investigations. Red flag symptoms include: new onset of constipation, unexplained weight loss, feeling tired or breathless, blood in stools, rectal bleeding, family history of bowel cancer, cramping pain in abdomen and rectum, unexplained anaemia, nausea, constantly feeling need to evacuate bowels and obstruction (Tack et al., 2011; Cancer Research UK, 2014).

Figure 2: Bristol Stool Chart (Lewis & Heaton, 1997)

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Separate hard lumps, like nuts (hard to pass)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces. Entirely Liquid</td>
</tr>
</tbody>
</table>

Figure 3: Position for Toilteting (SHB, 2004)
Critical Stop Point 4:

Review the history and assessment documentation of three adult clients/ patients who recently presented with constipation within your own clinical environment. Look for evidence of a systematic person-centred approach to assessment and management of constipation.

Treatment Options

Lifestyle and dietary modification with increased fibre and fluid intake is a recommended first line treatment approach for uncomplicated constipation (Woodward, 2012). Healthy lifestyle and increased fibre and fluids and exercise can reduce or alleviate constipation-associated symptoms. Fibre is effective in adults but needs to be introduced gradually and side effects can include bloating, distension, flatulence, and cramping (Suarees & Ford, 2011). The European Hydration Institute (2014) recommend six to eight glasses of fluid a day and the Health Service Executive (2018) recommend an intake of >25g of fibre a day. Fluid intake should be monitored closely especially in people with cardiac and renal disease (Rao & Go, 2010). Kumiaran and Simadibrata (2011) state that increasing fluids does not help if the older person is fully hydrated. Fibre intake can be increased by eating more high fibre foods such as whole grain bread or rice, vegetables, nuts dried fruits i.e. figs berries and prunes and reducing intake of high fat foods i.e. meat and cheese and refined sugars. If an older adult has a problem with chewing or swallowing of raw food or vegetables, then he/she can eat them cooked. It is important to limit caffeinated drinks such as colas, coffee, and tea (Udesky, 2015).

Table 3: Laxatives types, mechanism and evidence

<table>
<thead>
<tr>
<th>Laxatives</th>
<th>Mechanism</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulk forming laxatives: (Bran, Ispaghula Husk, Fybogel)</td>
<td>Bulk forming laxatives have fibre components. Fibre is undigested in the upper gastrointestinal (GI) tract, but fermented by colonic bacteria to produce short chain fatty acids and methane. Fibre absorbs water from the intestinal lumen thereby softening stool consistency and increasing stool bulk for ease of passage to defecation.</td>
<td>The National Institute for Health and Care Excellence (NICE) guidance recommends to start with bulkers, for example Fybogel. Bulk forming laxatives are most effective for people who are unable to increase their oral intake of fibre, have normal transit constipation and small hard stools. As fibre attracts water, it is important to ensure ample fluids are taken by the person. May be contraindicated for some older people (Emmanuel et al., 2017).</td>
</tr>
<tr>
<td>Stimulant Laxatives: (Senna, Bisacodyl, Sodium Picosulfate (Dulcolax), Glycerin suppositories)</td>
<td>Stimulant laxatives induce the myenteric nerve plexus causing muscle contractions and secretion of fluids and electrolytes that enhance peristalsis, and passage of stool.</td>
<td>Bisacodyl and Sodium Picosulfate are the only drugs which have been shown to considerably improve quality of life in patients with chronic constipation based on randomized clinical trials when treated over 4 weeks (Müller-Lissner et al., 2017). Dulcolax and Senna or Bisacodyl can be used alone or alongside other products and are for short-term use only. Should not be used if intestinal obstruction suspected. Side effects include abdominal pain and cramping. Senna might discolour urine or faeces yellow-brown or red-violet.</td>
</tr>
<tr>
<td>Osmotic Laxatives: (Lactulose, Sodium citrate (Micralax) Magnesium Sulphate Phosphate Enema, Movicol, (Polyethylene Glycol)</td>
<td>Osmotic agents increase water content in stool, thereby softening it. This assists the passage of the stool.</td>
<td>Can be poorly tolerated (bloating, flatulence). Adequate fluid intake is required when using with older people. A Cochrane review recommends that Polyethylene Glycol is used in preference to Lactulose for treatment of Chronic Constipation (Lee-Robichaud et al., 2010). Phosphate enemas are contraindicated for people with dehydration, renal impairment, cardiac dysfunction, or electrolyte disturbances, and therefore used with caution for older people due to serious electrolyte, renal, cardiovascular, and neurological concerns (Woodward, 2012). Suppositories or mini enema can be considered for patients experiencing difficulties with rectal evacuation, and presenting with a combination of constipation and faecal incontinence (Krogh et al., 2017).</td>
</tr>
</tbody>
</table>
If lifestyle and dietary changes do not work the next treatment option may include use of laxatives i.e. osmotic laxatives (Lactulose), stimulant laxatives (Senna), stool softeners (Liquid Paraffin) and bulk forming agents (Ispaghula Husk) (Refer Table 3). Laxatives work in different ways and some laxatives are contraindicated in certain circumstances and certain populations groups (Refer Table 3). Chronic laxative use can potentially alter electrolytes (Schuster et al., 2015). Guidance on the order in which laxative agents should be used is limited, but bulk-forming agents are often used as a first step unless the person is bedbound and is cognitively impaired and there are other contraindications (Schuster et al., 2015). Laxative use must be part of an individualised assessment and bowel care treatment plan. A European study by Müller-Lissner, et al. (2013) reported that the majority of people would have liked information on alternative treatment options and one-third of people with constipation were unhappy with their laxative treatment. No study to date has been conducted that compares “commonly used laxatives to each other or to investigate whether there is an additional effect from combining laxatives” (Krogh, Chiarioni, & Whitehead, 2017, p.468).

Prokinetic agents (Prucalopride, Lubiprostone) increase gastrointestinal motility and frequency of contractions in the small intestine making them stronger, but not disrupting their rhythm. Side effects can include nausea, vomiting and abdominal pain. Prucalopride is recommended for women with chronic constipation who have used two laxatives for at least six months with no satisfactory improvement in symptoms and it is the only agent which is recommended by the National Institute For Health Care Excellence (NICE) (NICE, 2010). Lubiprostone is recommended for chronic constipation if two categories of laxatives have failed to be effective in the past six months (NICE, 2014 ). Lubiprostone activates chloride channels in gastrointestinal epithelial cells, relieving symptoms of chronic constipation by improving intestinal secretion (NICE, 2014).

A meta-analysis of randomized controlled trials by Dimidi et al., (2014) on the effects of probiotics on functional constipation in adults reported that probiotics should be considered as an alternative treatment for functional constipation. Probiotics are associated with low risk of adverse events and significantly improved gut transit time, stool frequency and consistency, and constipation-related symptoms (Dimidi et al., 2014). Probiotics are regulated as foods but they do not undergo the rigorous testing and approval required for medicines (National Health services (NHS) Choices, 2014).

Variable outcomes have been reported for non-pharmacological interventions such as ritualizing bowel habits, biofeedback therapy, behaviour therapy, electrical stimulation of pelvic muscles and cognitive behavioural therapy. A systematic review by Woodward et al., (2014) reported insufficient evidence on the efficacy and safety of biofeedback for the management of chronic constipation. Randomized controlled trials support the effectiveness of biofeedback therapy for severe, refractory constipation due to functional defecation disorders (Chiarioni, 2016).

Abdominal massage increases peristalsis in the gut and reduces colonic transit time, and resultant changes to stool consistency may make them easier to pass (Harrington & Haskvitz, 2006). Abdominal massage can be used as a treatment for constipation (Connor et al., 2014; McKay, Lămås et al., 2012; Smith, 2013) however; there is a limited evidence base of its efficacy (National Clinical Effectiveness Committee, 2015). Abdominal massage can be pleasurable, reduce discomfort and pain, and improve the client/patient’s quality of life (Lămås et al., 2012). Participants reported that they were more relaxed with their bowel function after treatment (Lămås et al., 2012). Abdominal massage can be a cost-effective option when laxatives do not have the desired effect (Lămås et al., 2010). McClurg et al., (2016) and Bharucha et al., (2016) both reported that lifestyle advice and abdominal massage were perceived to be an effective treatment for constipation for people with Parkinson’s Disease.

Complementary and alternative medicine (CAM) is increasingly used for constipation and is perceived to be as effective by many people. However, further in-depth examination (patient and provider perspectives) as well as communication and decision-making around the use of CAM for safe, effective and coordinated care for clients/patients with constipation is required (Peng et al., 2016). Nursing practice needs to be evidence-based and guided by guidelines and algorithms for the management and treatment of chronic constipation. The management of constipation continues to evolve as well and the understanding of its complex aetiology.

**Critical Stop Point 5:**

**Identify the protocols and guidelines you use to care for clients/ patients with constipation in your own clinical areas. To what extent do these focus on the assessment, management and prevention of constipation as highlighted in this article? Are there any changes that you could possibly recommend when the protocol is due to be updated?**

**Conclusion**

In conclusion, chronic constipation is a common and often overlooked problem. Many people are vulnerable to chronic constipation owing to underlying chronic disease, dietary changes, reduced mobility, and medications. Bowel care is a fundamental aspect of client/patient care within the protocols and guidelines for constipation management. Critical reassessment of the evidence and guidelines is required to reflect current best practice and improving outcomes for people with chronic constipation.

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**References:**

- Krogh, Chiarioni, & Whitehead, 2017
- Lămås et al., 2010
- Lămås et al., 2012
- Harrington & Haskvitz, 2006
- Harrington & Haskvitz, 2006
- Dimidi et al., 2014
- Woodward et al., 2014
- Connor et al., 2014
- McKay, Lămås et al., 2012
- Smith, 2013
- McClurg et al., 2016
- Bharucha et al., 2016
- Peng et al., 2016
- Harrington & Haskvitz, 2006
- Harrington & Haskvitz, 2006
- Harrington & Haskvitz, 2006
care and nurses in acute, community and continuing care settings have a unique role in the prevention and management of constipation in adults. A careful history, physical examination and food, fluid and stool diary is the initial step in the diagnosis and assessment of constipation. The presence of red flag symptoms will require referral and further investigation. Digital Rectal Examination (DRE) can provide further information on sphincter pressure, presence of dysynergia and faecal impaction. A wide variety of laxatives are available, many of which are effective and well tolerated by some clients/patients who are constipated. There are several lifestyle changes and non-pharmacological interventions and alternative treatment options that may prevent and improve constipation. Nurses need to be knowledgeable about the various treatment options available so that they can inform and advice clients/patients, offer person-centred individualised care, and monitor the effectiveness of approaches and interventions used.

References


The Impact of Reminiscence Therapy with Older People Diagnosed with Dementia

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Abstract

Background

With an ageing population the number of people within the UK and Ireland living with Dementia will continue to rise. Psychosocial interventions, such as reminiscence therapy, have the potential to improve the quality of life of people with dementia. However, while reminiscence therapy is used widely in dementia care, its impact on the quality of life of people with dementia remains largely unrecognised and there is a need for a robust appraisal of its overall effectiveness.

Aim: The overall aim of this integrative literature review is to investigate the impact of reminiscence therapy on people living with dementia.

Methodology: A systematic review of three electronic databases, Science Direct, U Search and CINAHL was carried out to find appropriate literature on outcomes of reminiscence therapy. A thematic analysis of 15 research papers was undertaken to determine the impact of reminiscence therapy on people with dementia.

Results: A thematic analysis of identified research studies suggested that reminiscence therapy has had a positive effect on patient outcomes, which includes improving quality of life, cognitive behaviour and functioning, and decreasing depressive symptoms.

Conclusions: Reminiscence therapy has been widely used in caring for patients with dementia. However, trials on the effectiveness of reminiscence therapy have been sporadic and the quality of the information arising from those that have been completed has been undermined by methodological problems, particularly in relation to scale and scope. Further research is needed in this area.

Introduction

With an ageing population the number of people within the UK and Ireland living with Dementia will continue to rise. The Alzheimer’s Society (2017) report that there are 850,000 people living with dementia in the UK, with numbers set to rise to over one million by 2025. In Ireland there are approximately 55,000 people living with dementia. That number is expected to increase substantially to reach almost 70,000 by 2021 and approximately 147,000 by 2041 (Cahill et al., 2012; World Health Organisation, 2016)

Physicians often define dementia based on the criteria given in the Diagnostic and Statistical Manual of Mental Disorders [DSM], American Psychiatric Association, 2013). The latest version, the fifth edition (DSM-5), includes a new, broader diagnostic category called major neurocognitive disorders (NCD), which incorporates the former diagnosis of dementia. To meet the DSM-5 criteria for major neurocognitive disorder, an individual must have evidence of significant cognitive decline in memory or another cognitive ability, i.e. language or learning, which interferes with independence in everyday activities (American Psychiatric Association, 2013).

Dementia is an overall term for a set of symptoms that are caused by disorders affecting the brain. Symptoms may include memory loss and difficulties with thinking, problem solving or language, severe enough to reduce a person’s ability to perform everyday activities. A person with dementia may also experience changes in mood or behaviour. Dementia is progressive, which means the symptoms will gradually get worse as more brain cells become damaged and eventually die. Dementia is not a specific disease. Many diseases can cause dementia, including Alzheimer’s disease, vascular dementia (associated with stroke and white matter disease), Lewy Body disease, head trauma, fronto-temporal dementia, Creutzfeldt-Jakob disease, Parkinson’s disease, and Huntington’s disease. These conditions can have similar and overlapping symptoms (Alzheimer’s Society, 2017).

Symptoms of dementia vary depending on the individual. People can experience difficulties with concentration, orientation, language and communication and memory may become a struggle. As symptoms worsen and dementia progresses it is common for the person’s mood to alter and emotions to become affected. Confusion may result in the person becoming agitated and frustrated, this can be a difficult time for both the person and their family (Ryder, 2016). Patients suffering with dementia often experience other symptoms, e.g. depression,
Reminiscence Therapy (RT) is a form of therapeutic intervention that involves the use of life histories, written, oral, or both, to improve psychological well-being. This therapy is often used with older people (APA, 2013). This form of therapeutic intervention respects the life and experiences of the individual with the aim to help the patient maintain good mental health. Typically, a person with dementia is more able to recall things from many years ago than recent memories, so reminiscence therapy draws on this strength. So many of our conversations and interactions rely on short-term memory. Reminiscence can give people with dementia a sense of competence and confidence through using a skill they still have. Harrison-Dening (2013), propose that with the right multidisciplinary team support, the symptoms of dementia can be suitably managed and the person’s quality of life can be enhanced. Many benefits have been gathered from studies on the effects of RT on dementia patients. Nakamae et al., (2014) found that RT could help to alleviate depressive symptoms in dementia patients and improve cognitive function. Chung (2008) considers RT to be vitally important to patients in improving their memory, remembering past experiences and being able to put things together chronologically. McKeown et al., (2010) states that RT can enhance person-centred care when treating a patient with dementia, as it allows the nurse and patient to build a therapeutic relationship. However, research to date has been limited. Azcurra (2012), reports that a Cochrane Review of RT, determined that the quality of the research has been small hampered by undersized populations which could not enable effective conclusions on the effectiveness of RT to be drawn.

The literature review undertaken focused on the impact of RT on people living with dementia. Findings will be presented in the form of a thematic review, reviewing recent literature and research studies. A systematic review of three electronic databases, Science Direct, U Search and CINAHL was undertaken. An initial search was carried out using key words ‘reminiscence therapy’ and ‘dementia’ this gathered a large number of hits, 861 in total. The next search was then amended to include limiters to retrieve a more manageable and realistic number of hits. Keywords used remained the same across the three databases and included ‘Dementia OR Alzheimer’s AND Reminiscence Therapy.’ Eighty-nine research articles were found, although only 15 papers were used for the thematic review, as they appeared more appropriate to the topic. Two other sources were utilised within the integrative literature review, making the total 17 (Refer Table 1).

Table 1: Literature Search

<table>
<thead>
<tr>
<th>Keywords/ search terms</th>
<th>Limiters</th>
<th>Database</th>
<th>Total Hits</th>
<th>Selected References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia OR Alzheimer’s AND reminiscence therapy AND cognitive impairment</td>
<td>Full text English Language 2012-2017</td>
<td>Science Direct</td>
<td>29</td>
<td>5</td>
</tr>
<tr>
<td>Dementia OR Alzheimer’s AND Reminiscence Therapy</td>
<td>Full text English Language Peer reviewed 2011-2017 Subject: Dementia and reminiscence therapy</td>
<td>U Search</td>
<td>34</td>
<td>7</td>
</tr>
<tr>
<td>Dementia OR Alzheimer’s AND Reminiscence Therapy</td>
<td>English Language 2012-2017 Subject: Dementia and reminiscence therapy Aged 65+</td>
<td>CINAHL</td>
<td>26</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td></td>
<td>89</td>
<td>15</td>
</tr>
</tbody>
</table>
The PRISMA tool (Moher et al., 2009) [Refer Figure 1] was applied and aided the exclusion process. This tool was used to retrieve the final number of papers and sources that would be used within the thematic analysis; 861 articles were found at the initial database search and 8 articles from other sources were found. However, not all papers were suitable due to very various reasons, therefore the duplicates were removed (n=600) as shown on the PRISMA tool. A further (n=511) were excluded using the tool, based on title and abstract. The papers were excluded due to appearing to broad and irrelevant to the topic chosen or the title did not reflect what the topic was aiming to achieve. The remaining number of full text articles for eligibility (n=89) were evaluated. An additional (n=74) papers were excluded based on full text, for example the main principle of the paper did not reflect the title. Other reasons why papers were discarded were due to them not meeting the inclusion criteria such as unrelated population and not within the recommended dates. Applying the PRISMA tool together with the inclusion and exclusion criteria, a total number of 15 papers were selected and used, along with two additional sources.

Out of the 15 articles selected for inclusion within the thematic analysis, there are 10 randomised controlled trials, one quasi-experimental study, one cohort study, one systematic review, one meta-analysis of randomised controlled trials and one qualitative experimental design. This provides a mixture of quantitative and qualitative studies for the thematic analysis. A total of 12 quantitative articles, 2 qualitative articles were used and one systematic review.

Evans (2003) Hierarchy of evidence was used when selecting the papers, randomised controlled trials rate high within the hierarchy. According to Parahoo (2014) using articles that are high quality, up to date and rated high within the hierarchy are best for providing credible findings.

**Figure 1: PRISMA (2009) Flow Diagram (Amended)**

![PRISMA Flow Diagram](image)
Literature Review

A literature review was carried out using a thematic analysis approach identifying key themes found within the 15 research studies identified. Through comprehensive assessment of studies found within the search strategies utilised, three themes in total were selected for discussion and critical analysis in the thematic analysis. These themes were improved quality of life (QoL), improved cognitive behaviour and impairment, and improved depressive symptoms in dementia patients related to outcomes of RT. Papers were grouped together that identified common trends and results, to produce a thematic analysis. Caldwell et al., (2011), framework was used to help critique and structure the analysis of both qualitative and quantitative research studies. Reliability, validity, transferability and credibility of the papers, will also be addressed (Parahoo, 2014). Cognition will also be made of gaps in the literature and strengths and limitations of the studies.

Improved Quality of Life

A total of six papers discussed the effects of RT on outcomes for people with dementia. The findings of these six studies demonstrated similar trends and results i.e. an improved quality of life (QoL) for patients with dementia. Within these six papers, 5 were randomised controlled trials and one was a quasi-experimental study.

There has been previous research into the effects of RT on the quality of life of patients diagnosed with dementia. Despite this non-pharmacological method already being used in dementia care, the effectiveness of RT still remains uncertain (O’Shea et al., 2014). A Cochrane systematic review undertaken by Woods et al., (2005) showed some evidence of improved mood, cognition and quality of life. However the four studies used in the review were deemed small and the results stated were inconclusive. These findings were substantiated within a more recent systematic review undertaken by Subramaniam and Woods (2012). However, once again the sample size was small, therefore results were deemed unreliable and questionable. This highlights a need for larger population studies to provide reliable and valid results on the effectiveness of RT for people with dementia.

There have been several randomised controlled trials measuring positive QoL outcomes after RT (Azcurra, 2012; O’Shea et al., 2014; Gudex et al., 2010; Subramaniam & Woods, 2012; Huang et al., 2015; Woods et al., 2016). In a randomised controlled trial conducted by O’Shea et al., (2014), with 304 patients in Ireland, using a reliable methodology, found that RT had a positive effect on QoL. This study was supported by Azcurra (2012), who carried out a randomised controlled trial in Argentina on 135 patients and found RT to improve the patient’s QoL. Aply, Woods et al., (2009) carried out a randomised controlled trial in the U.K. consisting of 350 patients and found enhanced QoL for patients diagnosed with dementia. This trial has the largest sample size out of all the randomised controlled trials that found an improvement in QoL. That being said, Woods et al., (2016) had the largest sample size, however, trials such as O’Shea et al., (2014) and Azcurra (2012) also found a more significant increase in the number of people with improved QoL.

A randomised control trial undertaken by Gudex et al., (2010) in Denmark of 237 patients, using a reliable tool found positive effects on QoL, but only on a short-term basis. This is the only trial that commented on the duration of the effects of RT on patients; an estimation was made after 6 months and then again at 12 months. The sample size of O’Shea et al., (2014) and Subramaniam & Woods (2014) randomised controlled trials were larger than any previous trials carried out within this area of research. Parahoo (2014) states that a larger sample size is more beneficial to a study as the results will be more transferable for other researchers, and more consistent and reliable.

Although Subramaniam & Wood. (2014) carried out a randomised control trial within the U.K.; the sample size was small with only 23 patients taking part. The results were similar to the findings produced in previous randomised control trials with beneficial effects being noted on patient’s QoL following RT. However unlike Subramaniam & Woods (2014), O’Shea et al., (2014), Gudex et al., (2010) and Azcurra (2012) who focused mainly on group or individualised RT sessions at weekly intervals, Subramaniam & Woods. (2014) carried out a life review process. This involved patients creating a life storybook at the end of sessions. Although the resulting numbers did have improved QoL by the end of the study, the sample size was extensively smaller than the four other randomised controlled trials.

Jo and Song (2015) carried out a quasi-experimental quantitative study in South Korea with 19 patients and found improved QoL for patients using RT. There was no control group used and the sample was predominately female. This is similar to Azcurra (2012) study, which also consisted of mainly female patients, questioning the validity and reliability of the study.

Improved Cognitive Behaviour and Impairment

A total of five papers were used and found to have similar trends and results, drawing conclusions that RT improves cognitive behaviour and function in people with a diagnosis of dementia. A total of 3 randomised controlled trials, one quantitative experimental design and one longitudinal cohort experimental design were used to complete the thematic analysis. A mix of both quantitative and qualitative research studies were used.

Previous research studies undertaken on the benefits of RT on a person’s cognitive behaviour and function
have been limited, and more intensive research studies need to be carried out. Wu and Koo (2015) report on a previous systematic review carried out involving 6 randomised controlled trials, indicating that the use of RT can improve mood and behavioural functioning. These findings were criticised however due to the small sample size generated from 6 randomised controlled trials ranging from 5 to 36 patients (Cotelli et al., 2012). Hence, a more robust and reliable research approach is needed to close the gap in literature that is reported in each study.

Barban et al., (2016) carried out a randomised controlled trial (RCT) in 4 different countries Italy, Greece, Spain and Norway consisting of 301 patients and found that RT had a positive effect on cognitive functioning. This RCT tested results after the programme had finished and again at a follow up assessment, results were consistent, and maintained at the follow up assessment. Wu and Koo (2015) carried out a RCT consisting of 103 patients in central Taiwan; this study had similar findings to the Barban et al., (2016) study in that cognitive functioning notably improved for the patients after RT. Wu and Koo (2015) identified that patients with dementia can face lowered mood on a daily basis, questioning their purpose in life. However, they state that through RT symptoms can be alleviated and improvements demonstrated.

Wang et al., (2009), in a Taiwan study, and Akanuma et al., (2011) in a Japanese study have drawn similar conclusions in that patient’s with dementia can experience behavioural problems and cognitive impairment. They also concur that non-pharmacological interventions such as RT are necessary to alleviate symptoms of dementia. Both studies showed that similar minimal improvements were made to cognitive functioning and behaviour problems. Moreover, these two studies differ in methodology and sample size. Wang et al., (2009) used a longitudinal cohort experimental design, whereas Akanuma et al., (2011) used a randomised controlled trial. Although Akanuma’s study offers the gold standard methodology for a clinical trial, the sample size is relatively small with only 24 patients compared to 77 patients in Wang et al., (2009) study. Parahoo (2014) explains that a smaller sample size may run the risk of being over represented.

Chung (2009) undertook a quantitative experimental design study in Hong Kong, consisting of 49 patients and 117 youth volunteers. This is the only study that recruited volunteers to partake in the trial. Moreover, while the design of this study is unique, similar results were accumulated. The impact of RT on cognitive functioning of patients with dementia was enhanced along with overall psychological function. Chung (2008) states that these findings substantiated previous studies, e.g. Cky et al., (2004) and Thorgrimsen et al., (2002), who found that RT was beneficial to a person’s mood and cognitive behaviour. However, although the sample size was small, lesser numbers were used within Akanuma et al., (2011), and Chung’s (2008) studies.

Improvement in Depressive Symptoms

A total of six papers were selected within this theme, showing similar findings. The results determined an overall improvement in depressive symptoms due to RT. Out of the six papers selected for analysis, 4 were randomised controlled trials, 1 a meta-analysis of randomised controlled trial, and 1 a systematic review. On this occasion, 5 out of 6 papers were quantitative research and the systematic review consisted of a mixture of both qualitative and quantitative research studies.

Van Bogaert et al., (2016), carried out a randomised controlled trial, consisting of 60 participants in Belgium. The researcher hypothesized that depressive symptoms in patients with mild to moderate dementia would be greatly improved due to individual structured RT. The hypothesis was proved, as depressive symptoms in patients with dementia improved significantly. However, another randomised control trial by Barban et al., (2016), consisting of 301 participants, did not have a hypothesis statement within the study. This study used a unique way of testing RT by combining it with computerised cognitive training. Interestingly, the results varied as RT appeared to improve depressive symptoms with people diagnosed with dementia. However, computerised cognition training also helped patient’s memory. There is no correlation of the 2 different therapies working together to achieve a conjoined result. Previous studies have been carried out using healthy adults and computerised cognitive training; in this instance, the population used were patients with a dementia diagnosis.

Nakamae et al., (2014), and Chung (2008), applied different methodologies within their studies but had similar results. Chung (2008) conducted a quantitative group experimental design whereas Nakamae et al., (2014) carried out a randomised control trial. Both studies had small sample sizes 36 and 49 patients respectively. The results from both studies indicated that patients’ mood was greatly improved and depressive symptoms noticeably reduced by RT.

Elias et al., (2015), carried out a systematic review, a total of 8 studies were included in the review and all studies had a quantitative methodology. There were 3 studies from the USA, 1 from the UK, 1 from Iran and finally 3 studies were from Taiwan. This provided international research perspective findings, however the results may not be generalisable. In addition, the study populations varied in that 2 studies included male participants only, and 1 study had only female participants.

A meta-analysis of randomised controlled trials by Chin (2007) used papers from before 2001 only, which could suggest that the research was more dated. The sample size of this meta-analysis consisted of 96 papers, which is large number compared to the above systematic review consisting of only 8 research papers. Even by using dated literature and different sample sizes in comparison to Elias et al., (2015), Chin (2007) found similar results to the systematic review in that, depressive symptoms in
Discussion

Reminiscence therapy has been proposed as a potentially effective strategy to improve quality of life and psychological wellbeing for older people in care home settings. Based on the six studies identified within the thematic analysis (Azcurra, 2012; O’Shea et al., 2014; Gudex et al., 2010; Subramaniam & Woods, 2012; Woods et al., 2009, 2016), quality of life had improved in all studies implementing RT. However, there have been limitations identified in assessing the effectiveness of RT in improving QoL. One such limitation is geographical location of the research trials influencing the transferability of results. Moreover, larger population samples could have produced more reliable and trustworthy results. In addition, obtaining qualitative data regarding an individuals’ perceived improvement following RT may have been beneficial.

The majority of the studies examining improvement in cognitive behaviour and impairment following RT were randomised controlled trials, which are considered high in the hierarchy of evidence (Parahoo, 2014). All studies indicated an improvement in cognitive behaviour and functioning. In some cases only a slight improvement was noted. Limitations identified within several studies included varied geographical locations, with 2 studies produced in Taiwan (Wang et al., 2008; Wu and Koo 2015), 1 from Japan (Akanuma et al., 2011) and 1 from Hong Kong (Chung, 2008). A European study was undertaken in Italy, Greece, Spain and Norway (Barban et al., 2016). As the studies were carried out in different countries the results may not be transferable or generalisable to the United Kingdom. A further limitation as stated by Chung (2008) was the lack of a control sample within their study. This can be overcome by using a randomised controlled trial design to validate results.

A total of six papers were selected to identify improvement in depressive symptoms following RT. Of the research studies selected, 4 were randomised controlled trials, 1 was a meta-analysis of randomised controlled trials and 1 was a systematic review. Although differing methodologies were applied, results indicate that RT has an overall positive effect on helping depressive symptoms in patients with dementia. Several of the studies were undertaken worldwide, however, many of the studies were undertaken in Asian countries. Although common themes were found, the results still have to be examined in terms of how they can be generalised to the UK. Another shared limitation of research studies is that of small sample sizes. Overall, it is clear that further research is required to adequately measure the full effects on RT on patients with dementia. To facilitate this, larger sample sizes should be utilised within future studies.

Conclusion

The impact of RT on patients living with dementia was critically assessed and analysed within the 15 research studies selected for inclusion within the integrated literature review. Some of these results may not be generalisable for utilisation within the UK, and quite a number of studies had small sample sizes. However, three key themes were identified and discussed within the thematic analysis section: the themes of RT outcomes included, improving quality of life, cognitive behaviour/function and improving depressive symptoms in patients with dementia. Trial studies for reminiscence-based interventions for people with dementia have been scarce and the quality of the information arising from those that have been undertaken have been undermined by methodological problems, particularly in relation to scale and scope. However, there is some evidence that RT can improve QoL, cognition, and mood in people with dementia, although all the benefits identified were small, it would suggest that delivering reminiscence therapy programmes within the care home and residential sector has merit. More research is therefore required to understand the differences in the application of reminiscence therapy for people who have dementia with a significant focus on who is more likely to benefit most from what type of reminiscence therapy.

References


Living and Loving Later Life
An Interview with Mrs Margaret Doherty

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Introduction

Demographic trends worldwide indicate that people are living much longer (Want et al., 2008; Gitlin et al., 2009; GeoHive, 2017; Central Statistics Office, Ireland [CSO], 2016). The population of Ireland is approximately 4.7 million and the population growth of Ireland is 0.544% annually (GeoHive, 2017; CSO, 2016). The United Nations [UN] Population Division (2017) reports that approximately 20 countries in 2000 had over one-fifth of their total population aged 65 years and over. Population projection figures suggest that many of these countries will have well over 35% of their total population aged 65 years and over by 2050. Further, they suggest that in most regions and countries of the world, the population aged 60 or more is growing faster than younger adults and children, and this has important consequences for the family, the labour market, and public programs directed to different generational groups (UN, 2017).

The CSO (2016) suggest that population projection figures for Ireland in the over 85 years of age group may increase by approximately 21.6%. Life expectancy has thus increased significantly over the years and many people are now living well into old age and terminology emerges such as the young old (60+) and the very old (85+) are evident within the literature (Curtin, 2004; Layte et al., 2009).

A review of the empirical evidence suggests that the number of people being cared for and wanting to be cared for at home, is increasing with both Irish and UK Government strategic drivers emphasising this (Health Services Executive [HSE], 2011; Care Quality Commission, 2013). According to the Irish Medical Organisation (2016), older citizens value their independence and prefer to remain in their homes within their own community. Moreover, other empirical evidence suggests that an older person’s first choice and preference would be to remain in their own homes (Moore, 2013; Moore and Ryan, 2014; Hillier and Barrow, 2015).

The following interview is with Mrs Margaret Doherty, from Omagh, Co Tyrone, who is living at home, with support from family and Health and Social Care input daily. She is a person for whom her independence, personhood, personal place, social and familial contacts are enabling her human flourishing (McCormack, 2004) and who is clearly living and loving later life and ageing in place (Moore, 2013; Moore and Ryan, 2014; Ryan and McKenna, 2015).

Tell me about yourself?

Well firstly, I thank God for a long life and I am enjoying every minute of it. My name is Margaret and I will celebrate my Birthday on the 11th April when I reach the young age of 93. I was born in 1925. I have four girls, Jean aged 73, Colette aged 65, Marion aged 63 and Carmel aged 61. I have eight grandchildren, seven of whom are still alive, and I have four great grandchildren. I was married to the love of my life Tommy for over 63 years, and he died suddenly ten years ago. I am appreciative of my life with Tommy and for my wonderful family. I worked for many years in a shoe factory and before I retired, it was a shirt factory and my last job was with Desmonds clothing manufacturer for over 14 years. I worked there until I took voluntary retirement at 68 years of age. My own mother died when I was only 4 years of age and my younger brother and me...
were looked after by different aunts and uncles within the family.

Tell me about your life with Tommy?

Well I met Tommy in Strabane, Co Tyrone, when I was a younger girl at 19 years of age. I remember thinking at the time he was the one for me, but I was not a 100% sure initially, but what I was sure about was that he was the loveliest man in the world to me. Tommy was an electrician by trade and worked for most of his life until retirement. As I think back now, I can remember that we did not ‘court’ for very long, and got married when I was 20 years of age. As I look now at this picture of us and chat to you, I remember that I knitted that jumper he is wearing in this photo. I knitted it because firstly I wanted to show him how much I loved him, secondly, I wanted to keep him warm of course, and finally, because knitted jumpers where the whole go then anyway [laughter]. Tommy and I lived for over 11 years in Hunter’s Crescent in Omagh before moving to this house here, where I have now lived since 1966. We bought this house from the Housing Executive over 15 years ago and I am proud of this achievement.

Tommy died 10 years ago, and I found this to be a very difficult time in my life as he was after all, my life. I didn’t feel very good at this time of my life, but I know that there was little I could do about it, sure what else can you do? This was one of my milestones in life and what helped me to get over it was that Tommy was a good husband, and I have a good family. Tommy and I never argued in life about money, that was one of our rules, and if we did argue in life, our other rule was, always to make up before we went to bed. As I think now about Tommy and chat to you about him, I remember that he was a good-looking boy indeed and I was a good-looking girl. I believe that we were a good match. Often, in our earlier days we would go to the pub for a ‘tipple’, his was a pint of Guinness and mine was a small brandy.

Tell me about a typical day in your life?

Well I get up every day around about 9.30am and I go to bed every night at about 10pm. I generally sleep very well and I do not take any medications to help me sleep. I have carers who come in for half an hour, four times a day to assist me to live my life as independently as possible. I do most things for myself, thank God. My family are very supportive and they stay with me every night, using a rota. They have done this for me since Tommy died and I am now used to having their company and them in the house, particularly at night. I am a knitter, have always loved knitting. I am also an avid reader, although my failing eyesight has affected this mostly. I do have the talking newspaper, a Kindle, and an IPad for iBook’s, but I am not as fond of these as I am of the actual book. I love thrillers and love stories and have read most books by the author Catherine Cookson.

I love having my hair done and until quite recently I went out to get this done every week in the hairdressers. I take pride in my appearance and will always put on my makeup and most importantly my lipstick. My most favourite thing are my high heel shoes. I have always worn them, as I am quite small. At work, they referred to me as ‘High Heels Margaret’ [laughter].

Tell me about some of the major milestones in your life?

I suppose, like many people there are things like births, marriages and deaths that affect us all in life. For me one of the most significant milestones was Tommy’s death that I spoke to you about earlier. Another milestone was the sudden death of one of my grandchildren Barry. Barry was only 25 years of age and was living and working in London with his then girlfriend. He was out one evening in London and got into some altercation with another man, who fatally stabbed him. He was my daughter Jean’s son. It is difficult to understand in life why these things happen.

I would describe myself as reasonably healthy and I do not take too much medication, except for my hypertension and diabetes. I do have a touch of arthritis in my knees and hip, but would say that I am in pretty-good health thank God. I did fall down the stairs last May, and this has shattered my confidence quite a bit. I was not injured or hurt, but I lost a great deal of confidence and I now use a stair lift and a walker. I had surgery in 2009 to remove a tumour in my bowel, and I have not really looked back on this. I believe that not many people can live a life without some form of trial or tribulations. What helps me survive the darker days is that I have put my faith in religion/God and I now know that as time passes and things do heal, but I am left with my memories. I try everyday not to let it get me down or to be bad tempered. I keep on smiling even when I am faced with difficult times in life.

Tell me what you feel are your key tips for living and loving later life?

I do not think that this is really a big secret. You have to be natural, be happy, have patience and of course, you definitely have to learn to be patient. I have a few things that are important to me:

1. If you are married, make sure that it is a happy marriage.

2. No rows or fights, and if you do argue, well then always sort it out before you go to your bed at night.

3. Family first and foremost. Family is important, try to keep them together and remember you can then reap what you sow.
4. Wealth in life is just not as important as one’s health.

5. Conal Gallen, the comedian, he makes me smile and laugh and a daily dose of these things are very important for a long-life.

6. The ‘craic’. Having a bit of ‘craic’ especially with the grandchildren has always helped me.

7. My life has been fortunate as I have had a good husband, I have a good family, some good friends and it is the little things in life for me that are the most important.

What would you say Margaret is your greatest achievement in life?

Well that is an easy one, my husband and my family. I have also never driven a car, but I have still managed to get around, I used to ride a bike and that was a challenge also. And, I suppose buying this house over 20 years ago – now that was a challenge.

Can you recall a funny story Margaret?

Yes, but I am not sure if I should tell you this as I never told Tommy this either. Every week in life, Tommy would ask me to do the pools coupons. One week we actually won a substantial sum of money as our numbers came up. The problem was that I had forgotten to put the money on the numbers [laughter] and you know I never did tell Tommy.

Can you recall a holiday story Margaret?

I am not really a traveller. I do go to my daughter Carmel’s over in England at times, but the furthest I have been is to Holland in the late 1970’s and that was to see my daughter Carmel also as she was living there with her husband who was in the army. I have no regrets about not travelling really. I am content where I am in Omagh.

Is there anything else you want to tell me about Margaret?

No, not really, other than to say again that I am a fortunate person as I have had a good husband, and I still have a good family around me.

When I read Margaret’s answers back to her, she said to me “that was lovely to hear all that and to reminisce about my life, thank you”. As I left Margaret’s home, and reflected on the time that I had just spent with her, I felt quite humbled and inspired about Margaret’s resilience for living and loving her later years. If you would like to tell us your story about living and loving later life, please do not hesitate to contact AIGNA on aignainfo@gmail.com

References


Membership of AIGNA

Membership of the All Ireland Gerontological Nurses Association

Background

The All Ireland Gerontological Nurses Association (AIGNA) is the voice of Gerontological nursing in Ireland. Our aim is to promote healthy ageing and wellbeing of older adults through the advancement of excellence in nursing. The wellbeing of older adults is at the heart of our person-centred agenda. We make effective submissions on relevant policy and care issues and regularly feature in the media on subjects that affect our members and those we care for. Our aim is to influence policy, strategy, research, education and practice at national and European levels. There is strength in numbers therefore; we ask that you encourage colleagues to join us also and to contribute to the issues being discussed within our online discussion forum.

We represent those involved in the nursing care of older adults encompassing clinical practice, academia, education and research. AIGNA is focused on the advancement of Gerontological nursing as a career choice and we advocate for increased educational and employment opportunities. The President of AIGNA is Professor Assumpta Ryan, who is professor of Ageing and Health, Ulster University, Faculty of Life and Health Sciences, School of Nursing and Institute of Nursing and Health Research. Professor Ryan has published widely within the field of gerontological nursing and she holds various advisory, clinical and academic roles within Ireland and the United Kingdom.

Membership Benefits

We provide all AIGNA members with a twice-yearly Journal of the All Ireland Gerontological Nurses Association (JAIGNA), which has significant relevance within both an Irish and United Kingdom context, and it provides an accessible platform to disseminate information, research findings and quality initiatives. AIGNA members have full access to the AIGNA website www.aigna.ie. This is a valuable online resource that serves
as a vital tool for education and information sharing with availability of our conference presentations and masterclass presentations, with many other reports and papers available. This is beneficial for all nurses, in particular those who are studying Gerontological nursing or related areas.

Our **Annual Conference**, which is held normally in May each year and our annual **Master Classes**, which are held normally in October/November each year, have become essential platforms and significant highlights for the delivery of the latest advances in practice and education and have covered important and focussed topics. Previous topics have included, Person-centred Care; Falls and Bone Health; Dementia and Parkinson’s disease.

The Annual Masterclass and AIGNA AGM 2017 was held last year in the Radisson Hotel, Athlone on Thursday 19th October and more information is available now on line at [www.aigna.ie](http://www.aigna.ie). The Theme last year was significantly important and was entitled ‘Person Centred Care under the Assisted Decision Making Capacity Legislation’. Key Note presentations that were delivered are available at [www.aigna.ie](http://www.aigna.ie)

AIGNA’s 10th Annual Conference ‘Celebrating Advances in Older Persons Nursing’. This will be held on the 3rd May 2018, in the Clayton Hotel Galway. This year’s theme is ‘**Celebrating Advances in Older Persons Nursing**’ and it promises to be another engaging and informative event with accomplished international keynote speakers plus a diverse and wide-ranging poster display of local quality initiatives and research. Other platform presentations will be delivered from practitioners, educators and academics working within gerontological nursing. Full details of the excellent conference line-up and presentations for this year’s conference will be provided on AIGNA website in due course and is also detailed within this edition of the JAIGNA. **Remember Keep the Date, May 3rd 2018.**

**Membership Fees**

Our Annual Fee for AIGNA Membership is **only €100**. We believe that this represents outstanding and excellent value for your money, **and it covers**:  

1. Annual Membership Fee, with all of the membership benefits as detailed above to include your own personal copy of the Journal of the All Ireland Gerontological Nurses Association and full access to the Members Area on the AIGNA Website @ [www.aigna.ie](http://www.aigna.ie)

2. Your Annual Conference attendance fee. This does not include accommodation or travel costs.

3. Your Annual Master Class attendance fee. This does not include accommodation or travel costs.

We have also introduced **AIGNA Corporate Membership** for Directors of Care facilities that want the flexibility of sending any 4 members of staff (including nursing, allied health professionals, ancillary staff) to both Conference and Master Class. For an annual fee of €350, this represents excellent value for money. In addition to the benefits of membership listed above, a prestigious certificate of AIGNA Corporate Membership will be provided for display in your facility. This indicates your commitment to the professional development of staff and high quality care of older adults. You will also be well placed to network with others. For further information on this offer please do not hesitate to contact us via e-mail or on our website at [www.aigna.ie](http://www.aigna.ie)

We would encourage you to join us as a member in AIGNA, and to promote AIGNA membership within your organisation and with your professional nursing colleagues. For easy joining and payment options and further details please see [www.aigna.ie](http://www.aigna.ie) or E-Mail the AIGNA Administrative Officer on aignainfo@gmail.com or visit our active Facebook page: [https://www.facebook.com/All-Ireland-Gerontological-Nurses-Association](https://www.facebook.com/All-Ireland-Gerontological-Nurses-Association) Remember to like and perhaps share our Facebook page details with your professional colleagues and keep up to date regularly with our social media posts.
Submission Guidelines for the Journal of the All-Ireland Gerontological Nurses Association (JAIGNA)

Aims and Scope
Nurses need practical, useful, and timely information in order to deliver high quality care and support to older people and their families. The Journal of the All-Ireland Gerontological Nurses Association (JAIGNA) is the only journal in the island of Ireland dedicated specifically to gerontological nursing and the care of older people. JAIGNA publishes clinically relevant original articles and is written specifically for nurses who work with older people across a variety of settings including acute and long-term care whilst also recognising the importance of home and community in the lives of older people and their families. JAIGNA is a peer-reviewed bi-annual journal providing a forum for advancing knowledge and demonstrating excellence in practice within gerontological nursing. JAIGNA aims to highlight excellence in gerontological nursing practice, education and research and to promote an analysis within these broad areas in order to advance and enhance nursing practice standards and also to inform debates about health and social care for older people.

The journal’s peer-reviewed articles report the latest developments in the management of a range of clinical issues of everyday relevance to nurses working with older people. JAIGNA endorses inter-professional working and the important role played by voluntary and statutory organisations in the provision of care and support to older people and their families. The Journal of the All-Ireland Gerontological Nurses Association is published twice a year and is the official journal of the All-Ireland Gerontological Nurses Association, which promotes the clinical, educational and professional interests of gerontological nurses across the island of Ireland. The editorial team welcomes acceptance of submissions in accordance with the guidelines below for consideration for publication within the JAIGNA.

The Journal of the All-Ireland Gerontological Nurses Association welcomes scholarly papers on all aspects of older people nursing including research, practice, education, management, and policy. We publish manuscripts that demonstrate an improvement in practice through innovation in all aspects of gerontological nursing. We encourage submission of systematic reviews; original quantitative, qualitative, and mixed methods research; theoretical and conceptual analyses; evidence-based practice projects and other practice improvement reports. We also encourage submission from practitioners and/or primary carers within the scope of ‘A Day in the Life of’, or ‘Loving Later Life, an informal interview with’. All submissions must include an explicit perspective on gerontological nursing. Editorial perspectives are published in each issue and on occasions, Guest Editorials may be published by invitation only.

Keywords:
Keywords used to identify manuscripts published in JAIGNA can include but are not limited to: acute care, long-term care, nursing homes, rehabilitation, ageing, Alzheimer’s disease, cancer, cardiac disease, care, caregiving, carers, cognitive function, community nursing, community, comorbidity, compassion, continence, critical care, dementia, diagnosis, dignity, education, empathy, ethics, evidence-base, falls, family care, falling, frailty, functional status, gerontological nursing, gerontological nursing, health, heart failure, hospital, incontinence, intensive care, mental health, nurses, nursing older people, nutrition, older people, older person, oncology, ostomy, patient-centred, person-centred, policy, practice development, rehabilitation, research, social care, social welfare, stoma, welfare, wellness.

Author Guidelines
1. MANUSCRIPT TYPES ACCEPTED
The Journal of the All-Ireland Gerontological Nurses Association invites five types of papers and full details on the structure and types of submission are available to download on our website pages at www.aigna.ie and include the following:

1.1. Team-talk
1.2. A day in the life of…
1.3. Loving later life, an informal interview with…
1.4. Case studies
1.5. Literature reviews
1.6. Original research

1.1. Team Talk
The purpose of this feature is to create an insight into the ways in which teams operate on a day to day basis. Contributions should be no more than 1200 words (600 words per team member).

1.2. A day in the life of…
As the name suggest, this part of the journal centres on an individual. The idea behind this feature is to provide a detailed insight into a typical day in the life of a person of interest to readers of JAIGNA. The word limit for this section is fairly flexible but contributors are encouraged not to exceed 1000 words.

1.3. Loving Later Life, an informal interview with…
As the name suggest, this part of the journal centres primarily on, but not limited to, an informal interview with an older person, and will typically outline their lived experiences of loving later life. The word limit for this section is fairly flexible but contributors are encouraged not to exceed 1000 words.

1.4. Case Study
Case studies provide an important role in illustrating excellence in care practices and in demonstrating expertise in nursing. Case studies should be no more than 2000-2500 words in length. A proposed framework for the Case Study format is available at www.aigna.ie

1.5. Literature Review
Critical reviews of literature on any area of research relevant to Older People Nursing are invited. The structure of your submission is detailed on the AIGNA website at www.aigna.ie Literature reviews should not exceed 3000 words, excluding abstract, tables, figures, and reference list.

1.6. Original Research
We welcome reports of original research relevant to gerontological nursing and work with older people. The proposed structure for such papers is detailed on the AIGNA website at www.aigna.ie. Original research papers should not exceed 3000 words, excluding abstract, tables, figures, and reference list. Quotes are included in the overall word count of the main text.

Full details are available for downloading from the AIGNA website and e mail queries can be directed to aignainfo@gmail.com at any time.