

**An Investigation into the Influence of Professional
Socialisation on the Attitudes and Beliefs of Student
Nurses towards Older Adults in the Hospital
Setting**

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I certify that this thesis is the true and accurate version of the thesis approved by
the examiners

Signed.

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Abstract

This study aims to measure the attitudes and beliefs toward hospitalised older adults that student nurses bring in to nurse education and to evaluate whether they change during professional socialisation. A number of previous studies have explored the attitudes of student nurses towards older people. However many of those studies have produced inconclusive results. Moreover dated attitudinal measures have been utilised to answer a broad range of questions relating to older people. This research attempts to address the deficits in previous research. Phase I of the study describes the qualitative approach in the form of six semi-structured focus group interviews. Participants include trained nurses from the care of older adults areas ($n = 5 + 4$); and from the acute clinical areas ($n = 4$); nursing lecturers ($n = 6$) and student nurses ($n = 9+8$). Data are subjected to interpretational analysis and ten themes are explicated. A systematic approach is used to identify intergroup commonalities which are then incorporated into an eighty item questionnaire. Phase II describes the quantitative approach in the form of a twenty item Likert questionnaire. Convenience sampling is utilised in the selection of subjects. 295 questionnaires were returned from a total of 388 (77% return rate) from trained nurses in the acute areas ($n = 62, 82%$); from care of older adults areas ($n = 63, 69%$); nursing lecturers from a school of nursing and midwifery ($n = 55, 93%$); two cohorts of student nurses ($n = 64, 78%$ + $50, 63%$). Comparative results demonstrate that there are significant intergroup differences. Both student cohorts appear the least positive whereas the lecturers and nurses who worked with older adults seem to be the most positive. The nurses who work in the acute areas seem to be significantly less positive when compared to the nurses who work with older people. The results indicate that nurses who spend most time with student nurses have less positive attitudes and beliefs than other groups. This may well have a detrimental effect on how student nurses view older people. Awareness of our attitudes and beliefs are crucial so that older adults receive the care they deserve. Thus the policy implications which arise from the research relate to the implementation of strategies to raise the awareness of biases against entering a career in nursing older people.

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SECTION 1

BACKGROUND TO THE STUDY

LITERATURE REVIEW

Chapter 1. Background to the Study

1.1 Introduction

This study has been carried out during a period of time when nurse education in the United Kingdom has undergone rapid and fundamental change, from the introduction of the 1992 diploma programmes to the amalgamation of nursing colleges within institutes of higher education with the additional task of introducing new curricula. Furthermore, clinical settings where student nurses learn aspects of nursing practice have also changed in that much nursing practice commonly occurs out with the acute hospital setting and in the community and nursing home settings. Thus student nurses are allocated more frequently to placements where the majority of the clients are older. It is therefore important that student nurses are equipped with the appropriate skills to work in a variety of settings. The generic nature of nurse education precludes teaching student nurses all nursing knowledge. However, in the attempt to prepare student nurses appropriately for their career, nurse educationalists could be accused of allowing gerontological nursing issues to be subsumed under the myriad of "important" nursing skills i.e. the skills which equip student nurses to function safely in medical and surgical wards.

The changes within nurse education identified above, and the changing demographic trends, dictate that student nurses must be adequately prepared to nurse the client groups with whom they are going to come into contact. However, there is concern that, while students are being prepared for working with acute medical and surgical patients, this is done at the expense of the specific needs of older patients. If schools of nursing and midwifery neglect the needs of older adults through nurse education, this readily sends out the message to the students that the needs of this client group are unimportant.

This chapter begins with an outline of the main demographic changes in relation to older people in the United Kingdom and then goes on to consider both the status of

older people in society and that of the nurses who work with them. Older people are defined by Sutherland (1999) as being over retirement age. The thorny issue of educational preparation for working with older people is examined with reference to current trends within nurse education. Finally the aims and objectives of the research are contextualised.

1.2 Demographic Factors

Increasing longevity and declining fertility rates characterise the main demographic trends in industrialised societies. Those patterns have been identified in a number of diverse countries including the United Kingdom, Australia and Canada (Anderson and Hussey, 2000). The Audit Commission (1997) describes increasing longevity as one of the greatest achievements of the twentieth century, and as such, should be viewed as a cause for celebration. Instead, MacDowell, Proffitt and Frey (1999) describe how articles about older adults identify increasing longevity and decreasing fertility as major social and health problems which require some firm action. Anderson and Hussey (2000) estimate that people over 65 years old will account for 19.8% of the population in 2020 from 16% in the year 2000 whereas in 2020 the over 80 age group will account for 5.1% of the population having risen from 4.2% in the year 2000. There is a concern that too few younger people will be producing too little in the way of taxes to finance health and social services which will be used in the main by older people. Thus chronological age has a profound practical significance in everyday life. Bureaucratic organisations use age as a criterion for certain rights and responsibilities such as retirement and the distribution of an old age pension. Maddox (1996) describes how the age of 65 years may be a bureaucratic convenience which does not match reality.

The Audit Commission (1997) identifies the public sector as the major provider of services for older people. Conversely, Walker and Warren (1994) describe the role of the state as minor in direct care supervision while relying primarily on informal carers. The national figures for admissions to hospital for those over

aged 65 account for 47% of both the Department of Health expenditure and for local social services expenditure (Audit Commission, 1997). It seems reasonable and not entirely unexpected that people require more services as they grow older as there is a relationship between increasing age and a rise in incidence of ill health and disability (Walker and Warren, 1994). However, it is unreasonable to assume that ageing means inevitable decline (Levin and Levin, 1980) or that ageing is synonymous with disease (McPherson, 1992). This assumes that ageing is a medical condition whereas it is a normal process. If one follows the argument of ageing as inevitable decline to its logical conclusion this implies that ageing is incurable therefore not worth treating. In this context then, health education and promotion, in old age, would be seen as irrelevant as would disease prevention due to the inevitability of the condition of ageing. Latimer (2000) describes how older patients who come into medical wards as emergencies with acute problems such as a cerebrovascular accident, are often redefined as patients with chronic difficulties. Those patients are then cared for as social problems as opposed to medical or nursing problems. Crouch (1997) states that the resultant poor quality of life in old age devalues the whole of life. Furthermore the relationship with inevitability is not supported by the numbers of older people living independently as only 5% of older adults are institutionalised. In other words, 95% of older adults are living in their own homes.

Jacobzone (2000) states that there is a decline in functional disability among older adults in the United States of America which accompanies the increase in life expectancy, thus reinforcing the lack of a relationship between ageing and inevitable decline. Consequently, if Jacobzone is correct, older people are able to live more autonomous and independent lives and in turn, cause fewer pressures per capita on social services. However, it would be useful to replicate the research in the United Kingdom to evaluate whether there is a similar decrease in functional disability as there are unique cultural and social differences between the two countries especially with regard to health and social policies.

Nevertheless, it is the perception of decline which has an impact on how older adults are viewed in society.

1.3 Status of older adults in contemporary society

Older adults are frequently described as a burden, not as independent functioning beings who are going about their daily life. Edwards and Foster (1998) describe how this burden can be seen as costly, where older people are considered in terms of how many resources are required to support them. There is also the perception that older adults no longer make an economic contribution to society compounding the view that they are a drain on society (McPherson, 1992).

There are consequences to perpetuating those views, in that there is a sense of losing the things that older people can offer the youngest, for example, knowledge and experience. There is a loss of awareness that old age as a time of life is valuable (Audit Commission, 1997) and there is the ongoing conspiracy of pushing older people out of view of mainstream society by policies to ghettoise them in sheltered housing. Thus the views often put forward about older people seek to justify their social and economic exclusion from health and social services as they are of little economic and social value (Bytheway, 1995). Not only are older adults undervalued and excluded in society, they are ignored in hospital.

1.4 Status of older people in hospital

Clark (1998) puts forward evidence where admission to hospital itself can dramatically reduce the ability of older people to manage on their own both psychologically and physically. This may happen because older people can take longer to recover from treatment. This contrasts with one of the National Health priorities which is to increase turnover by early discharge of patients.

Furthermore, older people may need care which is not seen as medically active but crucial for fostering independence and autonomy (Sutherland, 1999). Older people who are taking up beds if they do not require active medical treatment are often ignored by staff who concentrate on “real” patients (Bullock, 2000). The

term bed blocking is thus applied. Crouch (1997) describes this term as derogatory and disrespectful to older people. She goes on to state that care in the community has failed and there is little provision for older patients who have little income and no one fit to care for them thus their only recourse may be a hospital bed.

Furthermore Nay (1998) describes how older patients are perceived. She goes on to explain how a combination of actions such as infantilisation; fostered dependency; not listening to the patient; telling rather than asking; all contribute to being, at best, just a number and, at worst, a worthless burden. Nursing practice reflects the assumption that nurses know best for older people, resulting in them being infantilised and even objectified. Reed and Clark (1999) describe how nursing care is often professionally defined as opposed to individually defined, thereby considering the needs of the organisation not those of the client. In other words the nurse very often decides if there is a problem with little recourse to the patient while paying lip service to the concept of individualised care and decision making on the part of the patient. Government led policies such as the Community Care Act 1990 increase the likelihood of clients remaining passive recipients of care rather than being involved in decision making (Walker and Warren, 1994) as the range of choices for older people are reduced. The evidence for this is demonstrated through the closure of long term beds without evaluating the consequences. The values and expectations attributed to older people are in turn reflected in the importance and status of nurses who work with older people.

1.5 Status of nurses who work with older people

There is the suggestion that nurses who work with older adults require less advanced nursing skills (Edwards and Foster, 1998) than those nurses working in the acute areas. Furthermore, the specialty has been described as the Cinderella service due to its unpopularity with nurses and its low status (Reed and Clark, 1999). There is also a perception that those areas are under resourced for trained staff and for equipment. The high number of nursing auxiliaries and health care

assistants further supports the notion that the work is largely unskilled labour. There has been little written in the literature about the specific skills required to work with older people or if indeed there are core competences for this specialty, although the report by the Standing Nursing and Midwifery Advisory Committee (2001) identifies some areas which require attention with respect to older people which are lacking in the pre-registration curricula. Furthermore, the framework which is used to organise nursing practice, the nursing model, is embedded in a culture of cure as opposed to fostering the skills of independence and self actualisation (Wade, 1993). The National League for Nursing (1992) discusses the importance of identifying core competences which are required for caring for older adults. They identify the need for nurses to be innovative and dynamic and furthermore, "it is nurses who will be needed to evaluate, create and redesign innovative ways to expand health care delivery to meet the changing demographic environment" (National League for Nursing, 1992, p.2). The Audit Commission (1997) warns that for longevity to be enjoyed other requirements including adequate finances, fitness and good health are crucial so that quality of life is maintained for both older people and their families. This would take the form of active care, preventing ill health wherever possible, providing active rehabilitation after illness and accessing the right kind of support when health is failing. Thus there are real opportunities for nurses to appraise critically their roles within gerontological nursing and to become much more creative and dynamic.

However, creativity and innovation are dependent on student nurses having the appropriate pre-registration educational preparation. There must also be a willingness to work with this age group which impacts on how older adults are viewed, especially with regard to nursing practice. Those factors are partly the concern and the responsibility of schools of nursing and midwifery.

1.6 Educational Preparation

Edwards and Foster (1998) describe how nurses caring for older people in both nursing homes and hospitals are inadequately prepared for their role. This could be

the result of a lack of preparation of faculty to teach gerontological content which was identified by Sheffler (1995). Thus it comes as no surprise that staff are ill prepared for their role if teachers are unprepared for teaching gerontological content. It could be argued that the changes in educational preparation for student nurses, in many ways, have contributed to a deterioration in knowledge and skills for working with an older age group.

The 1982 schemes of nurse training which were more the apprenticeship style training attempted to link theory to practice where students would be given the theory then they would go to the wards and supposedly put the theory to practice (United Kingdom Central Council for Nurses, Midwives and Health Visitors, U. K. C. C. 1986). The student nurses therefore had “a care of the elderly “ block where they received the related theory followed by practice in a care of the elderly ward. The main criticism of this format has been put forward by Fielding (1986) who identified that the lectures had a strong bio-medical influence and there was very much a disease oriented style. The students were taught about the problems associated with ageing, for example incontinence and senile dementia, yet those problems are in the minority when considering the lives of older people.

This is supported by the figures put forward by Wade (1993) 7.4% of older women are incontinent of urine every day whereas only 2.9% of men are incontinent. Only 10% of men and women over the age of 85 have considerable cognitive impairment which means that 90% of over 85's are not considerably cognitively impaired. If teaching staff portray older adults as having those types of problems, specifically linking them to ageing, it is no surprise that student nurses will think that those problems are the norm as opposed to the exception.

Much discussion and consultation took place within the U. K. C. C. (1986) during the development of the 1992 programmes where nurse education would lead to a diploma instead of a certificate. They decided to incorporate older adults as part of the adult programme instead of opening a separate register for those students who

may wish to specialise in working with older adults. The rationale for this was quite clear in that the register for nurses working with older adults was predicted to be under subscribed.

What is important is that all nurses need some gerontological nursing input as older people are not confined to the care of older adult settings but are in many acute and community areas. However, it seems that the knowledge and skills that are required to look after older adults effectively have been submerged and lost, meaning that qualified nurses are inadequately equipped to provide for the care needs of this group, valuing instead high technological models of care (Wade, 1993). Furthermore length of student placements in the care of older adult settings have accounted for an average of four to six weeks out of three years education so that student nurses have had little contact with older people.

Since the 1997 diploma programmes have been introduced, and in response to current demographic trends, student nurses now go to nursing homes and residential homes as well as ward settings thus they spend approximately eighteen weeks in settings where there are older adults. However local programmes still suffer from a lack of innovative and creative educational input. At one stage a lecture on the ageing process was thus described as "degeneration". After several pointed comments, the lecture is now called the ageing process.

Peach (1999) identified in the U. K. C. C. Report *Fitness for Practice* that pre-registration nurse education needs to take into account demographic changes so that nurses are prepared in caring for older adults effectively. Preparation will be influenced by changes in long term care arrangements as well as changes in societal views and attitudes towards ageing, dependency and death. If the trend involving reliance on informal networks of care remains, then nursing needs to take account of those networks also.

There is a real opportunity to try and identify some of the core competences

student nurses require to achieve fitness for practice where gerontological nursing is concerned. However, it depends on the collaboration of both the educationalists and the clinical staff to explore the issues associated with looking after older people and therefore to develop an innovative, non ageist and exciting programme to prepare students adequately. Innovative programmes on their own will not encourage nurses to go and work in the care of older adult settings without firstly examining nurses' attitudes and beliefs towards older people.

1.7 Aims of the research

Care of older patients will, for clear social and medical reasons, inevitably represent increasing levels of demand for health care services in general and nursing care in particular. Traditional nursing responses to ageing have been characterised as mainly concerned with chronicity and long term care. This area of nursing will have continuing importance but the largest change is likely to be a need to respond to increasing proportions of older adults requiring acute care. Put another way, the proportion of people requiring acute care who are older will increase considerably in the future. Furthermore, demands for provision of nursing care are predicted to increase substantially due to both the demographic changes previously identified and to philosophical developments suggesting the aim of the research should focus on facilitating social and personal independence.

Units that provide care for older adults continue to be seen as undesirable places to work (Treharne, 1990). More generally attitudes among nurses working with older adults tend to be negative (Courtney, Tong and Walsh, 2000). In the United Kingdom student nurses are now expected to spend more time in care of older adult placements throughout their three year education. It is clearly important to assess whether negative attitudes towards older adults persist. In addition there is concern as to whether these attitudes are merely reflections of general social attitudes or have components specific to nursing. There is also interest in the effects of education, early professional experience and the impact of professional socialisation on these attitudes. This study considers the attitudes of a range of

nurses and teaching staff drawn from different points of professional experience.

The overall aim of this research therefore is to examine how professional socialisation impacts on student nurses' attitudes and beliefs towards hospitalised older adults, in other words, to evaluate the attitudes and beliefs of nurses, the impact of their personal, training and societal experiences of ageing and in particular the impact of nursing older people within the hospital setting. Thus the attitudes and beliefs of student nurses are compared to those of clinical nurses working in the acute setting and the care of older adults setting and finally with those of the lecturing staff.

1.8 Objectives of the research

1. To compare the attitudes and beliefs towards older adults of student nurses with those of nursing lecturers.
2. To compare the attitudes and beliefs of student nurses with those of trained nurses who work either in acute and in older persons' care areas.
3. To compare the attitudes and beliefs of nurses who work with older people with those who work in the acute areas.
4. To evaluate whether student nurses' attitudes and beliefs towards older adults change after a clinical placement.
5. To evaluate whether student nurses attitudes and beliefs towards older adults change after theoretical input.

The aims and objectives were achieved by completing focus group interviews consisting of groups of lecturers, clinical nurses from both the care of older adult areas, the acute areas and also student nurses. The qualitative data were analysed using thematic analysis and from this data a questionnaire was formulated. This questionnaire was used to compare the attitudes and beliefs of student nurses with the attitudes and beliefs of the other nursing groups. Finally the results from the focus group interviews were compared with the results from the questionnaire to evaluate the utility of each method as a data collecting strategy.

Chapter 2. Literature Review

2.1 Introduction

The literature review considers the utility of attitude as an operational concept and its relevance to beliefs and stereotypes and their interchangeable use within the literature. Furthermore, the literature relating to the attitudes of both trained nurses and student nurses towards older adults are explored with consideration given to the influence of demographic variables. Factors which may influence nurses' attitudes and beliefs include educational preparation; the organisation and quality of the work ; the status of the work in the care of older adults setting are considered. Professional socialisation is put forward as the conceptual framework for the formation of negative attitudes towards older adults. It is argued that student nurses come into nurse education with society's attitudes and through the process of professional socialisation, they take on the attitudes of the profession. Consequently, the study involves investigating the attitudes of trained nurses and lecturers toward older adults as they are the most significant groups in this process (Bradby,1990). Their attitudes and beliefs are then compared to those of student nurses. A critique of the commonly used measures for attitudes towards older adults is presented. Finally, the incorporation of methodological triangulation, by utilising both qualitative methods in the form of focus groups and quantitative methods in the form of an attitudinal measure, is justified.

2.2 Methods employed for the literature review

Computerised literature searches were carried out on a regular basis for the following databases: CINAHL, BIDS and ASSIA for the years commencing from 1980. Searches used a series of combinations of the following text words: attitudes, elderly /older people, student nurses, trained nurses, nurse education, stereotypes, ageism, effects of ageism, the work in the care of older adults setting, professional socialisation, focus groups, qualitative and quantitative approaches, questionnaire design.

The Journal of Social Psychology was hand searched for the years 1960-1996. The database of references were further developed using an incremental approach, examining the list of references for each article retrieved. Articles which were relevant to the research were selected and this was an ongoing process.

Guidelines and policy documents relating to the nursing care of older people were also accessed. Sequential literature searches continued as dictated by the phase of the research. The literature review was updated frequently (at least every six months) until completion of the research.

2.3 Attitudes

A number of authors have identified the enduring popularity of studying attitudes within the psychological literature (Allport, 1954; Rokeach, 1972; Eiser, 1986). This is amply demonstrated through the plethora of definitions of attitudes plus the competing theories as to how attitudes are formed. Furthermore, there are a number of arguments as to how and what should be measured, in other words, can attitudes be measured as an entity or do attitudes consist of components which should be independently assessed? The following literature review puts forward the arguments for both stances. However, the evidence is weighted towards considering attitudes as a unified concept as opposed to measuring each component separately. Consequently, this stance was taken in the research.

The main purpose of the review is to explore the rationale for focussing on the constructs of attitudes and beliefs and their relationship to behaviour. The concept of attitude as likes or dislikes is considered by the author to be a naive view which does not take into account the situation or the object. Nor does it take into account the complex interplay between liking or disliking situations or objects which may have conflicting emotions attached. However, the concept of attitudes as inter-related beliefs fits well with some of the studies where those concepts are used interchangeably.

The notion that the activation of an attitude is both situation and object dependent

is supported as this is very relevant to the subject under study. It is argued that nurses hold views of older people which differ from the views of wider society. This is postulated as being due to the unique situations where nurses come into contact with older adults. Thus attitudes and beliefs are situation and object dependent. The genetic and instinctual nature of attitudes is discarded in favour of the view that attitudes are developed through direct and indirect experiences and acknowledging the importance of socialisation, of which the media is an important strand. It is argued here, that student nurses are professionally socialised into holding the attitudes of the profession towards older adults.

2.4 Definitions of attitudes

Allport defined an attitude in 1935 as “a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual’s response to all objects and situations with which it is related” (Allport, (1954, p. 24). Allport’s definition conveys a strong link between attitude and behaviour through the use of the words directive and dynamic which is not reflected in other more recent definitions. Ajzen (1988) defines an attitude as “a disposition to respond favourably or unfavourably toward an object, person, institution or event”(p. 4) Disposition could be further defined as an intention which is less forceful than dynamic or directive. However an intention does not necessarily result in a behaviour and for an attitude to be recognised, it must take the form of a response whether it is verbal, as in an expression of an opinion or in a non verbal response as in a facial expression (Rokeach 1972; Eiser, 1986). This response is identified by Eagly and Chaiken (1993) who define attitude as “a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour”(p. 1). They further explain what they mean by both a “psychological tendency” which they describe as an internal state, and “evaluate”, which refers to a class of response. They differentiate between affect as a component of attitude and evaluate as a type of response. They include within their descriptions of evaluative response, liking or disliking, whereas authors have used evaluate and affect interchangeably (Ajzen, 1988). Atkinson, Atkinson, Smith and Nolan-Hueksena (2000) also describe attitudes as expressing feelings,

leaving little distinction between affect and evaluative response. The final definition for consideration has been put forward by Rokeach (1972). This is the most complete and unambiguous definition of them all. "An attitude is a relatively enduring organisation of inter-related beliefs that describe, evaluate and advocate action with respect to an object or situation, with each belief having cognitive affective and behavioural components" (p.132). This definition as well as describing attitudes as beliefs also identifies the inter relatedness of the three components. The definitions by Allport (1954) and Rokeach (1972) also acknowledge the relevance of the object and the situation to the evocation of an attitude. Rokeach goes on to say that the inter- relationship between the object and the situation is important for the activation of an attitude. This inter-relationship between object and situation guides the direction of this study, as much of the work done on nurses' attitudes towards older people are carried out using generic measures. It is argued that nurses view older people, not from a generic stance but very much from a professional stance thus making generic tools largely redundant in this context.

2.5 Formation of Attitudes

There are a number of theories as to how attitudes are formed. Allport (1954) describes attitudes as having both an instinctual component as well as a habit component in any proportion. This instinctual component is further explored by McGuire (1969) in that he argues attitudes may have genetic and physiological strands. Furthermore, Eagly and Chaiken (1993) warn that the genetic influence should not necessarily be ignored. They claim that some attitudes may be unlearned i.e there is another route to acquiring attitudes other than direct or indirect experience. However, they do not suggest any examples of unlearned attitudes. The arguments put forward by McGuire (1969) are ill supported by empirical literature and some examples which he uses, in themselves, display negative views about both ageing and illness. The ageing example is when he describes how attitudes change to take account of the conservatism of old age. This relies on the assumption that as people grow older, they become more conservative. The second example which he uses is his description of the attitudes

of epileptics as being misanthropic and distrustful. People who have epilepsy have much to contend with through stigmatisation from society without having to contend with labels such as those. There is little research to suggest that people are genetically prone to having positive or negative attitudes towards objects or situations. This study argues from the stance that nurses' attitudes to older adults are influenced through the process of professional socialisation, in other words, through direct and indirect experiences, therefore they are not instinctual.

Ajzen and Fishbein (1980) put forward another model in their theory for reasoned action. They postulate that we form beliefs about an object by associating it with certain attributes. Since the attributes that come to be linked with the object are already viewed negatively or positively, we automatically and simultaneously acquire an attitude towards that object. There is almost an assumption of passivity or reactivity about those explanations where attitudes are formed through processes of instinct or genes whereas the explanation put forward by Ajzen and Fishbein (1980) tends to describe a more dynamic process. Furthermore attitude development occurs through direct experience with the attitude object or indirect experience. Indirect experience includes media images (Ajzen and Fishbein, 1980). Eiser (1987) concurs with them as to the influence of the media which allows for widely shared attitudes. Thus development of an attitude requires some sort of experience with the attitude object. Processes including socialisation are described as external variables in the development of attitudes (Ajzen and Fishbein, 1980).

Eagly and Chaiken (1993) further describe the process of acquisition of attitudes. Firstly, a person does not have an attitude until they respond to a situation. They state that a mental representation of an attitude may be stored in the memory and can be activated by the presence of the attitude object or cues which are related to it. Once the person has responded evaluatively whether on a cognitive, affective or behavioural level, they are then considered to have an attitude. The two processes described differ in the internalisation of the attitude. Eagly and Chaiken (1993) suggest that the development of the attitude depends on the evaluative

response whereas Ajzen and Fishbein (1980) suggest attitudes form from beliefs and attributes with or without direct experience of the attitude object and occur automatically. It is proposed, in this research that student nurses come in to nursing education with society' views of older people, obtained from both direct and indirect experiences and influenced by media images. Through contact with older people within the hospital setting, combined with the process of professional socialisation, they then develop attitudes, beliefs and values which are widely upheld in the profession. The staff involved in professional socialisation are both the clinical staff and the lecturing staff

2.6 Components of attitudes

Eagly and Chaiken (1993) support the notion that attitudes can be visualised as being on a continuum ranging from negative to neutral to positive. However, Rokeach (1972) disagrees with the concept of neutrality in that he argues that the affective component can be activated if our beliefs are challenged. Our beliefs therefore, are negative or positive. He further argues against the continuum in that our beliefs and behaviours do not always coincide. He goes on to describe two dimensions, the first being the like/dislike dimension and the goodness/badness dimension. The example he gives is smoking, where people may know smoking is bad for them but they still indulge in the behaviour. This argument can be applied to nurses' attitudes towards older adults in that nurses may like older adults but they may not necessarily value working with them.

Eagly and Chaiken (1993) argue that the cognitive, affective and behavioural components can all be ranged along a continuum, separately or integrated. What does differ is the measurement of the components, that is, whether the components can be measured tri-dimensionally or uni-dimensionally. Ajzen (1988) argues that the components can be measured as independent entities. However, Eagly and Chaiken (1993) suggest that no conceptual distinction of the components should be made when attempting to measure attitudes. Indeed, when the literature for attitudes to older adults is studied, there are often no conceptual distinctions made certainly between cognitions (beliefs) and attitudes. This

supports the view of Rokeach (1972) who defines attitudes as inter related beliefs.

Eiser (1986) describes how there is little research to indicate how the components relate to each other and it is this ambiguity which allows theorists to “treat attitudes as internally consistent structures or as conglomerations of essentially distinct components” (p. 54). Furthermore, in 1987 Eiser goes on to explain how well the three components go together will be influenced by the extent they were acquired together. In other words, there is little certainty as to how each of the components are acquired and whether they are acquired simultaneously. However, Rokeach (1972) describes attitudes as beliefs and it is the beliefs which have cognitive, affective and behavioural components. He agrees with Eagly and Chaiken (1993) that it is difficult to isolate and manipulate the components independently of each other.

2.7 Attitudes and Behaviour

The putative relationship between attitudes and behaviour is worthy of further consideration. There is little agreement in the literature as to whether there is a relationship between the two concepts, that is, whether attitudes predict and/or explain behaviour or indeed if there is any link between them at all. Eiser (1986) describes how different definitions have failed to resolve the relationship between inner experiences on one hand and observable behaviour on the other. Rokeach (1972) states that there must be a link between attitude and behaviour as a predisposition that does not lead to a response cannot be detected. However, Newcomb (1964) describe attitudes as determining behaviour. The concept of determining behaviour is more decisive and less thoughtful than the words used by Ajzen and Fishbein (1980) who argue that attitudes predict or indeed foretell behaviour. They rationalise this stance in their theory of reasoned action. They postulate that, in general, people behave sensibly and rationally and they consider the consequences of their actions prior to carrying them out. Thus behaviour lacks capriciousness and thoughtlessness so, unless there are unforeseen events people will act according to their intentions. Intentions will be influenced by the attitude towards the behaviour and the person's perception of the social pressures under

which they perform or do not perform the behaviour. This process is reflected in the comments made by Levin (1988) who suggests that the apparent decrease in negative attitudes to older people can be linked more to social pressures not to display negative attitudes as opposed to an actual change in society's attitudes.

Eiser (1986) however criticises attitude theorists who neglect the social and communicative context within which attitudes are expressed. Furthermore, he agrees that our attitudes are shaped by other people's interpretations of what we say and what we do. Thus the relationship between the attitude object and behaviour is complicated by other people's interpretations of the object and as Rokeach (1972) has previously identified, the particular situation in which the attitude object occurs. This is crucial to the objectives of this research as it is the attempt to discover how nurses view hospitalised older adults as opposed to how they view older adults as part of society. Thus, the central tenet of this research is that nurses view older adults in the context in which they care for them, that is in the social and communicative context of the hospital. Additionally, it is important to identify how both clinical nurses working with older adults in different settings and lecturers view older adults as their interpretations of the context may influence student nurses.

Eagly and Chaiken (1993) corroborate the link between attitude and behaviour in that people who evaluate an attitude object positively are more likely to behave toward the object positively and vice versa for a negative evaluation of an attitude object. Furthermore, they suggest that increasing behavioural or cognitive input relates more strongly to attitude relevant behaviours, however a link between affect and strength of attitude behaviour is yet to be made. Ajzen and Fishbein (1980) go on to differentiate between attitudes to the object as opposed to attitudes toward the behaviour. They are suggesting that it is not so much the attitude toward the object which is important but the behaviour towards the object. This would suggest that research should be aimed at the latter not the former.

2.8 Stereotypes of older people

If one accepts that attitudes are made up of three distinct components, whether they are measured independently or not, one of the components are cognitions, in other words, beliefs. Beliefs then, are an important part of attitudes and thus must be considered in relation to nurses' attitudes to older people especially when there is a further link between beliefs and stereotypes.

As previously stated Rokeach (1972) describes attitudes as inter related beliefs. Furthermore, Eagly and Chaiken (1993) define beliefs as “ the associations or linkages between the attitude object and various attributes” (p. 103) Interestingly, Katz (1960) succinctly describes the relationship between attitudes and beliefs as “ All attitudes thus include beliefs, but not all beliefs are attitudes” (p.168). Eagly and Chaiken (1993) further describe stereotypes as the beliefs about the group. Stereotypes usually have negative connotations despite their neutral description. Authors frequently discuss beliefs and/or stereotypes as stereotypical beliefs (Snyder and Miene, 1994; French, 1990). Thus the relationships between beliefs, stereotypes and attitudes are well documented.

Mackie, Hamilton, Suskind and Rosselli (1996) describe stereotyping as an efficient tool for making sense in a complex world where there are similarities and differences. However French (1990) identifies them as over generalisations which grossly simplify reality thereby relieving us of the need to consider people as individuals. Thus, they encourage homogeneity among groups of people with the effect of treating them similarly. To summarise, a stereotype can be defined as a pre-evaluation of the individual based on pre-existing assumptions about a group to which they are ascribed by the person. Stangor and Schallor (1996) explain how stereotypes come from two complimentary perspectives, the individual perspective and the cultural perspective. This can be likened to student nurses who come into nursing practice with their own stereotypes of older adults and they meet the stereotypes held by the nursing culture. Individual stereotypes rely on direct contact with the social group for development whereas cultural approaches depend on indirect contact such as parents, peers, television. If stereotypes are

formed through those sources, then student nurses may be very short of both direct and indirect sources especially with regard to their quality. Snyder and Miene (1994) identify how society is age segregated so that young adults may have limited contact with older adults unless there are grandparents living close by. Fennell, Phillipson and Evers (1988) describe how current social policies in the United Kingdom such as housing policies exacerbate this lack of contact. Consequently younger adults may have limited direct contact with older adults resulting in stereotypical beliefs being from indirect sources.

An example of an indirect source for stereotypes is the media. Both Snyder and Miene (1994) and Bytheway (1995) describe media depictions as powerful transmitters of cultural stereotypes. However the stereotypes of older people on television range from them being invisible (French, 1990; Bytheway, 1995) where they do not exist, to potentially negative stereotypes where they are portrayed as cantankerous old men or women spoiling family life. Even more damaging to older adults is when they are portrayed as being ill especially with Alzheimer's (Feldman, 1999). Finally adverts promoting the use of hair dyes and anti wrinkle creams, encourage a distaste for growing older where the signs of ageing are to be avoided at all costs (Bernard, 1998). McBride (2000) describes the forestalling of wrinkles as dealing with the surface issues rather than tackling the problems and issues associated with ageing. It could be argued therefore that not only is there a lack of positive images of ageing in the media, there is an abundance of negative images which encourage people to dislike and fear the ageing process. Furthermore, Stangor and Schaller (1996) argue that people do form stereotypes about people they have not met and they suggest that direct contact has little effect on the stereotypes formed. The consequence of this is obvious in that people are forming stereotypes from indirect sources which will remain despite direct evidence to the contrary.

Indirect contact also includes learning stereotypes by observation and imitation, listening to disparaging group labels or derogatory jokes which elicit approving laughter (Mackie et al, 1996). Bytheway (1995) describes how humour may well

be seen as laughing at ourselves but on the other hand it may be felt as humiliation among older adults especially if the humour is directed at older adults being incontinent and smelling of urine .

Snyder and Miene (1994) describe three orientations to stereotyping which are firstly, from a cognitive perspective which acts as a cognitive economy function. Secondly, there is a psychodynamic orientation which has an ego protective function and thirdly, a sociocultural orientation where stereotypes function to help people to fit their own social and cultural in-groups. Those orientations are particularly relevant to their research which found that when stereotypes belonging to men and women were examined in relation to attitudes to older people, their increase or decrease was dependent on the ego protection function. Thus stereotypes are not just about applying ready made labels to people but they protect people from their own frailties.

2.9 Ageism

Butler (1975) is attributed with being the first to coin the word ageism in 1968 within the cultural context of the United States of America. Thus ageism can be considered culture specific. He goes on to define this term as “ageism can be seen as a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender... Ageism allows younger generations to see older people as different from themselves, thus they subtly cease to identify with their elders as human beings” (p.12) Authors have argued against the concept of age stereotyping as applying only to older adults as all groups can be penalised because of their age (Bytheway, 1995; French, 1990). French gives examples of teenagers being seen as irresponsible or middle aged adults who are seen as “past it” in terms of their employment. Bytheway (1995) goes on to give a very straightforward definition of ageism as being “prejudice on the grounds of age, just as racism and sexism is prejudice on the grounds of race and sex” (p. 9). Furthermore, Bytheway states that prejudice against older people is indisputable as does Bernard (1998) whereas Schonfield (1982) argues against the wholesale application of age related

stereotypes in American society. There is ample evidence to support Bytheway's (1995) contention that society is indeed prejudiced towards older adults in a number of ways. Older adults are seen as a burden on society as they use up the majority of available resources in health and social care. Bytheway explains that this argument may be used in one of two ways. Firstly, it can be used to account for our own ambivalence to ageing. Secondly, it may be seen as cynical manipulation by politicians who suggest withdrawing funding for the support of older people as there is not enough money to meet their needs. Feldman (1999) suggests that ageing is not something we talk about comfortably in a culture which reveres youth. Interestingly, both Laws (1995) and Snyder and Miene (1994) describe ageism as central to our identity, however, unlike sexism or racism, it is something we will all encounter if we live long enough.

Bytheway (1995) states that there is a difference between negative ageism, realism and what he describes as positive ageism. Positive ageism includes being patronising, where older adults are described as really nice and fascinating with lots of interesting stories to tell. Whereas older people who are described as pretty ordinary is much less ageist. Positive ageism is routinely used in the newspapers where it is newsworthy that an octogenarian sky dives out of an aeroplane. This may be a remarkable event if it is a person in their thirties, however it would not be considered newsworthy. In other words, some everyday events become notable purely due to the person's age and for no other reason.

Language can be used as a tool for ageism where older adults are infantilised by nurses who call them such names as "poppet" or address them by their first name without seeking permission to do so. Phrases which apply ageist standards between older and younger people such as "mutton dressed as lamb" and "dirty old man" can convey our distaste for considering older adults as normal sexual beings (French, 1990).

2.10 Effects of ageism on older people

Ageism towards older adults not only has an effect on the people we are being

ageist towards from the individual's view of their own ageing, but it also has a deleterious effect on the quality of care they receive in a care giving situation. Brubaker and Powers (1976) explain that the stereotypes of old age affect younger people in the way that they perceive and interact with older people. However, they also influence the way that older people define themselves. Consequently, older adults may delay seeking help as they are socialised into thinking a health problem is inevitable and is a part of ageing therefore it is incurable (French, 1990). Nay (1998) describes how older adults who do seek help are made to feel like machines, not individuals.

Anecdotal evidence suggests that, up until recently, a number of specialised units within hospital settings had age related limits for admission to the unit, for example, coronary care units had an age limit of seventy years old. Older adults received less than perfect matches for organs for transplants as they were older and only recently publicity has surrounded the use of "Do Not Resuscitate" orders without consultation with both patients and relatives. Edwards and Forster (1998) describe one of the effects of ageism as the devaluation of care which directly affects its quality in a negative way resulting in patients receiving less than adequate standards of care. Consequences will include older adults being treated homogeneously with little account of individuality. Furthermore, treatment may be withheld due to using biased judgements relating to prognosis (Sharpe, 1995). Older adults can be forced into a dependent role as it is quicker to carry out tasks to them, rather than encouraging them to complete tasks for themselves (Courtney et al, 2000). The negative stereotyping of older adults therefore results in them being viewed in a depreciatory manner and as less valuable members of society. (Grant, 1996)

Nurses can be seen to contribute to ageism through negative attitudes and infantilising older adults (Sharpe, 1995). This may be manifested in a lack of interest in working with older adults plus valuing technological cure over care (Edwards and Forster, 1998). The care which may be practised conforms to the stereotypes of ageing. An example of this can be seen in not actively treating

older people with disability as it is considered to be an inevitable part of ageing (Reed and Clarke, 1999). Attitudes of both health professionals and those out with nursing are now discussed.

2.11 Student nurses' attitudes towards older people

Studies have investigated student nurses' attitudes with reference to well older adults, ill older adults and with consideration to classroom teaching. The studies have been ambiguous in their results as there seems to be little agreement among researchers as to how the above conditions influence student nurses' attitudes. Gomez, Otto, Blattstein and Gomez (1985) used the Tuckman and Lorge (1953) Attitude Toward Old People Scale in a pre and post test design to evaluate the impact of an eight hours per week over three weeks, clinical experience with ill older adults. No clinical experiences with other age groups nor any age specific content were presented. Their results demonstrated a higher post test score in comparison with the pre test score. King and Cobb (1983) used Palmore's (1977) Facts of Ageing questionnaire (F.A.Q.) in a pre and post test design to evaluate an eleven week structured experience with well older adults accompanied by a mix of lectures and contact with patients of varying wellness. However they did not define the concept of varying wellness nor did they explain how they operationalised the concept therefore it is difficult to interpret its meaning. Their findings suggest that there was an increase in knowledge levels which would be expected if there is theoretical input. Student nurses also became less biased. Their findings were based on a sample size of 46. Galbraith and Suttie (1987) had a sample size of 86 nursing students and using a pre and post test design. They used a scale called the Oberleder Attitude Toward Ageing Scale (1982). The questionnaire was completed prior to commencement of the classroom content, plus a clinical rotation with well older people in the community or a nursing home environment. The questionnaire was once again completed at the end of the placement. They do not indicate how the scale was developed nor tests for reliability and validity. Nevertheless, they suggest that student nurses' attitudes became significantly more positive for two reasons. Firstly, they postulated that this occurs through the students being exposed to classroom content which was

related to the normal ageing process. Secondly, they were exposed to the well elderly which encouraged a more holistic perspective of older adults. Fox and Wold (1996) evaluated student perceived learning and attitude change toward caring for older people using a researcher devised 4 item questionnaire. They used two other measures but they were for purposes other than measuring attitudes. Once again a pre and post test design was used, therefore students were being measured prior to a concentrated course on gerontological concepts and post clinical experiences. Interestingly, they describe their gerontological content as emphasising the capabilities of older adults, rather than addressing their overt physiological problems. They claim that there were significant improvements in attitudes using their four item questionnaire.

Knowles and Sarver (1985), investigated the influence of age and gender of the patient on student nurses' attitudes. They used a questionnaire for which there is no information given about reliability and validity. Their results indicated that older people are the least preferred and the decrease in preference is exponential to increasing age. Older women when compared to older men are the least preferred. Dellasega and Curriero (1991) carried out a longitudinal study using 39 junior student nurses. They were examined prior to commencement of clinical work in an institutional setting with older adults, after this experience, and once again after an experience with well older adults living in an apartment complex designed for older adults. Their measure was seeking to evaluate work preferences. Their results suggest that students prefer not to work with older adults and those results remained the same after both clinical experiences. However they do acknowledge their small sample size. Lusk, Williams and Hsuing (1995) using a sample of 63 junior students, corroborated the results found by Dellasega and Curriero (1991).

Fielding (1986) used a qualitative approach to evaluate student nurses' attitudes by using conversation analysis. She gathered the data by tape recording a sample of student nurses from first, second and third year during their clinical experiences and using two hour recording schedules. She also interviewed the students after their recording session. There was little evidence of consideration for ethical

issues except informed consent, especially as patients' conversations must have been included on the tapes. There also seems to be little attempt at thematic analysis and the discussion of the analysis relies almost wholly on the interview material as opposed to the recorded material. Consequently, the interview material seems to have yielded the most important findings. There are no comparisons made for stage of training when discussing the interviews and tape recordings. However, this is rectified through the use of a questionnaire which does not measure attitudes per se, but considered which placements students most and least enjoyed. The attributions Fielding does extrapolate from her interviews is that student nurses describe older adults in terms of dependency, mental confusion and the inability to care for themselves. The findings from the questionnaire were interesting in that the more senior students enjoyed the areas where the pace was fast and challenging, where patients recovered speedily and returned home. Conversely, some students found caring for older adults tedious, boring and heavy, although some students did learn from their experiences in the care of older adults which they described as worthwhile and interesting. The research by Fielding was notable for the fact that she tried to move away from a quantitative approach to a more qualitative approach where students were encouraged to explore their thoughts and ideas about the issues.

Goebel (1984) attempted to identify and compare characteristics ascribed by nurses to different age groups using a 35 statement scale derived from Kogan's (1961) Old People (KOP) scale and the scale designed by Tuckman and Lorge (1953). She also developed a sub scale from the amalgamated questionnaire representing six characteristics generally found to be viewed negatively towards older adults relating to value, security, interpersonal, habits, responsibility and mentality. She tested for reliability but there is no indication as to whether pilot studies were completed. This amalgamated questionnaire was used to evaluate student nurses' attitudes towards all age groups, not just older adults which is a cause for concern on two counts. Firstly, it was not validated and, secondly, it was originally designed to measure attitudes towards older adults. Her results indicate that older adults were viewed more negatively when compared younger adults.

However, it is difficult to accept results based primarily on an older adult measure. One could question how relevant the statements were to all age groups and if that was the intention, it would have been advisable to develop a completely new measure. Furthermore, the questions were not validated for use among younger adults which may have skewed the results. This literature review thus far has examined student nurses' attitudes under a variety of different conditions. However other studies have considered people out with nursing. Many of the same issues arise in that literature.

2.12 Attitudes of people out with nursing

Studies investigating attitudes to older adults have ranged from children's attitudes through to radiographers and medical staff attitudes. Both Aday , Aday, Arnold and Bendix (1996) and Newman, Faux and Larimer (1997) among other authors have investigated children's attitudes to older adults. Aday et al (1996) suggest that children of elementary school age have started to form negative attitudes to older adults in that they are generally described as being tired, ugly, helpless, ill and ready to die. Their study used a pre and post test design to measure attitudes after introducing a structured programme bringing older adults and fourth grade children together. The results of the measure indicate that there was a significant positive change in the pupils' attitudes. Newman et al (1997) criticise studies measuring children's attitudes as interpreting results using adult standards. However, they state that children may be entering school with negative attitudes. They introduced older adults into the school setting and utilised a pre and post test design. Newman et al (1997) seem to be supporting the notion that children can differentiate between the ageing process per se and the associated negative conditions. This point is critical in that it can be argued that it is not ageing itself which causes stereotyping and ageism but the perceived unpleasant conditions of ageing which give rise to negativity.

Other groups have been evaluated for attitudes towards older adults, including medical staff. Pacala, Boulton, Bland and O'Brien (1995) used a modified ageing

game exercise to examine its effectiveness in influencing medical students' attitudes towards caring for older people. The students were evaluated pre and post the ageing game workshops. The ageing game itself is based on some of the stereotypes of ageing where it is associated with an inevitable decline and illness such as arthritis. Due to an overwhelming positive response to the workshop, it became an integral part of the course. However, they concede that the workshop, while enhancing sympathy and attitudes, did not affect the general beliefs about the characteristics of older people. Those results are not surprising when the game itself is confirming those beliefs. Paris, Gold, Taylor, Fields, Mulvihill, Capello and deBeer (1997) used a cross sectional approach to examine the attitudes of medical staff. They used a time frame of nine years for their cross section. Their results suggest that attitudes between the different groups fluctuated between negative and neutral over the nine year span, therefore they came to the conclusion that there was no real improvement over time. Hellbusch, Corbin, Thorson and Stacey (1994) used the KOP scale (1961) to measure whether physicians' attitudes affect their quality of care. Their findings suggest that the less experienced the doctor, the more positive the attitude at a significant level. This confirms much of the previous work evaluating nurses' attitudes where more contact with older adults seems to result in more negative attitudes. However, a qualitative study by Fisher and Peterson (1993) investigated the use of a depersonalisation strategy by surgeons. The methods used to gather data included in depth interviews, participant observation and a structured questionnaire. They do not give details of the questionnaire. Nevertheless, their findings are interesting in that they claim that surgeons hold callous and uncaring attitudes toward older people. Some surgeons admitted that older people received less aggressive treatment depending on whether they were perceived to have a limited life expectancy. Nor did they worry about the cosmetic appearance of the surgery if the patient was older. However there were other surgeons who would treat all people the same regardless of age. No sample sizes are given so it is difficult to evaluate the scale of the problem. Worryingly, the authors state that nurses followed the lead of the surgeons.

Fowler (1997) used both trained and student radiographers in her study with the KOP scale (1961) and follow up interviews. According to her results, the range of scores elicited similar scores between the groups. However, in the follow up interviews, students identified the importance of treating older people as individuals. They were aware of the perceived lack of time to spend with older adults and they also identified how older adults are treated differently in hospital where there is an obligation to treat them well. Two major implications can be drawn from this study. Firstly, there is the perception that older adults are slower and are more time consuming than younger adults and thus more dependent. Secondly, they distinguish between an older person in society and an older person as their patient.

2.13 Comparative Studies

Other studies have gone on to compare student nurses' attitudes with other groups of health workers. Heliker, Brophy, Naughton-Walsh, Druyan, Hungelmann, Jacobs, Lapalio, Sabbia- Madden and Schulte (1993) used students from nursing, dentistry and medicine, incorporating a pre and post test design. They had a total of 28 students who were randomly assigned into control and experimental groups. They used an informal two hour interaction with an older adult on three separate occasions, as their intervention. Their measure was the KOP scale (1961). They acknowledge that the sample size was small but they go on to suggest that the results indicate that there were significant differences between the control group and the experimental group so that interaction does have an influence on attitudes. However, it is not until the discussion that the reader is made aware that the article is reporting on a pilot study.

Sherman, Roberto and Robinson (1996) investigated the knowledge and attitudes of hospital personnel using the FAQ (1977). The sample included all grades of nurses, occupational and physiotherapists, medical staff, housekeeping, dietitians and medical records personnel. Demographic variables of age and level of education had an effect in that increasing age and higher levels of education contributed to more positive attitudes whereas, not surprisingly for knowledge

levels across occupations, clinical staff had higher knowledge levels than non clinical staff. Carpenter (1996) used a survey approach to evaluate why students were interested in working with older adults. His sample was drawn from nursing, public policy, nutrition, social work and sociology courses whose interest developed from a desire to understand their own ageing and that of their families and friends. They also expressed the notion that older people are an undervalued group. However there is little information on how the groups compared.

Treharne (1990) used 40 students and 25 clinical staff including nursing auxiliaries in her longitudinal survey. Her question related to the continuing unpopularity of care of the older adult. Students were evaluated three times using the Ageing Opinion Survey (Kafer, Rakowski and Hickey, 1980) and a stress scale which was constructed for the study. There is no discussion as to the testing of the stress scale prior to use. Treharne (1990) also neglects to discuss how the data were analysed. But she states that her findings indicate that student nurses' attitudes became slightly more negative during the care of the older adult training module whereas the clinical nurses attitudes were found to be less positive when compared to the students although the difference was not significant.

Slevin (1991) used secondary school pupils who were in their final years of schooling with no formal input into the health care environment. He also set out to measure differences between males and females among these groups. Finally, he compared those attitudes to those of student nurses and trained nurses. He used a purpose designed instrument called Attitudes to the Elderly Inventory which had been used as a measure for medical students. The measure employed a yes/no scoring. There is little indication relating to the content of the questionnaire, however it could be argued that, one of the few examples of a statement given "it is better not to fight death and sometimes better to bring it about" (Slevin, p.1199) is a double barrelled statement seeking to elicit two separate issues, that of allowing older people to die and that of helping older people to die. Results suggest that both fourth year and fifth year school pupils had less positive attitudes and did not hold older adults in high esteem and this was mirrored in the student

nurse population. Boys were more negative than girls. However, the mean scores for trained nurses were more negative than both the student nurses and the school pupils. Slevin's (1991) results are confirmed by Lookinland and Anson's (1995) study which considered the impact of trained nurses' role modelling on high school students working in the health care environment as those high school students are potential students of the future. They used the KOP scale (1961). According to the results and in contrast to Slevin (1991), the high school students had less favourable attitudes than the trained nurses. When they further examined demographic variables, they claimed that female nurses were more positive than males and that Black, Hispanic and Asian nurses expressed unfavourable attitudes. Lookinland and Anson (1995) put forward the view that increased exposure to ill and infirm older adults increases negative attitudes.

McCracken, Fitzwater, Lockwood and Bjork (1995) compared student nurses' attitudes in Norway with those in the United States of America.(USA) Once again the KOP scale (1961) was used to measure attitudes as well as visual analogue scales, but a qualitative approach was also included in the design. Qualitative data took the form of asking student nurses to write a paragraph relating an important experience with an older adult. Interestingly no significant differences were explicated using the KOP scale (1961). However there were differences between the two groups depending on stage of education where first year student nurses were more positive in Norway than those in the USA although scores for the American students did improve over second and third year. They found no significant differences for age.

2.14 Trained Nurses' Attitudes Toward Older Adults

Sharpe (1995) discusses how ageism is evidenced in the nursing profession through our unwillingness to work with older adults and our lack of desire to specialise within this field. This is accompanied by our acceptance of the ageing process as a state of inevitable decline which justifies our inaction over the provision of treatment and active nursing management to improve the quality of life. Bernard (1998), in an exploratory study, investigated female nurses' views of

their own ageing. Those nurses were asked what they feared most and what they felt they had to look forward to in ageing. The issues most feared, not unexpectedly, were dependency, ill health, loneliness, loss of dignity and looking old. This study confirms the comment by both French (1990) and Bytheway (1995) where a society which supports youth encourages women to fear ageing. Furthermore, the issues most feared are what French (1990) describes as the myths of ageing and as such are phenomena of ageism. Interestingly those nurses who dreaded ageing are interpreting it from an ageist stance. Although, some of the nurses felt that there was nothing to look forward to in growing old, others saw time and freedom and the opportunity to be oneself as advantages to ageing.

Penner, Ludenia and Meads (1984), hypothesised that negative attitudes developed through nurses' experiences with older adults. They drew their 58 respondents from a nursing home, although they do not indicate their grades. They used three different scales including the KOP scale (1961) and FAQ (1977). They were trying to evaluate attitudes towards three groups of older persons, including older people in general, older patients and the types of patients they cared for. Their findings suggest that their sample was significantly more negative towards their own patients as opposed to an older patient or an older person. However it is not clear how they managed to distinguish between the attitudes of trained nurses towards the three groups of older people other than using three questionnaires. This study also suggested that younger, less experienced nursing staff were most likely to hold the negative stereotypes.

Brower (1985) studied the relationship between nurses' educational level, age and the extent to which they worked with older adults. The KOP scale (1961) was used on a sample of 581 trained nurses from different health care settings. According to findings, there were no significant effects for age, although older nurses under certain favourable conditions i.e. working in nursing homes were more positive than those older nurses with a higher level of education. Level of education had no effect among the younger nurses. A second main effect was that nurses who

spent a high percentage of their time with older adults had less favourable attitudes.

Tierney, Lewis and Vallis (1998) studied the knowledge and attitudes of nurses working in an acute ward with an orthopaedic specialty where the patients are predominantly in the older age group and usually account for approximately 70% of the admissions in one year. They used the KOP scale (1961) and a modified FAQ (1977). They sampled four orthopaedic centres in Scotland with a return rate of 71.9% for their questionnaires. Results suggest that, where there is gerontological input, knowledge scores are higher than those without this input. Gerontological input took the form of a gerontological medical specialist attached to the ward. Attitude scores were generally high and there was no significant association for gender and age. Finally, there was a link between higher levels of nursing qualification and knowledge.

Meyer, Bridges and Spilsbury (1999) investigated the specific needs of older adults in an Accident and Emergency department. They found that negative attitudes were related to unplanned and poorly delivered care for older people. The conclusion which can be drawn from the above studies, is that negative attitudes toward older adults does not necessarily occur in care of older adult settings, but are present within any hospital settings where older people are nursed.

2.15 Educational Preparation for Working with Older People

Education itself may have a powerful effect on the quality of care for older adults through issues such as decision making, viewing older patients holistically and promoting independence. Wade (1999) suggests that knowledge may be important in fostering positive attitudes and advocates that gerontology is built across the curriculum with a focus on self actualisation and independence. Edwards and Forster (1998) suggest that there is a lack of educational preparation for registered nurses as well as for all other groups of nurses and this may be enforcing the message that this speciality does not require appropriately trained nurses. Fielding (1986) when examining the gerontological content of the nursing programme in

her study, describes how lecture content was based on a decremental model of ageing where there was an emphasis on physical and mental deterioration. Wade (1999) suggests many years later that while societal views and stereotypes tend to shape attitudes, the process of education tends to consolidate rather than dispel ageism. The theories underpinning the care of older adults are incorporated into the adult programme so that the speciality has no identity of its own. Knowledge and skills to look after older adults have effectively been lost so that qualified staff are ill equipped to provide for the care needs of this group (Wade, 1999). MacDowell et al (1999) investigated the influence of gerontological input for both nurses who gave direct care and for workers who did not such as support staff and managers. They used the KOP scale (1961) and FAQ (1977). They found that their hypothesis where a gerontological educational programme would have a positive effect on both knowledge and attitudes was accepted, however the negative scores for the KOP scale had significantly improved whereas the positive scores had become more negative. Although the hypothesis can be accepted, the important issue is that gerontological educational preparation does have an effect.

Sheffler (1995) examined the role of faculty in influencing student nurses' attitudes towards older adults. Once again, a pre and post test design was used where students were evaluated prior to and post a nursing home experience. She hypothesised that there would be a positive relationship between nursing students' attitudes (n=42) and that of the instructors who taught in the clinical setting (n=3). Her findings suggest that faculty members with high scores, that is, more positive attitudes, had the students with the higher scores. However, those results need to be considered carefully with reference to sample size, particularly the clinical instructors.

Angiullo, Whitbourne and Powers (1996) used psychology students to measure change in attitudes and knowledge level after psychology and ageing classes. They were measured at three different times and control groups were considered in the design. There was an increase in positive attitudes over the whole class but no significant differences between the control and experimental groups. They suggest

therefore, that changes in attitudes and knowledge towards ageing can be accounted for through the positive effects of instruction.

Finally, McCracken et al (1995) identified a negative correlation between clinical/lecture time devoted to older adults and attitudes particularly in their American sample. Students in this sample reported that their schools place greater emphasis on gerontological clinical experiences as opposed to classroom learning. Gerontological content was frequently buried under the integrated and clinical learning experiences. Wade (1999) suggests that gerontological input should be taught by teachers who have a demonstrated interest in the subject and also by clinical staff who are equipped to teach.

There seems to be overwhelming evidence to suggest that gerontological content as a component of nurse education is important in shaping the attitudes of student nurses. Nevertheless, there is still an emphasis on the importance of clinical experiences with a lack of consideration as to how this message is being interpreted, in that the skills to look after older adults can be picked up in the wards with little preparation. Furthermore, there is an increasing tendency to use principles to teach nursing and nursing disorders with little acknowledgement of the special requirements for older people. Therefore student nurses will leave nurse education lacking in a basic knowledge concerning the specific needs of older adults.

2.16 The work in the care of older adults setting

The work within care of the older adult has been seen as an influencing factor which has an effect on nurses' attitudes to older adults. Studies have taken two main routes, that of identifying the components which produce the negative attitudes and that of identifying the components that make the care of older adults different from other areas.

The aim of identifying both components is to implement change to increase the popularity of the specialty.

Wade (1999) suggests that the history of continuing care does nothing to enhance the image of looking after older adults with its roots in institutions and its association with the workhouse. She goes on to explain the workload is seen as heavy, with care which is mainly routinised and physical. The reliance on a skill mix which is dependent on less skilled nurses being left to work with highly dependent patients does not enhance the image. This applies to both the acute units as well as the long term units. In the acute units it will be the junior staff who are allocated to the older patients whereas in the care of the older adult units, untrained carers will be looking after highly dependent patients.

Saltmarche, Koldovny and Mitchell (1998) challenge care givers to view older adults as human beings with health care needs rather than diagnoses or problems. Reed (1993) carried out a study among 34 nurses in a number of wards for older adults one of which was long term care. The aim of the study was to investigate the relationship between the physiotherapists and the nurses. However, she found that in the long term care wards, the nursing staff found satisfaction in achieving good geriatric care as opposed to allowing physiotherapists access to the patients. Reed defines good geriatric care as the "labourious and thorough completion of ward routines designed to maintain basic comfort and hygiene." (p. 86)

Consequently it is usually a means of achieving goals through the provision of physical care without necessarily responding to patient's needs. In other words, the patient may well be clean, well fed and toiletted, but lacking in interpersonal or psychological well being (Wade, 1999). Davies (1993) evaluated the influence of role models in the clinical setting with a sample of 6 students. Student nurses' positive perceptions of care provisions were described as; including holistic care; taking a personal interest in the patient, whereas negative perceptions included care which was routinised, rigid, rushed, standardised and imposed. The negative perceptions were viewed as increasing dependence among the patients.

Heiskanen (1988) compared the perceptions of nurses working in two different settings, one in a general hospital and one in the care of older adults. Her sample

consisted of both qualified and unqualified nurses. She does not indicate whether her measure was piloted and checked for reliability and validity. However, she states that her findings indicate that nurses in care of older adult settings found their work more unchallenging than those who worked in the acute clinical settings.

Purseley and Luker (1995) studied nurses who worked in a community setting. The design incorporated both qualitative and quantitative approaches. Nurses were asked to describe an incident in terms of impact on the life and career of the respondent. Interestingly, most of the nurses used a hospital based incident and some of the incidents dated back to their days as students. Nevertheless, the incidents they reported expressed a good deal of frustration towards a system which they felt presented barriers to effective nursing practice. One of the problems was getting through the routine. One of the participants stated that the care of older adults was the place to be avoided once they qualified. Wade (1999) describes how nurses who work with older adults are engulfed with a sense of inferiority where there is little recognition of the specialty and where the skills are considered basic.

Carr and Kazanowski (1994) attempted to identify the factors which caused satisfaction and dissatisfaction in long term care, the rationale being that work could begin in changing factors causing dissatisfaction. Wade (1999) suggests that nurses also need to explicate the skills and attributes required to work with older adults. Indeed, it could be argued that nurses in the care of older adults are carrying out very good work and being innovative in their approaches but they are not advertising their skills or their knowledge. However, Carr and Kazanowski (1994) designed a questionnaire for which they give no account of piloting nor for testing reliability and validity. The questionnaire was distributed to 1000 nurses and 347 completed questionnaires were returned. There is no indication how the data were analysed nor is the significance level given. It is not until further reading that it is evident that the nurses polled did not necessarily work in

long term care and in fact some of the sample did not primarily work with older adults.

The factors which they did identify as causing dissatisfaction in long term care included poor staff cohesiveness, poor staffing, tremendous workload and poor working relationships with the administrators. This list would indicate that it is not the actual work which causes dissatisfaction but staffing issues which can certainly be seen as fairly easily rectified. The participants identified factors which would increase satisfaction as being, firstly, more specialised education which has been identified in the previous section as an important issue. Secondly, strategies to improve the image of long term care were seen as crucial, and, finally, setting about informing people that the care of older adults was challenging. Once again, those factors can be reduced through improved education but there is also a responsibility for nurses who work in long term care as they need to learn to publicise their activities and their innovative practice.

One of the issues which has not been addressed by the above authors is the technological debate. Stevens and Herbert (1997) suggest that nurses are taught to value technology over basic nursing care and this is reinforced by the lack of theoretical content about older adults which gives a thinly veiled message about the low value of working with older adults. Wade (1999) also considers the value placed on high technology through the disease oriented model of care which devalues the skills required for the less acute areas. She goes on to say that if technological care is no longer required then care needs alter and the glamour associated with technical care subsides and the expertise then required to look after older adults is considered inferior.

The literature review thus far has considered the work of writers who have attempted to research factors which may or may not influence attitudes towards older adults, with varying results. However, one factor which has not been explored in any great depth has been the influence of professional socialisation and how this process impacts on nurses' attitudes towards older adults. It is

acknowledged that student nurses may come in to nurse education with society's attitudes towards older adults but the premise of this research is that society's attitudes, that is beginning nurses' attitudes, differs from those of the profession. Consequently, it is worth exploring how the process of clinical practice and education may influence the attitudes and beliefs of student nurses towards older adults in the hospital settings.

2.17 Process of professional socialisation

Philpin (1999) defines professional socialisation as “ the process of internalising the norms, beliefs and values of the professional culture to which students wish admission” (p. 1327) This definition by Philpin reflects the process put forward by du Toit (1995) who describes the process of professional socialisation as the novice entering the school with a set of values which may change during the socialisation process to reflect the values held in high esteem. Bradby (1990) sums it up by describing it as a status passage whereas Holland (1999) describes it as a period of transition where students are learning the roles of the nursing culture. Consequently, students are coming into nursing with one set of concepts and values which are changed in the light of socialisation with a resultant internalisation of those ideas. Once they have internalised the values, beliefs and norms of the occupation, then they can be considered socialised. Holland (1999) defines three transitions which students must go through in order to become a trained nurse including becoming a student nurse, being a student nurse and becoming a trained nurse. Some student nurses come into nursing with unrealistic images of what is involved (Holland, 1999), some of it being based on what they see on television (Kiger, 1993). Indeed, Spouse (2000) describes media portrayals of nurses as stereotypes, concerned with dramatic incidents of care. Some students come in with little knowledge as to what nursing is about (Bradby, 1990). Furthermore, some students enter nursing with preconceived ideas as nursing has always been a career goal. Some have had experience with a sick relative whereas others drift in (Kiger, 1993). Gray and Smith (1999) describe the process of professional socialisation as following a number of discrete stages when examining the diploma level students while Melia (1987) previously used the

apprentice type training to explicate her stages. However there are commonalities across both studies.

2.18 Stages of becoming a nurse

Gray and Smith (1999) called their first stage anticipatory anxiety when students who are going to the ward do not know what to expect. It is described as a momentous event. The next stage Gray and Smith identify as reality hits home where placement expectations do not reflect reality. Embedded within this stage is “fitting in” and “mucking in”. Bradby (1990) defined fitting in as being accepted by colleagues and becoming part of the team whereas Melia defines mucking in as pulling your weight or taking your fair share of the work and Yong (1996) describes it as getting the work done. Students at this stage are rigid in their approach to clinical skills. It is almost as if they require a recipe to follow. This tendency is described as following the rules. (Reutter, Field, Campbell and Day, 1997; Melia, 1987). Students at this stage are therefore unable to practise nursing in a holistic manner and are practising a series of tasks. Compounding this problem is the dichotomy between what the School of Nursing and Midwifery teaches as opposed to how practice is carried out in the clinical areas.

Reutter et al (1997) describes how the dichotomy is manifested. Firstly, students who are following the rules are presented with the first real versus ideal dichotomy where they need to take what they have learnt in the classroom and adapt it, taking consideration of the environment and the patient, while becoming aware of their limited knowledge base. Secondly, they have to come to terms with the realisation that there are more skills to be learned on top of the skills taught in the school. Thirdly, they may learn that what is practised in the clinical areas is not necessarily what is taught in the school. Interestingly, Simpson (1979) identified this problem many years ago yet it remains an ongoing problem, although, Fitzpatrick, While and Roberts (1996) suggest that the ability to discern between less effective behaviours is part of the socialisation process.

Contrary to popular belief, student nurses do not disregard the skills taught in the

school but they may fit in to get through the placement. However they don't give in to the norms and values of the unit but perhaps retain and perhaps reaffirm their concept of what constitutes good nursing practice. (Reutter et al, 1997)

Conversely, Wilson and Startup (1991) suggest that students are aware from the outset that teaching staff and clinical staff expect different performances. Students are under the impression that the school is where the theory is learned, and the clinical areas are where the psychomotor skills are learned. Kiger (1993) found the dichotomy between the school and the clinical areas as understandable, desirable and useful, which if substantiated, makes the perennial discussions about the theory practice gap irrelevant . Furthermore, Kiger (1993) states that students should be credited with the ability to adapt intelligently and safely, an aspect which is seldom recognised. Melia (1987) found that students were quite accepting of the differences between the school and clinical areas. They generally believed the school taught the right way whereas skills needed to be modified due to the time factor in the wards.

The next stage according to Gray and Smith (1999) is becoming branch students, that is, following their chosen programme. This is seen as the time when the real learning occurs. Students are keen to learn technical skills and aspects of care which only staff nurses can deliver (Melia, 1987; Gray and Smith, 1999). Students by this stage are well aware of the hierarchy of skills (Holland, 1999) and are trying to differentiate their role from that of a nursing auxiliary who carries out the so labelled basic nursing skills. (Melia, 1987). This may well be the root cause of the disregard nurses have for the basic nursing skills when they are viewed as being appropriate for delegation to unskilled people, people who require little training to carry out those skills. Nurses have been all too willing to pass those skills to untrained auxiliaries while they do the important work, the technical work, the ward management, the following of the doctors on the ward round.

As nurses advance in their education, they seem to forget that the task of carrying out personal hygiene for the patient involves a number of other skills such as the development of observation skills and assessment skills among many others. If the

argument relating to hierarchical skills, is followed to its natural conclusion in that the “basic nursing skills” are carried out by untrained nurses whereas trained nurses carry out the more technological skills, then areas where the bulk of the work is basic are going to be rejected as valuable learning areas. In other words, the art of nursing is subsumed under high technology. This is an unfortunate by product of turning over skills to unqualified staff as those skills automatically become devalued. This becomes obvious when senior students are more interested in carrying out technological skills to the detriment of the aesthetic skills of nursing. This is confirmed by Melia (1987), who differentiates between nursing work which is the province of the staff nurse and includes teaching and management, from student work. Student work is where they have responsibility for their own work, in other words they are taking on a patient load and organising the care for that group of patients. McBride (2000) describes this hierarchy as unspoken, where the profession values the high action areas, that is those areas with a high level of technological skills.

Philpin (1999) found that the work context was important, specifically in relation to the acute and chronic areas. The acute areas are where the emphasis is on cure, medical dominance and high technological interventions. Those acute areas include operating theatres, surgical areas and high dependency areas. The chronic areas are described as medical and care of older adults wards where the emphasis is on caring centred around nursing interventions. The chronic areas can be considered places where nurses have more autonomy as the medical model is less important and where patients are expected to participate more actively in their own care (Philpin, 1999). However, there is a fundamental problem where student nurses view nursing as being in the surgical wards (Kiger, 1993) and this tendency continues throughout student nurse education. Furthermore, Wilson and Startup (1991) identified in their study how nurses preferred surgical wards over medical wards, demonstrating that nurses prefer high technology nursing as opposed to care centred around nursing interventions.

Students in the study by Melia (1987) described the work in the care of older adults as being more or less the same every day, as just basic nursing care. They did not feel that they were nursing this particular group, rather they were keeping them clean, whereas real nursing was administering injections and doing dressings, in other words, the care carried out in surgical wards. Consequently, the attractiveness of wards as learning areas, relies heavily on the provision of sought after technological skills and student nurses' preferences reflect this hierarchy. Surgical wards are perceived as the most attractive where there is a high turnover of patients who require high technological skills to aid recovery. Lower, in the hierarchy are the medical wards where there is some high technology, but also an emphasis on basic nursing skills. At the base of the hierarchy is the care of older adults where all that may be learnt is basic nursing care. (Melia, 1987) Wilson and Startup (1991) emphasise the importance of good press for an area as that enhances its attractiveness. This is reflected in television programmes where high drama may be seen in a casualty.

Added to the issues of ward context and the hierarchy of skills is the perception that there is a different set of skills to be learnt in a care of older adults area. Philpin (1999) puts forward the view that students are encouraged to develop interpersonal skills as well as a greater knowledge of biological and social sciences in the care of older adults unit, whereas in the acute areas they are more likely to be picked on if they failed to conform to the area's norms. Philpin further reiterates the view put forward by Reutter et al (1997) that patient communication and interaction is the essence of nursing.

Interestingly, Caris-Verhallen, de Gruijter, Kerkstra and Bensing (1999) reported, in their study, that nurses with positive attitudes towards older adults are more likely to pay attention to psycho-social items and use more effective communication than those nurses with less positive attitudes. However communication skills can sometimes be seen as common sense skills which any good nurse can learn as they go through their education just as there is the idea that nurses who come in to nursing are "naturally caring". Both concepts require

education but there is such an emphasis on learning technical skills that interpersonal skills are treated arbitrarily. Places where communication skills can be practised include the care of older adults areas. However, there may be a more task oriented approach to the organisation of the workload due to staff shortages and this impacts on the quality of interpersonal skills. Kiger (1993) quotes a student who describes psycho-geriatrics as leaving your brain and your sense of humour at the door, going in to do your work and going home again. There is no discussion as to why the student expressed this sentiment but descriptions like this may result from the organisation of the workload especially where the workload is heavy and the work, monotonous (Melia, 1987).

A final strand of professional socialisation, identified by Simpson (1979) is the influence of the role model. She describes role models as not serving the major influence that they are given credit for. However, Simpson is the only dissenting voice as most authors who consider the influence of the role model describe it as important for the internalisation of occupational norms. Campbell, Larivee, Field, Day and Reutter (1994) describe how students have their own images of what a good role model should be like and how they take what they perceive as positive qualities from a number of role models as they develop their own image of nursing. Most nurses will be able to look back on their career and remember the nurses whom they wished to emulate and those whose behaviour appalled and outraged them.

Buckenham (1998) states that role models are important agents in the simultaneous processes of interaction and learning whereas Fitzpatrick et al (1996) describe the nurses in the clinical setting as the key people in the professional development of students. Other key players in the socialisation process who are not readily acknowledged are other student nurses. Wilson and Startup (1991) describe how student nurses gain support from each other. This is supported by anecdotal evidence where student nurses are well able to identify wards where they are allowed to carry out tasks and where the ward staff are helpful and supportive but they are also able to identify the wards where there is a

lack of interest in the student. This information is passed from student to student in a very efficient manner so that most wards and clinical settings will have a label as a good ward or indeed a bad ward.

The concepts of attitudes and professional socialisation have been examined in detail with reference to clinical nurses and students as well as people out with nursing. A number of measures have been used to explicate people's attitudes towards older adults. Therefore it is appropriate that those measures are considered in some depth.

2.19 Critique of the Commonly Used Measures

The most commonly used measures to quantitatively evaluate attitudes and stereotypes have been Tuckman and Lorge (1953) Attitudes to Older People (Gomez et al, 1985); Kogan (1961) Old People's Scale (KOP) (McDowell et al, 1999; Heliker et al, 1993); and Palmore's (1977) Facts on Ageing Quiz, (FAQ) (McDowell et al, 1999).

Tuckman and Lorge (1953) were the first to put a questionnaire together to measure attitudes towards older adults. They developed their measure through, as they described, "fairly unstructured interviews" (p.249) with fifteen adults ranging from 21 to 65 years in age by discussions with social workers and directors of institutions for older adults; by reading case notes of older clients. The measure consists of 137 statements divided among nine categories and utilising a straight yes/no format with mixture of factual and attitudinal items. The length of the questionnaire may well have an impact on the numbers of returns as it would be time consuming to complete (Kogan, 1979; Palmore, 1977). They acknowledge that while some of their statements are valid others lack evidence of validity. It is difficult to justify the use of some of the statements or to hazard a guess as to their purpose, for example, statement 99 is "They avoid going out in bad weather" (p. 253). This would seem to be a sensible precaution, not necessarily confined to older adults so how does it constitute an attitude?. Tuckman and Lorge (1953) admit that they avoided difficult questions or

statements which might discourage people from completing the questionnaire and the examples they gave were sexual irregularities which they do not define and criminal activities.

Kogan (1961) critiqued the Tuckman and Lorge (1953) scale for including beliefs which were difficult to imagine a positive or negative disposition, the example cited is “they worry about financial security.” (p. 153). Palmore (1977) commented on the lack of documentation to support the factual statements, thereby relying totally on the authors’ contention that the statements were true or false.

Kogan (1961) sought to add to the body of knowledge relating to attitudes to older adults having described the measure by Tuckman and Lorge (1953) as “a heterogeneous collection of belief and attitude statements”(p.14) His aim was to develop a Likert scale to facilitate the study of attitudes towards older people with respect both to norms and individual differences. He linked the development of the questionnaire to the notion of older adults being assigned the status of minority group. Consequently, his questionnaire was developed from items in ethnic minority measures where the words old were substituted. Other statements were derived from the author’s and others’ intuitions relating to older people in society. However, on examination of his statements, some are double barrelled, for example “Most old people spend too much time prying into the affairs of others and giving unsought advice”. (p. 46) Palmore (1977) critiqued the tool for its ambiguous terminology and the example he cites is the use of the word most. Kogan (1961) suggests that although his questionnaire was designed to evaluate society’s attitudes towards older adults, that it may well be considered appropriate for use in nursing settings.

However Slevin (1991) states that the lack of a caring dimension makes it difficult to use in this context. Nurses interact with older adults under specific conditions where they are in hospital for whatever reason. Consequently, consideration must be given to the contextual impact on nurses’ attitudes.

Palmore (1977) developed the Facts on Ageing Quiz (FAQ) after critiquing the measured developed by Tuckman and Lorge (1953) and Kogan (1961). His aim was to produce a short questionnaire confined to factual statements which can be evidenced by research. It was designed to cover basic physical, mental and social facts as well as the most common misperceptions. He does not discuss the development of the questionnaire. Palmore (1977) also put forward a number of purposes for the questionnaire including the indirect measurement of bias. Interestingly, he identifies 16 items from 25 which may be considered to measure negative bias if answered incorrectly but only 5 items which would measure positive bias under similar criteria. Furthermore, there remains 4 statements which have no bias including "In general most old people are pretty much alike" (p. 315) This statement would have a negative bias if it was answered as true as the implication would be that older adults as a group are viewed homogeneously. However, when viewing the numbers of statements with a negative bias and the numbers with a positive bias, it could be argued that the questionnaire has an inherent negativity. Palmore (1980) claimed that the FAQ was only ever an indirect measure of attitudes and consequently may be less accurate than direct measures of attitudes. Miller and Dodder (1980) challenge Palmore (1977) for using the word "most" in his FAQ, the self same criticism that Palmore had levelled at Kogan's (1961) questionnaire. They also mention that Palmore had used *double barrelled items* in the questionnaire.

For all their problems the three questionnaires have been used extensively in attitudinal research and certainly within nursing research. To summarise, then, the problems associated with the above measures include the advanced age of the measures; the cultural specificity of terminology used; the ambiguity in the construction of some of the statements. However, the main reason for rejecting the above measures is that they were designed to measure the attitudes of people within society. Few studies on nurses' attitudes have acknowledged that they have a unique relationship with older adults when compared with wider society as much of their work is attending to ill older adults. Consequently, the measures discussed are unsuitable for this study as it has been argued that student nurses

come into nurse education with society's view of older people, but through contact with clinical staff and lecturing staff, they develop similar attitudes to those of staff towards older adults. The attitudes developed by those in the profession are in response to the particular context in which they meet older people, thus they are peculiar to the profession. For the reasons discussed, it was important to develop a measure which would acknowledge the context of nurses' work with older people

The design of the research follows two phases, that of a qualitative phase and a quantitative phase. Consequently, the rationale for triangulation is discussed in the next section

2.20 Methodological Triangulation

Oppenheim (1992) describes how it is all too easy to impose a pre-conceived framework to measure attitudes, but this can result in unintentionally measuring the wrong attitude. He recommends a series of in depth interviews to decide more precisely what it is we wish to measure. He is therefore advocating the use of methodological triangulation.

However, it is worth considering whether attitudes should be evaluated quantitatively or qualitatively, whether one method is more appropriate than the other, or indeed do the methods compliment each other? There are difficulties in conceptualising attitudes as either relatively enduring psychological phenomena or as situationally transitory aspects of experience. If they are enduring psychological phenomena, they are in some sense quantifiable. However if they are transitory, then this will make them much more difficult to quantify, thus they may be more identifiable qualitatively. It has been argued that attitudes are internally consistent structures (Eiser, 1987) in other words stable, although they are context dependent (Oppenheim, 1992; Rokeach, 1972). Newcomb (1964) sums up the dilemma when he states that attitudes are enduring in the sense that we take some particles from a previous situation, but we acquire new particles through our experiences of new situations. In other words we carry attitudes with

us and add to them as we move on to other situations. This research is based on the argument put forward by Newcomb (1964) as the qualitative phase determines the situation specific phenomena whereas the quantitative phase evaluates the stability of those phenomena. The qualitative approach in the form of focus group interviews are used to identify the most appropriate items for the questionnaire, thus explicating attitudes qualitatively. The questionnaire is then constructed using a quantitative format. This is discussed in more detail when the construction of the questionnaire is considered.

There has been a great deal of debate regarding the epistemological, ontological and methodological differences between the rationalistic and the naturalistic paradigm. (Lincoln and Guba, 1985). Authors continue to be divided over the utility and the necessity of combining the two paradigms in research. Consequently, triangulating qualitative and quantitative methods remains an anathema to some writers whereas other writers accept that there are epistemological, ontological and methodological differences, but the outcomes of the research may well be similar as are some of the processes to achieve the outcomes. The following discussion provides an overview of the issues raised relating to triangulation of methods and are grounded in an exploration of the arguments put forward by writers relating to the qualitative versus quantitative debate. Kimchi, Plivka and Stevenson (1991) describe methods triangulation as the use of two or more research methods at the level of design or data collection.

Dootson (1995) describes the rationalistic and naturalistic paradigms as two world views where quantitative research lends itself to the rationalistic paradigm whereas qualitative research lends itself to the naturalistic paradigm. Leininger (1994) argues against mixing the paradigms as they have different goals, different uses of research methods and the need for different criteria to fit with each paradigm. She describes their mix as violating the intent and the philosophic purposes of the research. However, it can be argued that a relatively large amount of research does not adhere to the principles underlying the paradigms, for instance how much quantitative research incorporates random samples and

manipulation? Most of the studies described in the literature review do not adhere to those principles. Corner (1991) identifies how studies do not adhere to the purist letter of their paradigm and she cites as an example the use of words such as frequency, proportion and others which are slipped into qualitative studies thus implying some sort of measurement.

Morse (1991) takes a middle course between the separatists and the combinationists. Her argument is that when there are both qualitative and quantitative aspects in a research project then they cannot be weighted equally, rather it must be driven quantitatively or qualitatively with complementary input from the secondary approach. She argues that each aspect must be complete in itself and blending of the methods comes not from complementary philosophical approaches, nor the infeasible merging of numerical and textual data but from fitting the results into a coherent and cohesive outcome or theory, or confirming or revising existing theory. While Morse (1991) does acknowledge the two paradigms, she advocates a separatist approach within the research.

In direct contrast to Morse (1991), Myers and Haase (1989) argue that each approach should be valued equally and both subjective and objective data should be recognised as legitimate avenues for gaining understanding. Furthermore, the task becomes one of integrating the understanding of data from various sources. They are thus advocating that no one method is better than the other and the task of triangulated research is therefore to bring the results together in a comprehensive format.

Furthermore, Dzurec and Abraham, (1993) argue that the dichotomy between the paradigms should be rejected as the distinctions between them serves little purpose and limits nursing knowledge as the nature of the inquiry itself bring the two traditions together. Myers and Hause (1989) describe the integration of the approaches as inevitable and essential in furthering nursing science. Dzurec and Abraham (1993) identify a number of similarities between the two methods based specifically at the level of research outcome and related to; the findings; the

interpretation of validity and reliability; the generalisability issues; the use of data reduction. They also suggest that there are other commonalities which are relevant and integratively link qualitative and quantitative inquiry. (Please see Dzurec and Abraham (1993 for more detail)

There are a number of reasons why combining research methods enhance the project. Although Begley (1996) states that triangulation may be taken to represent the positivist view, as there is an inherent assumption that there is one single reality, data collection using both methods may well provide a complementary picture. Cowman (1993) further explains that the combination of dissimilar methods provides the opportunity to counterbalance the weakness of one method with the strength of another. DeVries, Weijts, Dijkstra and Kok (1992) use the word synergy to describe the combination of approaches in that the outcome of the combination is greater than the effects of the two used separately. Begley (1996) describes the aims of triangulation as completeness and confirmation of data. Brietmayer, Ayres and Knafl (1993) define triangulation for completeness as revealing multiple dimensions of an area of interest which can capture a contextual portrayal of the participants of the research. Analysis for confirmation arises from the convergence of the two measures. Banik (1993) argues that the purpose of triangulation is to answer research questions or to test hypotheses in the most effective way. Using multiple methods to explicate phenomena and discover different aspects assists in the validation of study findings, lends empirical support to the data and may contribute to convergent validity. Steckler, McLeroy, Goodman, Bird and McCormick (1992) believe that the adoption of mixed methods are usually a pragmatic decision and their application will help properly understand or evaluate complex phenomena.

The rationale for utilising methodological triangulation was governed by the need to identify the phenomena which encapsulated nurses' views and attitudes of older adults. This was completed by using the qualities of qualitative research which include the elicitation of individual and group constructions through interactions whilst acknowledging the subjectivity of the researcher. Whereas the quantitative

phase was aimed at evaluating the generalisability and stability of the attitudes and views identified through the focus group interviews whilst incorporating a more objective approach.

2.21 Conclusion to the chapter

There still seems to be a lack of clarity as to the components of an attitude and their role in predicting or determining behaviour, although there seems to be no doubt as to their acquisition. Beliefs are considered to be a component of attitudes. Furthermore, stereotypes are beliefs about a group. The acquisition of attitudes and beliefs are important to this research as it is postulated that student nurses' beliefs and attitudes towards older adults are influenced by their contact with trained nurses and lecturing staff, in other words through the professional socialisation process. It has been argued that student nurses enter the profession with the beliefs and attitudes developed through primary and secondary socialisation and then take on the beliefs and attitudes of the profession. The negative beliefs and attitudes result in older adults bearing the effects of ageism where they may be denied good quality nursing care or the necessary treatments to maintain or attain a satisfactory life. It is the seeming link between attitudes and beliefs with that of professional socialisation which has guided the literature review.

A number of studies have examined student nurses' attitudes, but most studies have adopted measures which are designed to be used in the wider society. It is suggested that those measures are inappropriate for evaluating nurses' attitudes for two main reasons. Firstly, the utility of the well established measures has been considered as has their wording and the purported aims of the questionnaires. Secondly, nurses meet many older adults under unique and different circumstances from society, in that they are meeting older adults when they are ill or have a health problem, and this in itself is thought to influence their attitudes and beliefs. Studies have attempted to identify whether this does have an effect on student attitudes and beliefs with varying results. There has been little qualitative work carried out in this area with some notable exceptions (Fielding, 1986).

Studies have considered the relevance of trained nurses' attitudes towards older adults in both the acute setting as well as the care of older adult setting while other studies have investigated the role of educational preparation and also the apparent unpopularity of the work in care of the older adult.

It is evident, throughout the literature review, that there has been a fair amount of work carried out on attitudes towards older adults, whether the work has been examining student and trained nurses, or other members of the multidisciplinary team. However, there is a lack of consensus with reference to the results. This may be due to flaws within the research or indeed the use of inappropriate measures. Few studies have used methodological triangulation to gain an insight into the attitudes and beliefs of nurses towards older adults, and this may have further contributed to the lack of consensus.

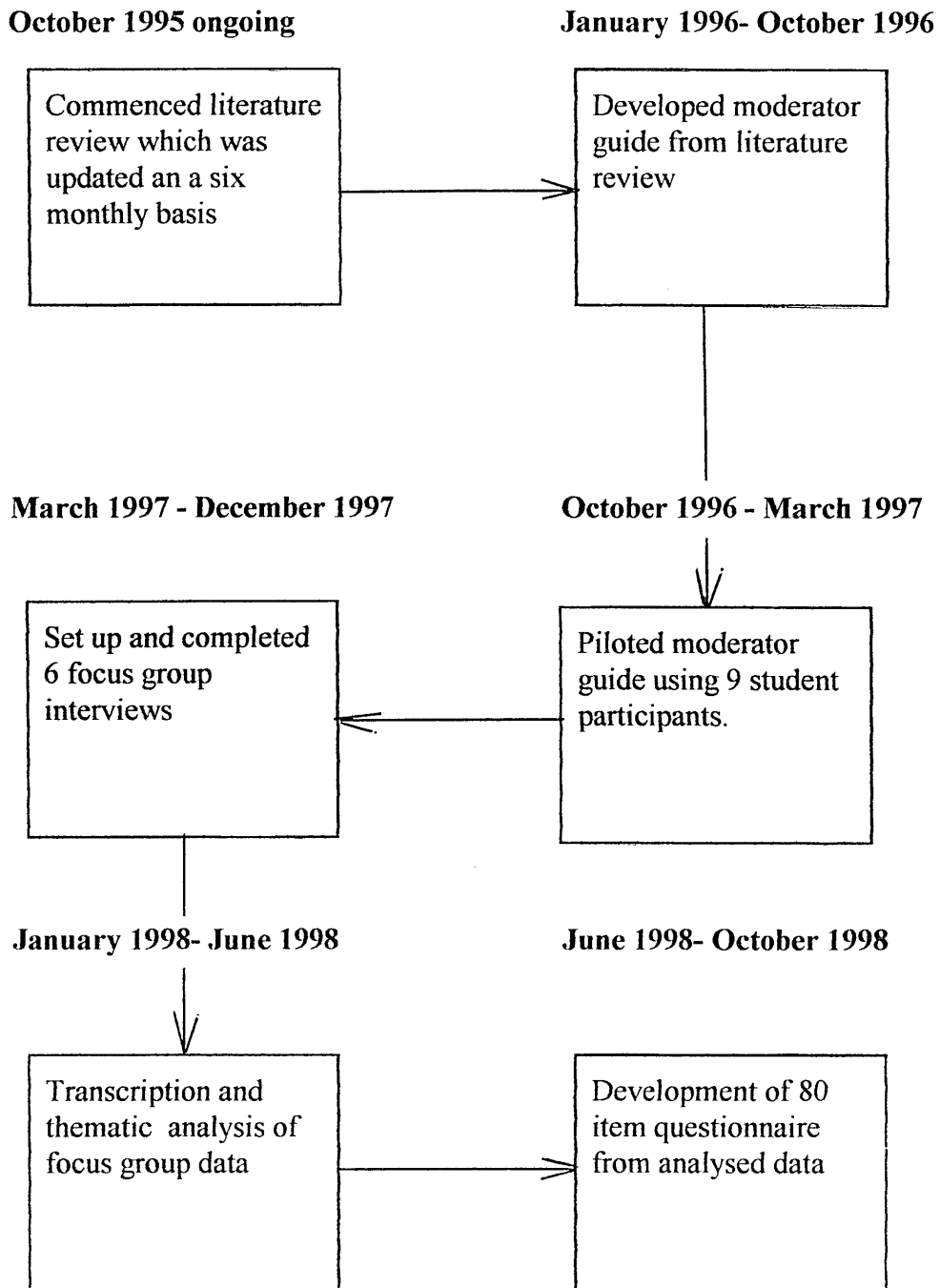
SECTION 2

STUDY DESIGN PHASE I

QUALITATIVE ANALYSIS

DEVELOPMENT OF THE QUESTIONNAIRE

**Fig 3.1 Overview of Study Design Phase I
(Qualitative phase)**



Chapter 3: Study Design Phase I

3.1 Introduction

Focus group interviews were used to collect qualitative data from nurses working in a variety of clinical settings, student nurses and nursing lecturers. This chapter explores the utility of focus groups as a qualitative strategy, through examining the literature. The literature pertaining to this method is ambiguous in relation to the size, constitution and execution of focus groups. This ambiguity is considered in the following sections. The chapter then concludes with a discussion about the operationalisation of the focus group strategy.

3.2 Defining Focus Groups

Carey (1994) describes the definition of the focus group technique as imprecise. However, she goes on to define it as “using a semi structured group session, moderated by a group leader, held in an informal setting, with the purpose of collecting information on a designated topic”(p. 226) Furthermore Kitzinger (1996) explains the ethos of focus groups by describing them as a form of group interview which capitalises on communication between research participants in order to generate data. This emphasis on interaction is reiterated by Morgan (1996) who then goes on to identify the three major components of focus group research as being, firstly, a method devoted to data collection, secondly, interaction as the source of data and finally acknowledgement of the active role of the researcher in creating the group discussion for data collection. The link between the essential components put forward by Morgan (1996) can readily be identified in Carey’s (1994) definition. Morgan (1996) goes on to state that his definition precludes other groups whose purpose is not research and interestingly where no one acts as interviewer.

Merton, Fiske and Kendall (1990) describe the purposeful use of group interaction as data which distinguishes them from other groups. The focussed nature of the activity also distinguishes them from other groups (Kitzinger, 1994).

Basch (1987) conceptualises focus groups as grounded within qualitative research. Therefore they do not necessarily reflect the strength of feelings or opinions which he states would be usefully followed up using more quantitative methods. Thus focus groups are useful in determining attitudes and opinions qualitatively whereas the data gathered can be quantified in questionnaires. The important elements of focus groups would be considered as the focussed nature of the discussion, using an appropriate but not necessarily representative sample who would explore the “whys and wherefores” of the topic with guidance from a moderator.

3.3 Types of focus groups.

Calder (1977) describes focus groups according to the type of knowledge they generate. He labels knowledge as everyday knowledge and scientific knowledge. The everyday knowledge stems from the terms and language people use to give meaning to their everyday world, whereas the scientific knowledge is where numerical measurement is used to test constructs and hypotheses. He therefore is quite clearly stating that everyday knowledge cannot be considered scientific. Those concepts are embedded in his descriptions of the types of focus groups he puts forward. They can be exploratory where their purpose is to generate hypotheses. They can be used to identify constructs prior to a quantitative approach and are labelled pre scientific. They can be clinical groups which he describes as an approach which attempts to conduct qualitative research as a scientific endeavour and is therefore labelled quasi scientific. The justification for this stance is that clinical judgement is used. This is considered to be a starting point which has been developed from scientifically valid theory where they are providing insights into people’s unconscious motivations. Finally, they can be phenomenological in that they give access to people’s common sense conceptions and everyday explanations, therefore they depend on collecting data which are everyday knowledge. Wilkinson (1998) uses an inclusive definition of phenomenology when referring to focus groups so that a wide variety of types of research are encompassed within it. As well as people’s own experiences, meanings and understandings, she includes the individual’s attitudes, opinions,

knowledge and beliefs as subsets of phenomenology. The rationale for this is that the researcher is trying to extract the participant's understanding of the issues under question. However Webb and Kerven (2001) call into question the compatibility of focus groups within a phenomenological framework.

Furthermore they state that the group context does not allow data to be gathered in an uncontaminated way. In other words they are suggesting that the group context contaminates the data thus it does not conform to a phenomenological philosophy. However, they present no supporting evidence to substantiate this claim. Calder (1977) goes on to state that the goals of the research will dictate how the group is conducted and the data is interpreted. The implications from the literature are therefore that focus group interviews are useful according to the objectives of the research.

3.4 Uses of focus groups

Focus group techniques, according to Morgan (1988) and Gray- Vickrey (1993) have been borrowed from marketing research and incorporated into social sciences and latterly into nursing research. However Powell, Single and Lloyd (1996) quote Bogardus as being the originator in 1926. He wrote about them as a technique for understanding people's attitudes and opinions about different social issues whether it was race relations or attitudes to what he describes as motion pictures (Bogardus, 1926). However, both Krueger (1994) and Carey (1994) credit the work of Merton et al in the 1940's as influencing their upsurge in popularity (Merton et al, 1990)

Within nursing, the research projects using focus groups have been many and varied, crossing different spheres of nursing and nurse education. Gray -Vickrey (1993) promotes the utility of focus groups within gerontological nursing and also as a method of collecting data from visually impaired older adults, therefore she is suggesting that it can be used for both nurses and client groups. Carey (1994) describes how they can be used to explore beliefs and attitudes towards AIDS. Powell et al (1996) used focus groups to enhance the validity of mental health questionnaires and Miller, Maggs, Warner and Whale (1996) used focus groups to

evaluate both nurses and users as to the levels of satisfaction with health services.

Not only are the uses of focus groups multifarious in their range of topics and their participant groups, they also lack homogeneity in how and the purposes for which they are organised. Consequently, focus groups interviews have not always been confined to research, although, Morgan (1996) would preclude all those which do not have a research purpose. Macintosh (1993) used focus groups as a teaching strategy, organised through teleconferencing and distance learning, the stated purpose being to explore issues and maintain maximum participation in class. McKinley, Manku-Scott, Hastings, French and Baker (1997) used two focus groups to develop a questionnaire to evaluate patient satisfaction with out of hours primary care. Miller et al (1996) used focus groups in a novel way in that the groups met on three separate occasions with the express purpose of allowing each group to challenge ideas from the other three groups to gain consensus for a project. Finally Howard, Hubelbank and Moore (1989) used only one focus group with four participants to evaluate student performance after graduation.

3.5 Purposes of focus groups

There are a number of reasons for using focus groups including the development of a new measuring instrument (McKinley et al, 1997; Gray -Vickrey, 1993) and the enhancement of the validity of questionnaires (Powell et al, 1996). Powell et al further explain the uses of focus groups as being, firstly, they pay explicit attention to the consumers rather than the professionals with the consumer being regarded as the expert. Secondly, they depend on dynamic interaction to derive information sought (Kitzinger, 1996) and, thirdly, they provide greater insights into attitudes, beliefs and opinions (Carey, 1994). Kitzinger (1996) goes on to explain the essence of focus groups. She describes the use of group interaction as part of the method where people are encouraged to talk with each other. Furthermore, they allow participants to explore issues of importance to them, using their own vocabulary. She describes focus groups “as reaching the parts that other methods cannot reach” (p.37). However she does identify a disadvantage in that they can silence individual voices of dissent.

Morgan (1996) identifies one of the uses of focus groups as combining them with surveys in that they can be used to design the content of questionnaires. However Morgan does acknowledge that this particular aspect is lacking in systematic publications. Krueger (1994) sounds a warning when he lists the misuses of focus groups where they may be used to improve morale by providing feelings of involvement where the impression is given that the organisation is listening where in fact they are giving the impression of listening without actually doing so.

Hughes and Dumont (1993) state that focus groups are particularly useful for reflecting the social realities of a cultural group through direct access to language and concepts which structure participants' experiences. Morgan (1996) points out that focus groups are neither as strong as participant observation in their ability to observe phenomena in their own settings nor as strong as in-depth individual interviews in providing a rich understanding of participants' knowledge but they are better at combining those two goals than either technique alone.

3.6 Focus Groups Versus Individual Interviews

Rubin and Rubin (1995), identify that participants in a group spark off each other and enrich the generation of data. However, Fern (1982) in his research identified that single interviews generated more ideas than group interviews. This was not comparable with Thomas, Macmillan, McColl, Hale and Bond (1995) who investigated the utility of both methods and stated that certain concepts were more likely to be raised through group interaction when compared with single interviews. However, they do state that the information was not any deeper or richer. (Thomas et al, 1995) White and Thomson (1995) state that focus groups provide a synergy which is not found in individual interviews.

A pragmatic reason for the use of focus groups also lies in the seeming reduction in the amount of time interviewing thirty individuals as opposed to six groups. However, focus groups are not the quick and easy option (Reed and Payton, 1997) eschewed by some authors but are difficult to arrange specifically around nurses' off duty which includes night shifts and days off. They also have a high drop out

rate where people have agreed to come but simply do not arrive and so researchers are put in a position where they must over recruit to meet the minimum sample size which constitutes a group.

3.7 Group and sample size

Greenbaum (1988) identifies three different types of focus groups which he goes on to describe as full groups where there are ten to twelve people, mini groups where there are four to six participants and telephone groups who are linked by conferencing facilities. However, Greenbaum (1988) looks at focus groups and their role in research very much from a marketing stance. Fern (1982) investigated how sample size influenced the focus group discussion. He used a sample size of four and one of eight. His results indicated that a focus group of four generated less concepts than a group of eight. This is diametrically opposed by Morgan (1996) who comments that smaller groups are easier to manage from a moderator stance especially if the topics are highly charged and there is much discussion. Carey (1994) reinforces this view when she states that the less people there are in the group, the increased likelihood that people will interact, again iterating the ease by which moderators can manage and attend to the group. However she does state that smaller focus groups can be more labour intensive.

However information about group sizes in the literature remain variable where some authors advise from six to ten people (Howard et al, 1989) or between four and eight (Kitzinger, 1996) or indeed four and five (Twinn, 1998). Merton et al (1990) however put forward this advice when they state that the size of the groups should be governed by the following considerations, it should not be so large “as to be unwieldy or to preclude adequate participation by most members nor should it be so small that it fails to provide substantially greater coverage than that of an interview with one individual. “ (p.137). They go on to recommend groups of twelve to fifteen or as many as fifteen to twenty participants.

Homogeneity has been discussed by a number of different authors. Carey (1994) recommends that focus groups should be homogeneous for age, status, class,

occupation and characteristics as they will have an influence on whether participants interact with each other. She also states that they should be strangers. However work by Fern (1982) states that there are only slight differences when comparing homogeneous and non homogeneous groups and the differences do not uphold the maintenance of homogeneity. Calder (1977) purports that the purpose of the group should dictate the homogeneity and he goes on to recommend that exploratory research should use heterogeneous groups as they may produce rich information whereas homogeneous groups may be used to facilitate rapport. Some authors such as MacIntosh (1993) do not appear to consider these issues as her focus groups were made up of people who attended her course on different teleconferencing sites while others such as Powell et al (1996) reject the use of homogeneity and the use of strangers for both pragmatic and ideological reasons, where pragmatic reasons include the limitations of time and available resources while ideologically pre-formed groups are more likely to offer a supportive environment conducive to open discussion as they are more likely to be groups of friends.

3.8 The number of focus groups

Millward (1995) states that data generated after about ten sessions is largely redundant whereas Krueger (1994) suggests that the minimum may be three and the maximum twelve. However he recommends that focus groups are conducted several times with similar types of participants. Nyamathi and Shuler (1990) state that four focus groups are sufficient but consideration of response saturation is made after the third interview. Finally Stewart and Shamdasani (1990) suggest that there are no general rules as to the optimal number of focus groups. They put forward the rationale of working out the number of groups resting on the homogeneity of the potential population, and the ease of research application. Furthermore, they suggest that one focus group may well be enough. (Stewart and Shamdasani, 1990).

Kitzinger (1994) claimed to have completed the largest number of group interviews at the time by carrying out 52 group interviews. Her justification for

this was the many types of people who were involved in the issues of AIDS. However, external influences such as costs in terms of time and resources often dictate the numbers of focus groups. This was demonstrated by Howard et al (1989) whose reason for carrying out one focus group interview was difficulty in arranging mutually convenient times for focus group discussions.

3.9 Role of the Moderator

Moderator effect has been considered by Fern (1982) who compared moderated groups with unmoderated groups. His findings suggest that there are no differences between the two. However, Agar and Macdonald (1995) warn that moderator control has an important effect on the quality of group discussion in that too much control can prevent discussion whereas too little control can result in the topic not being discussed. This warning is echoed by Morgan (1996) who states that the discussion may focus on the interests of the researcher not the participants and he goes on to elaborate by stating that too many questions on the moderator guide may indicate this phenomenon. Fern (1982) suggests that perceived differences are more likely to be linked to the inhibiting effects of group interaction.

Basch (1987) describes the role of the moderator as “the instrument where they create a non threatening supportive climate that encourages all participants to share views; facilitating interaction among members; interjecting probing comments, transitional questions and summaries without interfering too brusquely with the dialogue; covering important topics and questions while relying on judgements to abandon aspects of the outline, noting non verbal responses.” (P.415)

A decision has to be made as to who will take the role of moderator. Carey (1994) states that the researcher is not always the best person to moderate as they may not necessarily have moderator skills. However Millward (1995) states that it is useful for the moderator to be directly involved in the project because they are

sensitive to the issues and the need for methodological rigour even if their group management skills are not especially polished.

Millward (1995) identifies four types of moderator style relating to content and process which dictate the relative structure of the interviews where high control of content and process lead to a highly structured interview, more suited to a one to one interview, whereas the final type is least structured where there is low control of content and process. This is characterised by a self managed group. Millward (1995) goes on to suggest that the most appropriate type for the focus group is low control and high process where control over content is minimal but the moderator ensures all relevant issues are covered in depth. This moderator style was incorporated into the research strategy, however group dynamics dictate how well this can be adhered to as there is a tendency to move to a more didactic style when the group are not discussing issues with each other but through the moderator.

3.10 Interview Guide

The purpose of the interview guide is to direct the group discussion and to stimulate conversation about the research topic as well as to ensure all the desired information is covered (Dilorio, Hockenberry- Eaton, Maibach and Rivero, 1994) Principles in developing the questions are put forward by Kingry, Tiedje and Friedman (1990) who suggest that questions should move from general to specific and non threatening to more threatening, the purpose being, to encourage participation from all members of the group at the start of the interview. However the interview questions act only as a guide and the moderator may ask other questions or use comments as necessary to stimulate and focus discussion.

3.11 Data collection

There are inherent difficulties in recording information using video and audio equipment although the benefits can outweigh the difficulties. Polgar and Thomas (1995) describe the advantage of video recording as useful for gathering non verbal plus verbal data. However Bottorff (1994) warns that microphones may not

pick up all verbal behaviour nor does it record gross body movements. Participants may refuse to speak in the presence of the camera or sanitise their views so that there is a lack of true representation of feelings and this may hold true also for audio recording (Polgar and Thomas, 1995). The real advantage of both video and audio recording is that they act as validity checks in that raw data are available for scrutiny (Polgar and Thomas, 1995). Furthermore, the provision of data may serve a range of analytical interests. They also allow events to be reviewed as often as is desirable or necessary (Boltorff, 1994). Mwanga, Mugashe, Magnussen, Gabone and Aagaard-Hansen (1998) who used a video recorder in their focus group study, explain that, occasionally, the participants refer to the presence of the camera especially when it involves the use of swear words or crude references to body parts. However, participants seem to relax and ignore the camera once the interview is underway.

3.12 The ambiguities of focus group research.

The main problem with using focus groups is their relative lack of consistency in make up and content. This is supported by Fern (1982) who states that there is nothing sacred or necessarily correct about the current way of carrying out this type of research. This echoes Calder (1977) who describes a “vague sense of uneasiness” (p.353) with the focus group technique. Interestingly, Calder puts forward a number of questions concerning the design of focus groups which twenty years later remain unsatisfactorily answered. Those concerns include, the numbers of groups which should make up a project; the importance of heterogeneity versus homogeneity; the importance of the moderator as an influencing factor. One could argue that this concern with regard to the method may be labelled by others as the need for rules as identified by Burrows (1998) who describes novice researchers as being rule bound. However, writers do need to be more explicit in their research reports so that there is an increasing body of knowledge available about what works and what does not. This approach will then allow potential researchers to make more informed choices about the use of focus groups in their research. Morgan (1996) defends the limitations of focus group design as being due to the recent upsurge in popularity within social sciences

research where they consequently reflect a decade or so of activity which has been notable in its lack of standardisation with regard to questions and procedures. He goes on to argue that any tendency towards standardisation should not be influenced by either the tenets of qualitative research or past tradition, that is quantitative research, but by the goals of the research. Thus he is supporting the notion that it is not the paradigms which dictate the use of focus groups as a data collecting strategy but it is the goals which are important.

3.13 Advantages of Focus Groups.

A pragmatic advantage identified by Gray Vickrey (1993) is their productivity in that six people can be seen within one to one and a half hours as opposed to single interviews which can take up to ten hours. Carey (1994) claims that data can be enriched through the group process and depending on the setting, they can be more informative. They provide insights into the sources of complex behaviours and they differ from individual interviews in that participants can question each other and explain issues (Morgan and Krueger, 1998). They lend themselves to gathering data which may otherwise be difficult to collect i.e participant observation (Morgan and Spanish, 1984).

From the researcher's point of view, it is the chance to observe participants engage in interaction which is of real interest to the researcher (Morgan and Spanish, 1984). Kingry et al (1990) emphasise the importance of being skilled in the group process and they goes on to say that most nurses are comfortable with this type of interaction, although they do not explain how they came to that conclusion. It seems to negate the importance of learning small group management. Finally according to Basch (1987) synergy produces a wide range of information and the potential exposure of important understandings serendipitously is a key asset.

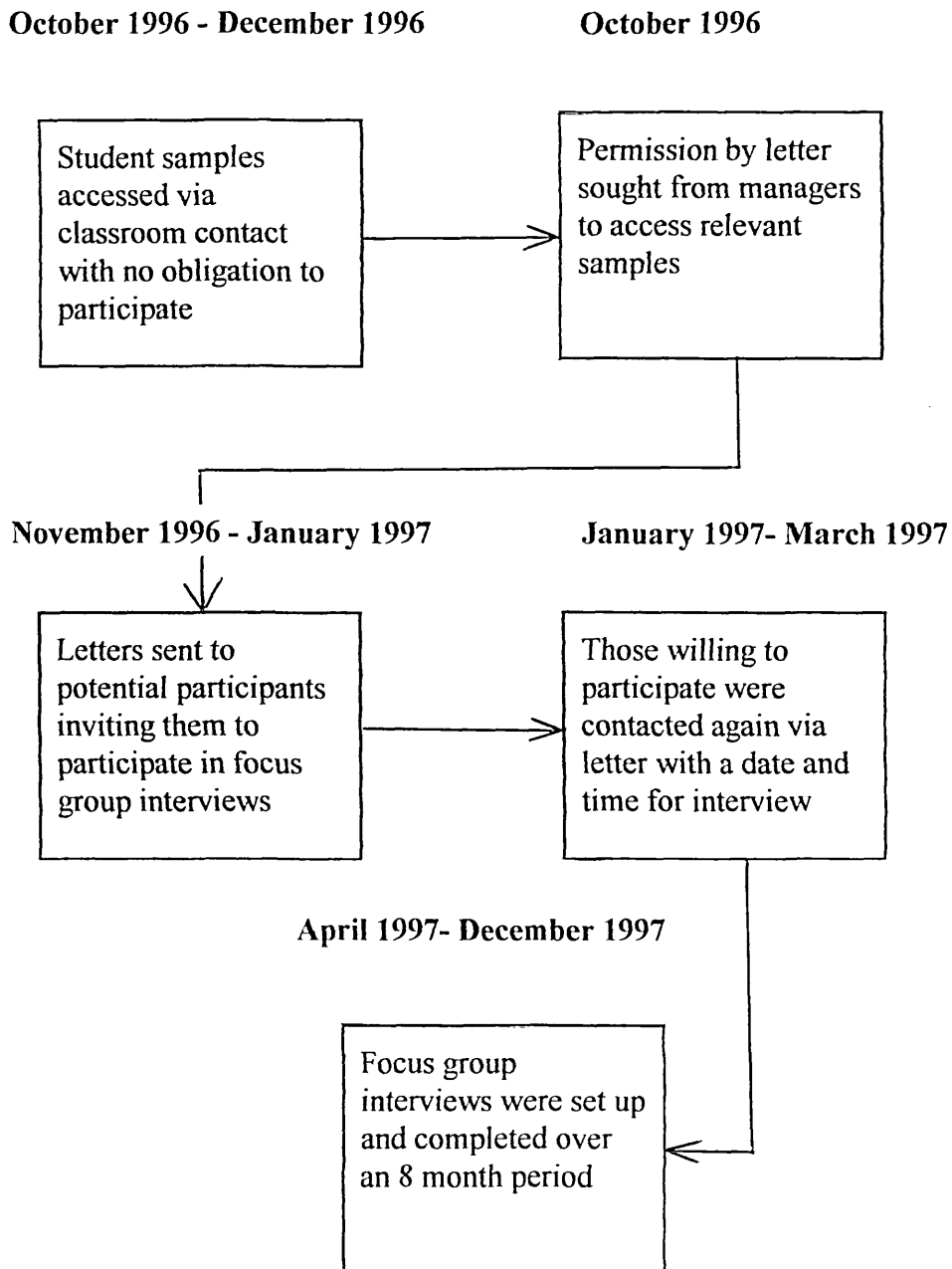
3.14 Disadvantages of focus groups

The data collected is not generalisable (Gray- Vickrey 1993; Basch, 1987), However, focus groups should not be used if generalisability is a prerequisite unless there are a number of focus groups being used. Some research for example,

by Kitzinger (1996) who used 52 groups, may be considered generalisable due to the sheer volume of focus groups, but on average they are not usually used in this context. Bias may be a problem if the researcher comes to the group with pre conceived ideas (Carey, 1994) Weaknesses, according to Morgan and Krueger (1998) relate to the process of producing focussed interactions raising both the role of the moderator in generating the data and the impact of the group itself. Where the moderator may be too directive, there may be a lack of experience related to group dynamics. The chief disadvantage relates to the unnatural setting and the researcher's relative lack of control on the proceedings (Morgan and Spanish, 1984). Basch (1987) identifies one of the disadvantages as excluding those who may be intimidated by expressing their views among other participants

Morgan and Krueger (1998) however, state a very important point in that there are many ways of doing focus groups and researchers have to make choices how they are going to carry out the research. They state that researchers who are using focus groups should be incorporating into their design a review of what they have done and why they have done it. Furthermore, Morgan (1996) has emphasised this point in a previous article about how research design within focus group research must be made explicit. A number of authors do want to leave a flexible approach to focus group research, arguing that inflexibility is not a tenet of qualitative research however, focus group design would benefit from more discussion about what works for this method and what does not.

Fig 3.2 Overview of the process of recruitment to the focus group interviews



3.15 Operationalisation of the focus group strategy

The goal of this phase of the research is to produce a questionnaire from the everyday knowledge of the focus groups. However a secondary aim is to compare both the qualitative and quantitative sets of data to evaluate the utility of each approach.

Focus groups interviews were used for a number of reasons. The intention was to explore nurses' attitudes, beliefs and values towards older adults within a hospital setting. The findings were to be incorporated in to an instrument to measure quantitatively nurses' attitudes, beliefs and values and to compare any difference across the levels of staff. Focus groups were identified as a method for developing a questionnaire as they would use the everyday language and constructs normally used by nurses.

A pilot interview was carried out using a convenience sample of nine third year student nurses, the purposes of which were to test the moderator guide and to evaluate, firstly, the most appropriate number of participants and secondly the length of time required to obtain rich and meaningful data. Topics were covered in depth over one hour but there were difficulties in facilitating a group of nine. For example, ensuring an equal contribution to the discussion was difficult to achieve in such a large group. For this reason, it was thought advisable to use 4-6 participants as they would be more manageable for facilitation. The moderator guide required no alteration as the questions were understood and answered satisfactorily. The moderation of the group was challenging in that it was tempting to contribute more than facilitation allows. However, the moderator acknowledged her deficiencies and remained in the background except for seeking clarification of answers when necessary. The pilot interview provided rich descriptions and was much more successful than anticipated. The data from the pilot interview were introduced to the main research as the quality of the data was excellent.

For the purposes of this research the groups were homogeneous for stage of education or nursing practice, for instance, students formed a group, nurses for the care of older adults formed a group as did nurses from the acute wards and finally nursing lecturers formed a group. There was no further attempt to maintain homogeneity as all groups were heterogeneous for age and for sex. Most of the groups knew each other whether as friends, colleagues, or simply acquaintances.

The only group who were strangers were the group from the acute wards. They met as a group of strangers and only two of the group were known to the moderator. Moderation of this group was more interventionist than for the other groups as the moderator had to probe and guide the discussion more than she had done for the previous groups. This may have been for a number of reasons, including their lack of acquaintanceship. However, it may have been due to the perceived irrelevance of the topic to them as they were coming to speak about the care of older adults.

Samples were drawn from the populations who would be involved in the professional socialisation process that is nurses from the care of older adults setting, from general medical/surgical setting and nursing lecturers from a School of Nursing and Midwifery. Third year student nurses were also included as they were part of the informal socialisation process in that they discuss the perceived advantages and disadvantages of the clinical areas among themselves. The number of focus groups therefore reached four. However, the data gathered during the pilot study were pertinent to the research therefore it was felt that they should be included with the remainder of the data, having first sought permission from the participants. Two focus groups were completed for the care of older adults group as the moderator did not remain as neutral as would be ideal for the first group interview. Consequently, another interview was carried out with participants from another hospital where older adults were nursed. In retrospect and after examining the transcription for the first interview there were too much rich data to abandon the whole interview therefore it was included in the research.

The intention had been to access participants using random sampling, as suggested by Kingry et al (1990) but particularly where the students were concerned, random sampling was difficult to achieve as a number of the class approached were in the process of re-sitting their exams after failing and it was unfair to put added pressure on them to use protected study time. Therefore convenience sampling was used to recruit to all groups (McDaniel and Bach, 1996).

Permission was sought and granted from senior managers of the relevant Trusts and the School of Nursing and Midwifery. (Appendix I Specimen letter to managers) Inclusion criteria were used for nurses who worked in the clinical settings. Only first level nurses who spent the majority of their time on day duty would be approached for inclusion in the study. The senior manager in the Primary Care Trust was approached for a list of names of first level nurses who worked in the care of the older adult wards. From this list, depending on the numbers of staff in the ward, from one to three participants were selected for invitation to participate in the research. An example of this selection process was, one of the wards had two first level nurses so only one nurse was selected whereas another ward had six first level nurses so three nurses were selected. The participants were selected purely on their position on the list i.e the first one, two or three grade (E) first level nurses on the list. This process was repeated when recruiting for the second interview with the care of older adults staff, however they were in a different hospital although they were under the same Trust.

The list for the general acute medical and surgical wards was obtained from Personnel after forwarding a copy of the letter of permission from the Senior Nurse for the Acute Trust. Nurses who were on permanent Night Duty and Enrolled Nurses were firstly excluded from the numbers. Every fourth name was then selected from the list and a letter was sent out seeking their participation in the research (Appendix II)

Inclusion criteria for third year student nurses were that they were following the adult nursing programme. Recruitment for the student population consisted of the researcher speaking to the class and explaining what she was doing and asking for volunteers to participate by adding their names to a list put on the noticeboard for them to complete whilst ensuring that there was no pressure for them to participate. Coolican (1994) discusses the position of influence, prestige and power which the investigator has over the participants. To counteract this position, the researcher is obliged to give the participant every chance not to participate both before and after the procedure whether it is qualitative or quantitative research. This was done for both sets of students, the pilot group and the main study group for both phases of the research. The students were also assured that there would be no consequences if they wished to withdraw at any stage of the research.

Inclusion criteria for the lecturing staff was to include only lecturers who were teaching the Common Foundation Programme or the Adult Programme, therefore lecturers from the other branches were excluded.

The school where the study took place had recently amalgamated with a University, bringing two campuses together, therefore, lecturers who were based on the other campus were approached to take part in the research as they were not so familiar to the researcher as her colleagues on her own campus.

Once the populations were identified, letters explaining the research were sent out accompanying a request for people's participation in the interviews. (Appendix II Specimen letter to potential participants) A self addressed envelope was included to increase the rate of return. Table 3.1 indicates the number of people asked to participate from each group and the actual number of replies confirming they were willing to take part.

Unit	Number of letters sent out	Number of replies	Response rate %
Care of the Elderly (A)	25	7	28%
Care of the Elderly (B)	21	7	33%
General Medical and Surgical Floors	37	13	35%
Lecturers	10	7	70%

Table 3. 1 Numbers of people asked to take part in the focus group interviews and the numbers of replies

The interview guide was developed through reading the literature on attitudes towards older adults (Kingry et al, 1990). A preliminary guide was put together entitled “what I want to know” (see table 3.2) This list was examined, the broad issues were identified and incorporated into the interview guide (see table 3.3). Broad questions were used and the participants were informed of the questions prior to coming to the group.

What I want to Know

1. Is there such a thing as negative attitudes to older adults?
2. Is there such a thing a positive attitudes?
3. How do negative and positive attitudes manifest themselves?
4. Do negative attitudes have an effect on the care of older adults in the acute sector and the care of older adult sector?
5. Do negative attitudes affect people working in the care of older adults?
6. How do negative attitudes affect the organisation of care?
7. Do they result in poor practice?
8. Are older adults neglected in the general acute wards?
8. What do you think about nurses choosing to work with older adults?
10. Do people's attitudes influence the quality of care?
11. There is the idea that attitudes and beliefs can be altered for a number of reasons one being working with older adults, does this change beliefs and if so, for better or worse?
12. Do teaching staff influence attitudes to older adults?
13. What age group would nurses prefer to work with and why?
14. Should there be a care of older adults branch?
15. Are older adults devalued in today's youth oriented culture?
16. High technology care versus low technology care.
17. What skills and knowledge do nurses require to work with older adults?
18. How do you feel about the work in the care of older adults?
19. Do negative attitudes come from social stereotypes of older adults?
20. Does society in general devalue it's older adults?

Table 3. 2 The questions which were developed from the literature review

They also managed the order by which the topics were covered. The focus group questions were changed slightly depending on the groups. In other words they were tailored to suit the groups. One topic which was developed by most of the

groups without prompting was the possible learning experiences for student nurses going to the care of older adult wards.

Along with the focus group questions ground rules were developed for all the groups where the process was explained to the participants in writing and once again prior to commencing the interviews. The use of the tape and video recorder were explained in that if one source failed another source for information was being gathered. The issue of confidentiality was reiterated (White and Thompson, 1995) and participants were informed that they could stop the interview if they wished at any time. The purpose of the group interview was once again explained, i.e to develop a questionnaire.

Thus participants were informed of the purpose of the research, the design and the dissemination of the research. They were assured that there would be privacy in gathering, storing and handling data. The only people who would view the video tapes would be the researcher and the supervisor of the research. They were also guaranteed that the data would be destroyed at the conclusion of the study. However the data would be stored on computer until that time (Cerinus, 2001; Medical Research Council, 2000). All data were anonymised by ensuring participants did not use names during the interviews. If names were used, they were changed during transcription of the research as were all references to hospitals.

Focus Group Questions

1. Are there positive and negative attitudes to older adults?
2. How are those attitudes portrayed?
3. How do attitudes to older adults differ from attitudes to working with older adults?
4. Do you think the care of older adults is a specialty?
5. What do you think about the work associated with older adults?
6. What do you think about the nurses who work with older adults?
7. Are older adults treated differently in the general acute wards as compared to the care of older adult wards?
8. How negative or positive do you think teachers are about older adults?
9. How have your experiences in nursing influenced your view of older adults?

Table 3. 3 Interview guide used during the focus group interviews

The role of moderator was explained which was to ask the questions and seek elaboration but to stay neutral within the discussion(Reiskin, 1992). They were asked to state what they felt about the topics and a promise of no repercussions was given for any issues raised. They were asked to speak individually and not speak over each other and the time limit of one hour was put on the discussion. At this stage they were afforded the opportunity to ask any questions prior to commencing the interview.

For all members of the group to participate it is important that an atmosphere conducive to facilitating trust is essential (White and Thomson, 1995). Dilorio et al (1994) describe the setting as crucial where it should be neutral but familiar and this was achieved for all interviews except for the acute staff who were required to come in to the school. The other staff interviews were carried out in the relevant hospital. Refreshments were provided in the form of tea and coffee, cakes and biscuits. McDaniel and Bach (1996) describe the use of refreshments as a measure to relax the atmosphere.

The numbers of males when compared to females reflect a higher ratio than would normally be found within the nursing occupation. This would be accounted for by the male student nurses willing to take part which would slightly skew the numbers. (See table 3.4 for the numbers of participants and distribution by gender)

The numbers of participants for each interview where staff nurses were taking part is accounted for by the numbers on duty at any one time. It was very difficult bringing together a sizeable group due to the shift system which includes night shift and days off and annual leave. Two focus groups had been arranged using staff from the acute wards, but potential participants for the first interview did not arrive and only one out of the four informed the researcher.

Focus groups	Males	Females	Total in each group
Care of the elderly (A)	0	5	5
Care of the elderly (B)	1	3	4
Medical and Surgical floors	0	4	4
Lecturers	1	5	6
Students (A)	3	6	9
Students (B)	3	5	8
Total	8	28	36

Table 3. 4 The Distribution of male and female participants of each focus group and the total numbers for each interview.

Data were collected using both a video recorder and an audio recorder, the purpose being that if one strategy failed then data would still be recorded using another method. The pilot interview had already shown that the moderator was unable to keep field notes during the interview while simultaneously facilitating the interview as it required following the flow of discussion and asking appropriate questions for clarification or explanation. There are disadvantages in relying solely on the use of free form notes in that information can be interpreted in a different manner from intended and that information may be lost during the interview. Britten (1995) identifies that writing notes during an interview can interfere with the process of interviewing so for those reasons field notes were completed once each interview was finished. The field notes recorded the moderator's feelings regarding the utility of each interview and the biases that may have influenced the interviews. This aspect is now explored.

The six interviews were completed approximately within one hour as agreed with all participants. All interviews produced very good quality data. The moderator was very aware of her biases and her commitment to minimise influencing the discussion. Nevertheless, an incident occurred in one of the care of older adults interviews where the moderator challenged one of the participants to explain a remark about how student nurses were unprepared for working in care of the older adult. The decision whether to abandon this interview due to the incident or whether to retain the interview for analysis required consideration. The final decision was made for both pragmatic and ideological reasons. Pragmatically, it would have been a waste of time for the participants who had kindly agreed to take part in the interview and ideologically a lot of good data were gathered from this interview which would have been lost to the research. In retrospect challenging the participants made little apparent difference to levels of participation in the interview.

There is a sense of self doubt when carrying out focus group interviews as to how much facilitation is appropriate and there is no question that facilitating each group was different depending on who was taking part. The student groups knew

each other and they knew the facilitator well as they had contact with her as a lecturer for almost three years. They communicated well with the facilitator and with each other. However there was a tendency for the students to talk over each other and there were certain disagreements among them which was entertaining and made for a livelier interview. There is no doubt that in one of the student groups, a participant used the focus group discussion to have his opinions heard and once this was done he settled down and took part in the interview. One participant in the other student interview was unhappy about that the discussion was heading in a negative direction and iterated this. She continued to participate in the interview. The lecturer group was much more sedate than the student groups but that may have been due to the moderator being intimidated by interviewing her peers. They were also very relaxed with each other. The decision had been made not to interview lecturers from the campus where the moderator worked but to use lecturers from the other campus who were not so well known to the moderator at that time. Consequently this may have influenced the discussion. However, the interview was a rich source of data.

The interviews within the care of older adults proceeded very satisfactorily except for the incident already discussed. The only interview which required the moderator to guide relatively consistently was the interview with the staff nurses from the acute areas. The moderator was not so well known to two of this group and they did not know each other to any degree and this impacted on the group dynamics which goes against one of the central tenets of focus group interviewing, that of participants being strangers (Krueger, 1994). This group did not gel so well, nor did they relax as readily as other groups. Another reason for this may have been the perceived irrelevance of the topic to nurses who work in the acute areas.

3.16 Conclusion

The process of organising and running focus groups is time consuming but as a data collection strategy, it is rewarding for the richness of the data alone. The group dynamics and interaction clearly enhance the data collection and this is

evidenced by a comparison of the data collected from the acute care staff and the other groups. They were noticeably less forward in their communications than the other groups. This may be for the aforementioned reasons, therefore it may be worth supporting the view of Powell et al, (1996) who recommends the use of groups consisting of people who know one another rather than following the advice that they should be strangers (Carey, 1994).

Chapter 4: Qualitative Analysis of Data and Results

4.1 Introduction

Six hours worth of focus group data were collected using the video and audio recorder. As there were no problems with the equipment, only the video recorded data were used. This decision was made for pragmatic reasons in that transcription was easier with sound and vision than depending on sound alone. However, as with all other aspects of the focus group method, there are differing depths of transcription which are dependent on purpose. Furthermore the process of data analysis has been described as the least well developed and agreed upon. Thus this chapter commences with a brief discussion of the transcription phase, then continues with some of the arguments put forward by a number of authors on how to conduct data analysis. A model of qualitative analysis is presented and finally the issues of reliability and validity are considered. Once the aspects of data analysis are explored the results extrapolated from the focus group interviews are presented.

4.2 Transcription of the Interviews

Level of transcription of qualitative data depends on the purpose of the interviews, whether the aims of the interviews are to extrapolate new concepts or whether the aim is to test a questionnaire. Therefore, the aims of the research need to be explicit. Krueger (1994) identifies how transcription can vary from a full verbatim transcription to note based or indeed memory-based transcription. Krueger describes a transcription-based strategy as the most time consuming and he goes on to suggest as does Knodel (1993) and Carey and Smith (1994) that all communications should be observed including body language, gestures and tones of voice. However Stewart and Shamdasani (1990) state that non verbal communication need not be included.

There is also a lack of consensus on how much editing should be carried out. Stewart and Shamdasani (1990) state that editing is a matter of preference

whereas Millward (1995) disagrees in that there should be no editing as data should be captured “warts and all” (p. 287) For the purposes of this research, a full verbatim transcription including behaviours and non verbal communication were included as the ultimate aim of this work is to evaluate the effectiveness of both the qualitative and quantitative methods used for data collection. Familiarity with the data is also an advantage of full transcription.

4.3 Analysis of Focus Group Data

Krueger (1994) states that no part of the focus group interview is as ill structured as analysis while Carey (1994) states that the process of analysis is the least agreed upon and the least well developed. Krueger (1994) goes on to suggest that analysis goes back to the intent of the study. In other words, the outcomes of the study dictate the level of analysis. There are three ways of dealing with qualitative data; that of staying close to the data as originally recorded and presenting swathes of quotes with the purpose of allowing the reader to make sense of the data; to systematic analysis of key factors which have been identified; to interpreting with a view to making sense of what is going on (Woolcott, 1994). Mason (1996) adds another dimension when she refers to analysis having a reflexive level. Both authors agree that different levels of analysis can occur in the same piece of research.

However, level of analysis has to be considered with method of analysis. Focus group data can be analysed both qualitatively and quantitatively. A quantitative method would be content analysis put forward by Stewart and Shamdasani (1990) although Millward (1995) does suggest that content analysis can be used both qualitatively and quantitatively, the qualitative approach emphasising more meaning than quantification. Berg (1998) explains how content analysis can be used effectively in qualitative analysis where textual elements can be counted thereby providing a “means for organising, indexing and retrieving data” (p.225) However, Polit and Hungler (1993) define content analysis as “ a procedure for analysing written and verbal communication in a systematic and objective fashion, often with a goal of quantitatively measuring variables” (p.433).

A qualitative approach to analysing focus group data may include thematic analysis. Banister, Burman, Parker, Taylor and Tindall (1994) define thematic analysis as “a coherent way of organising or reading some interview material in relation to specific research questions” (p.57). There are a number of models of thematic analysis with much the same approach. The model which is put forward here is the interpretive model discussed by Tesch (1990). She suggests that the data is, firstly, divided into segments. Segments can be sentences, paragraphs whatever, but the underpinning decision as to what constitutes a segment is dependent on comprehension of the segment if it stands alone without supporting text. Lincoln and Guba (1985) describe the segment in terms of a unit which can stand by itself and should be heuristic. Once the data have been segmented and assigned a unique identification tag, the next phase is to attach categories which can be described as an organising system where common elements are identified and related to concepts or themes. Lincoln and Guba (1985) describe the process of categorisation as being accomplished by ensuring the categories are internally homogeneous and externally heterogeneous. Tesch (1990) describes how analysis can be for either theory building or for description. The purpose of this analysis is for description which involves looking for commonalities across cases or for constituents of phenomena. There are two basic avenues for establishing an organising system, either from prior material i.e. the framework and questions or from the data themselves. Concepts were developed from the data themselves. Concept development included the naive reading of the transcripts, identifying features and patterns and labelling them as categories. Twenty-nine categories were eventually developed. During coding of categories, all data were included unless very obviously irrelevant. An example of an obviously irrelevant discussion can be found among the second student interview when there was a detour in the conversation to the cost of staying in nursing homes and how costs reflected whether visitors were invited to partake of tea when they came to the nursing home. However when coding advanced some data were re-categorised and some were discarded. Both Woolcott (1994) and Lincoln and Guba (1985) suggest that erring on the side of over inclusion is wiser than rejecting what may appear at first reading irrelevant rather than trying to trace back material which becomes more

relevant as the research proceeds. The twenty-nine categories were evaluated for similarities and differences and categories which were similar were collapsed into themes. Where there were no similarities, categories were re-labelled themes. A number of categories were too similar to stand on their own. Categories which became a theme were issues such as the influence of media on attitudes, the influence of relatives, or society, were subsumed under the theme of secondary socialisation. Once the themes were identified, the data were then de-contextualised and re-contextualised under the headings of the themes. (See table 4.1 for final list of themes)

Themes
1. Socialisation influences on student nurses' attitudes
2. Skills and knowledge required for care of the elderly
3. Organisation of nursing care
4. Looking after older adults
5. Labelling older adults
6. The learning opportunities and Expectations of student nurses towards care of the Elderly
7. Interpersonal skills including communication skills
8. Staff influences on students' attitudes to older adults.
9. Categorising nurses who work in care of the elderly
10. Lecturers' Influences on student nurses' attitudes to older adults

Table 4.1 Themes developed from the focus group data.

The data were analysed using the scissors and sort method where data were cut into segments once categories and themes were assigned. The segments were then glued on to different coloured cards, the different colours representing the focus groups. There are a number of computer programmes now available which have coding and retrieving facilities. There is no doubt that they are efficient at handling large amounts of data while improving rigour by producing counts of

phenomena and searching for deviant cases (Silverman, 2000). However, there are a number of concerns about computerised qualitative analysis discussed by Holloway and Wheeler (1996) which include the temptation to over collect data, lack of scrutiny of the data and the distancing of the researcher from the data. They also identify the difficulty in learning how to use qualitative analysis packages from manuals. Therefore, the advice put forward by Berg (1998) was heeded when he stated that if the length of time taken to learn a computer programme outweighs the advantages of computerised qualitative analysis then the process defeats the purpose. Using the more mechanical scissor and sort method encourages a familiarity with the data. An added bonus of manual analysis is put forward by Reed and Payton (1997) who tried to use computer software to analyse qualitative data. They found that the data were much richer than was apparent from the lists produced by the programme.

Kitzinger (1996) describes the analysis of focus group data as being the same as any other qualitative data where the researcher identifies themes and relates them to the variables within the same population. She does qualify this advice by stating that there should be some illustration of the talk between participants rather than presenting isolated quotations taken out of context.

However, focus group data differ from other data collection methods using a qualitative approach in that group dynamics must be taken into consideration in the analysis. Carey (1994) suggests that it is inappropriate to lift focus group data out of context and Carey and Smith (1994) in a further article explain that the group context must be incorporated within the analysis and this includes the relationship of the individual to the group. Carey (1994) emphasises the importance of reporting other group characteristics other than demographics and that would include participation in the conversation. Other group dynamics for example, heated discussion should also be incorporated.

In the event, during thematic analysis, the order of discussion was often maintained in that coding would occur uniformly over sequential conversational

segments. As all data were uniquely tagged, if there was doubt about the contextual relevance, then the data were easily re-contextualised back to the original transcription.

4.4 Rigour and the Decision Trail or Validity and Reliability

The issue of validity and reliability in qualitative research is contradictory and troublesome for novice researchers. There is a lack of agreement concerning the appropriateness of those concepts within qualitative research. This is confirmed by Beck (1993) who states that there is lack of consensus among the phenomenologists themselves as to the relevance of reliability and validity in phenomenological research. There seems to be four stances in relation to this issue. The first stance is to use the terms and check for their inclusion in the analysis as suggested by Brink (1991). She takes the quantitative theories of reliability and validity and discusses how they can be translated and incorporated into qualitative research. Her rationale for taking this approach is, firstly, to make qualitative papers more acceptable for attracting funding and, secondly, to try and establish common terms as opposed to the proliferation of terms now being discussed within qualitative research. Her discussion of validity and reliability are grounded in two key notions, that of error in reliability and validity, and that of measurement.

The second stance seems to be to use qualitative terms but to link them back to issues of reliability and validity. Bailey (1996) describes this as taking a positivistic approach and this is how Beck (1993) incorporates the concepts into her paper.

The third stance seems to be that reliability is not appropriate however validity is seen as appropriate. Banister et al (1994) expand on this notion by stating that there is no place for consistent accounts in qualitative analysis although they do suggest that replication may arise from re-interpreting the data from different standpoints or exploring the data within different contexts. Krefling (1990) agrees that the notion of reliability becomes irrelevant when one of the

assumptions of qualitative research is that there are multiple realities. Validity is seen as being relevant through the ability of the researcher to understand and represent people's meanings. (Banister et al, 1994)

The fourth stance is the seeming inappropriateness of both reliability and validity, which are replaced with the concepts of rigour and the decision trail. The fourth stance was taken for this phase of the research as valuable experience was gained in the use of an alternative framework instead of the more positivistic approaches for validity and reliability. However, it would appear that the qualitative researchers are still using reliability and validity in the guise of rigour and the decision trail to implement qualitative measures of those particular concepts.

Leininger (1992) has discussed the importance of not using quantitative criteria to evaluate qualitative research as this will weaken the research. Sandelowski (1993) on the other hand warns that care must be taken in keeping the term rigour as flexible as possible so that the spirit of qualitative approach may be maintained, that of "the artfulness, versatility and sensitivity to meaning and context that mark qualitative works of distinction" (p.1) There seems to be a conflict between the need for rules to implement rigour in the analysis of data and the need to maintain aestheticism which underpins qualitative research.

Rigour has been conceptualised by Holloway and Wheeler (1996) as requiring two elements, that of trustworthiness and that of the decision trail. Lincoln and Guba (1985) suggest how trustworthiness in a research project can be evaluated thereby enhancing rigour. They suggest that qualitative research is measured for credibility, transferability, dependability and confirmability. They go on to indicate how those four concepts can be measured.

Credibility should include describing and identifying in detail both the participants in the research and the researcher. The participants in the research are described on page 75. The researcher has been a nurse teacher for 15 years and has had direct links with care of older adult areas for 12 years where an interest in attitudes

and beliefs towards older adults has been awakened. There has also been a rising awareness of the injustices towards older people because they are old. From those experiences, the researcher is well aware of her own biases and her own shortcomings, which helps in the minimisation of them. Credibility is measured by prolonged engagement which means becoming oriented to the situation. This has been interpreted for this research, by the prolonged engagement within the field of the care of older adults as a clinical teacher and the prolonged contact with students talking to them about their experiences working with older people, also speaking to staff working in the area. This would include sharing ideas and experiences with other lecturing staff. The second measure for credibility is persistent observation and this again was achieved by working in the area. The third measure is triangulation.

Triangulation was achieved through using different sources to collect the focus group data, by using different methods i.e. qualitative and quantitative. However, it has already been argued that methods triangulation itself is frowned upon by researchers such as Leininger (1992) unless they are used as separate paradigmatic studies. Triangulation has been used in this research. The next method for enhancing credibility is peer debriefing which was not utilised, however the themes identified by the researcher were checked by two colleagues unconnected with the research. The colleagues were asked to read the transcriptions and to assign categories to the segments of data. The assignment of categories by the people unconnected with the research correlated well with the thematic analysis conducted by the researcher. Referential adequacy was gained through video tape recordings as they can be used to compare the analyses with the portrayal on video. Member checks as a method of enhancing credibility was rejected for two main reasons, the first being, the information was readily available on video tape therefore was credible. It would seem to be common practice that once the data were transcribed they could be taken back to the participant/s for clarification and expansion of the data as opposed to checking the accuracy of the data (Hoffart, 1991). This would appear then that it is acceptable to change the content in light of the participants changing their minds after seeing

the data. Sandelowski (1993) indeed explains that member checks can be a threat to validity as they may not be in the best position to check the accuracy of the data as they may well have forgotten giving some of the information.

Transferability has been put forward by Lincoln and Guba (1985) as being enhanced by providing thick description, however they do identify that thick description is not readily defined. They explain that the purpose of providing thick description is to allow the reader to decide whether it is transferable to their area. Thick description was used in this research to for this reason. Jasper (1994) uses the word generalisability and states that a strategy for ensuring this concept is to take the themes back to more quantitative measures to evaluate for co-existing themes and categories. However, the rationale for using qualitative research may be that there is a question regarding current measures, therefore it would be unreasonable to use other quantitative measures as a strategy for evaluating generalisability. This research makes no claims regarding the issue of generalisability as only six focus group interviews were completed. However comparisons between the two phases of the research may well confirm generalisability.

Dependability, according to Lincoln and Guba (1985) can be ensured in the following four ways. Firstly, if the study is demonstrably credible then it should be dependable. Secondly, the use of triangulation will establish validity while thirdly, the use of inquiry teams within the research conducting their inquiries independently will also establish dependability. Finally, fiscal audit as described by Lincoln and Guba (1985) is where an auditor examines the process of the inquiry. This process would also satisfy the final component of the model, that of confirmability. Dependability is sought through credibility and triangulation as there were no inquiry teams within the research.

The audit trail is confirmed through the examination of raw data, data reduction and analysis notes, data reconstruction and synthesis products, process notes, including methodological notes, materials relating to intentions and dispositions

and finally instrument development forms (Lincoln and Guba, 1985).

All of the above are available for examination until the research is completed.

4.5 Results of the thematic analysis

Themes were identified using the model of interpretive analysis put forward by Tesch (1990). Ten themes have been extrapolated from the analysis. The process of analysis includes consideration of the decision trail. Each theme will be presented using the commonalities and the idiosyncrasies from each of the focus group interviews.

4.5.1 Socialisation Influences on student nurses' attitudes

Two main strands were identified under this theme, those being the influence through the media and the manner in which people were raised, that is the influence of primary and secondary socialisation. Taking the media influence first, this was identified as an issue by three out of the six groups, that of the second set of students (*S*), the lecturers (*L*) and the first group from the care of older adults setting (*A*). The second student interview developed into a discussion into who had the most spending power.

S 7 Look at the way the media presents them. If you look at somebody buying the newest car, it's always a big blonde. Leggy dame. It's never anybody that has got the spending money nowadays. If you look at the magazines, it's mostly young folk.

S 2 That sort of magazine is geared towards young folk. There is a lot of magazines geared for the over 50's

S 7 What I'm saying is most advertisements, fair enough is geared for that age group, but you look at the folk advertising, who are they using, a youthful person

S 8 Because that is the person that has got the money to buy that.

S 7 No it's not, it's the old that has got the money to buy that.

S 7 was trying to say that adverts were not portraying older adults, but using youth to sell items. This coincides with Bytheway's (1995) comments about the

invisibility of older adults in the media.

The lecturers also picked up on the emphasis on youth in the television,

L 3 If it's beginning to sag, you get it tucked and puffed up...everything is geared towards trying to negate some of the things that are seen as negative and not good as you get older.

Another lecturer went on to explain how a lot of the media coverage is negative

L 6 The amount they are costing or how old they are, funding has broken down, and they show you people at the other end of the spectrum who are not coping, not doing well and becoming highly dependent. There is not the positive side, apart from jokes about Saga holidays and things like that, so a lot of images of Victor.....

L 4 Most of them portray the elderly with Alzheimer's or something like that.

Later in this discussion one of the lecturers defended people who come into nursing with negative attitudes and the example he used to demonstrate how people grow up faced with a society which gives them negative vibes

L 5would be the sign for two elderly people crossing the road..... and you have an old man and woman with a hunch back and a stick.....

The first care of older adults interview echoed the importance of the media in portraying stereotypes of older adults, that is if they appeared at all in television.

The common factors in the interviews of those three groups seems to be the inappropriate portrayal of older adults as frail and infirm, people who are a burden on society unless they are the butt of ageist jokes. There seems to be an overemphasis on youth within the media where becoming old is seen as less than desirable and this is reflected in soaps and comedies where there is not an old

person in sight unless they have Alzheimer's. Those descriptions put forward by the groups confirm the stereotypes identified by French, (1990); Bytheway (1995); Fieldman (1999).

Society's influence was identified as important among the first care of older adults group (A), the first student group (P), the second student group (S), and the nurses from the acute care setting (N). The participants from the first care of older adults group explained how working in an area predominantly for older adults was a conversation stopper. When asked to elaborate on this by the moderator,

A 4 As in when you're a nurse, and they'll say, where do you nurse and I'll say here (in a hospital caring for older adults) and that seems to be the end of the conversation.

A 2 I think you can put it in a broader perspective and look at society's attitudes to older people as very negative.

The example which was used to demonstrate this point was how people were written off as not being suitable to work because they are over a certain age.

The participants in the first student interview also identified society's role in perpetuating negative attitudes and they looked at it from two viewpoints, that of upbringing and that of how older adults are treated.

P 3 put the blame on the breakdown in family values

I feel we have to do something about family values to educate our youth to have a little respect for them.

Both P 3 and P 8 who came from different cultural backgrounds, African and Italian respectively, stated that, in their culture people were brought up to respect older adults. Their views about older people and the influence of culture is contrary to the definition of ageism put forward by Butler (1975)

The one example which seemed to sum up the attitudes of society came from this particular interview

P 9 I was going to say, I think society puts a divide between the young and the elderly as well. Likes of sheltered housing and things. All the elderly cluttered together. I know where I live there is quite a mixture and it's not so bad now, but when we first moved there it was mostly elderly people. When the kids were out playing the old folk were out saying "oh don't kick your ball here" and it caused like young against old. I think if they were mixed better all the time you wouldn't get that as much

This comment echoes the concept of ghettoisation of older adults. Fennell et al (1988) describe how current social policies exacerbate a lack of contact with older people. The idea that older adults are cluttered together, almost invisible from the rest of society, is a powerful image and it reduces the need for younger adults to have contact with them and indeed to be friends and neighbours with them. This is also confirmed by Snyder and Miene (1994) who describe our society as age segregated thus minimising contact between young and old.

The participants in the second student interview took a much more upbeat approach to society's influence on attitudes. They felt that attitudes were changing. Firstly, they felt that attitudes were an individual concept and that it related back to examples shown when they were younger. They all agreed with this comment. However, one participant qualified this by stating that attitudes can change

S 6 I think it can change as well, from when you were younger to now, working with them just changes.

Later in the interview one of the students referred to the role of companies, for example B and Q where there is a policy to employ older adults. One of the participants also identified how older adults were going into schools to

demonstrate skills which are not so prevalent today. The example they gave was knitting. However they did comment on the more negative aspects. One of the participants told a story of an incident which occurred in one of the wards where he was allocated.

S 5 We had one woman coming to our ward, she came in and we got her sorted out and everything else. When she was there, suddenly she got all those new clothes and everything else, and she was always dressed up smartly and yet when she came in with suspected hypothermia she wasn't and it set alarm bells ringing. It turned out her daughter hated old folk, her mum was an old person, an old biddy who didn't deserve to live.

The only comment made by the acute care group was about the “bug of ageism on students’ backs when they come into nursing. They did not acknowledge any influence from nurses, only that students come into the profession with stereotypes of ageing.

There was a common theme then from all the groups that society had a role to play in influencing student nurses’ attitudes, however this may be off set by good role models during secondary socialisation.

4.5.2 Skills and Knowledge required for looking after older adults

The literature is conflicting on whether the care of older adults is a speciality and this aspect was explored with each group after investigation with the first student group as to what should be taught about care of the older adult. The main strands this group identified were firstly making explicit how disease affects older adults because

P 6 We look at disease but not in relation to anyone in particular.

Other strands they felt were important were improved communication skills and taking into account the contextual lives of older adults.

The second student group when asked directly if the care of older adults should be a specialty they also identified the importance of communication skills.

S 3 Because of communication, relating to communicate, to get on well with them, you have to be very kind and caring towards them

Moderator *Do you not behave like that with all patients?*

S 3 You've got to be more so, I feel. I don't know what it is but they respond better to you

S 7 The body also reacts differently

S 3 You've got to be more gentle with them

The concept of body changes was picked up again later when one of the student participants stated that there are a lot more diseases which affect older adults.

S 5 They tend to be affected more than our age group. There is also their physiology, is different to ours, it is a good bit different, they're starting to get sags, lines and wrinkles, they're more vulnerable, their arteries are hardening.

They went on to discuss the effects of morphine and whether they were age related. The conclusion which was reached is that it is a specialised area so the "people can go more in depth about the differences."

Most groups seemed to agree that patience was an important attribute within the care of older adults. However, when both sets of participants from the care of older adults settings were asked if their area was a specialty, the one issue which did differ were their thoughts on the role of patience. The first group explained that patience was important as older adults were slower. Indeed they felt it was important to tread warily whereas the other care of older adults group dismissed the idea that nurses required any more patience in care of the older adult than in any other area

V 4 The favourite phrase I always hear when I say I work in care of the elderly. You must have wonderful patience. What patience do I have that I wouldn't have

in medical assessment in (name of an acute hospital) , it's exactly the same.

The first group from the care of older adults went on to explore how their area could be considered a specialty. They identified the wide knowledge required to work in this area.

A 5 It's not just one thing, they might be demented, they might be diabetic, they might have poor mobility. So you really have to have a wide knowledge of all those things and how to deal with them and not just lump the person in as an old person and that's it, for you have to deal with all these things separately, an old person with six different things wrong with them.

A 4 You have to be aware of things like drugs and that. Will they tolerate the same dose or will they react in the same way. And their sexuality that is even being brought in.

A 2 In those areas, if you go anywhere else, they are not really keen to talk about them, they don't think it's important.....

The issue of what happens in areas out with the care of older adults is followed up later under another theme as both groups from the care of older adults spent a fair amount of time talking about how they thought older adults were treated by nurses in the acute areas. However, there are similarities about what the student group said when compared to this care of older adults group. This strand was also present in the second care of older adults interview where one of the participants stated that nurses needed some knowledge of most medical conditions because there is a multiplicity of problems. Added to this was a requirement for knowledge of rehabilitation. There was broad general agreement then that nursing older adults required specialist skills relating to the multiple pathologies and some aspects which were particular to older adults.

This question was further explored in relation to having a specialist who was an expert in matters associated with older adults introduced into all acute areas where there were older people. It was felt worthwhile to test the reactions of

nurses who work with older adults. The second group from the care of older adults thought that they could have a role in the education and prophylaxis of problems associated with older adults claiming this would reduce hospital stays. They also suggested that they could ease the discomfort of some patients. The example given was the number of times older adults were becoming constipated in the acute areas due to lack of knowledge of the ageing process.

The lecturing staff personalised the issue of the care of older adults speciality and the specialist nurse in acute care. Discussion took place in relation to their roles as carers and on the whole they thought it was rather demeaning for older adults to have specialist nurses.

L 4*She would have bitterly resented having a special nurse assigned to her because she was in the elderly category because she didn't see herself as elderly. She would have been most annoyed if she thought anybody thought she was elderly. (She is talking about her own mother)*

L 3 *The fit ones, even the ones who come in to the acute situation, know that they are going to go out again. They are not elderly in their minds at all.*

L 3 picks up the thread again later when she says

I'm torn between the two because, yes, I think the older person does need someone who has a greater understanding about how to interact with the elderly, they maybe need more time. There are special skills particularly in the communication area, but having said that I recognise that many elderly don't want to be treated differently, and it's maybe to prepare nurses to be aware of the fact that people as they get older, they need to be made aware more of the difficulties and skills rather than singling them out, and yet I still feel there is a place for somebody who specialises and considers the elderly as important.

The lecturing group made the assumption that older people would be treated differently in the acute areas, but this is not necessarily the role of the specialist

who is there to advise and to ensure current best practice. It is this which is sometimes missing so that older people are not receiving as good care as is their entitlement.

The acute care group specified time and patience as the most important skills and one participant also asked the others in the group whether nurses working in the care of older adults lost their skills as there was more basic nursing care associated with this specialty. One member of this group did not feel that the care of older adults was a speciality.

N 1 I was going to say, it probably doesn't differ that much, but it's not a specialty. There is more a full team that sort of specialise in care of the elderly and they do really, well they try.

However one of the other participants said

N 1 I would say it should be, because they have different needs to us and there are different changes

Older adults take up most of the beds within the acute trusts so careful consideration needs to be given to the feasibility of providing post registration education for nurses to specialise in this area. The arguments put forward by the participants of focus group interviews are nebulous and ill-defined as it would seem that the issues put forward by the groups are the issues which should concern all areas. As an example, if a nurse works in a surgical ward they need detailed knowledge of their particular speciality to be able to nurse that person back to health. There has already been disagreement relating to the importance of patience within the care of older adults and should patience as a concept not apply to all areas. Good communication skills would appear to be essential no matter where a nurse works. Therefore, if nurses who work in the care of older adults wish to be seen as specialists they need to be more explicit about what they do. There was a tendency in the second care of older adults interview to emulate the acute areas by

emphasising the more technological aspects of their work but this seems to be self defeating if they wish to be recognised as a specialty in their own right, not as followers of the acute care model.

4.5.3 Organisation of Nursing care in the care of older adults setting

A number of categories were subsumed under this theme all related to the organisation of the work. Some categories were discussed more than others but they all produced relevant data.

The first category which will be addressed is the perennial problem of basic versus technical skills. A number of authors have already identified that the skills purported to be learnt by students are basic nursing skills or as some pundits are calling them essential skills. (Gray and Smith, 1999; Melia, 1987). Change of name alone is not going to alter student nurses' perceptions of those skills, only a fundamental shift in nurses' attitudes to technical skills will achieve this.

The groups varied in their ideas about the level of basic skills in the wards. The two student groups differed in their views about the level of skill required to work with older adults. However there was also intragroup disagreement.

The first group were more in agreement about this issue

P 6 They use terms like low tech nursing and everything. There is quite a stigma attached if you want to develop initially as it were. Perhaps you might be prevented from doing that in care of the elderly ward. It depends on what you want. I don't know, I think that's not true. There is a lot of technology in care of the elderly as well, but it isn't recognised really. People have this idea that it is really dull and all commodes

Another aspect of caring for older adults was put forward by one of the other participants from this interview.

P 5 *Mind you in saying that I worked on a psycho geriatric ward for about a year before college and fair enough you did use a lot of communication skills but after a while it's like maybe your socialisation got involved in it and you'd tend to switch off. It was like here's your lunch and that was it.....*

Later in the interview

P 2 *I think it is a different type of skills you are concentrating on, you're more concentrating on your communication skills and like what you can notice, it's all the wee things, it's not that you can use this machine or that machine, or I can do this or that, the next thing.*

P 6 *It's still hands on though. You can't get enough practice of that*

However when asked if care of the older adult was repetitive and boring one participant responded

P 4 *I think every place would get like that if you were there years and years, like if you were on the same ward for years and you got to know it really well, and it would become an automatic thing.*

Not all the other participants agreed with this remark

Moderator *So you say it wouldn't really matter where you work, the work would get really boring, repetitive and routine?*

P 4 *Yes, unless you could make it otherwise*

P 2 *I disagree*

P 9 *I don't think so either because I worked in a nursing home before I came into nursing for nearly four years and I never found it like that.*

P 5 *I thought the nursing home was quite good.*

P 9 *Maybe it was because the clients were changing every now and again, and I found as you get to know and build up your relationship, that it didn't make it boring, but then it depends on the team.*

It would appear that some of the students within this interview did find the care of older adults boring but were having difficulties in coming out and saying so. This may well have been due to a very strong contingent who believed that the care of older adults was a learning experience and the people who did not agree with this summary were unwilling to commit themselves to that point of view.

The second student interview was more consensual on the subject of basic nursing care. One of the participants had very obviously had a bad experience within care of the older adult and was very scathing about the quality of the work.

S 6 I like working with old people as such but I think the ward setting really puts you off. I don't know about anybody else. Well the ward that I was on, we got them up at 7 in the morning, got them up, got them washed, got them to the same table. Everyday they sat there, gave them their breakfast, toiletted them, gave them their lunch, toiletted them, gave them their dinner, toiletted them, and then six o' clock started putting them back to bed again, and that's all we did. I felt I was in that toilet, I mean that's what students are there for anyway. Once you wheel one in then out again, and you finished doing them all, and you start again. But I like old people individually, and I got on with them, and I learned a lot from them but it is the setting.

Later in the interview that same participant could see the possibilities within this type of area but she felt tied to the toileting regime. However, when she is speaking about the possibilities, she can almost be accused of infantilising older adults She went on to say

S 6 I wanted to take them for walks, play games with them all, but I was too busy toiletting them all the time. I feel if I could sit down and do all of these things which I feel is part of nursing

S 5 You should have just done it.

S 3 I did, one of my placements where I was, I said well I'm here to spend time with the ladies, so I did. I sat down and stimulated them, and I did, I enjoyed my

time.

One participant in this interview stated that care of the elderly was basic nursing care whereas surgical has what was perceived as the “high tech stuff” However a cautioning note came from one of the students

S 7 I think unless you can deliver the basic nursing care, you can't say you are a nurse. You can say you are a technician working with technological equipment, but a monkey could do that basically.

They are not disputing that care of the older adult is basic nursing care but what is disputed, is the value of basic nursing care in that it is the ability to give basic care which is perceived as an attribute of a good nurse. This altruism does not seem to be reflected in trained nurses where technological skills are valued more than basic nursing skills. Changing the name from basic nursing skills to essential nursing skills is certainly not going to solve the problem but there is a need for a fundamental shift in attitudes towards basic nursing skills. If nurses were to ask patients what they find the most beneficial, it is the quality of physical care they receive, the ability to feel comfortable and clean which helps patients to feel better and indeed, look better.

They are not worrying about concepts such as what is caring in nursing. What is sad is that nurses who work in the care of older adults are also falling into the trap of attempting to promote the technological over the basic nursing care. This is reinforced by the participants of the second care of older adults interview.

Firstly the participants felt that there was a strong influence from the college of nursing who emphasised to them that care of the elderly was a case of tender, loving care. One of the participants goes on to say how they were taught in college

V 2 You give them a wash, you give them a feed, feed them. They don't have anything really wrong with them they are only there because there is no other

place for them and they do get the wrong attitude.

Later, when asked directly about care of the older adult being about basic nursing skills.

V 4 You'll learn that in any of the wards, you'll learn that anywhere.

V 1 That's bad, people automatically link basic nursing skills, but they don't only link that they see that as the only input in care of the elderly. That's all you're going to do.....

However, V 1 started to question what constitutes basic nursing skills and, again, it was being questioned as to whether it was the college who defined what is considered a basic skill.

They do emphasise the intention of the medical staff within the hospital to make the area more acute, by expanding and introducing more technological equipment. However what is stated, is that nursing management is holding the ward staff back by not encouraging aspects of the expanded role. The example given is that of intravenous injection training. They see as the purpose of this to stop nurses moving out of the area. In other words they are implying that nursing management is de-skilling them. This is a difficult argument, as the question which can be posited is who benefits from nurses being able to do intravenous injections, the medical staff as it saves them another chore or the patients as they no longer have to wait on the doctors coming to the ward? Nevertheless, there is an attempt by nurses who work with older adults to become more technological.

Participants from the first care of older adults interview also felt a lack of support from teachers where their area was concerned in that they felt teachers did not emphasise the need for specific skills although they suggested that there were improvements. One of the participants went on to talk about how the care of older adults seems to her

A 3 It is not really as prestigious as high tech nursing, I.C.U. and stuff like that. People up there are nursing machinery, they've forgot their nursing care.

This participant went on to suggest that skills should not be considered basic but essential nursing skills or as suggested by one of the other participants, universal nursing skills. Within that definition she includes communication skills. One participant goes on to talk about how students react to machinery.

A 4 Sometimes students light up when there is something like that. Instead of like you're saying, sitting them down and talking to them, it is the way for them

A 1 When you ask students when they come down and you say to them, make a list of what you think you will learn, it's all things like T. P. R., catheterisation, all the technical stuff like that you hear and when you say to them what you think what the important things will be, communication skills is really what you will learn here. I think a lot of people think they have a checklist to say, I've done that and I've done the other

A 2 I think you should concentrate on the communication skills much more, and, okay, it is useful to them, how to play with a machine and it is useful to do a BP but it is just as essential to work out, okay, there is something wrong with this lady, what is it, and be able to go through the global assessment, than just say, right I'll do her BP and that'll be the end of the story

This participant was therefore indicating that there are more skills involved in learning to nurse, including problem solving skills and observational skills, than knowing how to operate machinery. This group made no attempt to make the care of older adults setting more technological than it was but they were saying that there is more to basic nursing care than just carrying out the skills. They were also scathing of the work in acute care where the hierarchy of skills was perceived to operate where the junior nurses carried out the washes and help with getting out of bed whereas the more senior nurses helped with the younger patients and checked the machinery.

The participants from acute care, when asked about learning only basic skills in care of the older adult, were mixed in their views.

N 2 *Obviously not looking into other aspects because within basic nursing care you are looking at their diet, you're looking at their pressure areas, you're looking at their mobility, you're looking at all that, aren't you? It's not just basic nursing care. You've got peg tubes, diabetes, M. S. sufferers. You've got all that haven't you?*

Moderator *So are you saying there is more than basic nursing care in care of the elderly?*

N 1 *What I was away to say is my impression is that a lot of care of the elderly wards don't seem to manage to cope with much more than, and I say that because I have seen the patients come into our ward. I see it in trying to get patients back into care of the elderly home and they won't take them back because they've got x, y, z, happening to them and they won't take them*

N 4 *Do you not think a lot of them lose their skills because there is more than basic nursing care, and yet a lot of it is basic nursing care with a little bit of specialised care on the side?*

Later in the discussion one of the participants described how patients come into her ward from nursing homes with pressure sores and she went on to say

N 1 *..... there could be an excuse if they didn't realise all the factors, you know turning them and feeding them. There can't be an excuse to come in, some of the states they come in, in and you think, what am I going to do? This is a nursing home with trained staff. They should be able to see this problem, and sort it out long before it got to that stage.*

N 4 *But then a lot of the homes are short staffed too.*

N 1 *I always think that's not an excuse*

The lecturers talked about how the students viewed the care of older adults and one of the aspects which students enjoyed was the discussions they had with older

adults however

L 6if it's down to the case, where it's down to how many people you get up, washed and dressed and toiletted and whatever

L 3 I think we are still lingering in a backwater and this is where people go if they are not good enough..... it's more exciting in acute where things are happening

Another of the lecturers identified how more senior students did not see the care of older adults area as beneficial in developing their skills. However the perception of the work was summed up in this comment

L 1 It's the perception of the type of work in the terms of, it's all you ever do with elderly people, mostly in a continuing care ward than in rehabilitation is all you're doing is toiletting them, feeding them and washing them, and in a sense all of that takes longer because of the person being elderly in the first place.....

The views from all groups were mixed as to whether the care of older adults was more than basic nursing skills. The most important issue is the devaluing of basic nursing skills as something that junior nurses and nursing assistants do.

Creating dependence came up mostly in relation to bed blocking and was only considered briefly in all groups except the second student interview. The first care of older adults group considered it in the most detail. This group felt that acute care created dependence by not looking beyond the diagnosis for nursing problems

A 1 A lot of them as well, say they have been admitted with a fractured neck of femur or something, that's what they are treated for, everything else is not a problem, a lot of problems should have been dealt with straight away, even in rehab we have a lot of people coming in who have deteriorated a lot, generally you find that before they came in they were independent, they lived on their own and doing everything for themselves, and by the time they get to us, because a lot

of things haven't been seen to, they become immobile and a lot of them don't get home again. Whereas maybe at the start if their whole picture had been looked at, it would have been better for them.

All members of this group agreed that care in the acute areas inhibited recovery. Other stories were told about patients being left in chairs which are now banned in the care of older adults and also being left sitting with no pyjama trousers. They accounted for patients becoming more dependent in the acute areas due to the perceived lack of time to mobilise older people.

A 4 The pace in the acute hospital is faster so an elderly person who is slower, it is quicker to wheel them than to walk them

This comment is echoed by one of the other participants where it takes too long to walk people to the toilet. Bed blocking was also seen as a consequence of not looking after older adults in the acute areas and allowing them to become dependent in hospital. Courtney et al (2000) identify how patients can be forced into the dependent role by nurses doing tasks to patients because it is quicker than allowing them to do tasks for themselves. The second group from the care of older adults identified a lack of knowledge about older adults in acute care as being the source of older adults being allowed to become more dependent. The group from the acute areas agreed that older adults did become more dependent as they were left to cope while the sicker patients took up the nurse's time. The first student interview also identified this aspect where older people were being ignored and suffering from sensory deprivation as nurses were too busy to communicate, resulting in patients becoming depressed, thereby doing even less for themselves. One of the lecturers expressed surprise at how quickly her mother was expecting tasks that she had been well able to do to be done for her by the nursing staff.

Time resources were very much an influencing factor on the care older adults received in the acute areas. This was considered a major issue during the first student interview.

P 2 I think more time spent communicating seeing how the person is feeling in care of the elderly ward rather than an acute ward. Nursing staff here have got other more important things to do than to spend time having a chat with somebody for 5 or 10 minutes.

P 6 It still seems wrong to sit down and talk to anybody. You feel or think you're skiving especially in acute.

P 9 I think they are genuinely busy and understaffed as well, you know which is not entirely their fault. They've got so much to do and they've not got the time to do it.

P 6 It puts you under pressure because it is a vicious cycle. Where nurses are under pressure the elderly will be neglected. So it goes on.

This participant then went on to say that sometimes the nurses were bringing their personal problems to work and she also identified that some people were really unpleasant to work with.

The lecturing staff discussed the time resources in relation to the volume of work in a given time and how this may well be compounded by older adults requiring more time to be spent with them. One of the lecturers elaborated on this

L 4 I think in an acute setting where you have elderly, a surgical ward in particular, there is this perception where people have their operation, be well enough in two or three days then go out the door, and if they don't recover at the expected rate, if they require more help, if they are a bit slower to mobilise.....then I'm afraid a lot of the time it will be the younger patients that get more of the nurse's time if it has been rationed, which in fact is happening a lot of the time

The second student interview reiterated the time constraints. The group from acute care admitted that there was a problem with time resources. However they indicated that nurses in the care of older adults had more time whereas the argument which could be put forward is the nurses who work with older adults are better at prioritising time resources. The staff in the acute areas also felt that they were having problems with time for all their patients no matter the age. They expressed feeling of guilt about their lack of time.

N 4 Their psychological side is definitely not taken care of not in our wards as such.

Moderator *In what ways?*

N 4 Because you just don't have the time to sit and speak to them, find out if they're having problems, what's bothering them

N 2 In our ward the psychological input is quite a big factor, our breast ladies, colorectals, lots of stomas, body image input is minimal. What you're relying on again, is, and I'm not knocking them because they do a brilliant job is the stoma and the breast nurse and the specialist nurse. They come in but you think what did I train for?.....

One of the participants commented on how the patients remark on how busy the nurses are especially with documentation and the paperwork. The nurses in the acute areas were well aware of their responsibilities to their patients but they felt under constant time pressures to complete tasks. They all agreed about the importance of communication skills but they expressed concern that they did not have the time to sit down and listen to their patients. It was expressed in this quote

N 2 Time factor that's when you're always working against the clock, and every minute you're looking, well so and so is going there..... (everyone speaks at once, talking about how they juggle tasks)

The time factor also influenced priorities for care although this topic was very briefly alluded to by the acute care staff. The example given was how priorities

were governed by the acuteness of the problems. For example, a patient coming back to the ward having had a general anaesthetic would take priority over other patients. They also stated that they depended on other usually more junior staff feeding back the appropriate information. When asked what they were doing when they were not doing hands on care they all spoke together giving a list of tasks

Together Drugs, computer, as little as possible (laughs) we'd rather do hands on stuff, admitting people, pre and post op recordings

N 4 Making beds, handing out the dinners. There is a lot of things you have to do, well that's one of the factors of surgical. They heal better if they have good nutrition.

The final category for this theme are the issues of individualised and holistic care. This was raised in the interview among the nurses who worked in the acute areas in relation to the fragmentation of care. This has already been considered earlier in this commentary where different specialists come into, in this instance surgical areas, to carry out care and the examples used were the stoma nurse or the breast cancer nurse. However, the lecturing staff did not so much consider fragmentation but the grouping of patients simply through their age

L 1 they tended to be more grouped as this ageing population that was incontinent, immobile and couldn't eat.....

The lecturers considered how it was much easier for older adults to maintain their individuality if they were being nursed at home, however,

L 6 And I think in institutions, it's hard, it's a loss of individuality, everybody starts to wear the same type of clothing. The ward setting is very much the same, however hard you try, however relatives bring in things.....

The participants from the first care of older adults interview brought up the

subject of individuality through trying to move away from institutionalisation. They discussed how their areas were changing to a more individualised approach. What was interesting was how they saw acute care as being much more conveyor belt care as compared to care of the older adult and they discussed it in relation to hip surgery

A 2 It's like a factory, it is a completely different ball game here, because you have got your clientele and you've got to build up a relationship with them and as you said, trust, and their family and everything.

A 3 We work a lot with the whole family and not just the patient and really get involved in their social circumstances and everything. You've got to sort out and help them sort out their future.

Later in the discussion the group return to the fractured femur and one of the participants talked about an experience of one of the patients who had fallen at home. She was brought into Casualty and an X ray was carried out. The woman was sent home only to return a few hours later with a fracture. The point the participant was making was that lack of assessment put the patient at risk and the patient was returned to an unsafe environment.

The discussion then moved on to how lecturers can teach the subject without starting from the negatives but nobody resolves this dilemma with a way of preparing students realistically for the care of older adults.

4.5.4 Looking after Older Adults

This was a category which remained on its own as there was a lot of input from all groups. The second student group spent more time with this issue therefore this will be the starting point. One participant was talking about her upbringing and the relationship she had with her grandmothers then she goes on to say that if you have a positive attitude then you are more likely to have a good working relationship. This point is explored further later in the interview when they are talking about quality of care

S 7 As long as they get the same care and the same quality.

S 4 But what some people will think is, if you have these attitudes, you can't help let it affect your work.

S 2 I don't think that's always true though. I think you can separate how you feel about things

This conversation is linked to whether nurses do allow their stereotypes to influence their care and there is disagreement within the group which is not resolved. Some of the participants enjoyed looking after older adults especially "the wealth of information" However S 2 returned to the issue of separating social life from work life . The example he used was standing on the bus.

S 2 Out in public life, I've got on a bus and paid my fare, people get on and expect you to stand, but I mean, if they are agile enough to get out and walk and get on a bus, then they have the same expectations to stand as I have, but that doesn't affect the way I am on the ward, and on the ward these people are in need and I will make their stay on the ward and do everything to make their stay as pleasant as it can be.

S 7 I think in public, if you don't get on with someone, an elderly person or someone that is older, you'll avoid them. Whereas I think in the ward, it doesn't matter whether you can get on with them or not. Hopefully most folk will give the same standard of care.

S 5 I think you can hit on the problem of the bad patient then.

The topic is revisited again later in the interview

S 4 I think it is a job that some people don't like doing, therefore if they don't like doing it and they're forced to, day after day their work will be affected. Therefore you want people to work in that setting, who want to work in that setting, therefore will be better at the job.

S 5 explained that the advice he was given was to remember that they could be his

grandparents and he then went on to make a salient point in that some nurses felt unable to use this analogy as it was distressing for them. They returned to the aspect of being able to work with older adults

S 4 I don't think if you can't enjoy what you are doing, you can't do it as effectively as you could if you were enjoying what you are doing, and there is an awful lot of people in care of the elderly wards that are not enjoying what they are doing, therefore not doing it as effectively as they could

This particular group of student participants also described the staff who work in the care of older adults as not keeping up to date with knowledge and another participant described the work in the care of older adults as “numbing monotony”. They described how attitudes in the care of older adults have an effect on themselves

S 4 And not only if you're there for a short while, you can feel that creeping into yourself (everyone agrees)

S 2 You end up not being bothered about the care but when your next break is, or when it is almost 4 o' clock (everyone agrees)

One issue which did cause distress to this group was the lack of cultures for sensitivities being sent to the bacteriological laboratory if patients had urinary infections. They cited cost for not sending away specimens and people were commenced on broad spectrum antibiotics. Other patients were left waiting for treatment from the medical staff for example, six hours for a male catheterisation. One participant at this juncture was annoyed at the negative focus of the discussion.

S 3 I have to say out of all my experience I have had working with the elderly the majority have been good. There is one or two that just don't want to be there, and they've been there too long and realise that they have to move on.

S 7 Two staff nurses I have to admit really did care and they did try to pick up on

the standard of care given, and they just got told basically to shut up.

S 2 It's not that the staff are bad, it's there is so few of them, they can't do what they want to do so they are spending the whole day just trying to keep up the normal routine

It does not take long for the negative stories to begin again

S 7 This is a really bad attitude. I saw two N A's going around with rubber gloves on all day. They would not touch anything, they didn't know what was in the bed, they didn't know what had happened, and that was their attitude the minute they got in the ward, the latex gloves were on.

However, they did suggest that some of the staff nurses in the care of older adults do care and try to improve standards. When asked, if older adults were treated differently within the acute areas compared to the care of the older adult areas, they all agreed that there is a difference and when asked to elaborate

S 7 They get treated for illness like a broad spec. It's not really seen as an old person really

S 5 Some of them get treated like they are really thick. There was one ward I was on, it was over a certain age cot sides on, we don't fancy them falling out.

One participant explained that there was good and bad to be seen in the acute areas and she gave an example of how an old lady with dementia was allowed to stay in the ward where she was and other patients would be moved if they objected to her moving about the ward in the night.

The conveyor belt analogy is used by the students in relation to the care of older adults areas and it seems to refer to different types of clinical setting. One of the participants referred to a dementia ward within a psychiatric hospital where the care depended on nurses going on duty getting the patients up, washed, showered, toiletted and breakfasted but she suggested that the motivation in this particular

ward was that the staff could sit down and read the newspaper or watch television. The most poignant story comes at the end of the second student interview

S 2 We had this old guy and he just stopped walking right. He wouldn't walk, he couldn't walk and he just kept saying I cannae walk. He ran out of fags in the smoke room and we caught him walking down the corridor, wanting to get his fags out of the cupboard, but he couldn't walk. We said what are you walking for, and he said, no I'm not and we said, well you're standing, then he just collapsed (everyone laughs).

The first student interview was much more positive about working with older adults. One of the participants stated that he would be very happy to go and work in a care of older adults hospital due to the "right kind of atmosphere" not like the acute hospital with their attitudes to older adults.

When asked what they enjoyed about the care of older adults it seemed to be sitting and chatting to them, it was also seen as challenging to nurse them and rehabilitate them. This group felt that nursing assistants in the care of older adults were unwilling to change. They also felt that time spent chatting to patients in the acute area was interpreted as "skiving" because they were not seen as working. One of the participants gave an example of this

P 8 I was feeding a patient who had a stroke but he had something else, and I was sitting down feeding him and the sister looked at me and said "what are you sitting down for?" Well I wasn't going to stand over him, but she wasn't happy, because I pulled up a seat to feed him. She wanted me to stand over him, and that attitude was you don't have to feed him, just shove it in his mouth.

The participants all agreed with this statement, however, they felt that there was more time in the care of older adults for patients and for relatives also. They all agreed that there was much to learn in the care of older adults wards.

The lecturers talked about looking after older adults in terms of how they were grouped, not being treated as individuals. One participant from this group identified how perceptions of being in hospital may differ for the older person compared to when they are in the community in that there can be an expectation that in hospital “things are done for them.” This may be due to people having a closer sense of their identity at home. When asked about the type of work in the care of older adults setting

L 1 It's the perception of the type of work in terms of, it's all you ever do with elderly people, mostly in a continuing care ward than in rehabilitation is all you're doing is toileting them, feeding them and washing them.....

L 4 I think in an acute setting where you have elderly, in a surgical ward in particular, there is this perception, where people have their operation, be well enough in two or three days then go out again, and if you don't recover at the expected rate, if they require more help..... then I'm afraid a lot of the time it will be the younger patients that get more of the nurse's time if it has been rationed.

As one of the participants explained, older adults are devalued if they take longer to recover from illness. Later in the discussion an important point is made that nurses may well be recharged by the positive feedback received from younger patients but in the care of older adults there may be a lack of positive feedback

The participants from the first care of older adults interview felt that most people in their area were there because they wanted to be there. To underline this statement, the following comment was made

A 5 I think if they don't have it when they come, they develop it, because when one of the young girls said on the ward, that when she first came to the ward and when she saw a nurse kissing one of the old people, she thought, oh how could they do that and now, she does it herself and she has developed a positive attitude to her job.

It could also be argued that this statement demonstrates how older adults are treated like children to be kissed and cuddled. However, it was agreed by all participants that nurses in the care of older adults setting were treating patients more as individuals and institutionalisation was on the decline. They were more scathing of the care given in the acute areas where older adults were seen as bed blockers, stuck in side rooms and left, because they were making a noise. One of the participants went on to describe an incident where a patient was left in one of the acute areas with a catheter dangling down his legs and with no pants to cover him. Another example of care was given

A 3 When I was in the senior medical block, an old man died in the side room and his relatives went in at visiting time and found him

During the second care of older adults interview, one of the participants explained how patients who were coming into continuing care required more care now. This comment was reinforced by a participant working in assessment where there was a perception that older adults were being admitted frailer and with more medical problems, sometimes with more mental health problems. They emphasised the importance of allowing patients to do as much as possible for themselves. When asked about their perception of the care given to older adults in the acute areas, one participant identified how younger patients received more care and older patients were encouraged to become dependent and this in turn slowed recovery. They also talked about how the units were abused by the general practitioners when social admissions were being masked by them as falls. In other words they were trying to have people admitted for a medical problem when there may be none. The most common reason for this was to allow carers to go on holiday.

The participants from the acute area also have considerable experience in looking after older adults. They talked about how they can become ratty with the demented patients when they are wandering off the ward and there were acutely ill patients in the ward. They talked about the difficulties of bed blocking when there were no beds in rehabilitation to move them as they no longer required acute care. Some of

those patients were waiting many months for a bed in another area. While they were waiting these patients lost motivation and became fed up and depressed. One thing this group did suggest that age is irrelevant with patients being nice or nasty.

4.5.5 Labelling older Adults

Labelling of older adults, when discussed with the acute care participants, considered it in the context of bed blocking. Although it was recognised that older adults were not necessarily bed blockers, it tended to be associated with them. One of the participants found it abhorrent that older adults were considered using this label. The only other label used by this group was in association with the lack of family support.

The lecturers raised a number of issues under this theme. They talked about how older adults were grouped in the care of older adult wards

L 1 they were subdivided into either grannies or walkers, and the walkers were the people who were more independent and the grannies were the ones that were more dependent.....

They went on to discuss how labels are more readily applied to older adults particularly labels such as confusion. Furthermore they discussed how, when teaching about older adults, they started by trying to dismiss the negative images, the very point the first student group made where, if the negative labels had not been considered in the first place, this particular group would not have thought of them. The handover was also seen by the lecturing staff as a vehicle for labelling where older adults are spoken about in terms of the task. This point was expanded on by one of the lecturers

L 4 I was listening to a report in a surgical ward a few years ago, it was the charge nurse and there was at least ten other nurses in the office listening to the report and she said "Well Mrs. So and So, she is just lying there like a beached whale doing nothing for herself at all" This was a lady in her late eighties and had

an emergency surgery for a ruptured peptic ulcer and she was not exactly a fit and healthy person at the best of times.....

L 3 Young people can't see themselves as old it's almost that you see this old person coming in and you can't imagine that they have a family, that they have done all this, have seen all this, that they have been able, active, independent people who have controlled and run their own lives.

One participant went on to say that the nurses don't even bother to learn the patient's name. However another participant commented that this was not necessarily reciprocal as older adults enjoyed having younger adults around them as opposed to being surrounded by doom and gloom. One of the community lecturers remarked on the checks for older adults being called M.O.T.s rather like a car when they are being passed fit for another year.

The participants from the first care of older adults interview identified the negative language used about older adults, words such as decrepit, senile, old woman. They considered how older adults are seen to be on the scrapheap when they retire from work. What was interesting and has been observed by the author is that older people don't see themselves as old but they do see others as old.

The participants from the first student interview also discussed how older adults were labelled and there was a tendency among them to do the labelling, the example of which is the following description

P 5 Like you go down to the shopping centre on a Saturday morning and you're in a rush or something like that. Who'd be in the way? It would be an old person when you're in a rush. They always seem to spring out of the woodwork.....

This group identified, as did the lecturing group, the tendency to forget that older adults have a past and they have a lot to offer. However one of the participants makes a poignant statement about what is lost when older adults die

P 6 *Some of them have lived through things, and have history they can only share. They've seen it first hand. So they are really valuable. When the elderly die, first hand experience can't be told by anybody else. It's sad because people don't really respect old people and what they've been through*

Labelling is further explored later in the interview with reference to how older adults are treated by some nursing staff.

P 6 *Very patronising, they need to feel the power and control, but patronising someone who is much older than you, really it's embarrassing.*

M. *You're saying patronising, but how do they do it?*

P 6 *Just the way they talk to them and treat them*

P 5 *Talk down to them*

M *Talk down to them?*

P 6 *Call them dear or something, treat them like children really.*

The subject was returned to yet again when one of the participants talked about what he called bizarre behaviour and he explained

P 2 *What I found quite bizarre is that working here (acute hospital) you'll find a lot of the staff although they laugh and joke with the younger patients they won't try that with the older patients. They are a completely different species, you can't laugh and joke with them, which is completely untrue*

He rationalised this behaviour by explaining that those particular nurses felt that they did not know how to get a laugh from an older person.

At the end of the interview one of the participants suggested that the government must shoulder some of the blame for the position of older adults in society

P 6 *That's sad, that's really what the government decided, we don't value elderly people. So we'll just let you set up a home regardless of who you are and you can*

abuse your patients and that's fine by us, that's what the government seem to think.

The only other group who had identified issues which were appropriate to this theme were participants from the second student interview. They discuss how a lot of older adults were viewed with what they describe as the Victor Meldrew syndrome. They went on to talk about the skills that older people have and then one of the participants considered the issue of homogeneity

S 2 I think what we find is people see the elderly as a whole group, but they will have a group of elderly friends and who they know won't treat them that way.

S 7 Or don't even think of them as elderly.

This remark is followed up in relation to their own parents and relatives who they did not perceive as old yet other nurses may do so. When asked directly about the stereotypes held, the first remark relates to “old women with blue rinses” the second to having them push in front of you at the supermarket. What was distasteful was how one of the staff nurses had been talking about an “old wrinkly” being admitted to the acute ward. One of the participants in this group did identify that older adults were to be found in numerous wards out with the care of older adults however it was identified that stigma does have a negative effect on the care of older adults wards. The concept of humour or indeed lack of humour was raised in this group as it did in the other student group where older adults were being seen as humourless. Whereas one of the participants had been given a row by an older adult for raising their voice unnecessarily when speaking with him. However one participant called some of the older adults cantankerous. What did cause amusement in this particular group was the idea of a care of the elderly branch

S 5 Look at project 2000, they looked at a care of the elderly branch and they decided not to do that, because they thought nobody would want to do that (everyone laughs)

4.5.6 Learning opportunities and expectations of student nurses in the care of older adults setting

The most appropriate place to start in considering this theme was felt to be student expectations. What did students expect from the care of older adults setting? The second student interview is examined first as they, on the whole were much more negative about their experience.

One of the students did not come out and say that there were no learning opportunities but she was unhappy about spending her shifts as she saw it toileting patients. She had previous experience of working with older adults but this area as she said “put her off” She explained that she thought this type of area would involve more activities with older adults for example going for walks. One of the other participants who had a more positive experience described how there was no set routine and patients were allowed to get up when they so desired and there was music with patients doing jigs. One participant added

S 8 If you work up on A or B, it's much more of an assessment ward for the elderly, so it's less everyday stuff that's going on. There is more investigations of this and that going on.

Lack of stimulation for the patients was raised again and one of the participants stated that they may not want stimulation in continuing care wards. This remark seems to demonstrate a lack of insight into older adults lives. He went on to describe care of the older adult as “samey”.

The first student interview had more variety in their discussion about the care of older adults. What has been noticeable, as a link lecturer in older adults areas, since Project 2000 commenced, students were allocated to the setting for four weeks throughout their whole experience but they could come back during elective. They chose not to do so and this question was explored with this group. The answer given was

P 1 *When you're in C. F. P. you get four weeks placement of care of the elderly situation along with all the other branches, you know, whereas you come into the branch situation whether it be medical or surgical, you can only get one choice for an elective. If you want to work in care of the elderly, well, yeah, but a lot of people may have had a bad experience in care of the elderly when they were in C. F. P. so they are put off so they don't want to go back.*

M. *So are you saying then there should be another care of the elderly compulsory in the adult branch?*

P 3 *If it is possible, we would agree with that.*

P 1 *P 3 said earlier on about multiple pathologies. That's really the only opportunity you have to see people with multiple pathologies and how it affects their lifestyles*

This group identified how teaching staff and clinical staff talked about the care of older adults with them; how it was the Cinderella job in nursing; how nurses who went into this specialty were unable to get out. When asked about their ideas of this perception

P 3 *I think it is rubbish. It is wrong and that perception needs to be changed because with this group there are a lot of pathologies as I said earlier and there is a lot you can learn.*

One of the group later described how busy the assessment ward for the care of older adults was in relation to a busy surgical ward. This is further expanded

P 6 *I was on an assessment ward in (name of hospital) and it was really busy as well. There was lots to do, different things to do*

This group certainly felt that nursing older adults was more than clinical nursing skills, that there were other skills to be learned in this type of area. However this was not further explored.

When asking the lecturers group about the skills learned in the care of older adults, they identified the communication skills where students had enjoyed listening to older adults' stories. However, this group expressed that once students have developed the confidence and skills in nursing, the skills on offer in the care of older adults may not be seen by the students as the most appropriate skills for progress, though they did see the relevance of management skills within the area. One participant put forward the notion that when students have needs and outcomes to achieve, where there are skills which have to be acquired this can have an effect on the perception of the placement. This was readily identified by both Melia (1987) and Gray and Smith (1999) in their studies where the hierarchy of skills are linked to the process of professional socialisation.

Only one of the care of older adults groups made much comment on learning opportunities for students. However, they used this question more as a grumbling session about the quality of students being sent to the area.

V 4 There is some that don't want anything to do with the patients. Like they just sit there and look through the books and see all the medical procedures, but not actually have to speak to them or anything. There are still students that would rather sit at the desk and read rather than sit in the sitting room and speak to them and find out things.

V 2 Or "I've made a bed, I don't have to make another one"

V 4 (Laughs) "I've done blood pressure. I did that on surgical"

This group felt that the students lacked life experience and were being allocated to the care of older adults too early in their nursing education. However, all students, at this time were allocated to the care of older adults areas as their third clinical experience. The length of the placement was also perceived to be a problem and indeed this was an issue that students complained about themselves.

V 1 It's only a four week placement and that's a major problem. The placements are not enough, they come in terrified.

V 4 *You're looking after people with renal failure and heart failure, may well be all at once.*

V 3 *They may well know the theory, I'm not saying they don't know the theory. Practically they are so far behind to what we were used to being in the modular training that you really have to supervise them on every little detail, and the way the staffing is sometimes, it is just impossible*

This next extract from the conversation demonstrates how stereotyping is widespread within nursing and is certainly not confined to older adults.

V 3 *I think the psychiatric placements is a bad time. They could be using that time better. I mean a first year student nurse when he or she goes into a psychiatric ward, basically they are not involved in anything. They sit with the patients.*

V 4 *I suppose that is enhancing their communication skills.*

V 3 *Yeas, but it doesn't do them great, it doesn't do their clinical experience any great help coming here. It might be a bad time to have a psychiatric experience*

This group are unwittingly using stereotypes to describe the role of the nurse who works in psychiatry, where skills offered in this area are seen as almost valueless in that they sit about with the patients. All that is missing from the stereotype is that they are usually labelled as drinking tea all day as well.

When asked directly whether the care of older adults had any more than basic nursing skills to offer, they were emphatic that there was more. They felt that they had more to offer than a medical ward for the range of medical problems, enhancing communication skills, and indeed actively encouraging students to go and speak to patients. One participant stated that nurses needed to have some degree of knowledge about most medical conditions.

Very little consideration was given to learning opportunities for students in the care of older adults by the acute care staff. However, it was felt that it was a matter of learning as you go along "hands on"

It was difficult to pin people down as to what they meant by learning opportunities in the care of older adults although most participants did acknowledge that there was a different set of skills to be learned. There seems to be a disregard for the so called basic nursing skills. What is wrong with offering basic nursing skills and surely every ward, no matter where, has their routine basic nursing care as well as their technological skills No matter what ward a patient is on they still need washed and offered the very basics of hygiene.

The other topic which was associated with this theme was student expectations. The first care of older adults group started off by saying that students, initially were quite negative about coming to care of the older adult and the reason for this is described in the following statement

A 3 They come in and expect to find a lot of old "cronos" because when they were getting their lectures for college, we had an incident recently, it was a student from (named) college, she was either on the access or preparatory course, I can't remember but she was surprised to see old people that were quite with it, because they got so many lectures on dementia, incontinence and disease, to see someone that was quite normal and old, it was quite surprising

The participants in this group handled the student nurses by asking them what they expected to gain out of this placement

A 2 Then that puts the ball in their court, and you can work out exactly whether they are being totally unrealistic about what they are going to learn

A 5 We had a student recently who wasn't really looking forward to coming down here, because she thought she was going to a ward where patients were going to be dying all around her. We've got to get the point over to them that they can come down here and not necessarily even see a death on the ward.

Other issues are raised and reiterated by the second care of older adults group, one example being the issue of incontinence. The first group also mentioned the

surprise students have when they find that most older adults can hold a sensible conversation. However they felt that they were able to identify students who did not want to be there and this again is a common concept across both the care of older adults groups. When asked how they knew who was interested

A 4 Because they are more keen, more involved with the elderly, whereas the others will stand around saying they are bored, stand there flicking through a magazine, when everyone else is rushing around.

When asked to expand on the bored students the participants agreed that if a student had completed a task once, they felt that they did not need to do it again but they went on to say that these students probably behaved in that manner no matter what ward they were on. However they all agreed that students who came to the care of older adults setting usually enjoyed their placements, even though they decided they may not want stay in this area of nursing.

The second care of older adults group felt that student nurses' attitudes had changed over the past couple of years in that they were more positive about their placement. They felt that many of them were surprised by how acute the wards were.

V 3 I think a lot of them are surprised by how many acute patients you can have in a ward.

V 1 They often say they are pleasantly surprised you know with what actually happened in the ward. "I didn't expect this, I didn't expect to see variety." So yes they come in with an attitude but go out with a change for the better

What they did identify was that there were students, no matter what was done for them, just did not want to be there. This particular group identified that the medical staff were exactly the same. When asked where students develop the idea that the care of older adults is about basic nursing care, this group identified both the acute care staff and the teachers as the culprits.

V 3 Whether it is because they have been to the acute setting first, and getting the information from them, the trained staff at the acute hospital or the tutors, I don't know, but they are certainly coming in with the expectations that you turn patients, wash patients, all patients are incontinent, basically that's it.

The care of older adults group describe students as being “ gob smacked at the amount of work, the quality of work and the quality of patients as well”.

The lecturing staff were in disagreement as to what students' expectations were

L 4 They (students) don't see it as real nursing.

L 2 And yet, isn't it interesting because I have been in various interviews where we have been interviewing for places and the emphasis on discussion or past experience has been with the elderly. Like “I've worked in a shop and the people I have to care for most is the elderly. When they come into the shop I have to help them look for what they want, I have to help them out the door.” It's almost like at interview, some of them do perceive nursing as being related to the elderly and want to emphasise that even though they haven't been in a caring situation per se they have been in situations where they have helped the elderly

The participants from this group also described how expectations did not match reality in that students remarked that they were surprised that patients could walk. However later in their education they emphasised other skills to be learnt in the care of older adults such as liaising and coordinating all the services as opposed to the hands on care .

The first student interview considered how the college coloured their expectations of the care of older adults which they described as a negative view.

P 2 At least if you had already been on your placement first you've got the opportunity to make your own mind up, instead of that already being in there before you head out for placement.

P 7 *Yes, but someone saying that should not necessarily make up your mind straight away.*

P 2 *No it doesn't make your mind up but it gives you an impression that well why do people think that. I totally disagree, I'd love to go and work in care of the elderly, I really enjoy it, but I still felt when I first went there ,why did they say that? Why do they feel it's going to be the end of your career, or if you can't get something else then go and get a job in care of the elderly?*

In the second student interview only one comment was made about expectations

S 6 *I was looking forward to going there, I thought I'd get to take them for walks, play games with them. Talk to them and all that kind of stuff, and as soon as I got there all my ideas were shattered*

This participant had found the experience very disheartening and discouraging. She had high hopes of the area but she felt badly let down by the experience.

4.5.7 Contact with older Adults

The acute care group were asked whether student nurses come into nursing with negative attitudes.

N 4 *Not really. I think there might be the odd one, it depends on what they've done before nursing. Some of the more mature students that maybe have worked in homes and they might have an attitude problem*

M *Why do you think that might be?*

N 4 *Because they've had to deal with difficult older people, and they've just got this in their mind I think*

N 3 *A lot of students before they come to us have been to (Named care of older adult hospitals) , so they know sort of. We've got quite a lot of elderly people in the ward , so they've nursed them before like in rehab or continuing care.*

N 4 *Quite a lot of it is down to first impressions or having to nurse someone older, gives them a sort of attitude, you know the way they go, whether it is positive or*

negative. If they've looked after someone who is really nice, they're always quite willing, but if they've looked after someone who is cantankerous or hard!
N 1 *I was thinking that another thing that might influence them, their own dealings with grandparents and that, because a lot of people don't have grandparents nowadays.*

This group acknowledged that older adults were integrated into all wards, therefore students did not necessarily need to go to the care of older adults to nurse older people. One of the participants quoted a figure of 80% of older adults taking up surgical beds. What was identified was that the numbers of older adults in the wards would fluctuate according to the weather i.e. more older adults in the Winter.

The staff from the second care of older adult interview felt that the negative attitudes held by the students were coming from the other nurses and medical staff in the acute areas and they also identified that the majority of beds in acute areas were occupied by older adults.

The participants from the first care of older adults interview felt, contrary to what the staff from the acute areas expressed, that the older students seemed to relate more successfully with the older patients and this was attributed to younger students having less contact with older adults. They also identified the numbers of older adults in the acute care areas.

A 3 You know I enjoyed all of my training, but preferred care of the elderly, and what kills me is, it doesn't matter what ward you go into, the majority of your patients are older, you know and the nurses on these wards say " I wouldn't like to nurse care of the elderly people" yet they are doing it all the time.

The students from the first interview readily distinguished between older people as part of society and older people who required nursing care. They also agreed that the majority of wards would have a number of older adults although they did not

define what they meant by older adults. What was interesting was the figure quoted. The acute care staff put forward the figure of 80% whereas the care of older adult staff put forward the figure of 70% and the students put forward the figure of 50% however they succeeded in making their point.

The participants in the second student interview thought the quality of contact with older adults was pivotal to attitude. They all agreed that it goes back to what people were first shown as a younger person

S 7 Like I had a brilliant grannie so I'm looking forward to growing older 'cause she has a very active life, whereas somebody else might have had a grannie that's a grouch basically and their perception of the elderly might be different.

S 6 I think it can change as well, from when you're younger to now, working with them just changes.

One of the participants was not sure that she agreed with how attitudes might change but another participant had felt that she had moved from a slightly negative stance because she knew very little about older adults to a more positive stance. However one of the other participants stated

S 4 My attitude changed the other way round, I would have liked to work with the elderly before I started on the course. Now I've worked with them I don't want to work with them

Infantilisation of older adults was considered also with reference to thinking about older adults as grandparents rather than as adults, in other words, not considering them as adults in their own right. This participant also comments on the increase in negative attitudes within society.

The lecturing staff reiterated the point that attitudes of students depended on perceptions of older adults they had met either as grandparents or next door neighbours. According to one of the lecturers, a student had been taken aback that

there were old people in the hospital and the same lecturer talked about the numbers of potential students who focussed on the young and children and one of the participants made a pertinent point in relation to this comment.

L 5 If you look at the similarities between looking after elderly people and very young children, often you are doing the same for both groups and you can argue that people might perceive a certain charm with young children that isn't around for the elderly, a beautiful young child, eighteen months or two years, this is a wrinkly old person at eighty nine who's heavy and who smells, doesn't cooperate, and maybe bites even.

However, one could argue that remarks like this reinforce the notion of a second childhood which in itself is a negative stereotype.

4.5.8 Categorising nurses who work in the care of older adults.

This theme was considered pertinent to the overall research as there is anecdotal evidence to suggest that the care of older adults setting continues to be perceived as an area suitable for people who can't quite make the grade as a real nurse and it was with this in mind that the topic was explored because it was felt that this might discourage students from settling into this specialty.

One of the participants from the lecturers' interview stated that it was still thought of as a back water and lacking in a career structure whereas the acute areas are seen to be much more exciting. This was the only relevant comment made by them for this theme.

However the students from the first interview made comment about this issue.

P 9 Definitely when you hear nurses qualify. If they get a job in care of the elderly, it's like second best.

P 1 There certainly seems to be an attitude

P 9 If you're working in care of the elderly then you're not seen as clever.

Other terms this group had heard from the teaching staff were the job being called the Cinderella of Nursing, and nurses could not get out of the area once they were employed there. However, it was not only the lecturing staff who made comments. One of the participants was told by a member of the nursing staff in the acute area that there would be no problem getting a job because no-one wants to work there. One other participant had been told that he would lose all his skills.

The second student group interview were ambivalent about this question. They felt that there were faults on both sides. They did state that nurses out with the care of older adults did see those who worked in this specialty as having no real ability. However another participant felt that the staff in care of the older adult were partly to blame for this

S 8 Someone needed a syringe driver for a morphine pump, you know how they make them up, and nobody on the ward knew how to do it, and one of the staff nurses from another ward came over to show them. Do you know not a single staff nurse was remotely interested in how to do it. They just let her do it and that was it, fine.

However all of the participants had been warned that if they want promotion not to come into care of the older adult as it was a dead end job.

S 7 If you look at most of the staff that's in the care of the elderly ward, it's not their first option to be there. It's always people that are looking for a part time job. It's the dead end job that nobody else wants to do and it's a last resort.

S 5 There was one that qualified from here one or two years back and it was her first choice. They were surprised that she enjoyed herself and it was her first choice to go back there and she is still enjoying it

The overwhelming feelings expressed by the nurses who work with older adults and this accounts for both groups, was the impression of being second class citizens and this is coming from both the nursing and medical staff out with the

care of older adults area. When asked how they knew that they are almost second class, as they described it, both groups said that it was the way they were spoken to. One of the participants of the second group from the care of older adults group described it thus

V 2 I think it comes over in the way they speak to you. I think they treat you like lesser citizens, if that's a good enough phrase as though you don't know what you are talking about.

V 1 It's disdain to a certain extent as well and at first I thought, no that's not happening at all, but as everybody in the group here is saying, if you make a telephone call to say the acute hospital (Named) for example you can hear this iciness and you can hear this change in the tone when you say where you're from..... Disdain, nonchalance and sometimes lack of interest.....

Later in the interview the concept of second class came back into the conversation and one of the participants felt very strongly about the importance of patience when working with older adults.

V 4 The favourite phrase I always hear when I say I work in care of the elderly. You must have wonderful patience. What patience do I have that I wouldn't have in medical assessment. It's exactly the same.

V 2 Another perception is once you get into care of the elderly, you are stuck

V 3 You are to an extent

V 2 if you are determined enough to get out you would manage it.

This group then proceeded to discuss their various experiences of applying for jobs out with care of the older adult and how working with older adults was not considered legitimate experience for the general areas unless they were willing to drop grades.

The first group from care of the older adult were asked how they felt about the perception of being stuck in the care of older adults.

A 1 *They think that you weren't good enough to work anywhere else and you got a job in care of the elderly, and if possible you're wishing all the time to get a job somewhere else..... well obviously she's rubbish and couldn't get a job anywhere else.*

Two participants from this group had gone into the School of Nursing and Midwifery to speak to third year students about working in the area to explain to students that nurses come into this field as this is where they want to work. One of the other participants described the perception of nurses in the care of older adults as dunces who couldn't get a job anywhere else. One of the participants then said

A 4 *It gets to the stage, I just wouldn't say where I am because you know the response you are going to get.*

A 3 *You kind of find you are making excuses for yourself. We do this and we do that, your excuses, well I know it's not everybody's cup of tea but I enjoy it. I do find myself saying things like that.*

A 1 *When I was doing my P. S. I's (Professional Studies) there were trained staff from the acute areas and you know you have to go round and introduce yourself and that, everyone's saying I'm blah and I work in I. T. U. I say I work in (name of Hospital) care of older adults hospital, and it was when it was around the corner and they would say, oh you work here, oh.*

A 3 *(laughs) They feel sorry for you, because you are the dumber of the class (everyone laughs)*

A 1 *It was worse when it was here, because they would look out the window and go, oh right. It looks a bit depressing doesn't it?*

4.5.9 Clinical staff influences on students attitudes to older adults

The lecturers were asked how clinical staff influenced students in their attitudes. They identified the importance of the nurse as role model, and they accounted for this through nurses' values and beliefs systems where the philosophy of the ward intimated that all patients are to be respected regardless of age. This is described

in more detail by one of the participants.

L 6and they will go through the type of ward where the philosophy is good, it is very patient centred, where people are pulling out all the stops and the individual patients are valued

When asked directly about the relationship between clinical staff and student attitudes, one of the lecturers suggested that students did not necessarily come into nursing with negative attitudes but,

L 1 it certainly is the attitudes of the staff on the wards, that has an influence on the new student coming in and they see role models treating elderly patients, how they see them, how they talk to them, how they see the importance of the work that they are doing.

One participant added that the role of the preceptor was instrumental in colouring students' views. However the perceived lack of resources and the workload were also seen as inhibitors to nurses wanting to work with older adults. The setting was also considered as being influential and the example given was community nursing where the vast majority of the patients were old but the students enjoyed their nursing experience. The speed at which older adults recovered was also thought to be important where the longer people took to recover from illness, the more likely they were to be devalued.

The first care of older adults group stated that trained staff within the acute areas were worse than the nursing auxiliaries when it came to influencing student nurses' views. This was seen to be due to priorities being different where there were so many ill people requiring care and nurses not meaning to be negative.

A 1 If you're a student on a ward and you see how people are treated then, you just take that on board don't you?

A comment confirming this view was made later in the interview by one of the other participants.

A 3 Even if they are unaware of it, when they are in placement, they are picking up the vibes even though it is not obvious.

When asked about changing attitudes they explained how it was so much easier going with the flow. When asked directly about going with the flow in the care of older adults

A 1 A lot of things are taking a lot longer to change, than maybe they should have done because people go with the flow.

The second care of older adults group, when asked about the influence of staff attitudes, mentioned that attitudes not only came from staff but from patients also.

V 1 sometimes patients themselves don't want to come into this area. They are horrified, this lady was borderline, she was horrified and she's saying "all these women are elderly" You know there is this attitude as well. Now where did she get that from?

The interesting aspect of this research has been how the clinical staff from the care of older adults view the staff from the acute areas in much the same light as they accuse the acute staff of viewing them and vice versa. One of the participants from the acute areas recalled her experience within the care of older adults setting as a student.

N 4 I remember as a student working in (named care of older adult hospital) and like a majority of the nurses were really good, but you get one or two really quite short tempered. You couldn't understand why at that time because you were really just in the door. You wondered how folk could be like that.

This group reflected the sentiments put forward by the lecturers when they discussed how the tasks students were allocated may influence their views as well as attitudes “rubbing off” from existing nursing staff. They also discussed the importance of good role models. This is explained by one of the group

N 1 But you do hear about people abusing the elderly. I don't mean that...but em, if people go into a situation and see people treating anyone badly, and they think that's alright for me to do that as well. They might not even realise they are thinking that. So I think a role model is very important.

This group however did note that there could be problems with less than sympathetic preceptors. Motivation from the charge nurse was also considered important no matter what type of areas.

Participants in the first student interview spoke in detail about staff influences. One of the participants stated that he did not like the attitudes towards staff and patients within the local acute hospital. However one of the other participants was scathing about attitudes and not necessarily trained staff in one of the local care of older adults hospitals. This was elaborated upon by another participant

P 8 I think the nursing assistants on the elderly wards, they don't want to change. The attitude is, we get a new staff nurse , they come in here with big ideas, but we'll soon get her sorted out and I feel that there is too much time sitting around drinking tea.

Patronising older adults by the staff through infantilising them was also discussed. One of the participants however had a different experience in the care of older adults where patients were not patronised. She thought that this was due to the team leader, an opinion reflected in the acute care interview.

However one of the participants from this student group felt that there was a complete mix

P 2 *There were some like that yes but some were really motivating. You could see they loved what they were doing and they were good at it.*

P 6 *I think enthusiasm brings out the best in the elderly ward. I think it takes quite a special kind of person really to have the patience and everything. I've worked in an area where the ward sister was very enthusiastic and the patients adored her. She was fun and treated them with respect and it really enhanced the whole area.*

When considering areas out with the care of older adults, the students again had mixed experiences where they were seeing examples of caring behaviour and not so caring behaviour. One participant put the variations down to the personality of the nurse. Another participant further explored personality

P 6 *Sometimes they don't even make an effort to smile. I know they have personal problems and take them to work and can't put them away..... I really feel we can't be negative and sometimes people are really unpleasant to work with. It's really, it's awful. I know they need the money, or whatever, but it just won't do. It reduces morale and is really unpleasant.*

Staff in acute care are also accused of wanting “super efficiency” over “good quality care”. One participant who had moved from the mental health branch to the adult branch asked people she met whether they enjoyed their job and she stated that most nurses within the care of older adults actually liked it. They discussed the relevance of age to staff nurses who enjoy working with older adults, however they did not reach a consensus.

4.5.10 Lecturers' Influences on Student Nurses' Attitudes towards older Adults.

Consideration is given to the first student interview to start this theme as the overwhelming impression from one of the participants within this group had what seemed to him real concerns about the methods used in teaching about older

adults. He felt that teaching staff, as he described it, implant views prior to them even being considered.

P 2 Well I think we originally got it from the college personally, before we went out on placement. It was the college that said a lot of people don't like working with the elderly. They feel they'll end their career. That used to be the attitude, but we would never have thought of it if it hadn't been brought up in the first place in college

When asked to elaborate he stated that he thought it was unnecessary to go back to the way people used to think about the care of older adults and then indicate that it had all changed. He felt this created a negative image of the placement and asked why it was mentioned in the first place. The conversation moved on.

P 5 And they're (lecturers) preaching at us to be non-judgmental as well but on the other hand they're saying that to us, so what about them being non-judgmental

P 2 And also just a few weeks ago, one of the tutors in the college mentioned, we don't want to go and work in care of the elderly, so it's still there now, they are still saying that. That's reinforcing what I said before.

Mod So one of the teachers said recently "I wouldn't like to work in care of the elderly"

P 8 I just got told last week from one of the senior tutors, when I said I wanted to work in care of the elderly he went, well that's a start and I said it's what I want to do. He said "well there's not much to do in wards that are dingy and don't do anything, do you think you can make a difference?" Well, if people don't go into it then it won't make a difference. So that was last week, that is the attitude of most teachers.

When asked if they wished to comment on other issues surrounding teaching, one of the participants stated that there was a lack of lectures in the care of older adults, both in the Common Foundation Programme and the Branch Programme

about the importance of the subject. However, one of the participants did not agree with some of the comments made about the teaching staff and had felt that some of the teachers welcomed an interest in the subject. One of the teachers did call the speciality the “Cinderella” job of nursing, a job that nobody wanted to do. There were some mixed comments within this group but one of the participants had obviously been angry and upset about how the speciality was portrayed and this was expressed in the following comment

P 2 I resented it because I don't see how any tutor in this college can say you're not being a proper nurse if you're working in care of the elderly which was an impression I got, not too good, whereas I enjoy it, I love it, I think it's great and how dare anybody else say I am not being a proper nurse.

The second group of students did not have the same feelings about lecturers' portrayal of older adults other than to identify those who were enthusiastic about the subject and those who lacked enthusiasm. One comment was made about lecturers making jokes about older adults, however added to this was the remark “is humour a bad thing?”

They did comment that few teachers raised the care of older adults as a separate issue or stood up for them and there was a lack of education as to how illnesses affected older adults. There was also ignorance among this group of students to the fact that illnesses could present differently in an older age group.

The lecturers were asked whether they had any influence on student nurses' attitudes. They tackled this question from the point of view of the need to change attitudes.

L 1 It's incredibly difficult. It seems attitudes are a difficult thing to change once they are embedded, and we can try very hard as teachers to give a positive attitude over towards caring for elderly people. We can try and highlight the skills you can give caring for elderly people and the rewards you get professionally for

caring for elderly people.

L 6 And I think we always start by being on the defensive, by saying elderly people aren't all continually incontinent and cantankerous but you are always starting off from working against the negative images..... You've always got to talk about perceptions, the negative aspects and that seems to be what sticks.

However one of the participants questioned whether there was any effect from the teaching staff, other than the expert's word. He felt that influence came from their experiences working with older adults and the preceptors. When questioned about the staff view from the care of older adult, that is, lecturers encouraging a negative attitude, one of the participants agreed that there was a mismatch between the two sides but the mismatch was coming from the clinical staff who did not want change in their areas and the example given was promoting continence in older adults whereas this was seen as an impossible task in the care of older adults setting. One lecturer did voice the role of the clinical teacher when more time could be spent with the student doing tasks and acting as a good role model.

There was little comment about the subject from the acute care staff. However one participant stated that college input was important for younger people because they "have never really come into contact with elderly people before" They all felt that the college influence was positive and one participant who had gone to the local Technical College to complete her nurse education via degree stated that the lectures were brilliant on care of the older adult thus giving purpose to the placement.

The staff from the first care of older adults interview were quite scathing about nurse education and it's effect. One of the participants complained that there was too much emphasis on problems of older adults so that when students come to the area, they are surprised that people could be normal and old, although they did agree that there was less emphasis on institutionalisation in the school and less concern that the care of older adults was perceived to be a problem area. They,

however, did feel that the care of older adults should be a specialty therefore teachers should have the appropriate skills and knowledge to teach the subject. They also felt that lecturing staff as they had little experience in the specialty were not up to date with their knowledge. One of the participants did describe an incident on how a teaching session was enlivened by a lecturer role playing an older person. She felt that this was a positive portrayal.

The only comment made by the participants from the second care of older adults interview reiterated what was discussed in the first interview, that a lot of lecturers had not been in care of the older adult in years and were probably giving out the wrong information and she put out a general invitation for lecturers to come down on to the shop floor to have a look at the place in action.

4.6 Conclusion

Although the aim of this research has been to produce a questionnaire from the focus group data there is no doubt that focus group discussions provide some interesting and worthwhile data. The data are rich in description and compatible with what occurs within the clinical areas promoting the concepts of transferability and dependability. The justification for producing a questionnaire was discussed as a component of the literature review when previous tools which have been used to measure attitudes towards older adults were critiqued. The rationale for rejecting those tools include a question over their ability to evaluate nurses' attitudes. This research has argued that nurses, because of their unique relationships with older adults and the context in which they come in to contact with them, encourages nurses to hold different attitudes. Those attitudes have been developed from professional socialisation.

The results from the thematic analysis appears to support this notion in that there are a number of factors which were identified during the focus group interviews encouraging nurses to evaluate older adults negatively. The next step will be to identify and operationalise the most frequently occurring factors. Those factors will be validated through the development and distribution of the questionnaire.

However, it is worth noting that a number of very important factors were identified during the focus group interviews which are important to nurses and to nursing practice. Those factors are not present in any of the current tools which are used to measure attitudes toward older adults. Thus there are no references to older adults being incontinent/ continent or the work being routinised and tedious. Other factors which do not arise are those underpinning the basic nursing care versus technological skills debate and the influence of infantilising older adults. Those factors will be tested for relevance during the next phase of the research.

Chapter 5: Development of the Questionnaire from Focus Group Data

5.1 Introduction

Once the qualitative analysis was completed and themes were identified, the next phase of the project was to produce a questionnaire. The purpose of the questionnaire was to test five hypotheses listed below.

This chapter sets out the process which was used to formulate the questionnaire from the focus group data. The process of principal components analysis is discussed with reference to the explication of items for the questionnaire. Finally, consideration will be given to the subsequent distribution of the questionnaire for piloting and refining purposes.

5.2 The Survey method

Fife-Schaw (1995) describes the questionnaire as the most common research tool whereas Oppenheim (1992) describes it as an important instrument of research which has the function of measurement. Fife-Schaw (1995) cites some of the many advantages as including their apparent simplicity, their versatility and their low cost as a method of data collection. However he goes on to state that designing a perfect questionnaire is unachievable in that neither all your respondents nor your peers will be entirely satisfied with the design. Oppenheim (1992) describes the intensity of thought and action which is used in the design of a questionnaire and this belies their apparent simplicity.

However there are inherent problems associated with their design. Woolff, Knodel and Sittitrai (1993) describe the bias which sometimes can be inherent within the survey and which can be perceived as unrepresentative as the items selected for inclusion in the questionnaire are under the control of the researcher therefore the bias of the researcher. However, this argument can be levelled at all

research as objectivity is difficult to achieve whether it is in the qualitative or quantitative paradigm.

Morgan (1996) describes the propensity of researchers to borrow questionnaires and to borrow questions from questionnaires or indeed add questions into the questionnaires. Problems with internal reliability may occur especially if the last two options are selected.

5.3 Formulating questionnaire items from focus group data

A number of authors including Krueger (1994) ; Carey (1994) ; and Morgan (1996) state that focus group data are useful for the development of a survey instrument. Morgan (1996) develops this argument by explaining how focus group data can be combined with survey methods but he does suggest that there is a lack of systematic methodological publications on this theme. However, one of the strengths of focus group interviews is their utility in counteracting the bias which may be found using the survey approach alone (Krueger, 1994 ; Carey, 1994 ; Morgan, 1996).

The counter argument could be put forward that researcher bias may be perpetuated through both the focus groups and the survey and it is this potential problem which makes it all the more imperative that, if researchers are to triangulate focus group data with survey data, they explain the principles or protocols on which they make their judgements. The following are examples of research where data has been triangulated.

McKinley et al (1997) used two focus groups with the aim of producing a valid and reliable measure in the form of a questionnaire. In their focus groups they included a range of ages, ethnic, cultural and social groups plus parents and guardians of children. They go on to discuss their questionnaire but they don't explain how they explicated the statements from the data.

Aminzadeh, Plotnikoff and Edwards (1999) used four focus groups to generate items for a questionnaire but they do not explain the principles on which they developed their 42 item questionnaire other than their use of interviews and previous empirical and theoretical literature. This is a common theme throughout discussions on triangulating focus group interviews with questionnaire development in that the method for explicating survey items from focus groups data has not been widely discussed in any great detail. Yet there are so many proponents of this particular strategy (Morgan, 1996).

5.4 Identifying the Statements

The data were re-contextualised under their main themes in preparation for the explication of appropriate statements for inclusion in the questionnaire.

The criterion discussed by Tripp- Reimer (1985) was adopted. She considered a view expressed once by any group out of 102 group interviews as idiosyncratic. Thus comments which were stated by more than one group were considered relevant to her research. This criterion coincides with the advice put forward by Priest, McColl, Thomas and Bond (1995) who state that when developing a questionnaire it is wise to err on the side of over-inclusivity so that the first item pool is relatively large.

In contrast, Fife-Schaw (1995) advises that the guiding principle in developing a questionnaire is to be mindful of the aims of the research as there is the temptation to meet a number of aims while fulfilling none of them well. Furthermore, Coolican (1994) suggests that the principle of parsimony is worth following which he defines as “limiting effort to the necessary while maintaining efficiency” (p.136) He advises that an interesting concept is too vague a basis for inclusion however tempting it may be. This is the temptation which can be afforded to the researcher where there are interesting concepts raised through the focus groups which are seemingly irrelevant to the research or raised in only one group. Consequently, concepts which were discussed by participants over two focus groups were included within the questionnaire. By doing so, there was a relatively

large pool of items (80) which meets the guiding principle of Priest et al (1995) whilst ensuring that the more idiosyncratic concepts were excluded.

Following this principle, an item which was raised by more than one group was the issue of the perception of incontinence in older adults. This, therefore, was considered a relevant item for the questionnaire whereas only one group mentioned the role of government in the provision of beds for older adults and it was consequently excluded from the item pool. Each statement, while following the above criteria was also viewed within the context of the research question and the topic guide to ensure relevance. (Babbie, 1990)

5.5 Constructing the questionnaire

Having formalised a method for generating an item pool, that is firstly, the concept occurring across two focus groups and secondly, meeting the aims of the research, other pragmatic issues required decisions. As one of the aims of this questionnaire was to measure attitudes, statements were developed and the instrument of measure was a five point Likert scale. The Likert scale ranged from strongly agree to agree, to unsure, to disagree and finally strongly disagree.

Coolican (1994) describes the undecided score as unclear in intention as it can mean that the respondent is unsure or indeed it may mean that they are sitting on the fence. However, Schuman and Presser (1996) have demonstrated that the inclusion of a middle alternative does increase the size of that category but it does not affect the “for” versus the “against” responses. People who do not feel strongly about an issues are more likely to use the middle category but Sudman and Bradburn (1982) advise the inclusion of a middle category as it will give as much information on the general favourableness or unfavourableness of an issue. They also indicate that the size of the middle response may give extra information about the intensity of an attitude which would be lost from a forced choice questionnaire. A five point scale was used intentionally as the questionnaire was ultimately distributed to student nurses who had newly commenced nurse education, some of whom had no previous experience of nursing work. There was

an expectation that, at this stage, there would be a substantial number of respondents using the middle response due to a lack of knowledge or opinion. However, it was hypothesised that there would be a shift in attitudes during nurse education. Consequently collecting data about the middle response was important for the research.

Oppenheim (1992) and Priest et al (1995) discuss the use of positive and negative worded statements. Priest et al further explain that using a combination of both types of statements helps to minimise affirmation bias. This survey was designed using the combination of both positive and negative statements. Scores were allocated according to the most positivity. In other words if the statement was positive, strongly agree received the highest score and if the statement was negative, strongly disagree received the highest score. (Oppenheim, 1992) The items from the themes were also mixed so that response set bias was also minimised.

Another issue which required consideration in constructing the questionnaire was the language which was used during the focus group interviews. The language of the groups was incorporated into the measure. A number of authors including O'Brien (1993) and Morgan (1993) describe the potential for focus groups to identify the language used by participants. Oppenheim (1992) describes how interviews provide the vivid expressions which are used to describe attitudes and which makes them so suitable for use. Oppenheim further discusses the need to take into account the prevailing culture and fashion of the day, which can be reinforced through contentious language. A statement which was included in the first two questionnaires which was contentious and drew comment from a number of respondents was *Most student nurses are surprised that older adults are "normal"*. However this statement was used in a number of the focus groups in the context of wellness and illness where there is often an expectation from students that older adults in an institution are incapable through dementia or other disorders.

Finally, relevant demographic data were included in the questionnaire. The relevant data collected were age using three age bands, gender and, for the students only, past experiences within nursing, including nursing homes, residential homes, hospitals and community. Questionnaires to the clinical staff were coded with their areas of clinical practice therefore it was possible to identify the types of wards the nurses who completed the questionnaire were employed. Demographic data were collected at the end of the questionnaire. Fife-Schaw (1995) describes this as a growing convention. Both Fife- Schaw (1995) and Oppenheim (1992) rationalise this as it allows respondents who are becoming tired of filling in the questionnaire to have some straightforward questions at the end which are less tiring.

5.6 Overview of the Questionnaire

The first questionnaire, (Appendix III 80 item questionnaire) consisted of a top cover which had the title of the questionnaire Attitudes to Working with Older Adults, definitions of the care of the older adults, acute/general areas and older adults. There were also instructions on completing and returning the questionnaire. An assurance of confidentiality was included in the questionnaire. There was a space for an individual code number. This was not utilised during the pilot work, but for the final format, all questionnaires had a unique code number. This was carried out for a number of reasons, including being able to collect data about numbers of returns from clinical specialties, about non returns for follow up and also being able to match up the pre and post test scores for the students who participated in the research.

There were eighty statements on this questionnaire, a number of items were reversed and included in the questionnaire, for example there was a statement (42) *Most older adults have the sense of humour they have always had* whereas further on in the questionnaire (46) the statement *Most older adults have lost their sense of humour*. Finally demographic data were sought at the end of the questionnaire with a rationale for collecting them.

5.7 Principal Components Analysis (1)

The questionnaire was sent out to 68 third year student nurses after permission was sought from the Programme Leader of the Adult Programme. This cohort were approached informally by the researcher and asked to participate in the pilot work. They were also requested to highlight any difficult or incomprehensible statements. There were a few comments, two of which related to the repetitive nature of some of the statements. Two respondents also commented on the use of the phrase “basic nursing skills”. A number of respondents did not like the use of the word “most” Some of the comments were incorporated into the new questionnaire for example, the use of the word most was reduced and the numbers of repetitive statements were reduced. However, the word basic nursing care/skills was deliberately used as there is a common perception that working in care of the older adult requires only of basic nursing care/skills. There was a return rate of 51 (75%) questionnaires. Students were requested to return the questionnaire through the internal mail.

The questionnaires were scored from 1-5 according to their positivity and then entered on to a database for statistical analysis using Statistical Package for the Social Sciences for Windows Release 6.1 (SPSS) Missing data were minimal and did not reach the criterion of 5% put forward by Priest et al (1995). Consequently variables where missing data occurred were identified, the total percentage for each cell was calculated. Where a clear majority of opinion for one cell was obvious, the missing data were scored according to that category. There was no one statement where there was consistency for missing data. If this had occurred, it would have raised concerns about that particular statement.

Once the data were entered on to the database, a reliability analysis produced a standardised item alpha of .8147 which according to Oppenheim (1992) is an acceptable value for a reliability coefficient.

The data were then further analysed using the multivariate technique of principal components analysis (P C A). Everitt (1996), suggests that, although the literature

sometimes does not differentiate between factor analysis (FA) and P C A, they should be treated as two separate concepts. This becomes important when further investigation indicates that they have different purposes. Ferketich and Muller (1990) differentiate between the two concepts by describing principal components analysis as being based on the notion that all measurement error is random therefore variance is unique to an individual item and not shared with another item, whereas in factor analysis, measurement error is considered to be both random and have a systematic component which has an influence on the common variance of factors Anthony (1999), further suggests that factor analysis is a method of obtaining meaningful factors from the data set whereas P C A is used to remove data that are either irrelevant or contain little useful information.

Principal components analysis can be considered to have three main purposes, as put forward by Bryman and Cramer (1997). They include, firstly, to assess the degree to which items are tapping into the same concepts. Secondly, the degree to which the data can be reduced to a smaller set of variables can be determined. Finally, it can be used to make sense of the “bewildering complexity of social behaviour” (p. 277) by reducing the items to more manageable factors. However, the purpose of principal components analysis for this research, is to transform the eighty variables extrapolated from the focus group data into a smaller set of unrelated or uncorrelated variables, thereby reducing the number of variables (Everitt, 1996); (Polit, 1996). Polit does describe this process as controversial as it is more subjective than is normally typical in statistical analysis.

The main concern using this procedure is the sample size which according to Ferguson and Cox (1993) should be a minimum of no less than 100 whereas Polit (1996) recommends that the sample size should be large to avoid capitalising on small random differences and she puts forward the suggestion of 5 per variable. However, although Hammond (1995) supports the concept of large sample sizes for factor analysis, he does go on to state the minimum should be at least more numbers in the sample as compared to the variable. This was achieved for the second pilot questionnaire but not for the first. Finally, Bryman and Cramer

(1997) state that there is a lack of consensus as to the appropriate size of sample. They do go on to suggest that the smaller samples may not produce the same factors, but this problem seems to be related to a number of decisions when using factor analysis and the whole procedure has caused doubts to be raised over validity (Ehrenberg, 1991). Anthony (1999) suggests that data analysis using principal components analysis is not generalisable and this is echoed by Munro and Page (1993) who suggest that the need for replication of factor analysis is being increasingly emphasised. Furthermore, Anthony suggests that the factors identified are not necessarily the most useful, rather they are simply those that describe the data at that time.

Consequently, the aim of the principal components analysis is to make no claims as to the nature of attitudes to older adults, nor is that the intention, but merely to summarise the numbers of items following qualitative analysis. Following P C A, a number of the items were deleted according to the results from the original sample of 51 respondents. Thus 80 statements were reduced to 33 statements, with a standardised alpha coefficient of .8308. This would indicate that using P C A as a method of data reduction coincides with maintaining internal consistency

5.8 Selecting the principal components

Munro and Page (1993) state that the criteria for cut off points for inclusion of factors varies from researcher to researcher. Everitt (1996) describes them as arbitrary procedures which can be used to identify the number of principal components which are required to adequately represent a set of multivariate data. However there are some commonalities within the literature. The first issue which will be considered is the loading which is the correlation of the variable with the factor. Suggestions for the cut off point for factor loading has variously ranged from 0.3 (Polit, 1996), through 0.35 (Munro and Page, 1993) to 0.4 (Ferguson and Cox, 1993). The factor loading for this research was 0.4 as recommended by Ferguson and Cox, the purpose of which is to increase factor saturation.

The second issue to be considered is the number of factors and therefore the number of variables which were to be retained and the methods put forward are the use of the eigenvalues, the percentage of variance and the scree plot. Most of the literature quotes an eigenvalue of >1 as desirable, the eigenvalue being the total amount of the variance explained by a factor (Munro and Page, 1993; Anthony, 1999; Bryman and Cramer, 1997). Polit (1996) suggests that the eigenvalue acts as a useful measure and that a factor with an eigenvalue less than 1 can be considered unimportant. However Bryman and Cramer (1997) have suggested that the eigenvalue as a retention criterion lacks a scientific basis. The scree plot exhibiting factors graphically can be used to further suggest which factors may be usefully retained or discarded by using the elbow as a guide as described by Everitt (1996). In other words, where the scree plot starts to even out can be considered the cut off point. Polit (1996) suggests that the scree plot, although criticised for its subjectivity is at its most useful when there is a large sample size.

Finally, proportion of variance may act as a guide and should correspond to a reasonable solution (Everitt, 1996). Polit (1996) suggests that a factor which accounts for less than 5% of the total variance should be excluded. Excluding factors are identified by Anthony (1999), as firstly, variables loading on to more than one factor when the purpose of orthogonal rotation is to identify variables which uniquely load on to certain factors. Ferguson and Cox (1993) describe this as cross loading and they go into more detail about this concept. Secondly, Anthony (1999) states that if variables are highly correlated then one can probably be removed, as one variable is largely predictable from the other.

5.9 Procedure for principal components analysis

Principal components analysis was carried out using varimax orthogonal rotation. Factors are rotated to maximise loadings thereby increasing interpretability. They can be rotated orthogonally or obliquely. Oblique rotation produces factors which are correlated whereas orthogonal rotation produces factors which are unrelated.

However, the disadvantage of orthogonal rotation is that factors may be forced to be unrelated when in reality they are not (Bryman and Cramer, 1997; Anthony, 1999) Nevertheless, Munro and Page (1993) describe orthogonal rotation as being useful for instrument development which is congruent with the purpose of this research.

There were 80 variables for P CA and 51 cases. They were entered on to the database using S. P. S. S. Factors were extracted using varimax orthogonal rotation. The P C A extracted 25 factors using loadings of >0.4 . Correlations for the reliability analysis were also identified as >0.4 . After scrutinising the twenty five factors for correlations and variances, only 12 factors were considered. Initial statistics for the 12 factors were as follows, Eigenvalue 2.4 and cumulative percentage 60.7. Scree plot indicated that 9 factors were relevant (see appendix IV) The relevant items loading on to seven of the nine factors are as follows,

Table 5.1 Rotated Factor Matrix for the Principal Components Analysis of the 80 item Questionnaire

Items	Factor Loading						
	F 1	F 2	F 3	F 4	F 5	F 6	F 7
Looking after older adults							
12. Nurses who work in care of the elderly require little more than basic nursing skills	.49						
13. Nurses have to take more time looking after older adults as they are slow	.47						
15. Any nurse with a bit of common sense can look after older adults	.43						
17. Care of the elderly is repetitive and boring	.44						
21. Care of the elderly is no more than washing feeding and toileting	.51						
23. Working in care of the elderly is interesting	.56						
26. When nurses are busy the priority for care should be given to younger patients	.47						
27. Looking after older adults in the acute areas will encourage them to recover more quickly	-.43						
28. Older adults are entitled to the same level of care as younger adults	.59						
34. In care of the elderly, patients are motivated to be independent	.45						

Items	Factor Loading						
	F 1	F 2	F 3	F 4	F 5	F 6	F 7
35. Nurses in care of the elderly will encourage patients to self care	.55						
36. Most patients in care of the elderly are incontinent of urine	.61						
37. There is as much nursing care in a continuing care ward as there is in a medical ward	.43						
38. Most patients in care of the elderly are unable to walk	.60						
41. Most older adults tend to use their age as a means of taking advantage of younger adults	.48						
43. Most older adults are cantankerous	.62						
44. All older adults are different from each other	.48						
46. Most older adults have lost their sense of humour	.55						
53. There is nothing to learn in care of the elderly	.41						
57. It is interesting to talk with older adults	.43						
67. Most nurses who work in care of the elderly are not clever	.54						
Staff influences on student nurses' attitudes							
4. Younger people nowadays have little time for older adults		.41					
22. All wards no matter their specialty can be repetitive and boring		-.41					
24. Older adults in the acute wards are more likely to be ignored than younger adults		.53					

Items	Factor Loading						
	F 1	F 2	F 3	F 4	F 5	F 6	F 7
50. Most student nurses think care of the elderly is about basic nursing care		.44					
54. Most student nurses are surprised that most older adults can hold a sensible conversation		.59					
56. There is more to learn in care of the elderly than basic nursing skills		-.52					
58. Most nurses will take time to chat with older patients		.41					
61. Most nurses tend not to laugh and joke with older adults		.45					
63. Most nurses prefer to talk with younger adults		.43					
64. Young people have a lot of time for older adults		.70					
65. Once in care of the elderly, nurses will not get a job out of care of the elderly		.47					
72. Only lecturers who are experts should teach care of the elderly		.44					
80. It is essential that staff nurses who work with older adults are good role models		-.56					
Interpersonal relationships							
9. Nurses who work with older adults need to know the ageing process			.72				
25. It is easier for older adults to be nursed in side rooms in the acute areas rather than in the main wards			-.52				
30. Older adults are more prone to isolation if they are nursed in side rooms			-.45				

Items	Factor Loading						
	F 1	F 2	F 3	F 4	F 5	F 6	F 7
34. In care of the elderly patients are motivated to be independent			-.42				
39. Older adults are treated as children as they become older			.61				
60. It's a myth that older adults dislike younger adults			.71				
62. Working in care of the elderly can really enhance communication skills			.57				
Interpersonal relationships							
8. Patience is a very important quality when working with older adults				.65			
9. Nurses who work with older adults need to know the ageing process				.57			
30. Older adults are more prone to isolation if they are nursed in side rooms				.47			
39. Older people are treated as children as they become older				.61			
53. There is nothing to learn in care of the elderly				-.58			
60. It's a myth that older adults dislike younger adults				.59			
62. Working in care of the elderly can really enhance communication skills				-.42			
Student nurses expectations							
48. Most older adults lose their personality as they grow older					-.52		
49. Most student nurses have little idea what to expect in care of the elderly					.41		

Items	Factor Loading						
	F 1	F 2	F 3	F 4	F 5	F 6	F 7
50. Most student nurses think care of the elderly is about basic nursing care					.46		
51. Most student nurses are surprised that older adults are “normal”					.44		
71. Most lecturers promote an interest in care of the elderly					.41		
Organisation of care							
29. Older people are treated as individuals in the acute areas						.46	
31. Looking after older adults means taking them for walks and playing games with them						.40	
32. Older adults in care of the elderly are treated as individuals						.48	
Skills and knowledge required for care of older adults							
7. When we become older we are less able to do a days work							-.46
14. All general wards where there are older people should have nurses who specialise in care of the elderly							.44
74. Most lecturers are out of date with the advances in care of the elderly							.41
77. Some staff nurses can be short tempered with older adults							.41

Items	Factor Loading						
	F 1	F 2	F 3	F 4	F 5	F 6	F 7
Eigenvalue	8.0	6.4	5.2	5.1	3.8	3.2	2.9
%of variance explained	10.2	8.1	6.6	6.5	4.8	4.2	3.7

The factor titles reflect the themes used in the qualitative analysis although they are not so readily explicated. Factors 3 and 4 had almost identical items loading on to those factors therefore it seemed sensible to label them in the same manner. Items for factors 7 and 8 also loaded on to other factors therefore they were considered under their original factors. Using principal components analysis alone yielded 51 items therefore the questionnaire remained unwieldy.

5.10 Further reducing the item pool

To reduce the item pool still further, the strategy put forward by Priest et al (1995) which excludes items where there is an overall response rate of over 80% for one cell/category, was utilised. This was done by adding the positive responses together i.e strongly agree and agree were combined as were the strongly disagree and disagree. Over 80% agreement occurred for the following items:-

9. Nurses who work with older adults need to know the ageing process
10. Patients come into care of the elderly with a variety of nursing problems.
11. Patience is important no matter where you nurse.
20. There is as much nursing care on a surgical ward as there is on a care of elderly ward.
28. Older adults are entitled to the same level of care as younger adults.
37. There is as much nursing care on a continuing care ward as there is in a medical ward
- .44. All older adults are different from each other.
56. There is more to learn in care of the elderly than basic nursing skills.
57. It is interesting to talk to older adults.
- 62 Working in care of the elderly can really enhance communication skills.

The purpose of using the 80% rule was to exclude items where there was overwhelming agreement. However, it is worth noting the types of statements which were attracting those results from the students who completed the questionnaires in that there is recognition among the cohort that working with older adults was rewarding and valuable.

Over 80% disagreement occurred for the following statements:

- 17. Care of the elderly is repetitive and boring.
- 21. Care of the elderly is no more than washing, toileting and feeding patients.
- 25. It is easier for older adults to be nursed in side rooms in the acute areas rather than in the main wards.
- 26. When nurses are busy, the priority for care should be given to younger patients.
- 46. Most older people have lost their sense of humour.
- 48. Most older adults lose their personality as they grow older.
- 59. Communication skills are less important in care of the elderly than other areas.
- 67. Most nurses who work in care of the elderly are not clever.
- 69. Nurses who work in care of the elderly will lose all their nursing skills.

As with the positively answered statements, the majority of the students who participated in the testing of the questionnaire were staunch in their defence of the care of older adult settings as being useful placements. They also demonstrated that they did not support some of the common stereotypes and myths about older adults.

Items 10, 11, 20, 59 and 69 had not loaded on to the factors so they had already been eliminated from the item pool during principal components analysis. Out of the above list, only items 9, 25, 48 and 62 were removed from the item pool resulting in 47 statements remaining in the questionnaire. The purpose of keeping so many high scoring items related to the aims of the research. Piloting of the questionnaire was carried out on student nurses therefore it was important to remember that other grades of staff would be involved in the main study. Furthermore the items which had been selected for the questionnaire arose out of intergroup agreement /disagreement during the qualitative analysis. Consequently, it would be useful to evaluate whether the strength of agreement continues over both phases. Added to that there is an expectation that there will be inter group differences in the main study. Thus some high scoring items were retained.

The item pool was reduced further by examining the differences and similarities between items. Where there were similarities, items were deleted. Most reverse items were also deleted but some were retained to minimise affirmation bias. Two reverse items were retained including the reverse of items 36 and 44. An example of an item which was deleted although it loaded on to factor 1 was *most older adults are similar* as it was the reverse of *All older adults are different from each other*. Other reversed items which were excluded from the second questionnaire were items 4, 38 and 60. An example of an item which was similar was *surgical is more interesting than care of the older adult* was deleted and *there is as much nursing care in a continuing care ward as a medical ward* was retained. Overall, items which were similar and therefore deleted accounted for items 8, 14, 22, 24, 29, 30, 31, 32, 49, 50 and 63. Those decisions were taken in an attempt to balance both positive and negative statements so that there was an equal proportion of both types of statements.

The aims of the study and the hypotheses remained under consideration when retaining and deleting items from the first questionnaire for inclusion in the second questionnaire. Consequently two statements were removed from the item pool as they were lacking relevance with the research, one item relating to work and another item relating to nurses in care of the older adult being short tempered. The resulting analysis accounted for 33 statements from 80 and 3 statements were added to the questionnaire giving a total of 36 statements. The statements which were added included one more reverse item which was not on the original questionnaire. This item was added as the participants in the pilot study were unhappy about the wording of the question so it was reversed to make the statement more acceptable and both statements were then included in the second questionnaire. The statements referred to are items 30 and 36 in the second questionnaire with 36 being the statement which was added to act as a check for bias. Statements 70 and 75 were also included as the aim of the research was to investigate the influence of professional socialisation and there was only two statements relating to the lecturing staff extracted through principal components

analysis. Consequently a further two statements were added to the questionnaire. (See appendix V for the 36 item questionnaire)

5.11 Principal Components Analysis (2)

The second questionnaire was piloted, using different cohorts of third year student nurses. There are normally two cohorts in each year thus both cohorts in third year were used to improve sample size. Both classes were approached informally and their participation in the second pilot study was requested. 98 questionnaires were distributed and 71 (72%) were returned. The second sample still remains low for P C A but there is almost a sample size of two per variable. A second P C A was performed utilising the same method as for the first questionnaire, that is, varimax orthogonal rotation for the same reasons as before. The standardised item alpha was .7852 which is within the acceptable range and the data were scrutinised for correlations of > 0.4 and variances of > 0.4 . as would be expected there were few correlations as a number of them had been deleted from the first statistical analysis. The P C A extracted 13 factors which were examined for correlations and variances. Items which were not extracted were deleted and items where there were correlations, were examined for relevance to the aims of the study and were retained on that criterion. Therefore items from 9 factors were included in the final questionnaire, resulting in an eigenvalue of 1.3 and a cumulative percentage of 58.7. The scree plot indicated 7/8 factors were relevant.(Appendix VI) Items loaded on to the factors as shown on table 5.2

Table 5.2 Rotated Factor Matrix for the principal components analysis of the 36 item questionnaire

Items	Factor Loading						
	F 1	F 2	F 3	F 4	F 5	F 6	F 7
Looking after older adults							
1. Older adults tend to use their age as a means for taking advantage of younger people.	.51						
2. Older adults are cantankerous	.58						
3. Care of the elderly is repetitive and boring	.60						
4. Nurses who work with the elderly require only basic nursing skills	.52						
7. Working in care of the elderly is interesting	.57						
13. When nurses are busy in an acute ward priority should be given to younger patients.	.54						
15. Nurses in care of the elderly encourage patients to self care	.45						
17. Nurses have to take their time with older adults as they are so slow	.56						
18. It is interesting to talk to older adults	.50						
19. Any lecturer can teach about older adults	.54						
20. Care of the elderly is no more than washing, toileting and feeding older patients.	.62						
22. Only lecturers who are expert in the subject should teach care of the elderly	.50						

Items	Factor Loading						
	F 1	F 2	F 3	F 4	F 5	F 6	F 7
24. There is more to learn in care of the elderly than basic nursing skills	.64						
25. I have a lot of time for older adults	.52						
Staff influences on student nurses' attitudes							
11. In care of the elderly older adults are motivated to be independent		.55					
12. There is as much nursing care on a continuing care ward as there is in a medical ward		.42					
21. Most nurses will take time to chat with older patients		.41					
26. I was surprised to find that older adults are "normal"		.41					
28. Most lecturers will promote an interest in care of the older adult		.45					
29. Nurses who work with older adults are good role models		.52					
30. I was surprised that patients in care of the elderly can hold a normal conversation		-.58					
33. Most lecturers think care of the elderly is second rate		.42					
Stereotyping the work							
3. Care of the elderly is repetitive and boring					-.52		
8. Most older adults are incontinent of urine					.46		
21. Most nurses will take time to chat with older patients					.48		

Items	Factor Loading						
	F 1	F 2	F 3	F 4	F 5	F 6	F 7
Educational influences							
27. Once in care of the elderly, nurses will not get out of the area				.42			
29. Nurses who work with older adults are good role models				-.46			
32. Most lecturers are out of date with advances in care of the elderly				.50			
33. Most lecturers think care of the elderly is second rate.				.59			
Student expectations							
26. I was surprised to find older adults are "normal"					.52		
30. I was surprised that older adults can hold a normal conversation					-.42		
Interpersonal relationships							
6. All older adults are different from each other						.49	
25. I have a lot of time for older adults.						.41	
32. Most lecturers are out of date with advances in care of the elderly						.42	
35. Most older adults are continent of urine						.52	

Items	Factor Loading						
	F 1	F 2	F 3	F 4	F 5	F 6	F 7
Miscellaneous							
9. Most older adults retain their sense of humour							.41
24. There is more to learn in care of the elderly than basic nursing skills							-.44
Eigenvalue	5.4	3.3	2.3	2.0	1.9	1.7	1.5
%of variance explained	15.1	9.2	6.4	5.6	5.3	4.9	4.3

Factors 8 and 9 had one item only loading on to those factors therefore they were discounted. On further examination there was a similarity in items loading on to the remaining factors as would be expected. However, item loading was not exactly the same for a number of reasons. Items were included in the questionnaire which had not loaded on to factors in the original questionnaire therefore the inclusion of those items would change aspects of the second questionnaire. The obvious example was factor 4 which has been named teaching influences. It will be recalled from the previous discussion that two items on teaching influences were purposively included in accordance with the aims of the research, therefore they were bound to affect the loading of the items. Furthermore, factor 7 was named miscellaneous. This came about as, once again item 9, a new item was included in this questionnaire as a reverse item, thus it loaded on to a factor which was difficult to name.

This resulted in retaining 28 items in the pool at this moment. Items excluded through the principal components analysis were as follows, items 5, 10, 14, 16, 23, 31,34 and 36. Further items were removed where there were reverse or similar items. Examples of this process can be found when considering the following statements. Item 3 *Care of the elderly is repetitive and boring* is the reverse of item 7 *Working in care of the elderly is interesting*. Item 35 *Most older adults are continent of urine* was retained whereas the reverse of this item was removed i.e. item 8. Item 36 was retained but reversed to become more positive and it replaced items 26 and 30. Item 15 was removed whereas item 11 was retained. Item 22 was retained whereas item 19 was removed. Item 33 was removed as it was a poorly worded statement in that it was asking people to predict how lecturers think. Item 24 was reversed to become *There is nothing to learn in care of the elderly*. Remaining statements were removed.

Finally, statements were examined for the 80% rule (Priest et al, 1995). Items 2,3,4,6,8,10,13,18,19,20,24,25,29,32,33 and 36 reached over 80% agreement or disagreement by combining the strongly agree/disagree and agree/ disagree

together thus expressing the positivity or negativity of an item. Some of those items had already been removed through principal components analysis and through the removal of reversed or similar items. However 6 items were retained which were over 80% and those are as follows:-

4. Nurses who work in care of the elderly require only basic nursing skills.
13. When nurses are busy in an acute ward priority should be given to younger patients.
18. It is interesting to talk to older adults.
20. Care of the elderly in no more than washing, toileting and feeding patients.
29. Nurses who work with older adults are good role models.
32. Most lecturers are out of date with advances in care of the elderly.

Items which were removed according to the 80% rule but identified in the principal components analysis account for the following statements:-

2. Most older adults are cantankerous
3. Care of the elderly is repetitive and boring
6. All older adults are different from each other.
9. Most older adults have retained their sense of humour
19. Any lecturer can teach about older adults.
24. There is more to learn in care of the elderly than basic nursing skills.
25. I have a lot of time for older adults.
33. Most older lecturers think care of the elderly is second rate.

The decision to accept or reject items which reached more than 80% agreement/disagreement was confirmed through the correlation matrix i.e if items correlated with each other then they were more likely to be rejected. Item 4 *Nurses who work in care of the elderly require only basic nursing skills* correlated with item 24 *there is more to learn in care of the elderly than basic nursing skills*. Thus item 4 was retained and item 24 was changed to *There is nothing to learn in care of the elderly*. Item 13 correlated with item 19. Therefore this confirmed the rejection of this item and the retention of item 13. Item 20 which refers to care of the older

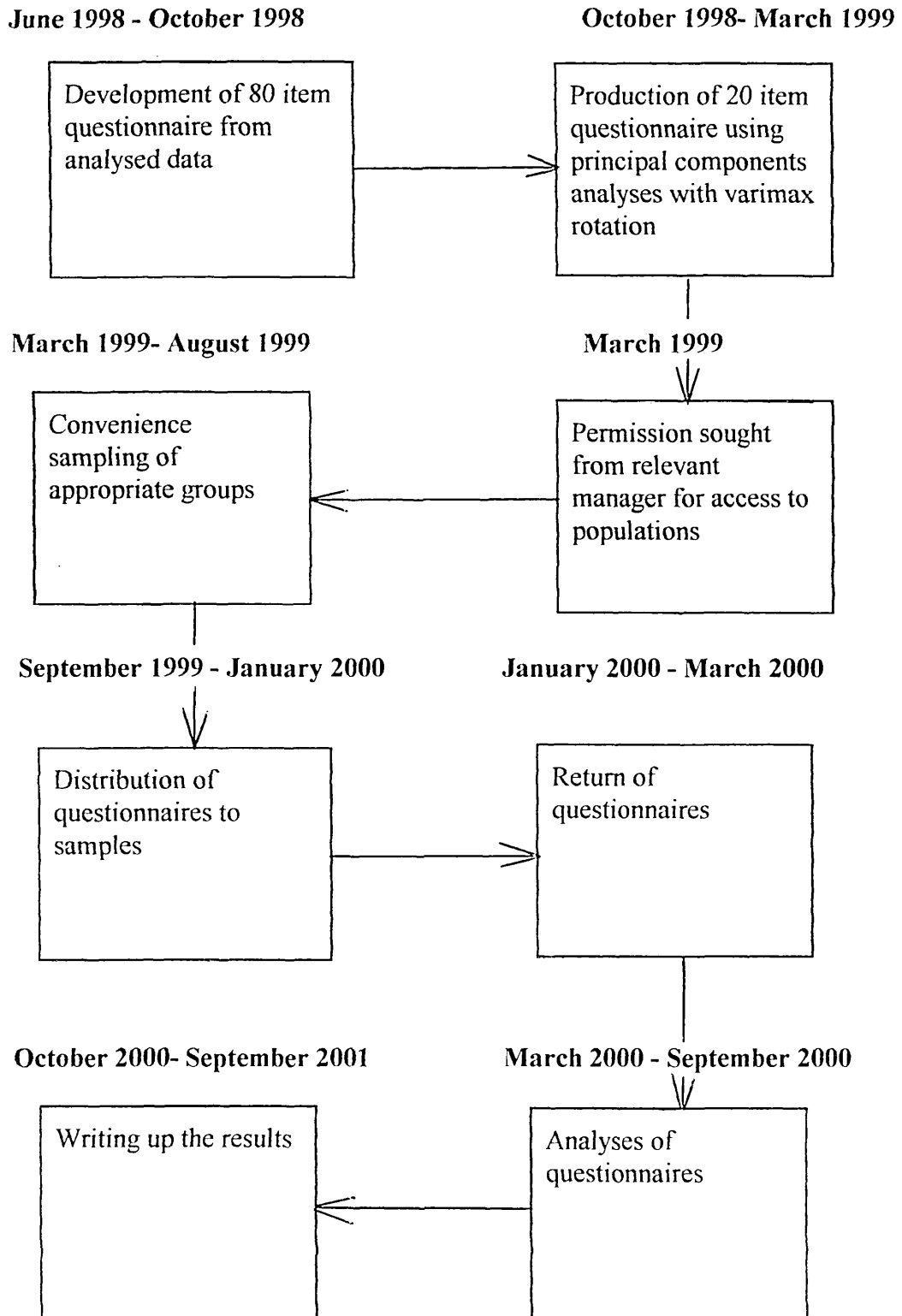
adult being nothing more than washing, toileting and feeding patients correlated with item 2 where older adults are cantankerous. Item 20 was retained and item 2 was rejected. The retention of all items which received over 80% agreement/disagreement were scrutinised in this manner. This brought the total on the final questionnaire to 18. The alpha co-efficient of the final 18 items revealed a standardised alpha of .7055 which is still well within acceptable limits. However two items were included from the first questionnaire which had not met the original criteria but were included for interest, although literature advises against this rationale. (Appendix VII final 20 item questionnaire) Nevertheless, one of the focus group participants was so adamant about how patience was seen as the prerogative of the nurse who works with older adults, it was seen as being a justifiable inclusion. The other item which was included related to nurses preferring to talk with younger adults was also included as a number of the participants in the first student group had obviously been surprised at how older adults were ignored and sidelined into side rooms.

5.12 Conclusion

In summary, the original questionnaire was formulated from focus group data and incorporated 80 statements. The questionnaire was piloted twice with subsequent reductions in the item pool. Convenience samples of third year student nurses from both campuses were utilised to test the questionnaires and the resulting data were submitted to principal components analyses using varimax orthogonal rotation. Finally a questionnaire with twenty statements was produced, ready for the final stage of the research.

SECTION 3
STUDY DESIGN PHASE II
ANALYSES
RESULTS
EVALUATION OF THE METHODS
CONCLUSIONS

**Fig. 6.1 Overview of design Phase II
(Quantitative Phase)**



Chapter 6: Study Design Phase II

6.1 Introduction

In order to evaluate attitudinal responses towards older people within the hospital setting, the appropriate groups of nurses were identified and self-completion questionnaires sent out. This chapter commences with charting the process of identifying the samples and collecting the data. The questionnaire returns are considered and the rationale for the selection of the statistical analyses are presented.

6.2 Sampling Strategy

Non probability convenience samples were drawn from the following populations

1. First level registered nurses from two care of older adult hospitals.
2. First level registered nurses from general medical and surgical wards
3. Two cohorts of first year student nurses.
 - a) Cohort (A) were commencing a practice placement.
 - b) Cohort (B) had just commenced nurse education
4. Nursing lecturers from one University, all known to the researcher.

The clinical staff were drawn from hospitals within a city in Scotland whereas both the lecturing staff and the students were drawn from two campuses situated nearly forty miles apart.

Non probability convenience sampling was used for pragmatic reasons, one of which was to obtain reasonably high sample sizes. According to Bryman and Cramer (1997) a great deal of research carried out by social scientists does not derive from probability sampling. In other words non probability sampling seems to be the norm as opposed to the exception. They go on to state that the difference between research based on random sampling and convenience sampling, especially in the light of low return rates is not always as great as sometimes implied. Furthermore, Hilton (1995) states that it is almost impossible to obtain a truly representative sample no matter the sampling strategy, where every characteristic of the sample matches the population characteristics. However, it is

important that the sampling procedure is made explicit so that other readers can make a judgement on systematic bias. Fink (1995) describes a good sample as being a “faithful representation of the target group” (p 3). As well as considering a sampling strategy, a prerequisite is an adequate sample size. Bryman and Cramer (1997) explain that a larger sample size will improve accuracy while Burns and Grove (1995) equate small sample size with sampling error.

Bryman and Cramer put forward the strategy of over recruiting to counteract non-response. However, non- response, in itself, may be an important issue as there may be valid reasons for non-response, for example possible relevance of the subject matter to a particular sample. In this circumstance, over recruitment will not overcome potential respondents’ willingness or unwillingness to participate in the research. Methods used for identifying optimal sample sizes include power analysis (Burns and Grove, 1995) or, as Fink (1995) suggests, thirty people per group as a rule of thumb for estimating the desired level of significance. Bryman and Cramer (1995) suggest the use of cells where answers are multiplied by the numbers of categories and, depending on the total, gives a table of cells. Using this formula and taking cognisance of the independent variables for age (3), gender (2) and prior experience prior to commencing nurse education, the aim is for 10 subjects per cell, and there are 30 cells, giving an optimal sample size of 300.

$$3 \times 2 \times 5 \times 10 = 300$$

6.3 Exclusion and Inclusion Criteria

The exclusion criteria used for first level registered nurses in the acute areas and the care of older adults areas were similar in that only first level nurses were to be targeted, which excluded second level registered nurses. Charge nurses and nurses who worked predominantly on night duty were also excluded. Those excluded had minimal contact with the student nurses in their role as preceptor. The inclusive criteria, therefore, were first level nurses who spent the majority of their working time on day duty and who were preceptors to the students. The rationale for those

criteria were the sample identified would spend more time with students nurses. Furthermore, the local educational audit document which is used to evaluate the learning environment as a suitable placement for student nurses has a requirement that preceptors will be available to the students for 40% of the total working week. However, that does not necessarily mean that the preceptors spend that amount of time with the students.

Inclusion criteria for the first year student nurses were that they were following the adult programme. Thus the exclusion criteria were students who were following the mental health, learning disabilities, child and midwifery programmes. Students from mental health and learning disabilities have a placement in what is termed long term psycho- geriatrics whereas the students from the midwifery programme do not attend any older adult placements.

All nursing lecturers were included in the study as they all have contact with all students during the eighteen month Common Foundation Programme. The midwifery lecturers were excluded as their work is predominantly with the midwifery students.

6.4 Accessing the populations

Senior managers of the Acute Care and Primary Care Trusts and the School of Nursing and Midwifery were contacted by letter and permission was sought to approach potential subjects to take part in the research and in all instances permission was granted (Appendix VIII for a copy of a letter).

The next stage was to identify the appropriate samples. The nurse managers who supervised the targeted areas were contacted for an up to date list of staff names. This was forthcoming from the care of the older adult areas, but not the acute areas. Consequently, the Nursing Personnel department in the Acute Care Trust was contacted by telephone and they very kindly sent out a list of all first level nurses within the general medical and surgical areas. However the list did not

indicate where in the hospital the nurses worked, therefore the names were collected by visiting each of the targeted wards and asking permission to copy the list of names from the off duty. This had a hidden benefit which was not appreciated at the time. The list collected by visiting the wards provided an accurate and up to date list of the people who were on permanent night duty or who were or who were second level registered nurses whereas the list sent by the Primary Care Trust was a little out of date and this had repercussions on the return of questionnaires.

Once the respondents had been identified via class or ward lists each questionnaire was given a unique identification number for two main reasons, one, to permit more efficient entry on to the data base and two, to permit the follow up of respondents if there was a poor return from any of the groups. All respondents were given a covering letter, explaining the purpose of the study and asking them for their cooperation while ensuring their anonymity and promising confidentiality. (Appendix IX letter to potential recruits) One participant who completed the questionnaire did underline the code number and insert a question mark.

Using the exclusion criteria, there was a total of 91 potential respondents working in the two care of older adult hospitals, therefore the whole population was targeted. Those numbers can be broken down into specialties within the units, 27 questionnaires to assessment, 34 to continuing care and 30 to rehabilitation.

There was a total of 165 possible respondents from the acute areas, 78 from the medical areas and 87 from the surgical areas. To improve congruence with the numbers from the care of older adults, every second first level nurse in each of the areas were selected. This procedure was not followed for High Dependency where there was a greater number of first level nurses, therefore, every fourth nurse was selected, commencing at the first ward and counting from the first name on the list. The total sample identified numbered 76 (40 medical and 36 surgical).

Lists for students were accessed from the Records Office within the School of Nursing and Midwifery. Two cohorts were targeted as the intention was to collect data from the students at different time periods within the first six months of nurse education. To be able to do this within the time frame of the study a cross sectional approach was utilised. Cohort (1) had completed a practice placement and were about to commence on their second placement therefore data were collected from this cohort prior to them commencing placement and immediately on return to the school from placement. The second cohort (2) had just commenced nurse education, therefore they were targeted at the beginning of their theory and again at the end of the theory input (ten weeks). All students who met the criteria were approached both informally in the lecture theatre and formally by letter seeking their cooperation in the research. Questionnaires were put into their pigeon holes in the School therefore they had the choice whether to complete them. The numbers for each cohort on the first distribution numbered 114 for cohort (1) and 132 for cohort (2).

6.5 Return of the questionnaires

6.5.1 The care of Older Adult: A total of 63 (69%) questionnaires out of 91 questionnaires were returned, 18 (60%) from rehabilitation, 24 (70%) from continuing care and 21 (78%) from assessment. From the total respondents age was distributed across the three age bands. 12 respondents(19%) were in the age range 18-29, 34 (54%) were in the age range 30-44 and 16 (25.4%) were in the age range 45-59. One respondent did not complete this section. As would be expected, when considering gender 56 respondents (88.9%) were female and 5 were male (7.9%) Two respondents did not complete this statement. (See table 6.1 for return rates for questionnaires.)

Population	Questionnaires sent	Questionnaires returned (%)
Care of older adults	91	63(69%)
Acute Staff	76	63 (82%)
Lecturers	59	55 (93%)
Cohort (1) pre practice	114	82 (72%)
post practice	82	64 (78%)
Cohort (2) pre theory	132	81 (61%)
post theory	80	50(63%)

Table 6.1 Numbers of questionnaires sent out and returned from the population

6.5.2 Acute care: At the first attempt, 22 (55%) questionnaires out of 40 from the medical areas and 17 (47%) from surgical were returned giving a total of 37 (48%) returns. This was considered to be quite a low return, therefore the nurses who had not returned their questionnaires were contacted again and asked to return them. This resulted in an overall return rate of 63 (82%) out of 76 divided into 35 (87.5%) out of 40 medical and 28 (78%) out of 36 which was really an excellent return. The poor response first time may well be due to a perceived lack of relevance about ageing matters to nurses who work in the acute areas, however that is mere speculation. The reasons may well be more mundane in that there may be a disinterest in the whole research process, a perceived lack of time to participate etcetera. However the re-sending of the questionnaires certainly improved the return rate. Age range for this group was 32 (50.8%) were between the ages 18-29, 21 (33.3%) were between the ages of 30-44 and 8 (12.6%) were between the ages of 45-59. 2 participants did not answer this question. Distribution according to gender was 3 (4.8%) were males whereas 57 (90.4%) were females and 3 (4.8%) did not complete this answer.

6.5.3 Lecturing Staff: 55 (93%) out of 59 questionnaires were returned which

was another excellent return. Distribution for age range was 15 (27.3%) were in the range 30-44 and 40 (72.7%) were in the age range 45-59. Distribution by sex was 21 (38.2%) were male and 34 (61.8%) were female. The distribution by gender reflects the trend for men who enter nursing to move into the more managerial jobs and reinforces the disproportionate ratios for men coming into nursing.

6.5.4 The student groups: For cohort (1), a total of 114 questionnaires were distributed prior to this cohort going out on placement. Of the 114 distributed there was a return rate of 82 (72%). Data on age and gender were collected for this cohort. Age distribution, as would be expected, accounted for the majority of the students being in the lowest age range in that 47 (57.1%) were between the ages 18-29 whereas 30 (36.6%) were in the 30-44 age range. 4 (4.9%) were in the age range 45-59 and 1 student declined to circle this response. For gender distribution, 4 (4.9%) were male and 69 (84%) were female 9 (11%) did not answer.

The 82 respondents who had returned their questionnaire were then targeted for post clinical experience testing. From the 82 questionnaires distributed 64 (78%) were returned. Age distribution for the post test were 34 (53.1%) from the 18-29 age range, 24 (37.5%) from the middle age range and the number of returns from the top age range remained the same as for the pretest 4 (6.3%) and two this time declined to circle their age. 5 (7.8%) were male and 52 (81.3%) were female and there were 7 no responses.

Pre and post testing was also carried out on cohort (2) but with less success than cohort (1). There were fundamental reasons why this occurred and in retrospect the return rates could have been improved. Recruitment for this phase of the study had commenced on the second day of a three year course for this cohort. A number of them were new to nursing, new to University and were unaware of what was expected of them where the course was concerned. Furthermore, they were

expected to listen to a number of lecturers imparting a lot of information. They had also received letters at their home address asking them to volunteer for another study. There was also a real and unexpected difficulty in having the questionnaires distributed and returned as the students were unaware of the School postal system in place for them, nor did they know the internal system used for mail to be returned to lecturing staff. Considering the problems cited, the return rate could be considered adequate. The cohort was therefore tested on commencement of the theoretical input and then again approximately two weeks prior to the end of theory. This accounted for the first eight weeks of the course. 132 questionnaires were distributed at the commencement of theory and 81 (61%) were returned. Age range for cohort (2) were 57 (70.3%) between the ages 18-29 and 23 (28.4%) for ages 30-44 and 1 (1.2%) between the age of 45-59. Distribution by gender is very similar to cohort (1) where there were 5 (6.2%) males and 71 (87.7%) females with 5 (6.2%) declining to answer. Eighty questionnaires were distributed near the end of theory and 50 (63%) were returned. Age distribution was 32 (64%) were between the ages 18-29 and 16 (32%) were between the ages 30-44 and 1 (2%) was 45-59 and one respondent declined to answer.

6.6 Non parametric tests

Kruskall-Wallis H test is normally used with three or more unrelated samples. This test was used to compare scores of more than two unrelated independent variables, those being identity and age. The rationale for this test was its utility in evaluating the differences among the average ranks to determine whether they are disparate. However, it does not identify where the disparity lies i.e which groups are different and indeed how many groups are different. A further non parametric test therefore was employed for direct intergroup comparisons using identity as an independent variable. The test which was used was the Mann-Whitney U test for two unrelated samples.

The other main non parametric test used was the Wilcoxon matched-pairs signed-ranks test for two related samples. The rationale for this test was to measure whether there were any changes between pre and post clinical or theoretical experience. This test takes into consideration the size of differences between the two sets of related scores. Data were analysed for each cohort so that there was a comparison for pre and post testing for each cohort pre clinical and pre theoretical and comparing with post clinical and post theoretical experience. This test was also carried out on the two cohorts as one group.

6.7 Parametric tests.

The equivalent parametric tests were also conducted on both data sets. Munro and Page (1993) describe the parametric equivalent test for the Kruskal-Wallis H test as the One way Analysis of variance (ANOVA). The one way ANOVA was utilised with both identity and age as grouping variables, the purpose of which was to estimate the between groups variance and then compare this to the within groups variance (Bryman and Cramer, 1997). The equivalent for the Mann-Whitney is the unrelated t test. However, Munro and Page (1993) discuss the danger of using multiple comparisons of pairs of means using the t test as there is the risk of a type I error, where the rate of error increases exponentially by the number of tests conducted. Furthermore, the Mann-Whitney test, according to Siegel and Castellan (1988), is about 95% as powerful as the t test. A possible resolution for this problem is the use of a post hoc comparison to identify where the differences lie between the groups. This can be achieved by doing a secondary analysis on the ANOVA results using the Scheffe test.

The related t test for paired samples which is the equivalent of the Wilcoxon matched-pairs signed-ranks test (Munro and Page, 1993) was used for comparing data prior and post theory/practice.

6.8 Parametric or nonparametric tests

Data were analysed using both parametric and non parametric procedures. As in many spheres of research there seems to be fundamental disagreements among

authors and researchers about the use of specifically parametric tests and the appropriate level of data. Bryman and Cramer (1997) put forward three criteria for using parametric tests, one being, the level of measurement should reach interval or ratio scaling. However, they go on to state that the three criteria have been strongly questioned and they argue that parametric tests may be used on ordinal data as the tests apply to numbers not their meaning. Furthermore, they claim that parametric tests are routinely used on attitudinal variables. Polit (1996) however adopts a more moderate position in the argument by stating that, when deviations from the normal are modest and when the measures are at approximately interval level, then it is probably safe to use a parametric test. Approximate in this context is not defined. However, Polit (1996) also makes explicit when parametric tests should not be used, the reasons including markedly skewed data, especially with small samples, although small sample size is not specified. Bryman and Cramer (1997) define small sample size as being less than 15. Anthony (1999) is absolutely opposed to the use of parametric tests on non interval data. Furthermore, he suggests the philosophy of always using parametric tests is wrong and he puts this practice down to the desire for getting a positive result rather than a valid one and furthermore, they will give more apparently significant results but this may be through type I errors. The only excuse he sees as valid for using parametric tests on non interval data are for exploratory reasons whereas Bryman and Cramer (1997) suggest that both parametric and non parametric tests are used on the same data and the results then compared. The strategy followed here is to use both parametric and non parametric tests on the two data sets for the very reason put forward by Anthony (1999) as acceptable and that is as an exploratory exercise. However, the results from the parametric tests only will be presented in the next chapter with reference made to the non parametric tests only if there are notable differences between the two sets of results.

6.9 Data Analyses.

Five hypotheses were to be tested, thus the analyses must be selected appropriately. The hypotheses were based on the premise that each population has differing attitudes and beliefs towards older adults in the hospital setting.

Consequently, the purpose of the analyses were , firstly, to compare the attitudes of student nurses with those of nursing lecturers and those of clinical nurses; secondly, to compare the attitudes and beliefs of staff who work with older adults to those who work in the acute settings; thirdly to use a pre and post test design to compare student nurses attitudes before and after either theory or practice. The tests used were as follows;

Cronbach alpha and test re-test reliability were utilised to measure internal consistency and principal components analysis with varimax rotation were used to measure validity.

The Kruskal-Wallis H test and the ANOVA plus Scheffe test to test intergroup relationships for the factors, items and the independent variable of age, whereas the unrelated t test and Mann-Whitney U test were utilised to evaluate the differences between the clinical nurses from the care of older adults and those of nurses working in the acute settings.

Finally the related t test and Wilcoxon matched-pairs signed-ranks test for two related samples are useful for testing the same sample pre and post an intervention. In this case the interventions were either a clinical placement or theoretical input.

Both parametric tests and non parametric tests were used on the data for a number of reasons. Non parametric tests are acceptable for the type of data collected, in other words on ordinal data. However, Bryman and Cramer (1997) justify the use of parametric tests on ordinal data as they are primarily applied to numbers not

meanings. Furthermore, the purpose of the questionnaire was to measure attitudes and beliefs thus the use of parametric tests on this type of data is routine. Finally the rationale for using both parametric and non parametric tests was as a confirmation that results were significant using rigorous methods. Interestingly there were very few differences between the two sets of tests thus confirming that both types of tests can be used on ordinal data, certainly in this instance.

6.10 Setting up the data sets

Data were entered on to SPSS as per principal components analysis. However, two separate data sets were constructed, the first data set consisted of all 458 questionnaires, including the pre and post scores for the two student cohorts (data set 1) whereas a smaller data set (data set 2) was constructed using only the matched pre and post scores of students so that direct comparisons could be made between their scores prior to the relevant experience. Consequently, appropriate statistical tests were identified for each data set.

Descriptive statistics were used on both data sets, particularly for the demographic data to permit a summary of the demographic data. They were also used as a preliminary exploration of the data, particularly for any glaring differences among the groups.

6.11 Conclusion

A summary of the results are presented consisting of a table of means for each experiments group on the scale items and a mean for each group on the total scale score.(appendix X) The scores for each group are considered with reference to the interpreted factors, identified by principal components analysis The groups are then subsumed into three subgroups, that of nursing lecturers, clinical staff and nursing students. The subgroups are compared using both parametric and non parametric tests of Kruskal- Wallis H test and ANOVA This stage provides an overview of the data and also the evidence to accept or reject the null hypotheses, that students are expected to change their attitudes and beliefs over a

period of time relating to the intervention of either a clinical experience or theoretical experience. It is also suggested that student nurses' attitudes become more negative over this period of time. Finally, it is hypothesised that the attitudes and beliefs of clinical staff and lecturing staff influence student nurses attitudes and beliefs in a negative direction. To further evaluate the hypotheses the data sets are finally examined using comparisons across all groups and with reference to the items on the scale.

Chapter 7: Results of Phase II

7.1 Introduction

The properties of the scale are firstly considered with reference to reliability as indicated by the alpha co-efficient and a test re-test correlation. Validity is evaluated using Principal Components analysis with Varimax rotation. According to Bryman and Cramer (1997) factorial validity is indicated when the questions or, in this case, items seem to be measuring the same concepts or variables. Absolute values under 0.4 are suppressed. Next, a summary of the results is presented using the full data set, (data set 1, which was constructed using the results from all populations).

The populations were combined into three main subgroups, that is, clinical nursing staff, (the staff from the care of older adults and those from acute care were combined under one subgroup), student nurses (both cohorts) under the second subgroup and nursing lecturers made up the third subgroup. Significant results are discussed by comparing the responses from the subgroups with the factors which were identified through the principal components analysis. Subsequently, intergroup differences are considered for the items. Discussion focuses on whether the analyses justify accepting or rejecting the null hypotheses.

Significant results are presented from the second data set, (data set 2) that is the data from both student cohorts, using a pre and post test design. Discussion takes place at the end of each phase of the data analyses including consideration of the acceptance or rejection of the hypotheses.

7.2 Reliability of the questionnaire

Reliability using Cronbachs alpha resulted in a standardised item alpha of .6195. This result was calculated from the first data set where scores were evaluated using samples which excluded those whose scores are recorded at two different

time periods. Thus the first set of results from the two student cohorts were retained and the second set of results were excluded. Cronbachs alpha was within acceptable limits given the heterogeneity of the samples and the breadth of the instrument. Anthony (1999) suggests a result of between 0.7 and 0.8 as increasing reliability. However Gibbon (1995) suggests that a co-efficient is generally acceptable over 0.6. Furthermore, the measure has had a higher co-efficient when evaluating the individual groups, therefore, with such diverse groups a high alpha co-efficient may be an unrealistic expectation as the hypotheses predict that there will be intergroup differences.

The results for data set (2) where test retest reliability was calculated using Pearson's correlation produced a result of .657 at time 1 and time 2, that is before the intervention and after the intervention. The correlation was significant at the 0.01 level.

7.3 Validity of the questionnaire

Evidence of factorial validity was sought through principal components analysis with Varimax rotation and suppressing scores of less than 0.4. 8 factors over 0.4 were extracted, resulting in an eigenvalue of 1.006 and they accounted for 60.7 of the cumulative percentage. (See table 7.1 for the results of the factor analysis)

Table 7.1 Rotated Factor Matrix for Principal Components Analysis of the 20 item questionnaire

Items	Factor Loading							
	F 1	F 2	F 3	F 4	F 5	F 6	F 7	F 8
Learning Opportunities								
9. It is interesting to talk with older adults	.72							
17. There is nothing to learn in care of the elderly	.50							
8. In care of the elderly older adults are motivated to be independent	.41							
12. There is as much nursing care in a continuing care ward as there is in a medical ward	.48							
2. Working in care of the elderly is interesting	.69							
Communication skills								
20. Most nurses prefer to talk with younger adults		.59						
14. Nurses who work with older adults are usually good role models		.63						
11. Most nurses will take time to chat with older adults		.80						
Practical skills								
3. Nurses who work in care of the elderly require only basic nursing skills					.71			
17. There is nothing to learn in care of the elderly					.41			
6. Care of the elderly is no more than washing, feeding and toileting older adults					.78			

Items	Factor Loading							
	F 1	F 2	F 3	F 4	F 5	F 6	F 7	F 8
Stereotypes and myths								
13. Most older adults are able to hold a sensible conversation				.70				
7. Most older adults are continent of urine				.77				
4. Only lecturers who are expert should teach care of the elderly				.51				
Lecturing input								
15. Most lecturers are out of date with advances in care of the elderly					.77			
10. Most lecturers will promote an interest in care of the elderly					.79			
Time factors								
19. Patience is a more important quality in care of the elderly than in the acute areas						.76		
18. Nurse have to take their time with older adults as they are so slow						.66		
Age related relationships								
1. Older adults tend to use their age as a means of taking advantage of younger people							.66	
8. In care of the elderly older adults are motivated to be independent							.41	
5. When nurses are busy priority should be given to younger patients							.64	

Items	Factor Loading							
	F 1	F 2	F 3	F 4	F 5	F 6	F 7	F 8
Employment								
16.Once in care of the elderly nurses find it difficult to find employment in the acute areas								.80
Eigenvalue	3.1	1.9	1.6	1.4	1.2	1.1	1.0	1.0
% of variance explained	15.4	9.4	7.8	6.8	5.8	5.4	5.2	5.0

The principal components analysis demonstrates clear relationships between groups of items in the questionnaire, therefore, the production of psychologically interpretable solutions attests to the factorial validity of scale. Consequently, there are important factors which are being tested. Those factors influence how nurses perceive the care of older adults setting and were originally identified as important in the literature review. Issues which affect nurses' views of working with older adults were also considered important in the focus group interviews. The factors can also be linked to some of the themes originally explicated from the focus group interviews. (See table 7.2 for comparison between the factors and the themes)

Factor	Theme
Factor 1	Student learning opportunities
Factor 2	Interpersonal/communication skills
Factor 3	Skill and knowledge required for c/e
Factor 4	Labelling older adults
Factor 5	Lecturers' influences
Factor 6	Looking after older adults
Factor 7	Interpersonal relationships
Factor 8	Categorising nurses

Table 7.2 A comparison of the factors identified through principal components analysis with the themes identified explicated from the focus group interviews

Only two themes have been lost from the original focus groups and they account for socialisation influences and clinical staff influences. It is also difficult to justify the continued inclusion of a one item factor, in other words factor 8, but this item has had continued importance throughout the research. There is anecdotal evidence to suggest that nurses who work in the care of older adults perceive that they are unlikely to progress in their career out with this specialty and only with great difficulty. This perception was borne out in comments made

in the focus group interviews and will be demonstrated in the results presented later in the chapter when significant intergroup differences were extrapolated. It would be useful in future research to explore factor 8 in more detail with additional items.

7.4 Comparing the results from the three subgroups using the factors

Prior to computing the results of the statistical tests, the samples were subsumed into three subgroups, that is, the two student groups were analysed as one group as were the two groups of clinical staff plus the nursing lecturers. Consequently the three groups were analysed as subgroups. The rationale for this was to be able to analyse the differences between the main subgroups as this was relevant to accepting or rejecting hypotheses 1 and 2. Hypothesis 1 states that the attitudes and beliefs of nursing lecturers will be more negative than those of student nurses and hypothesis 2 states that the attitudes and beliefs of clinical nurses will be more negative than those of student nurses. Thus it was expedient to bring the groups together to test the hypotheses. The subgroups became group 1, student nurses, group 2, lecturers and group 3, clinical staff. The student group was composed of those who completed the questionnaire prior to theoretical/ clinical experience. An overview of any significant intergroup relationships will be considered with reference to the factors.

7.5 Analyses of the subgroups with the factors as variables.

Only analyses using parametric tests will be presented as stated in chapter 6. Thus ANOVA and Scheffe test were used on the sub groups using the factors as independent variables. (see appendix XI for ANOVA results for this comparison) What is most striking about the results, is that all factors were found to be significant, factors 1, 2, 3, 4, 5 and 7 are significant at $p < .000$ whereas factors 6 and 8 are significant at $p < .05$. The ANOVA indicates only that there are significant intergroup differences, however the Scheffe test indicates where the intergroup differences occur. A majority of the factors follow the same pattern for distribution of means as identified by the Scheffe test.

Furthermore three factors are interesting in that they follow a very different pattern.

The mean intergroup differences using the Scheffe test were significant at the level $p < 0.05$ where the significance occurred between subgroups 1 and 2 and subgroups 1 and 3. In other words significant differences can be found between the student nurses and lecturers as well as the student nurses and staff nurses. Those differences accounted for factors 1,3,4,6 and 7. Consequently the intergroup differences accounted for factors which were labelled learning opportunities (1); practical skills (3); stereotypes and myths (4); time factors (6); and age related relationships (7). Those results are interesting as hypotheses 1 and 2 state there will be differences between those two sets of groups.

Using the bar chart as an indication of the relationship between the means for each factor, the following pattern emerged for factors 1, 3, 4, 6 and 7. Fig 7.1 exemplifies the distribution of means for the three subgroups where the student groups had the lowest mean, the clinical staff had the middle means and the lecturing group had the highest mean.

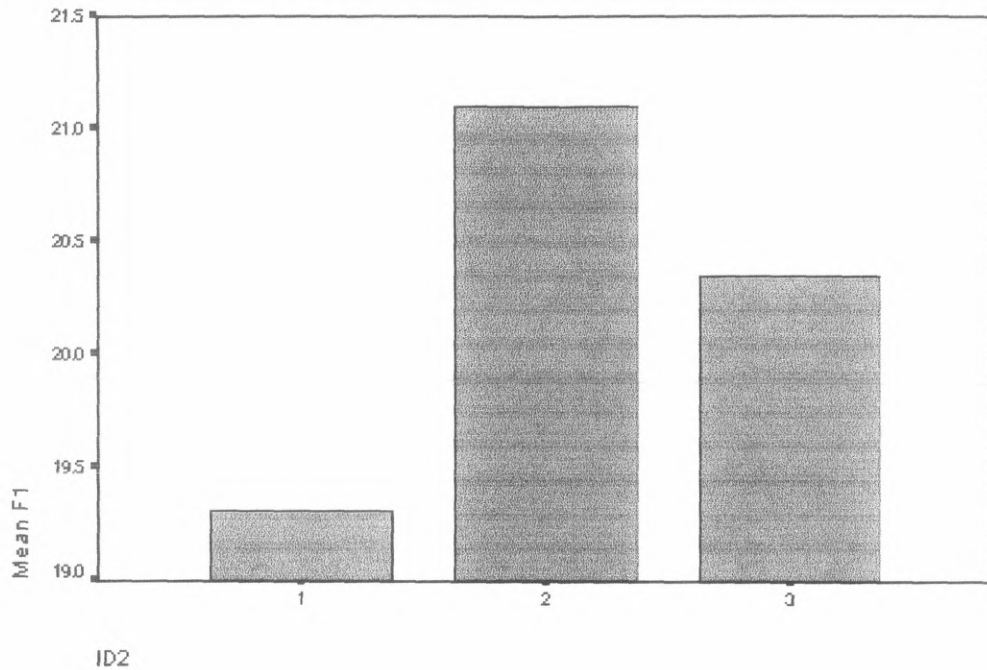


Fig 7.1 Comparing the means for student nurses, lecturers and clinical staff for student learning opportunities

Thus the conclusions which can be drawn are that student nurses are least positive for most factors. The factors where they are least positive account for learning opportunities, practical skills, stereotypes and myths, time factors and age related relationships. Students are therefore coming in to nursing with relatively neutral or more negative views about older adults than the groups found within nursing practice and education.

Furthermore, they are not developing those attitudes and beliefs from the nursing and lecturing staff. This may be accounted for by considering some of the issues raised in the literature review, where the real nursing is carried out in medical and surgical wards but not in the care of older adults areas. (Kiger, 1993) However this will be explored in more detail later in the chapter.

	Sum of Squares	df	Mean Square	F	Sig.
Between groups	158.18	2	79.09	12.15	0.000
Within groups	2219.53	341	6.51		
Total	2377.71	343			

Table 7.3 Analysis of variance comparing student nurses, lecturers and clinical staff on communication skills

Factor 2, labelled communication skills, was also found to be significant at $p < 0.00$ (see table 7.3 For ANOVA results for factor 2). The Scheffe test indicated that significance ($p < 0.05$) occurred between groups 1 and 3 and groups 2 and 3, (student nurses and clinical staff and lecturers and clinical staff respectively) for this factor.

Thus there are significant differences between the student cohorts and the clinical staff and between the lecturers and the clinical staff. Factor 2 therefore demonstrates a different distribution of intergroup means. (See fig. 7.2) The subgroup means for factor 2 reflected a pattern where the lecturing group had the lowest mean, followed by the students with the clinical staff having the highest mean.

The mean scores would indicate that the lecturing staff are less positive or more negative as to whether nurses will take time with and prefer to work with older adults whereas the other two groups are more positive about this issue. Research has indicated in the past that nurses do overestimate the time they spend communicating with any adults in hospital and this issue is compounded in the care of older adults areas (Caris-Verhallen et al, 1999).

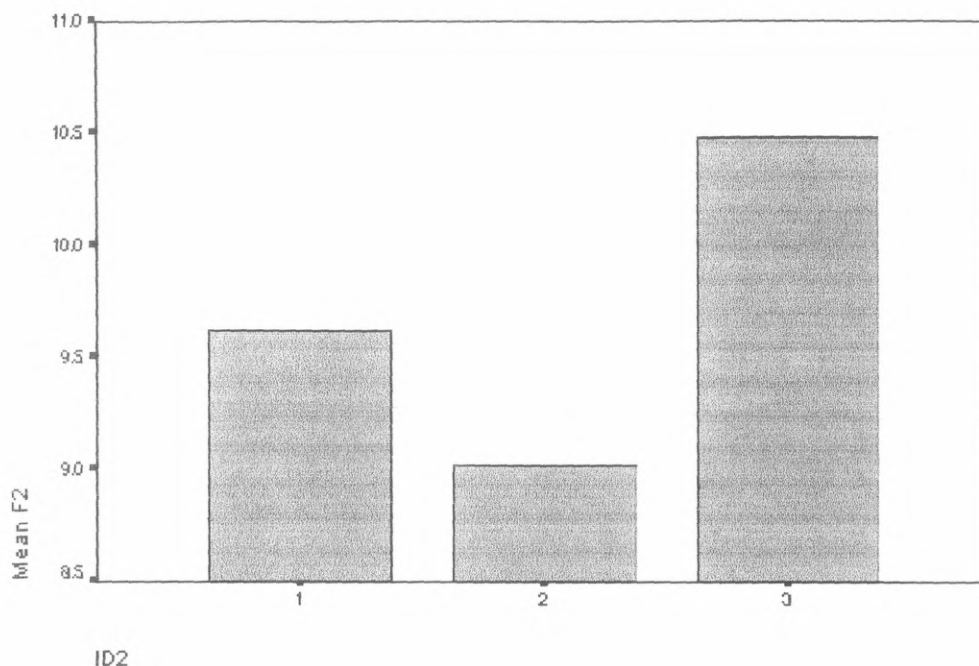


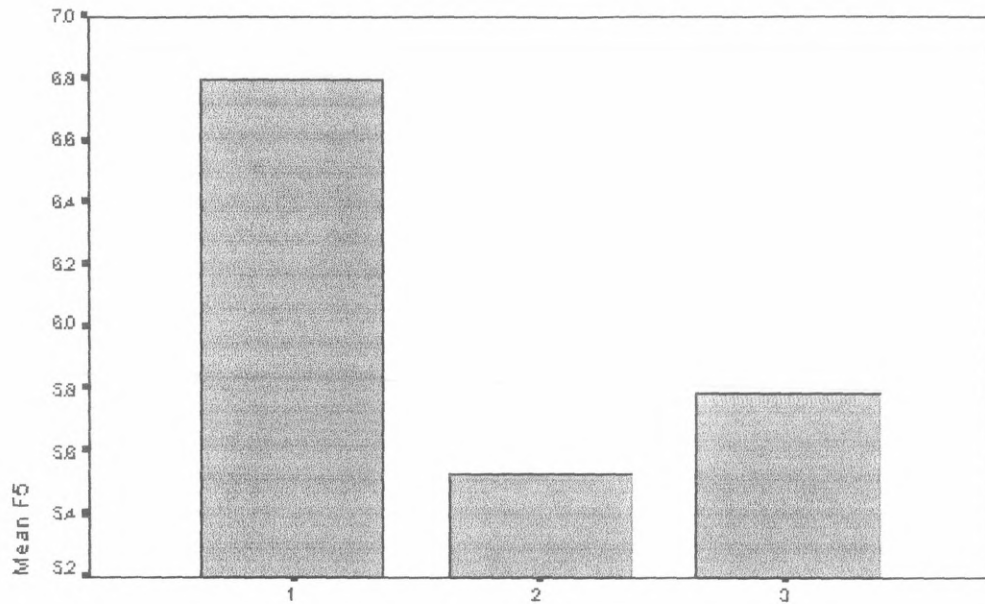
Fig. 7.2 The distribution of means for the student nurses, lecturers and clinical staff for the factor communication skills

The lecturers may well be describing the norm as opposed to the rule whereas the clinical staff may be seen as being overly generous in their estimations. The students are obviously less certain about communication in those areas.

The ANOVA once again demonstrated that factor 5 which relates to lecturing input was significant (see table 7.4 for ANOVA results for factor 5).

	Sum of Squares	df	Mean Square	F	Sig.
Between groups	104.52	2	73.03	33.55	.000
Within groups	1474.06	341	4.32		
Total	635.76	343			

Table 7.4 Analysis of variance comparing student nurses, lecturers and clinical nurses for the factor lecturing input



ID2

Fig. 7.3 The distribution of means for student nurses, lecturers and clinical nurses for lecturing input

A different distribution of means yet again occurs for factor 5 where the lecturing staff once again achieved the lowest means whereas there was a reversal for the clinical staff and the students when comparing the results with factor 2 i.e. the students achieved the highest means. (See fig 7.3)

Mean intergroup differences were significant ($p < .05$) for groups 1 and 2 and groups 1 and 3 once again using the Scheffe test. Thus significant intergroup differences occurred between the students and the lecturing staff and the students and the clinical staff. The students therefore seemed to be much more positive about lecturing input than were the clinical staff and the lecturers themselves. Finally factor 8 or item 8 had a different distribution of means and with significant intergroup differences ($p < 0.05$). (see fig 7.4) The ANOVA results for this item can be found in table 7.5.

	Sum of Squares	df	Mean Square	F	Sig
Between groups	11.22	2	5.61	7.28	0.001
Within groups	262.96	341	.77		
Total	274.18	343			

Fig. 7.5 Comparing the means of student nurses, lecturers and clinical nurses for the item relating to employment

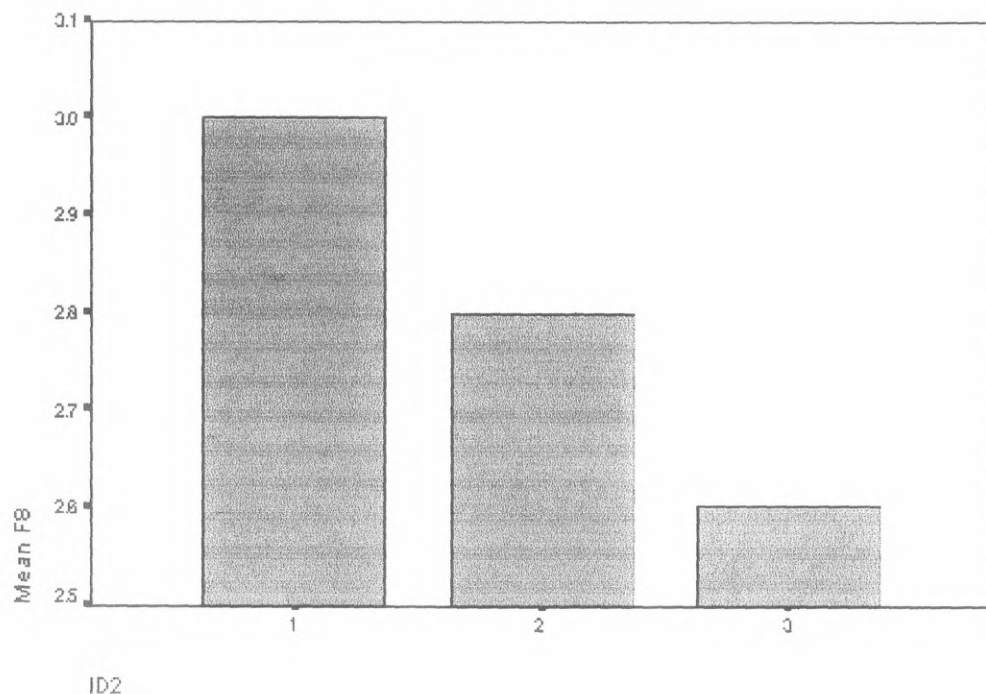


Table 7.5 Analysis of variance comparing student nurses, lecturers and clinical staff for the item on employment

The clinical staff were the least positive whereas the lecturing staff took a middle course while the student nurses were the most positive about this item.

The result confirms the suspicion that the clinical staff, no matter whether they are in the acute areas or care of older adults, they perceive difficulties in leaving

the specialty to work elsewhere. This therefore must be considered a very real problem for clinical nurses.

It is the clinical staff, whether they are clinical nurse managers or charge nurses, as they all come under the broad umbrella of clinical staff, who are the people interviewing candidates to fill nursing posts. Consequently, they are not going to employ nurses from the care of older adults if they believe that nurses who work in those settings are unemployable in acute areas. There may also be very real concerns for leaving disenfranchised nurses in areas which they feel they cannot leave. They will perceive the attempt to move as hopeless.

7.6 Discussion relating to the results from the analyses of the factors

The factors which followed the same pattern for distribution of means i.e. the student having the lowest means, the clinical staff the middle means and the lecturing staff the highest means included, factor 1 relating to learning opportunities, factor 3 which related to the skills required to work in care of the older adults, factor 4 relating to the stereotypes, factor 6 relating to time factors and factor 7 relating to interpersonal relationships. This pattern would suggest support for rejecting hypotheses one and two where the student nurses are displaying more negative attitudes than both the clinical staff and the lecturing staff. However, the hypotheses cannot be completely dismissed as lecturing staff have the lowest means both factor 2 and factor 5. Factor 2 relates to communication skills in the care of older adults and factor 5 which relates directly to the role of the lecturer in teaching skills for nursing older adults. The results from the lecturing staff would support the notion that younger nurses prefer to work with and communicate with younger adults and this is supported in the literature (Knowles and Sarver, 1985; Dellasega and Curriero, 1991).

What is interesting is that the lecturing staff seem to support the notion that they are out of date with advances in the care of older adults as well as not promoting an interest in this specialty, but those assumptions require further examination.

However the student nurses were much more positive about the lecturing input. An explanation for those distribution of means could be accounted for using two arguments, one being, that the lecturing staff genuinely perceive themselves to be out of date or, two, they are modest about their own abilities. The students are relatively new to nurse education therefore they have little past experience upon which to base their judgements. However, it is worth noting that the researcher is also their lecturer.

The means for factor 8, investigating nurses' views about employment prospects having worked in care of older adults, demonstrated very different returns where the clinical staff had the lowest means. The clinical staff obviously felt that working in care of the older adult reduced the likelihood of employment in other more acute areas. This level of response (mean = 2.6) was very low leaving the impression, as anecdotal evidence suggests that, once nurses commit themselves to the care of older adults setting, they are stuck in that specialty. The lack of opportunities for employment out of the area may well contribute to a lack of interest in working with older adults (Edwards and Foster, 1998). It also confirms the assumption that the skills learned and used in this area are irrelevant for other areas. However, this discussion is based upon the combinations of items and of populations thus providing an overview. The next stage involves giving a more detailed account using the individual groups' responses to specific significant items. There has been a tentative rejection of hypotheses one and two as the students on the whole are more negative than both the lecturing staff and the clinical staff.

7.7 Comparison of the results using the individual groups and items

The evidence so far suggests that hypotheses 1 and 2 can be rejected after comparing the results across the subgroups using the factors within the questionnaire to come to this conclusion. The subgroups as entities have been useful as they have given an overall view of the attitudes and beliefs held towards older adults. To produce a more complete view, the individual groups were

examined in relation to items in the questionnaire. The only group which had not been combined was the lecturers, however this was not so for the student cohorts and the clinical staff. Both of those subgroups were measured to evaluate their overall attitudes and beliefs. The purpose of which was to confirm or reject hypotheses 1 and 2.

Once again, ANOVA and the Scheffe test were used to analyse the data. (see appendix XII for complete table of results from the Kruskal-Wallis H test and ANOVA comparing each group for all items.) Using the ANOVA for comparisons, firstly, it will be noted that thirteen items reach a significance $p < 0.00$ and a further five items are significant at $p < 0.05$. When examining the data, using the Scheffe test, individual group significance becomes more obvious. Furthermore, when means and standard deviations are compared, the most striking observation is the similarities between the lecturing staff and the clinical staff who work in the care of older adults in that there is broad agreement between the two groups. Those two groups are the most likely to be significantly different from the other groups.

Considering the lecturing group first, there were significant intergroup differences between the lecturers and both student groups, including before and after either practical or theoretical experience, for item 7 which states that most older adults are continent of urine.(see table 7.6 for ANOVA results for this item)

	Sum of Squares	df	Mean square	F	Sig
Between groups	46.23	6	4.13	6.211	.000
Within groups	559.54	451	1.03		
Total	605.77	457			

Table 7.6 ANOVA comparing all groups on item 7 Most older adults are continent of urine

The group with the lowest mean and standard deviation were cohort 2(A) (mean 2.73, SD .91) whereas the lecturers had a mean of 3.78, SD 1.38. Interestingly the care of older adults group for this item reached a mean of 3.25, SD 1.32. As can be seen by table 7.6, the F ratio was 6.211 and significance $p < 0.00$

Item 5, When nurses are busy in an acute ward priority should be given to younger patients, reflected similar results where the lecturing staff differed significantly from all student cohorts where the mean for the lecturing group is 4.75, SD .48 whereas the lowest mean was recorded for 4.22 SD .79 for student cohort 2 (B) which means those students have completed their first theoretical experience. The ANOVA results indicated an F ration of 5.29 and a significance of $p = 0.00$. For both those items the lecturers had the highest mean scores in comparison to all other groups. Both of those items whether related to urinary continence or prioritising care in relation to age have an effect on the appropriateness of care which older people will receive.

The lecturing group also differed significantly from three student groups for item 13, most older adults are able to hold a sensible conversation. This time there was no significance with cohort 2 (B), the lecturing group having a mean score of 4.44 SD .63 and the lowest mean score was for student cohort 1 (B) (mean 3.81 SD .83). The f ratio for item 13 was 5.81 and the significance $p = 0.000$ The three items identified will all have an impact on the quality of care given towards older people.

Interestingly the lecturers differed significantly from one student group only for item 3 which states that nurses who work with older adults require only basic nursing skills. The F ratio was 6.36 and the significance $p = 0.00$ However, on closer examination of the means, although the item was significant the mean for the lecturers reached 4.67 and the student cohort who were tested prior to and post practice had a mean of 4.12 prior to practice and a mean of 4.03 post practice therefore the mean is falling as after practice.

Both the lecturing group and the care of older adults group differed significantly from the student groups for the following items, 10, (Most lecturers will promote an interest in care of the elderly) 12, (There is as much nursing care in a continuing care ward as there is in a medical ward) and 15 (Most lecturers are out of date with care of the elderly). Item 12 is considered first as both the lecturers and the care of older adults group were most positive about this item when compared to the student cohorts. There was also a significant intergroup difference for the lecturers and the acute care group which is not reflected in the scores between the care of older adults group and the acute care group. Nevertheless, the scores for this mean and SD for this item can be seen in table 7.7

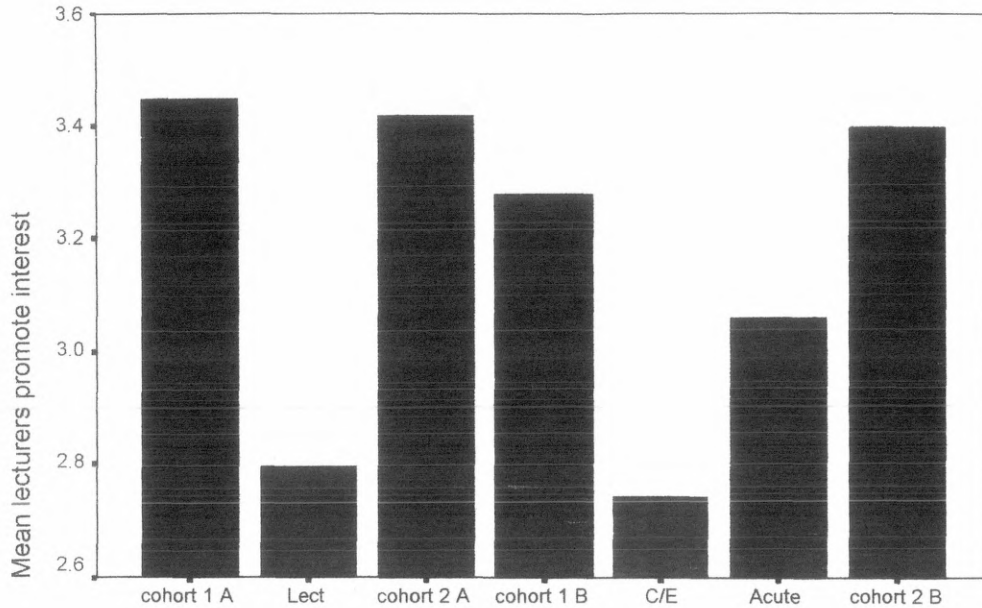
Identity	Mean	SD
Cohort 1 A	3.35	0.81
Cohort 1 B	3.44	1.04
Cohort 2 A	3.4	0.82
Cohort 2 B	3.46	0.73
Acute care	3.73	0.88
Care of older adult	4.02	0.98
Lecturers	4.4	0.63

(F ratio 13.01, $p = 0.00$)

Table 7.7 Comparison of the means for each group relating to item 12 There is as much nursing care in a continuing care ward as there is in a medical ward

This trend was reversed for items 10 and 15 although both the lecturers and the care of older adults staff differed significantly from the student cohorts.

Interestingly both groups agree that lecturers are out of date and experts should teach the care of older adults whereas the student groups do not agree with those statements.



id

(F ratio 9.25 and $p = 0.00$)

Fig 7.5 Comparison of means for all groups for item 10 Most lecturers will promote an interest in care of the elderly

As fig. 7.5 demonstrates the nurses for the care of older adults and lecturers had the lowest means for item 10. The results for item 15 were similar. Thus they were the most negative about the impact of the role of the lecturer whereas the student nurses were more positive.

The care of older adults group however, did not always agree with the lecturers.. For items 8 (In care of the elderly, older adults are motivated to be independent) and 14 (Nurses who work with older adults are usually good role models) the care of older adults group differed significantly from cohort 1 (A) and also with the lecturers. The means demonstrated that the clinical staff were more positive whereas the student cohort and lecturers were more negative. (See table 7.8 for mean scores and standard deviations for the significant intergroup differences.) Indeed the table demonstrates that the lecturers were the most negative for item 14.

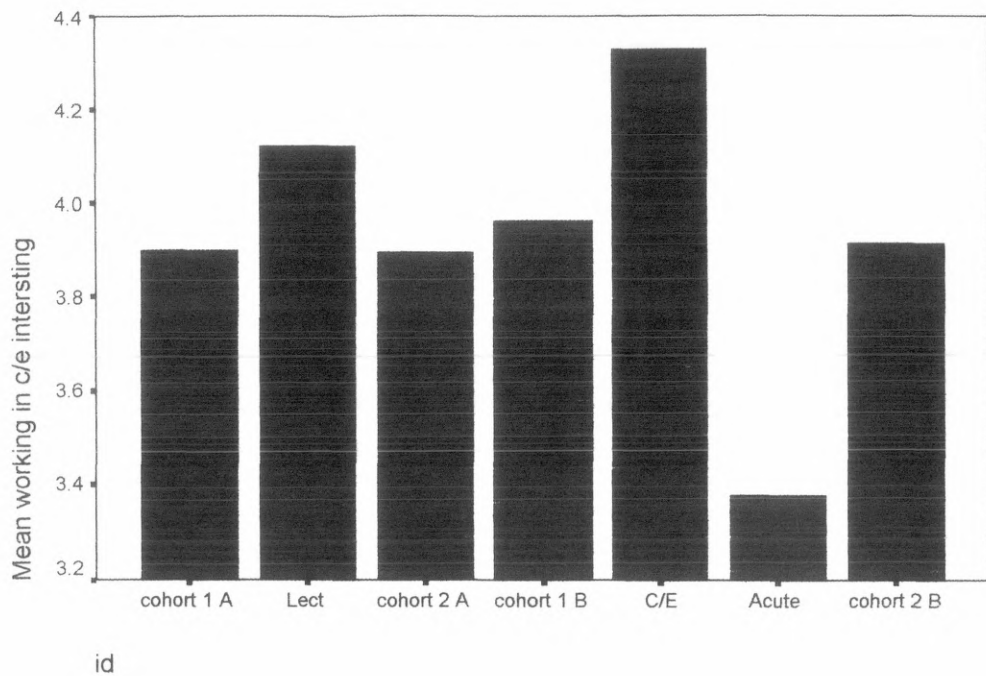
Identity	Item 8	Item 14
Lecturers	Mean 3.33 SD 1.04	Mean 2.89 SD .86
Cohort 1 A	Mean 3.27 SD .98	Mean 2.91 SD .83
Care of older adult group	Mean 4.00 SD 1.06	Mean 3.56 SD .89

(Item 8 F ratio 4.00 and $p = 0.001$ and item 14 F Ratio 4.93 and $p = 0.00$)

Table 7.8 Comparison of means for significant group differences for the item 8; In care of the elderly, older adults are motivated to be independent and item 14; Nurses who work with older adults are usually good role models

The staff who worked with older adults therefore saw their roles as motivating older adults to be independent and they also thought that they were good role models. The other two groups were less positive that they were good role models.

The acute clinical staff differed significantly with other groups for three items, those being items 2, 16 and 20. They differed significantly with all other groups for the item working in care of the elderly is interesting (2) however they differed only with three student cohorts and the care of older adults group for item 16 (Once in care of the elderly, nurses find it difficult to find employment in the acute areas). Finally for item 20 (Most nurses prefer to talk with younger adults), they differed with one student cohort (cohort 1 A) and the lecturers. Discussion will take place for items 2 and 16. For item 2 the acute care staff were notable in their neutrality in comparison to all other groups (see fig. 7.6)



(F ratio 7.89 and $p = .000$)

Fig. 7.6 Comparison of means for all groups for item 2 relating to Working in care of the elderly is interesting.

The mean scores for the least positive i.e. the acute staff was 3.38 SD .98 whereas the care of older adults group reached a mean score of 4.33 SD .88. For item 16 the acute staff once again had the most negative mean response but this time they were significantly different from three student cohorts, with the acute group means 2.33 and SD .86 while the most positive mean was achieved by student cohort 2 B with a mean score of 3.08 SD .49 (F ratio 6.06 and $p = 0.00$)

7.8 Discussion of the intergroup results

It can readily be identified that the lecturing staff and the clinical staff in the care of older adults are scoring more positive scores for a number of items.

Furthermore, student nurses appear to be coming in to nursing with more negative or at best neutral attitudes and beliefs, although for occasional items they reach a mean score of 4 for some items, an example of which has already been discussed

in the analyses, the item being referred to relating to item 3 which states that nurses who work in care of the elderly require only basic nursing skills.

However, the discussion will now follow the results section by considering how the lecturing group differs from the student groups, then on to consider the similarities between the care of the older adult group and the lecturing group.

The main intergroup differences for the students and the lecturing staff occurred for the item stating that most older adult are continent of urine. The students responded relatively negatively to this statement whereas the older adult group responded in a more neutral manner yet the lecturers were the most positive.

The more neutral score from the nurses who work with older adults is a cause for concern as it leaves doubt as to whether they believe older adults are continent of urine. Those results also have implications for older adults if the nurses who work predominantly with older people are unsure as to whether most older adults are continent of urine as they are the people who should be preventing and minimising the occurrence of the problem instead of managing the problem if and when it occurs. Those mean scores also reflect the concern of a number of authors, including Edwards and Forster (1998), who discuss the assumption that incontinence is a natural consequence of ageing. If this perception is perpetuated, then nurses will make little attempt to re-educate those older adults who may have incontinence and thus condemn them to a preventable and more than likely very embarrassing condition. The lecturing staff were also most positive for the item relating to giving priorities to younger people in busy wards in that they disagreed relatively strongly with this statement. The students at this stage were also disagreeing that younger patients should be given priority which does not support Grant's (1996) assertion that older adults are less valuable members of society when it comes to priorities. Nor are students at this stage reflecting Melia's (1987) findings where working with older adults was seen as basic nursing care.

It could be argued that the nurses who work with older adults should be the most

positive about those items yet this is not always reflected in the results. Nor is it reflected for the item which states that most older adults are able to hold a sensible conversation. Both items 7 and 13 are stereotypes of ill older people where older adults are sometimes seen as incontinent and confused or demented. The staff who are caring for those people should be working to reduce the negative images and promote positive images of older people. However this may be difficult if nurses, themselves, are neutral about those images.

Both the lecturers and the care of older adults staff were most positive for a number of items except for the role of the lecturing staff in teaching about older adults. There seems to be agreement in both groups that lecturers are out of date and that they are not promoting an interest in the specialty. A number of studies have emphasised the importance of educational preparation and the influence on shaping student nurses' attitudes (Wade, 1999; MacDowell et al, 1999; Angiullo et al, 1996). This issue becomes more critical if the findings from this study are accepted where students seem to be coming in to nurse education with less positive/ more neutral attitudes and beliefs. In contrast, the lecturing staff are doubting their effectiveness in being up to date and promoting positive images of older adults and they are not alone in this as, relatively negative views relating to their effectiveness are also being put forward by the nurses who work with older adults. This general dissatisfaction from the clinical staff relating to the knowledge that students bring to the care of older adults was expressed during the qualitative interviews. There is a perception that the lecturing staff are not teaching up to date issues, nor are they teaching relevant issues for this specialty.

Meanwhile, the perception that lecturers are out of date and do not promote an interest may not so much rest with what is taught in the school but what students bring to the placement via the media. If, as Snyder and Miene (1994); and Bytheway (1995) suggest, the media are putting forward the stereotypes of older adults as being cantankerous or as having Alzheimer's then students are bound to bring those stereotypes to their placements which is why the clinical staff doubt

the veracity of lecturers' knowledge and keenness to promote the specialty. However it is difficult to argue with the results from the lecturing staff unless, they do genuinely doubt the relevance of their skills and knowledge. This aspect does require further exploration. The role of the clinical staff in the care of older adults also requires further examination when considering their neutrality in answering the items relating to stereotypes in that are they perpetuating the stereotypes or, are they justified in maintaining that it is a problem within the School of Nursing and Midwifery?

Interestingly, the main difference between the care of older adults staff and the lecturers occurs in a statement relating to the clinical staff being good role models, where the clinical staff see themselves as good role models but the lecturing staff are more neutral.

The items where the acute care staff were most negative included the statements that; the care of older adults is interesting; most nurses will take time to chat with older patients. All other groups disagreed with them about the care of older adults being interesting. The assumption, by the nurses from acute care, that the specialty is not interesting, probably stems from the perception that it is no more than basic nursing care. This can be accounted for through the continuing debate relating to the basic versus technological skills where the care of older adults is about basic nursing skills only whereas the acute areas have the real nursing skills, that is the technological skills (Edwards and Forster, 1998). The acute care staff also agreed with the item relating to preferring to talk with younger adults and this is reflected in the literature by Knowles and Sarver (1985) who comment on how older adults are less preferred when compared with younger adults. The results reflect the divide between the acute care staff and the care of older adults staff where the acute care staff have little regard for the work of nurses who work with older adults. This is affirmed in the item where nurses who work predominantly with older adults will have difficulties with employment elsewhere, the assumption being that the skills learned and practised in the care of older adults are of little

value within the acute areas, as they are only basic nursing skills.

There are decided intergroup differences according to the results of the questionnaire where the student groups on the whole are less positive than the other groups for most items thus rejecting hypotheses 1 and 2.

7.9 Age as an independent variable

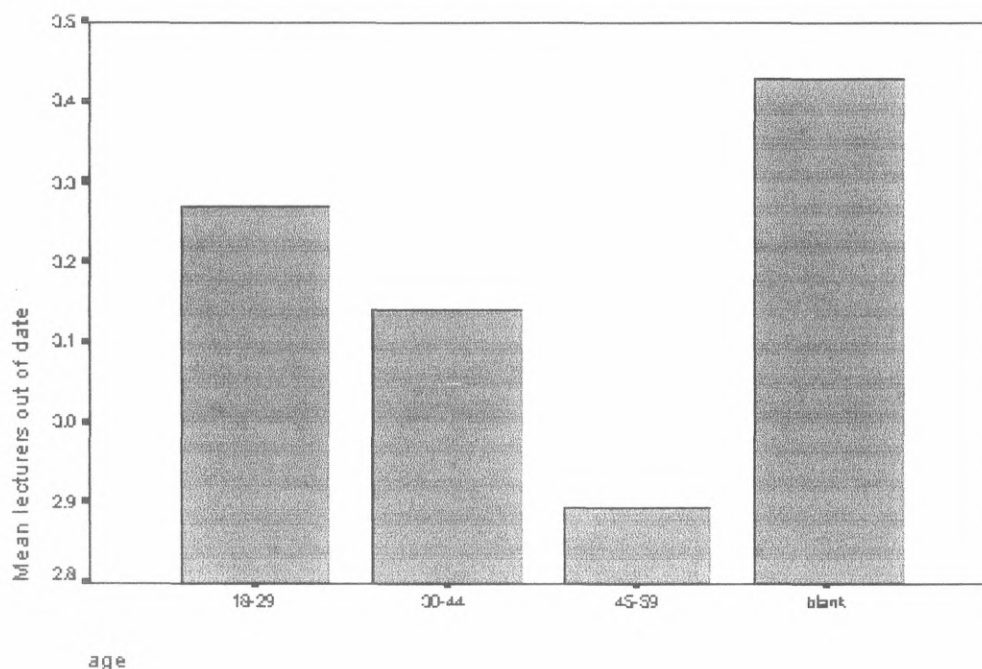
The ANOVA resulted in there being 7 items significant at $p < .001$ and 2 items being significant at $p < 0.05$. Intergroup differences for age were calculated using the Scheffe test with a significance of $p < .05$ and D. F. 2. The 18-29 year old age group differed most frequently from both the 30-44 age group and the 45-59 age group. The differences occurred on the following 6 items, items 1, 2, 3, 7, 15 and 17. (See table 7.9)

ITEM	F RATIO	F. PROB
1. Older adults tend to use their age as a means of taking advantage of younger people	17.2207	.000
2. Working in care of the elderly is interesting	7.0435	.001
3. Nurses who work in care of the elderly require only basic nursing skills	12.3626	.000
7. Most older adults are continent of urine	7.7619	.005
15. Most lecturers are out of date with advances in care of the elderly	7.1470	.009
17. There is nothing to learn in care of the elderly	11.6706	.000

Table 7.9 The F ratio and F probability for the items where age 18-29 age groups differed significantly from the other two age groups

The 18-29 age group differed from the other two groups on issues such as the work, whether it is a learning experience and whether it is interesting. Once again

the issue as to whether the care of older adults is about basic nursing skills or more, differs significantly when associated with age. On examination of means for each age group, once again there is a notable pattern for all the above items except 15 Most lecturers are out of date with advances in care of the elderly (see fig 7.7). where they are arranged in the same order in that the age group 18-29 is more neutral/ less positive than the 30-44 age group who are less positive than the 45-60 age group.



(F ratio 7.14 $p = .0009$)

Fig 7.7 Comparison of the distribution of means by age group for item 15 Most lecturers are out of date with advances in care of the elderly

The tentative conclusion which can be drawn for those statements are, that age does have seem to have an effect on perceptions according to the quality and the interest of the work in that the younger age groups are more neutral/less positive than the older age groups. However, there are caveats, in that the results must be interpreted cautiously as there was an unequal distribution across the age range

where the 18-29 year old age group accounted for 214 of the population, the 30-44 year age group accounted for 163 and the 45-59 age group accounted for only 74 with 7 respondents leaving age blank. Furthermore the range of age differences for the lecturers were skewed in that most of them were in the upper age group (40), 15 in the middle age group whereas none were in the 18-29 age group. For all other groups, ages primarily ranged over the first two age groups. This in turn is reflected in item 15 which follows previous patterns where the older the age group the less positive so that there is an exact reverse for the age groups. Nevertheless, it is useful to consider age as an independent variable. (See Appendix XII for significant results of Kruskal Wallis H test and ANOVA for both identity and age as independent variables)

7.10 Sex as an independent variable

It was felt that sex as an independent variable could not be carried out due to the disproportionate distribution between males and females returning the questionnaire where a total of 45 males and 381 females returning the questionnaire with 32 participants not completing this section. The other issues which skews the numbers of males and females returning questionnaires are the disproportionate lecturers who are male.

7.11 Comparing the attitudes and beliefs of nurses working in the acute clinical areas with those in the care of older adults

Hypothesis 3 states that the attitudes and beliefs of nurses working in the acute clinical areas will be more negative than those of nurses working in care of the older adult areas.

A comparative analysis was calculated using the data from the acute clinical staff and the care of older adults staff seeking differences between the two groups. Both parametric (unrelated t test) and nonparametric (Mann Whitney U) tests were used. However, the unrelated t test results will be presented at this time. (See Appendix XIII for significant results of the Mann Whitney U test and the unrelated t test)

The *t* test (d f 124) was significant (2 tailed $p < .05$) for items 1, 2, 3, 8, 9, 10, 14, 15, 16, 17 and 19.

Interestingly, the items identified as significant can be considered in two main groupings, that of the actual skills required for caring for older adults (items 1,2,3,8,9, and 19) and that of role of learning where older adults are concerned. (Items 10, 14,15, 16 and 17)

The items which considered the skills required for caring for older adults are as follows:-

1. Older adults tend to use their age as a means of taking advantage of younger people
2. Working in care of the elderly is interesting
3. Nurses who work in care of the elderly require only basic nursing skills.
8. In care of the elderly nurses are motivated to be independent.
9. It is interesting to talk with older adults.
19. Patience is a more important quality in care of the elderly than in the acute areas.

The second grouping identified the role of learning in this specialty and the items were identified as follows:-

10. Most lecturers promote an interest in care of the elderly.
14. Nurses who work with older adults are usually good role models
15. Most lecturers are out of date with advances in care of the elderly
16. Once in care of the elderly, nurses find it difficult to find employment in the acute areas
17. There is nothing to learn in care of the elderly.

The items are thus considered under those main headings for ease of discussion. The acute staff were less positive/ neutral about a number of aspects associated with looking after looking after older people. (See fig 7.8)

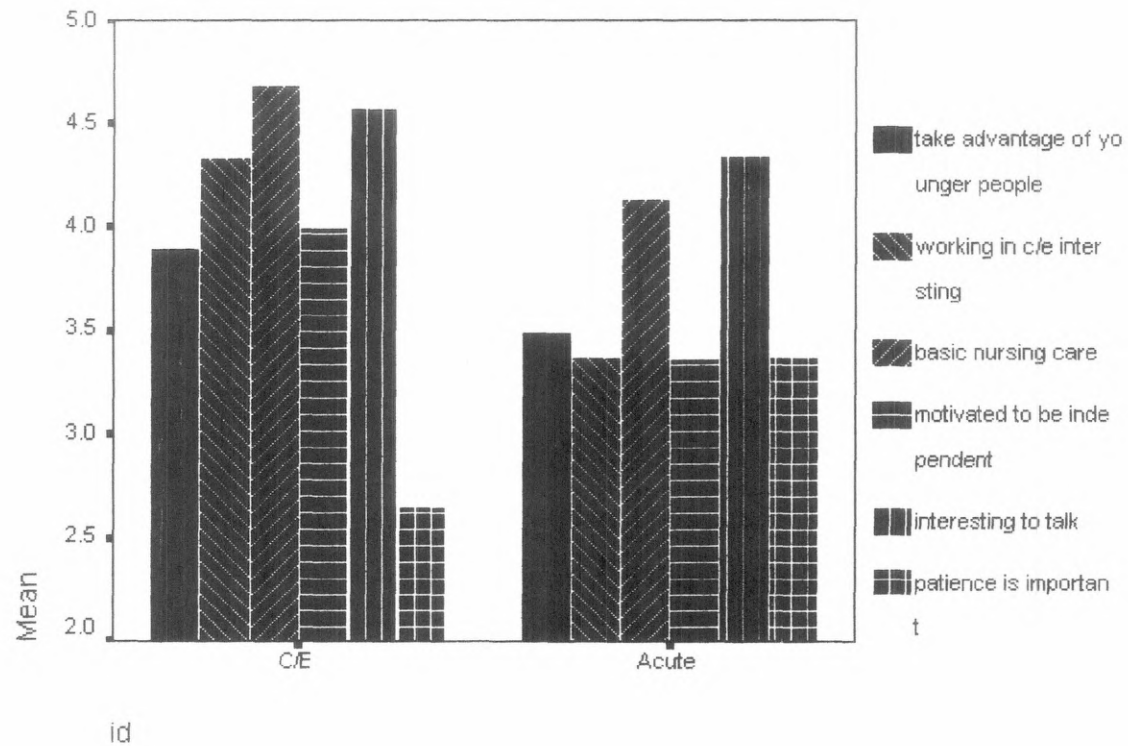


Fig. 7.8 Comparison of means for the care of older adults group and the acute staff for items 1,2,3,8,9 and 19

Working in the care of older adults was not seen as interesting according to the acute care staff, mean 4.33, SD .88 for the care of older adults staff and 3.38 SD 1.04 for the acute care staff ($t = 5.55$ and $p = 0.00$) but the statement about care of the elderly being no more than basic nursing care, although significant ($t = 44.378$, $p = .000$) the means for both groups were generally positive, in that the care of older adults group had means of 4.68, SD .67 whereas the mean scores for the acute care staff were 4.14 SD .72.

The item stating that it is interesting to talk to older people although significant ($t = 2.465$, $p = .015$) was also generally positive (see table 7.10)

Identity	Mean	SD
Care of older adult	4.57	1.06
Acute care	4.35	1.11

($t = -2.46$ and $p = 0.016$)

Table 7.10 Mean and SD for the care of older adults and the acute care groups for item 9 It is interesting to talk with older adults

The one item where the means were reversed was for patience being important in the care of older adults ($t = -3.140$, $p = .002$). The care of older adults staff agreed that it was more important than for other areas whereas the acute care staff were more neutral (see table 7.11 for mean and standard deviation)

Identity	Mean	SD
Care of the older adult	2.65	1.32
Acute care	3.38	1.29

Table 7.11 Comparison of means and SD between the care of older adults group and the acute care group for item 19 patience is a more important quality in care of the elderly than the acute areas.

The acute care staff were more neutral when asked about nurses in the care of older adults being good role models. The care of older adults staff fell short of being positive in that the t test was 3.768, $p = 0.00$ but the means and SD were 3.56 and .89 for the care of older adults staff. However the scores were 3.03 and SD .65 for the acute care staff. Where fig 7.9 is concerned, it can be seen that the care of older adults staff were less positive than the acute care staff for two items, those being lecturers promoting an interest (t is -2.095, $p = .038$) in care of the older adult and lecturers being out of date (t is -2.460, $p = .015$). The scores for both statements were more negative than the acute care staff who can be described as being neutral at best for both of those statements. Scores for each statement respectively were for the care of older adults mean 2.75, SD .88 and mean 2.71 and SD .91 whereas the acute care staff had scores of mean 3.06 SD .82 and mean 3.05 and SD .58.

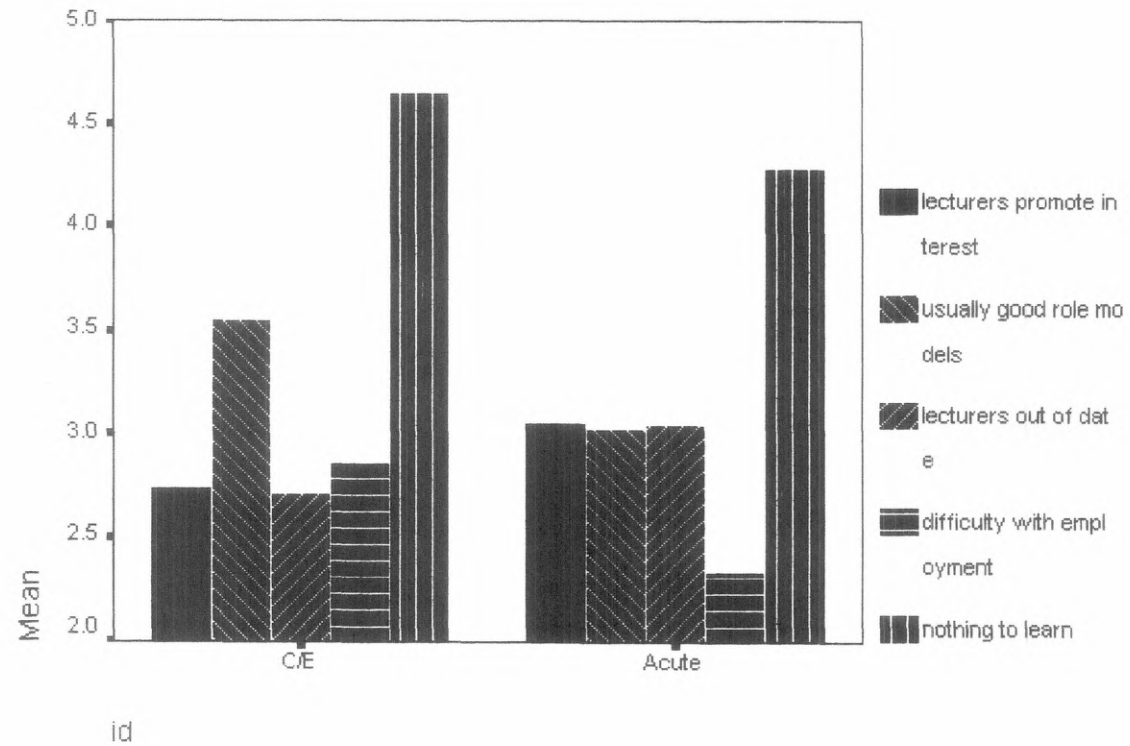


Fig 7.9 A comparison of the means between the care of older adults staff and the acute care staff for items 10,14,15,16 and 17

Once again, on further scrutiny of the results it is comforting to realise that both the acute care staff and the care of the older adult staff disagree with the statement that there is nothing to learn in care of the older adult, ($t = 2.597, p = .011$) Both mean scores are positive. (See table 7.12)

Identity	Mean	SD
Care of older adult	4.65	.90
Acute care staff	4.29	.66

Table 7.12 A comparison of the Means and standard deviations between the care of the older adult staff and the acute care staff for item 17, there is nothing to learn in care of the elderly

The final item which is considered is item 16 where the acute care staff were less positive than the care of the older adult staff but once again they had lower scores than would be expected. The statement, once in care of the elderly, nurses find it difficult to find employment in acute areas ($t = 2.821, p = .006$) had scores of mean 2.87 for the care of older adults staff and 2.33 for the acute care staff, SD respectively was 1.25 and .86 Both sets of scores were less than neutral and moving towards the negative scores. This demonstrates that the perception of both groups was that there would be difficulty in finding employment out with the care of older adults.

7.12 Discussion relating to the trained staff results

There are significant differences between the two groups of nurses. However the two groups are not as far apart as would be first thought as there were significant differences for only eleven items. The nurses from the acute areas agreed that the care of older adults is more than basic nursing care. This notion requires further exploration as the focus group interviews and anecdotal evidence lend credence to the view that the care of older adults areas are perceived to be about little more than basic nursing care.

The care of older adults staff were more negative on only three occasions when compared to the acute care staff, firstly concerning the importance of patience in their area whereas the acute staff were more neutral about this issue. It could be argued that patience is important no matter the area, not necessarily because nurses are dealing with older adults.

The other two occasions when the care of the older adult staff were more negative than the acute care staff occurred in relation to what is being taught by the lecturers. The results would indicate that there seems to be a very strong perception that the lecturing staff are both out of touch with what is happening in the care of older adults and not preparing students appropriately for those areas. Those results are reflected in the answers put forward by the lecturers who seem to be voicing the same concerns that they are out of touch with current practice in those areas and they are not promoting the interests of the elderly. If this is so, then it is a very unsatisfactory situation as it was stipulated at the commencement of this thesis that the older age group is the fastest growing group and will therefore require high quality realistic nursing care for them to achieve or maintain a level of independence in the community. However this may well be a perception as opposed to an actuality therefore this issue requires further investigation. Furthermore, the care of older adults staff were less than convincing about their influence as good role models although the acute care staff were more neutral about this aspect. It could be argued that they should be able to portray their role positively so that student nurses would be attracted back to their areas. It is unfortunate that they are so neutral about this issue.

The final issue which attracted more neutral and indeed negative scores for both groups, although the acute care staff were negative as opposed to neutral, was for employment. There is a perception from both groups that employment out of the area is a potential problem. Anecdotal evidence certainly suggests that both groups of nurses do believe this but this issue does require more formal research to confirm or negate the perception.

Sharpe (1995) discusses nurses' unwillingness to specialise in this area, postulating, that it may be associated with our unwillingness to accept the seemingly inevitable decline associated with ageing, however it would be feasible to suggest that it may well be linked with the reluctance to accept nurses with skills which are transferable from the care of older adult areas.

The null hypothesis for there being no difference between the clinical staff of both areas can be rejected as there were significant differences, however the hypothesis itself has not been accepted as both sets of nurses are more negative for some items but not others.

Having considered the differences between the acute care staff and the care of the older adult staff, the final aspect to be considered is the influence of theoretical and clinical placements on student nurses' attitudes and beliefs

7.13 Comparing the student cohorts before and after a theoretical and a practical experience

This final section considers hypotheses 4 and 5, where hypothesis 4 states that student nurses attitudes and beliefs will become more negative after an experience in a clinical placement and, 5 further states that student nurses attitudes and beliefs will become more negative after their theoretical input. The Wilcoxon Signed ranks test and the related *t* test were used for each cohort. There were few significant differences for either cohort. However the differences are demonstrated and discussed as there were interesting changes of view for the cohorts.

Considering cohort (1) first, this being the students who were evaluated pre and post a clinical experience. There were significant differences when comparing this cohort before and after their clinical experiences for three items. 2 tailed significance was $p < .05$ (see table 7.13, for Wilcoxon and *t* test for those items)

Cohort (1)	Z statistic	P	t value	P
Most nurses will take time to chat with older adults.	-2.116	0.034	2.13	0.037
Once in care of the elderly, nurses find it difficult to find employment in the acute areas	-1.98	0.047	2.03	0.047
Most lecturers will promote an interest in care of the elderly	-1.975	0.048	2.07	0.042

Table 7.13 Results using the Wilcoxon and the t test for cohort (1) identifying the items where there was a significant difference after clinical experience

The results for cohort (2), the students who were evaluated pre and post theory input, for both parametric and non parametric tests yielded a significance for two items (d f 66, 2 tailed significance $p < .05$) The items which were significant were items 7 and 9 (see table 7.14 for results of both Wilcoxon and related t tests for those items)

Cohort (2)	Z statistic	P	t value	P
Most older adults are continent of urine	-1.994	0.046	-2.04	0.047
It is interesting to talk with older adults	-2.448	0.014	2.59	0.013

Table 7.14 Results using the Wilcoxon and t test for cohort (2) where there was a significant difference in the items theoretical experience

7.14 Discussion of the student nurse results

There is the temptation to draw the conclusion that there is little change in attitudes and beliefs when comparing the before and after clinical experience for cohort (1) as the obvious myths and stereotypes such as older adults being

incontinent show no significant change. However, if the means for the significant items are examined, there is a downward trend in all three items. Thus for those items the students are becoming less positive over time and clinical experience. The students therefore seem to be seeing nurses who are not taking time to chat with older adults and more worrying, they are starting to pick up the cues from the clinical staff that employment prospects are not enhanced by working with older adults. From the lecturer's point of view, there is a real concern that lecturers are contributing to the lack of interest in specialising in the care of older adults and it seems that the students are starting to realise that there may be penalties associated with working in this area.

Cohort (2) demonstrated a slightly different trend where the item relating to continence was evaluated more positively post theoretical experience, however the means for the item pertaining to it is interesting to talk with older adult decreased. It could be argued that the students are reevaluating their perceptions of issues such as continence but where do they start learning that older adults are not very interesting? Are attitudes and beliefs such as this transmitted through lectures and tutorials?

The items where significant differences occur have been identified and discussed. However, there has been little change associated with either the clinical placements or the theoretical input. It is encouraging in one way that students are not becoming more negative, but it is also disheartening that they are not becoming more positive but remaining relatively neutral in the light of clinical or theoretical experiences. One could argue that this neutrality is a reflection of the comments put forward by Edwards and Foster (1998) in that nurses are inadequately prepared for their roles in caring for older adults, while Sheffler (1995) states that nursing lecturers also lack preparation to teach gerontological content. Therefore this lack of preparation by the two main protagonists of professional socialisation is bound to result in producing neutral student nurses. Furthermore, it is unlikely that students will be positive about this specialty unless

we move away from the dedication to technological skills and embrace the comments put forward by the National League of Nursing(1992) where nursing practice aimed at older adults needs to be innovative and dynamic and important in its own right.

Hypothesis 4 must be rejected as there is some evidence to support that there are changes in attitudes and beliefs, but the changes are more concerned with the perceptions of the interest in the work. Hypothesis 5 must also be rejected as there is no evidence to support that students are becoming more negative towards older adults

7.15 Conclusion

The quantitative analyses have disclosed some very interesting and compelling results. Students certainly appear to be coming in to nurse education with neutral/less positive attitudes and beliefs. The conclusion which can be drawn would support the assumption that students' beliefs and attitudes do reflect those of society. The clinical staff who work with the acute patients, that is medical and surgical patients, seem to be portraying relatively neutral to less positive attitudes and beliefs whereas the lecturers and the care of older adults groups on the whole are the most positive about a number of items. Furthermore, the results from each of those two groups are very similar. However there are very real intergroup differences relating to employment, up to date teaching , the ambivalence towards nurses in the care of older adult setting as good role models, in particular as the importance of this is contextualised by Davies (1993). The work in the care of older adult setting on the whole has been evaluated positively in that it is not perceived as just basic nursing care nor is it seen as a place where student nurses do not learn.

However, nurses who work with older adults are not as positive about some issues as would be expected. They are the people who are working with older patients and they should be up to date with their knowledge and striving to promote the

image of older adults as alert, independent human beings. They are prepared to level the accusation of not being up to date with current practice at the lecturing staff whereas they may need to examine their own practice.

The results from the nurses who worked with acute patients were not entirely surprising. There is a conceptual divide between the two groups of nurses, which was first demonstrated through the focus group interviews and was further explicated in the quantitative analyses but this will be further explored when the results from both the focus groups and the questionnaires will be compared and contrasted. However, it is reasonable to conclude that the nurses from the acute areas are more neutral/ less positive than those who work in the care of older adult.

There is little doubt that there are conceptual differences between the two groups of clinical nurses as each group have elected to enter different specialties. Nevertheless, those ideological differences need to be considered when students are in the acute clinical areas. They are exposed to nurses who are neutral/ less positive about the care of older adults setting as a learning experience, as an interesting experience or as an area where nurses will learn more than basic nursing care. Student nurses are well able to identify good role models and poor role models within nursing practice (Davies, 1993) therefore they may be internalising those perceptions from good role models in the acute clinical areas.

Finally, the students do seem to be changing in their attitudes and beliefs towards certain items. They are starting to internalise the negative items from the clinical staff such as employment out of the older adult setting and that lecturers do not promote an interest in the care of older adult. Whereas the students who have completed a theoretical module are changing their views on the myths and stereotypes of older adults.

The conclusion which could be drawn is that lecturers are encouraging more

positive attitudes and beliefs, while in the clinical areas, students are internalising the attitudes and beliefs of the clinical staff.

7.16 Limitations and recommendations for the quantitative method

This study was carried out in one small region within Scotland, involving one School of Nursing and Midwifery. It would be useful to compare the results for this area with another area to evaluate whether the results obtained were typical of other institutions. The School of Nursing and Midwifery have had an unchanging teaching population until recently due to the employment situation and the staff are very well known to the researcher which may have influenced the results, therefore it would be useful to compare views of lecturing staff from different campuses.

The age range also varies considerably from the other groups and it is not known whether this is typical in other schools although there is a suspicion that this is the norm. The obvious intergroup differences in age range may account for the results, therefore it would have been useful to have matched samples. There are implications for matched samples in that they will inevitably reduce the size of the samples.

Random sampling was also an option but once again this would have reduced sample sizes as the only group large enough to sample randomly were the nurses from the acute areas. All nurses from continuing care who fitted the criteria were asked to participate as were all lecturers and all students from both cohorts who once again matched the criteria.

Preparation of the cohort who had newly commenced their nursing education could have been much improved with a little forethought, nevertheless there was a reasonable response from both groups. It would have been unethical to force the students to complete the questionnaires in the class and this would have made it difficult to match the pre and post samples. Only two cohorts were included in the

research, but this project would lend itself to a longitudinal study especially now that there is a baseline from the different groups of teaching and clinical staff for comparisons. It would be interesting to track through the changes which certainly seems to be occurring between clinical and theoretical experiences. Furthermore it would be reasonable to try and match the questionnaires from the relevant staff in the clinical areas to those of the students who have completed an experience in that area. Consequently, there is much comparative work which is feasible with the questionnaire, including further testing and refinement of the questionnaire itself, certainly to try and improve the internal reliability and validity.

There are some interesting results which warrant more investigation including the perceptions of the lecturing staff and the care of older adults staff relating to whether nurse lecturers are up to date with advances as this is a critical issue in nurse education. The literature review has previously considered the importance of educational preparation on attitudes and beliefs but few authors except Fielding (1986) have explicitly attempted to measure if there is bias in the educational component. There is evident bias in the ageing game put forward by Pacala et al (1995) but other authors do not explain the content of their educational preparation. This aspect requires further in depth examination as one could speculate as to the causes of this anomaly but it would be just that, speculation.

Another interesting result which would benefit further investigation is the perception relating to employment in settings out with the care of older adults setting. It would be reasonable to measure whether nurses who wish to move out of this setting meet the selection criteria for interview, whether they are actually called for interview and if they are on what grounds are they accepted or rejected. This might encourage nurses to respect each other's skills.

Finally, nurses who work with older adults need to examine the skills that they have in their clinical settings, how do they differ from those of nurses in other areas and then they need to emphasise those skills to student nurses. They also

need to demonstrate their up to date, relevant knowledge and maybe measure their own attitudes and beliefs about older adults, thereby moving away from some stereotypical practices such as accepting incontinence as an inevitable aspect of ageing.

A number of interesting results have been explicated from the research but there is still much work to do to move away from the stereotypical images nurses have of older adults. Those include embracing innovative approaches to teaching student nurses about ageing which do not emphasise degeneration and where nurses who work with older adults demonstrate good interpersonal skills towards older adults which are then internalised by the student nurses.

Chapter 8 Evaluation of the utility of both methods

8.1 Introduction

It was identified at the beginning of the chapter on the quantitative results that there were clear relationships between the principal components analysis and the themes explicated from the qualitative analyses. This chapter will further explore those relationships by comparing and contrasting the results from each paradigm, to evaluate whether the groups are consistent in their attitudes and beliefs under the different circumstances. The discussion will follow the quantitative themes outlined in table 7.1 set out on page 183. Items which were not significant quantitatively will be considered if they were important in the qualitative data. Finally, there will be an exploration of the utility of the concept of triangulation for this research.

8.2 Factor 1/ theme:- Learning Opportunities.

Factor 1 followed the theme of learning opportunities. All items for this factor were significant using the ANOVA. However, there was no intergroup significance for item 17. The items will be considered in the order that they appear on the questionnaire.

The results for item (2) *working in care of the elderly is interesting* were similar for both methods. Where the quantitative analyses were concerned, the acute care staff were the least positive and significantly so from all other groups. This was reflected in the qualitative analysis where some members of the acute care staff indicated that nurses in the care of older adults settings were barely able to cope with much more than basic nursing skills. It was also felt by this group of participants, that much of the learning in the care of older adults setting could be “hands on” learning i.e. the “sitting by Nellie” syndrome where learning is by doing. This method of learning, in a way was seen as a negative aspect of learning by American students in the study by McCracken et al (1995). The participants in that study commented on the emphasis of clinical learning experiences as opposed

to classroom learning experiences. It was seen to contribute to negative attitudes by implying that looking after older adults did not really require classroom input but it could be learned in the care setting.

Although there are similarities in the results from the two analyses for item (2), it is not so evident in the qualitative analysis whereas the significant difference quantitatively is quite marked. There may have been a reluctance on the part of the participants from the acute areas to express their true thoughts relating to how interesting the specialty was and this is certainly one of the failings of qualitative research especially if the participants are unwilling to have their opinions recorded. Indeed one of the participants from this particular interview at one stage indicated that she felt the questions were too probing. She commented,

N 1. *These are very personal things* (Laughing)

The quantitative results for item (8) *in care of the elderly, older adults are motivated to be independent* do not do justice to the diversity of opinions and discussion which were demonstrated in the focus group interviews. Where the quantitative results were concerned, significant differences arose between both the lecturing staff and one student group as compared to the care of older adult staff. In other words the care of older adults staff were more positive than those two groups

However, attitudes were much more wide ranging within the focus groups and discussion occasionally resorted to an “us and them” attitude especially between the staff who worked with older adults and the staff who worked in the acute sector. However, this was not reflected within the student focus group interviews. One of the participants in the second student focus group interview very much gave the impression of doing things to patients e.g. toileting and washing. This concept of “doing” was expressed by a participant in the second care of older adult interview where the participant indicated that lecturers taught this concept of

“doing”. This perception was reiterated by the lecturers in that there is an assumption that nurses “do” to older people. The implication of “doing to” is that patients are not being encouraged to help themselves. However, the most interesting comments were put forward by the participants from the first care of older adults interview when they discussed how it was the nurses who worked in acute care created dependence by allowing patients to become immobile under their care, especially with regard to taking people in chairs as opposed to accompanying them while they mobilised and this was identified variously by Clark, (1998) ; Courtney et al, (2000) where the pace in an acute hospital does not allow for the pace of an older person. Lack of time is not confined to nurses only but to other professionals within the health service including radiographers (Fowler, 1997). To give the acute staff their due they admitted that it was due to time factors that sicker people took priority thereby encouraging dependence in older people by doing things for them.

The disagreement between the staff who worked with older adults and the participants from the acute areas as to who created dependence, both sides accorded each other with the same nursing attributes where the care was compared to a conveyor belt and there was a lack of motivation to encourage older adults to maintain independence. The students in the first interview had also become aware of how older adults were ignored in the acute areas and sensorily deprived resulting in a cycle of depression and dependency. Nurses working with older people were considered to have more time therefore were able to put this time to good use. The nurses from those areas emphasised the importance not only of maintaining independence but actively encouraging it. The staff who worked with older adults therefore viewed themselves as motivating patients to remain independent as reflected in both the qualitative and quantitative results, however not all groups agreed with this evaluation, as once again the staff who worked with older adults were much more positive than the other groups.

Item (9) *It is interesting to talk with older adults* was also significant

quantitatively. This was reflected in most of the focus group interviews where older adults were valued for their past experience and knowledge. One of the students were actually quite poignant in their description,

P 6 Some of them have lived through things, and have history they can only share. They've seen it first hand. When the elderly die, first hand experience can't be told by anyone else

This respect for older adults' history was not always reflected by the other groups. The acute care staff indicated that patience was required to listen to their stories.

The next item for this factor relates to item (12) *there is as much nursing care in a continuing care ward as there is in a medical ward*. Participants from the second student group reflect the student views expressed in the quantitative analyses where there is a level of doubt relating to the nursing care in a continuing care ward. There is also an indication that some participants from this interview felt that patients were in fact not getting the same standard of care as they would in an acute ward. The work was seen as monotonous and they indicated that patients sometimes had to wait several hours for treatment. This unchallenging nature of continuing care was identified by Heiskanen (1988). There was concern also from students and this came from both the student interviews, that the nursing assistants were negative and they wielded a lot of power in their ability to shape nursing staff attitudes. This power base is not identified as an issue in the process of professional socialisation whereas the hierarchy of skills is acknowledged (Melia, 1987). The perceived power base may be worthy of further exploration at a later date. However the students from both interviews felt that there was more leeway to sit down and talk to patients in the care of older adults wards whereas this opportunity was not only missing but felt to be frowned upon in the acute areas. The comment was made during the second care of older adults interview that patients coming in to continuing care now reflected the changes within assessment where they were more acutely ill.

The lack of intergroup significance for item (17) *there is nothing to learn in care of the elderly* was reflected in the qualitative data where there was a lack of unanimity both inter and intragroup in those results. Some of the students did see it as a learning opportunity whereas other students did not. The students gave valid reasons as to why they felt there were few learning opportunities. However the students who did value the placements felt that they would see things in this placement which they would not have the opportunity for in other placements. There was little evidence in the student focus groups which bore out the view of Spier (1992) who describes how the sights, sounds and odours of the care of older adults settings can traumatize student nurses. The lecturing staff were unconvinced that the students saw the placement as a learning opportunity as they become more senior. The care of older adults staff from both focus groups, on the other hand, stated that there were many opportunities for learning in this speciality.

8.3 Factor 2/ Theme: Communication Skills

Communication skills was a category which was subsumed into the theme of Skills and Knowledge for the reasons stated in the discussion relating to the qualitative analysis. All three items were significant for the quantitative analyses. Interestingly, the staff from the acute areas were the most positive for items (11) *Most nurses will take time to chat with older adults* and (20) *most nurses prefer to talk with younger adults*. Issues from the qualitative analysis do not concur with those answers as the students in their interviews were aware that they were not encouraged to chat/talk with any patients no matter their age in the acute clinical areas. They indicated that chatting with patients in the acute areas was well down the list of priorities. Furthermore they perceived that the implication from staff seemed to be that older patients were not worth the time. The students also expressed concern that older people in the acute areas were being ignored and becoming depressed due to a lack of sensory stimulation. However, on the care of older adults wards, the students felt that the staff took time with the patients, listening to them and to their relatives. One of the students from the first focus

group interview identified what would be lost if people did not listen to older adults in the way of history and experience. However, this portrayal of older adults as historians is described as stereotypical by Lookinland and Anson (1995). In contrast, it could be argued that older people are historians and as such, much information will be lost through death. One could speculate as to why there is an obvious discrepancy between the quantitative and qualitative results. There may be a number of reasons why it has occurred, including, the issue which arose during the focus group interview with the acute staff, where there was an expressed concern that the staff did not feel they have the time to speak with anybody let alone older adults due to the numbers of priorities competing with their limited time and resources. There was an expressed concern that physical needs were taken care of at the expense of psychological needs and indeed psychological needs were often allocated to the nurse specialists. Reed (1993), however, regards the lack of psychological care as not necessarily a prerogative of nurses in the acute areas, but can be found in continuing care areas where satisfaction is felt by nurses who give good geriatric care and which is epitomised as physical care. The other issue in relation to communication skills has been raised in a previous section but research indicates that nurses espouse the importance of interpersonal relations but this is not borne out by research (Nolan and Grant, 1993). Furthermore Philipose, Tate and Jacobs (1999) describe how the majority of interactions were restricted to the minimum demanded by the need for the physical care which instigated them.

The final item for this factor was item (14) *nurses who work with older adults are usually good role models*. The quantitative analysis indicated that there was a significant difference between the care of older adults staff and both Cohort 1 A and the lecturing group. Interestingly this student group's results improved after their placement although they did not equal the results of the cohort who had just commenced nurse education nor was there a significant improvement. Although the difference for this statement between the lecturing group and the new cohort

was not significant, what is interesting is that after the theory module for this cohort there is little difference in the results.

One of the participants in the second student interview identified that the quality of work would be affected if nurses did not enjoy what they were doing and students seemed to be well able to identify nurses who were not interested in their day to day work. They described how those nurses have an effect on the standard of care given by the students. However, the opposite was also true where there were nurses who did care and did attempt to influence practice. There is an important issue here especially if, as suggested in the literature review, that stereotypes can be learned through imitation and observation (Mackie et al, 1996). The student learns by imitating and observing the role model, therefore if the role model is disinterested in the work, then students may well come to see that working with older adults is uninteresting. This attitude towards work must also be considered within the cultural context where students may have had limited contact with older adults out with nursing and the contact they may have had are through media images. It is imperative that one of the tasks of the role model will be to emphasise the positive aspects of working with older people.

The powerful image of the nurse as role model probably encourages the continuance of the hierarchy of skills where the real nurse is carrying out the technical aspects whereas the auxiliaries are carrying out the care that anyone can do. This is reflected in the numbers of less skilled workers in the care of older adults settings. If nurses who work with older adults acknowledge the importance of the role model, then they need to examine why they emphasise the technical over the basic skills and go back to exploring what they do and how it differs from other specialties.

8.4 Factor 3/ Theme: Practical Skills

The quantitative results indicated that only one out of the three statements for this factor was not significant. The statements which were significant related to item

(3) *Nurses who work in care of the elderly require only basic nursing skills and item (17) there is nothing to learn in care of the elderly.* The statement which was not significant quantitatively related to item (6) *care of the elderly is no more than washing, feeding and toileting older adults* Item (17) has already been discussed under factor 1 as it loaded with that factor as well as factor 3. Therefore it will not be considered again. However the other two items will be compared with the qualitative results as both were very much contentious issues during the focus group interviews.

Item (3) was significant quantitatively, specifically with the lecturers and the care of older adults staff who differed with other groups. Furthermore, although lacking significance, the first cohort of students who went out to their placement came back into the school more negative whereas the students who had theoretical input only were becoming more positive. However the issue of basic nursing skills was discussed extensively in the qualitative data and by all groups. It is indeed heartening that all groups were positive in their disagreement that working with older adults is no more than basic nursing care. It is difficult for nurses and lecturers, for that matter, to verbalise what makes the care of older adults a specialty other than communication skills and the effects of ageing on illness plus the inter relatedness of disease. Watson (1992) has stated that it is important for nurses who work in this specialty to try and move away from current perceptions of the area through the use of evidence based nursing. Nurses also need to highlight prevalent problems and counterbalance them wherever possible with research. Only by doing this can the true nature of nursing older adults which involves highly developed technical and personal skills be revealed. (Watson, 1992) There was some evidence in the focus group data that nurses in the acute areas as well as student nurses did see the specialty as basic but this is not reflected in the quantitative results. The opinion that nurses working with older adults lose skills was expressed during the acute care focus group interview and that nurses in those areas could barely cope with more than basic nursing care. Students in both interviews expressed how they thought of the specialty as tedious

and boring. Conversely, other students felt that the ability to deliver basic nursing care was at the core of nursing practice. The breadth and depth of opinion is not so explicit in the quantitative data and the item becomes rather bland with little range in the answers.

Item (6) demonstrated no intergroup significance, although, a number of the groups expressed the opinion that the care of older adults is viewed in this manner. One of the students in the second student interview was very unhappy with the area due to this routine of washing, feeding and toileting while the lecturers stated that this is the view of this specialty. The work by Pursey and Luker (1995) emphasised the unhappiness of student nurses with specifically toileting regimes.

Nevertheless, the quantitative results do not support the views that the work is basic or tedious and it was iterated earlier in the thesis that the scores may or may not be significant but they are not overly negative with the minimum mean being 4 for basic nursing care and 4.2 for item (6). Therefore it can be safely postulated that all grades of nurses do not necessarily view the specialty as being about basic nursing as suggested by Wade (1999) and seems to confirm the view of Carr and Kazanowski, (1994) that it is not necessarily the work which engenders dissatisfaction but other issues such as working conditions and relationships.

8.5 Factor 4 / Theme: stereotypes and myths

Three items make up this factor, those items being item (13) *most older adults are able to hold a sensible conversation*, item (7) *most older adults are continent of urine* and item (4) *only lecturers who are experts in the subject should teach care of the elderly*. All three items were significant quantitatively. The qualitative results for item (4) were ambivalent as to the utility of experts teaching the subject. The main complaints from both the students and the staff who worked with older adults related to the lack of input in the subject and where the staff were concerned, the heightening of student nurses' expectations that all they would see in those areas are demented, incontinent old crones. Therefore their

main complaint was the inappropriateness of some of the educational input. Some of the students, on the other hand, were upset about the portrayal of the specialty by the academic staff. However those results are not reflected in the quantitative responses where there is evidence of ambivalence in that results for each group where means range from 2.7 to 3.5. Over all, the group results can be considered neutral. Both Scheffler (1995); and Angiullo et al, (1996) suggest that specific gerontological educational preparation can improve student attitudes. Furthermore, Wade (1999) suggests that gerontological input should be taught by teachers who have a demonstrated interest in the subject. The literature supports the view that lecturers who teach the subject should at least have an interest if not an expertise, however the ambivalence demonstrated in the results may be an outcome of the belief that anybody can teach the subject. The other argument that could be considered is the apparent lack of visibility of the subject, in the curriculum at a local level but that issue is beyond the scope of this study. However, in retrospect it might have been more prudent to use the word interest as opposed to expert when wording the item. Nevertheless, I am of the opinion that student nurses deserve to be taught by lecturers who at least have a strong evidence base in the subject and this issue is worthy of further exploration at a later date.

The other two items (7 and 13) were significant quantitatively, where the lecturers differed significantly from the other student groups. The lecturers were also the most positive for both items and indeed, if the means are further explored the acute care staff had higher means for both those statements when compared to the care of older adult groups, although the mean differences were slight and therefore by no means significant. Those two results in many ways confirm both the common ageing stereotypes perpetuated by the media in how they portray older adults. Therefore it is not surprising that student nurses come into the occupation with those stereotypes. It is evident, on those results, that trained nurses obviously change their views through contact with older adults and are therefore less inclined to view them as being incontinent and insensible. On

examining the means for both statements, there is an interesting albeit minor and insignificant change for the two student groups where clinical experience has influenced the attitude in a negative direction for the first student group, however post theoretical input for the second student group there is a change to a more positive attitude. Is it fair to draw the conclusion then that the lecturers are encouraging a positive change in attitude whereas clinical experience at this stage is encouraging a negative change in attitude?

The qualitative results reflected the portrayal of older people as being confused and as having Alzheimer's disease. This was discussed by a number of groups. The clinical staff in the care of older adults settings identified that student nurses came in with preconceived ideas relating to incontinence and dementia. They suggested that it was the fault of the lecturing staff, but this is not supported by the quantitative results as students were coming into nursing with those ideas already which tends to confirm the view that they were already socialised into viewing older people as incontinent and insensible. However, Speir (1992) argues that it is contact with high numbers of patients with dementia and the inability to communicate in long term facilities which encourage student nurses to see this as the norm. Both Edwards and Foster (1998); and French (1990) confirm the consequences of stereotyping older people in this way in that they will delay seeking help as it is perceived as an inevitable consequence of ageing. This perceived inevitability about incontinence is evidenced in the qualitative results by the discussion among a number of the groups relating to the chore of toileting where toileting is routinely carried out to minimise incontinence instead of examining the possibility of preventing incontinence. Adverts are now screened on television proclaiming the worth of particular urinary incontinence devices which is important in that the topic is aired on prime time television but they are accompanied by a sense of futility and inevitability.

8.6 Factor 5/ Theme: Lecturing input

Two items loaded on to this factor, those being, items (10) *most lecturers will promote an interest in care of the elderly* and (15) *most lecturers are out of date with advances in care of the elderly*. The two items were significant quantitatively where both the lecturers and the care of older adult staff differed significantly from most of the student groups. Both groups also had very similar means for both items. In other words, the results for the care of older adults group almost mirrors the results from the lecturers. The qualitative results confirm that the care of older adults staff were unhappy with the input from the school of nursing and midwifery. Indeed, they accused the lecturers of being out of date with advances in gerontology and not promoting an interest in the specialty. One of the student groups were in agreement, although by no means unanimously, that lecturers were certainly not promoting an interest. They gave examples of how lecturers promoted the idea that the speciality was difficult to leave once working in the area and the wards were dingy. It is pertinent at this point to recall that the students used in the group interviews were senior students as opposed to junior students therefore the quantitative results may change as the course advances.

Much of the literature supports the notion that lecturers are an important factor in the formation of positive attitudes but very little research actually examines the content of what lecturers teach. There is the assumption, that because lecturers are teaching the subject then there will be a positive impact on attitudes. However, the nurses who are working in the wards cast doubt on this relationship. Furthermore they have difficulty in explaining how lecturers are impacting on the knowledge student nurses bring to the clinical areas. Fielding back in 1986 identified that teaching input relied heavily on the medical model with a decremental approach taken to the specialty. However, if current research is to be believed, the topic is invisible, justifying the argument that they are not promoting an interest nor are they demonstrating an up to date knowledge. This may be what the lecturers are expressing in this statement. On further examination of the qualitative data the lecturing staff are well aware that they are trying to undo the

stereotypes which accompany student nurses in to nurse education but this may be why the accusation of being out of date can be levelled at them. As one of the students in the group interview identified, why plant images and stereotypes of older people and nursing practice as it was done and iterate the changes, instead of starting as practice is now.

8.7 Factor 6/ Theme: Time factors

The following two items loaded on to this factor, item (18) *nurses have to take more time with them as they are so slow* and item (19) *patience is a more important quality in care of the elderly than in the acute areas*. The quantitative results indicate no significant differences for item (18). On examination of item (19) there was a significant difference between the students at the onset of their nursing career and the staff who work in the acute areas. During the qualitative interviews, most groups identified that patience was an important attribute, however it was felt by one of the care of older adults groups that they required no more patience than any other patient. They also identified how older people were slower. The conception of older people as slower can have a deleterious effect on their nursing care as the staff in the clinical areas identified. The staff in the acute areas were inclined to encourage dependence by using wheeled chairs to transport them from one part of the ward to another instead of mobilising and accompanying them while they walk. This attitude is further reflected in a comment relating to continuing care where a student alluded to wheeling patients in and out of the toilets. Consequently, it is not only staff in the acute areas who were guilty of using wheelchairs for transport. However it was the participants from the care of older adults who gave example of how older patients were allowed to become dependent through enforced immobility. The rationale for this included time factors and lack of specialist knowledge. The group from the acute areas had agreed that older adults did become more dependent in their areas once the acute phase of their illness passed and they were waiting for a bed in another area. The students also felt the pressures from lack of staff and lack of time. All groups agreed that there were time pressures and therefore care was rationed for

those people who were perceived to require it and this excludes older adults past the acute phase of the illness. The quantitative results reinforce the intergroup unanimity with which those items were answered.

8.8 Factor 7/theme: Age related relationships

Three items loaded on to this factor, firstly item (1) *older adults tend to use their age as a means of taking advantage of younger people*, secondly, item (8) *in care of the elderly, older adults are motivated to be independent* and, finally, item (5) *when nurses are busy in an acute ward, priority should be given to younger patients*. All three items had intergroup significance. Item (8) has loaded on to factor 1, thus was considered at that stage.

In comparing the qualitative data with the quantitative data the student groups, on the whole, were less positive for item (1) than the trained nurses although the nurses from the acute areas were slightly less positive than the students who were going out on placement. This is reflected in the qualitative data where the students discussed how interpersonal relationships influenced how they viewed older adults. The issues they raised related to whether one should give up their seat on a bus if the person was old and jumping queues. Viewing older adults as patients and as members of society was also raised by Fowler, (1997) whose study used radiographers, which would imply that student nurses are not alone in this view. The lecturers also identified how older patients expected to have things done for them rather than doing for themselves. However, this may well be due to the interpretation of what nurses do and nurses themselves have developed the notion that they do for patients as opposed to encouraging patients to do for themselves. The qualitative results very much reflected the quantitative results where the students, on the whole viewed older adults as taking more advantage.

The time factor also influenced priorities and this is identified by the students, nursing lecturers as well as the clinical staff. The quantitative results demonstrated that the responses from the lecturers were significantly different from both student

groups and also more positive than both the trained groups. Therefore they were against the notion that priorities should be given to younger patients whereas both sets of trained staff were less positive about this issue which is surprising in a way as you would expect the nurses who work with them to support the concept of allocating them a fair time. However on examination of the qualitative data students were made to feel that standing chatting was “skiving” although they felt that communication was an important aspect of nursing care. The staff in the acute clinical areas admitted that their priorities were really related to getting through the workload. Furthermore, they admitted that priorities were geared to giving physical care as opposed to psychological care. Consequently, if patients do not require physical care then they receive the bare minimum attention and this is the situation in which some older patients find themselves when they are waiting on beds out of a busy acute area. One could argue that the educational system colludes with this approach to nursing practice in that an emphasis is put on prioritising care according to needs and communication may be well down on the list of priorities when other aspects of the work requires completion. However it is sad, that nurses choose to spend time with younger patients rather than make an effort to communicate with older people.

8.9 Factor 8/Theme: Employment

The final factor relates to one item only for which the rationale for its retention has already been discussed. This item (16) states *once in care of the elderly, nurses find it difficult to find employment in the acute areas*. The quantitative results revealed that the acute care staff were significantly more negative than the student groups and the care of older adults staff. There is a perception therefore that nurses who work with older adults will have a problem gaining employment out with their own sphere. There is little doubt that nurses who work with older people need to justify their choices as it is not perceived to be the most dynamic area in which to work and as one of the participants who work in this field, describes it as a conversation stopper. The literature describes how continuing care is perceived as lacking in glamour, can lead to a sense of isolation and a

feeling of being undervalued (Wade, 1999). This sense of inferiority was evident in a number of the focus group interviews. One participant from the acute areas stated that nurses who work with older people cannot cope with much more than basic nursing care. Consequently, it is not surprising that scores are so low for this group of nurses. Nor is it any wonder that nurses who work with older adults feel that they are inferior to the “real nurses”. The lecturing staff also stated that it was down to the perception of the work whether it was seen as routine toileting, cleaning and washing. This is reflected in the remark about the specialty being a backwater. One group of student participants had also picked up the idea that the care of older adults setting was second best. However the other group of student participants felt that the specialty was partly to blame in their perceived unwillingness to learn new skills.

It is unfortunate too that the nurses who work with older adults feel that they are looked upon as second best. Cheah and Moon (1993) argue that nursing has been obscured by assertions that working in care of older adults settings will lead to stagnation and obscured opportunities for promotion in comparison with other more glamorous high technological fields. It is up to the people who work within the specialty to establish their unique and valuable contribution to nursing and to move away from the concern for being second best.

8.10 Conclusion

Having compared the qualitative and quantitative results there are a number of similarities between the quantitative and the qualitative data and they are reflective of the different groups. However, the actual themes although broadly similar in title did not necessarily fit across the two paradigms. For example, an item which was categorised under a theme using principal components analysis was not necessarily found under the same theme in the qualitative analysis. This may have occurred for a number of reasons. Firstly, it may be down to the different interpretive processes, where one process is intellectual whereas the other process is statistical. Secondly, it may be as stated by other researchers, that

triangulation is impossible due to the opposing philosophical approaches or, thirdly, it may simply be due to the number of refinements carried out to the measure so that the items no longer fitted under the same themes.

I would tend to favour the final suggestion as the measure went through three main refinements therefore there was bound to be slippage from the qualitative themes. The most important issue was that there were similarities in intergroup responses across the paradigms which in many ways helps to enhance the validity of the questionnaire.

Chapter 9 Implications from the Findings

9.1 Introduction

This concluding chapter examines the relationship between the work done, the original research questions and the previous work discussed in the literature review. The implications for both clinical nursing staff and lecturers in relation to their role in educating student nurses about aspects of looking after older adults are then considered. Finally, the limitations and the recommendations of the study are identified.

In order to address the research question this study has adopted a two phase approach. The overall aim of the study was to examine how professional socialisation impacts on student nurses' attitudes and beliefs towards hospitalised older adults. To achieve this aim, a questionnaire was developed by identifying the commonalities extrapolated from focus group interviews with clinical, lecturing and student groups. Thus this research has combined both qualitative and quantitative data. The qualitative data were collected through the focus group interviews, from which the questionnaire was developed. The quantitative phase involved refining and distributing the questionnaire.

This chapter considers the extent to which the study has provided the answers postulated.

9.2 Discussion relating to the results of the research with the previous work done

The research demonstrated that there was little change in the attitudes of student nurses either after theoretical or practical experience. Indeed student nurses are coming into the occupation with attitudes less positive and more neutral than the nurses who work with older adults and nursing lecturers. Other researchers have found positive correlations between nurses attitudes before and after a placement and also after theoretical experience (Gomez et al, 1985; King and Cobb, 1983; Galbraith and Suttie, 1987). However those results have not been replicated here.

This may be due to the use of generic measures in previous research. The minimal change in attitudes and beliefs does not augur well for the future of the care of older adults. If student nurses continue to covet mastering technological skills as opposed to essential skills, this will be to the detriment of the care of older people. Student nurses take their cues from the nurses in the acute areas who create dependency in older people by discouraging them from helping themselves. Furthermore, student nurses as in Fowler's (1997) study of radiographers identified the need to separate social life from work life, thus they recognised that they may or may not like older people but that would not interfere with how they nursed older people.

The results also do not correlate with research by Treharne (1990) or by Slevin (1991) who found that student nurses were less negative than trained nurses. The student nurses in this research were more negative for a number of the items when compared with the trained nurses and the lecturers. It would be interesting to further investigate the attitudes and beliefs of nurses who work in the acute areas where older adults are concerned, to ascertain in more depth, their conceptions of older people. There would be an opportunity to explore further whether they would agree with the perception that they create dependence as opposed to minimising the risk. Both the literature review and student nurses identified that government priorities are not in the best interests of older people due to the emphasis on increased throughput. Furthermore student nurses identified how priorities differed between the care of older adults wards and the acute care wards. The examples given were communication, taking time and the use of restraints.

Very few studies were found where nursing lecturers' attitudes and beliefs were measured other than in the context of gerontological input within the curriculum. Thus it was interesting to find that the lecturers attitudes and beliefs were on the whole relatively positive when compared to the other groups. However, that does not imply that they have no work to do in examining their attitudes. There needs to be consideration relating to how gerontological nursing should be taught and in

what quantity. Therefore the curriculum requires monitoring for innovation and appropriateness. It also needs to be monitored in relation to how both nursing lecturers and clinical staff talk about older people. In other words, the positive aspects of ageing should be emphasised. Therefore, rather than stating that so many older people will develop dementia, it would be much more realistic to emphasise the numbers who do not, as they vastly outweigh the numbers of people who do. It is important that the U.K.C.C. (1999) report which acknowledges the numbers of older adults is implemented so that nurses are fit to practise nursing older adults.

9.3 Discussion of the Qualitative Phase

The literature relating to attitudes toward older adults has been neglectful of the use of qualitative approaches in collecting data. Most research has utilised a quantitative approach except for a few studies such as the seminal work by Fielding as long ago as 1986 when she used interviews and tape recordings to collect data. The research suffered from a lack of explanation about how the results were explicated from the data. However, the research allowed more in depth exploration of the subject. Not only have researchers under utilised qualitative methods, they have limited their research measures to a handful of generic measures.

This research relied on the use of focus group interviews. All that was written and critiqued about this method in the chapter on focus group interviews was justified. There remains a lack of consistency in how focus group can and should be used, how the data should be analysed and the relevance of interaction. However, notwithstanding, they were an excellent source of information, they were enlightening and they were thought provoking. The smaller groups for interview were much more manageable. They did not seem to suffer from heterogeneity relating to gender and most participants contributed full to the discussion. Only one focus group interview failed to materialise and the reasons for that were discussed. However for the moderator, there is a great deal of anxiety until

everyone arrives so that the interview can proceed.

It would have been useful to complete more interviews so that their utility could be evaluated more fully but they do produce a lot of data for transcription and analysis. Now that the interviews have been completed, transcribed, analysed and evaluated, there is no doubt they are a useful method for collecting qualitative data. Some of the richness was lost from the adaption of the data to a quantitative measure but this is a consequence of this process. Nevertheless, when the analyses from each paradigm are explicated there is congruence between both sets of results which confirms validity between the methods.

The literature review has demonstrated that a great number of research studies into nurses' attitudes towards older people have relied heavily upon generic questionnaires developed in the 1950's, 1960's and 1970's. Not only were they developed a number of years ago, most of the commonly used measures were developed in the U. S. A. Therefore there are issues both with age and with cultural aspects which at least one set of authors did acknowledge (Tuckman and Lorge, 1953). Most of the studies have been ambiguous in their findings and it is suggested that this ambiguity is related to using inappropriate tools. The inappropriateness lies with what researchers have been trying to measure. The premise of this research has been based on the view that nurses view older people differently from society due to the specific context in which they meet older people, that is, they meet ill older people. Thus the notion put forward by Eiser (1986) that attitudes are both situation and object dependent is important. This notion has been demonstrated through the qualitative research.

Student nurses were able to identify that there were nurses who were working with older adults who very obviously did not want to be there. However, the issues which did affect their views of working with hospitalised older adults included the work itself, the perceived lack of resources and the high numbers of untrained staff who were carrying out the care. Those factors have been identified in the

literature review as crucial in influencing nurses whether to come and work in the area. Thus it was not older people themselves that precipitated less positive attitudes but extraneous factors which impinge on the everyday work with older people. One of the student participants also identified how the views of lecturers influenced their attitudes and beliefs. This was not an isolated incident as staff from one of the care of older adults wards also implicated the lecturing staff in preparing students in such a way as to expect only incontinent, demented old people who were unable to sustain a normal conversation. Throughout the qualitative phase there was evidence to support the notion that attitudes are situation and object dependent.

Due to the nature of the generic measures used, there are issues which arose from the qualitative research which could not have been collected using the conventional tools. However, as a caveat, this research must be considered in light of the data gathered in its qualitative format, therefore, is not necessarily transferable.

Anecdotal evidence has always suggested that working with older adults is second rate or that nurses who work with older adults are not necessarily as able as those working in the acute areas. The nurses who worked with older adults identified, through the focus group interviews, that this was how they perceived other people viewed them, giving examples of how this perception was conveyed. Anecdotal evidence has also suggested that nurses who work with older adults lose important technological skills, thus the skills they have in older adults settings are non transferrable as they are less valuable. Therefore, the groups did indicate that there was a perception that the skills used in the care of older adults settings were seen as less valuable by both some of the students, some of the lecturers and by the acute care staff. It could also be suggested that one of the care of older adults groups perceived the introduction of technological skills enhanced their standing with students. This should come as no surprise as all first level nurses go through much the same training/education where there is a hierarchy of skills. Thus, it could be argued that nurses who work with older adults feel that they use only

basic nursing skills. Furthermore, this disregard for their skills is felt to result in the unlikelihood of promotion or employment out of the care of older adults clinical setting. Attitudes to older adults are therefore, not just about whether older people are liked or disliked. But it is the situation which has an effect on the object, not just the object itself.

The mutual antipathy between the groups of clinical nurses is also not identified in the literature where both groups of nurses accuse each other of poor standards of practice. This standard of practice can take the form of not assessing patients adequately in the acute areas and creating dependence or not being able to carry out much more than basic nursing care in the care of older adults areas. These conflicts do not augur well for the harmony of the different nursing groups whose collective goals is to educate student nurses appropriately for first level registration. The literature, due to the methods utilised to collect data, can be seen to have a number of gaps of knowledge relating to nurses' attitudes.

One further issue which does not seem to occur in the literature in any great detail is the issue of looking after older adults as a speciality. The results were ambiguous with some intergroup disagreement concerning nurses' conceptions of gerontological nursing as a speciality. This issue needs to be explored in much greater depth. It is reasonable for the National League of Nursing (1992) to suggest that there is an opportunity for nurses to be innovative and dynamic in their approach to nursing older people but for it to qualify as a specialty, it should have definable skills that make it thus. Therefore nurses need to identify those skills or should care of older adults be moved within mainstream nursing? The answer to this question has not been adequately explored in this research and does require further study. However, if it is a specialty, then serious consideration needs to be given to providing nurses with this specialist background to wards which nurse predominantly older people and this will include most of the adult wards in any hospital.

As has been stated previous research has relied on measures which have principally set out to measure society's views of older adults, and indeed, that is why they were designed. Consequently, there is no real surprise that there were varying results in the literature. Furthermore, a number of previous researchers who have developed other measures for evaluating attitudes have given very little detail about the developing and testing of these measures. Relatively few authors have indicated the content of the questionnaires so it has been very difficult to make judgements on the evidence presented.

9.4 Comparing the developed questionnaire with the generic measures

The questionnaire used for this study was developed from the focus group interviews and was tested for reliability and validity during the piloting work and as a result of the piloting and testing an eighty item questionnaire was further refined to a 20 item questionnaire.

The differences between the generic questionnaires and the questionnaire for this study can be readily appreciated when the measures are compared. The Tuckman and Lorge (1953) scale has only one item which is similar to the questionnaire developed as a result of this research and it accounts for item 67 which states that *they walk slowly* and which can be compared to item 18 on the new scale *nurses have to take more time with older adults as they are so slow*. There is also one fairly similar item on the KOP (1961) scale when comparing that scale with the measure developed for the research. Item 16 on the KOP (1961) scale states *Most older people are constantly complaining about the behaviour of the younger generation*. The similarity occurs for item 1 *Older adults tend to use their age to take advantage of younger people*. There are no similarities for Palmore's FAQ (1977). Thus a measure has been produced which has little in common with the generic measures used to evaluate attitudes towards older adults. This confirms the view that nurses come into contact with older people under unique circumstances and it is those circumstances which were extrapolated from the focus group interviews. The conclusion which can be drawn from this discussion,

therefore, is that the focus group interviews were useful in identifying the contextual factors which influence nurses' attitudes.

Thus those factors were used to formulate the questionnaire.

9.5 The Quantitative Results

There is a clear relationship between the quantitative phase and the qualitative phase when comparing the themes and the factors. Furthermore, the themes are related to the literature review which was used to guide the questions asked during the focus group interviews.

The quantitative results demonstrate significant intergroup differences across a number of items some of which are inconsistent with the literature. For instance, the students were least positive across a number of items when compared to the clinical staff and to the lecturers. Both Treharne (1990) and Slevin (1991) found the opposite where students were more positive than the clinical staff. Although studies have been found comparing student nurses' attitudes with those of clinical staff, none have been found which directly evaluate the attitudes and beliefs of lecturers except for Sheffler (1995) who made her judgements on a sample size of three. Most studies have concentrated on type of theoretical content, whether it was aimed at wellness or illness. The results relating to the comparison between the lecturers and the students were unexpected, using the focus group interviews plus anecdotal evidence as indicators. The students in two interviews clearly found the lecturers making comments about the futility of working with people in a care of older adults setting. Anecdotal evidence also suggests that lecturers do label student nurses as being suitable for working in the care of older adult areas but not in the acute areas.

What has also been striking and to a certain extent unexpected is the similarities across the results for both the lecturers and the nurses who work with older adults. This was an unexpected finding and had not been considered as one of the hypotheses. Once again the literature is lacking on this aspect of attitudes, namely

because lecturers are not considered, which is surprising as they do have a role to play in the preparation and socialisation of students.

Finally, when comparing the nurses who work with older adults and those who work in the acute areas, on the whole the nurses who work with older adults were significantly more positive than those who work in the acute areas. There seems to be a lack of literature once again comparing groups who work in older adult settings and those who do not. Each type of group has been evaluated individually but not comparatively. Thus it is interesting that there are significant differences between the two groups.

Having considered the intergroup differences and having established that the literature has neglected some aspects associated with attitudes towards hospitalised older adults, the final part of the research is considered, that is the hypotheses expecting changes in student nurses attitudes between pre and post theory/ practice. There was little significant change item for item although there was some negative movement. Most of the literature has indicated that there was a positive movement in student nurses' attitudes and knowledge for both theory and practice but this movement has not been found in this research. In fact there was little change in attitudes and beliefs.

What conclusions can we therefore draw from those results? There are conceptual differences between society's attitudes toward older adults and nurses' attitudes as explicated from the focus group interviews which are situation dependent as well as object dependent.

From that aspect, we can conclude that student nurses' attitudes and beliefs are significantly the least positive when compared to the other groups. It would be unrealistic to label their attitudes and beliefs as negative, as very few items were outright negative but varied from barely neutral to fairly positive.

We can conclude that the lecturers and the nurses who work in the care of older

adults settings have relatively similar attitudes and beliefs. While there are notable differences between the attitudes of nurses who work in acute areas when compared to those who work in care of older adults settings.

9.6 Implications of the study

There are a number of implications which can be drawn from this study concerning primarily the work nurses do, whether in the acute settings or the care of older adults settings. There are also wide reaching implications for nursing practice in both types of areas as it has already been established that high numbers of older adults form the workload of most nurses. Finally gerontological education needs to be examined and evaluated to ensure that it meets the needs of nurses working with older adults. However the work will be considered first.

Clinical nurses need to be more aware of the effects of role modelling on student nurses. Students come in to nurse education with the mind set that nursing in surgical ward is the norm. The disregard for basic nursing skills creates the illusion that nursing is about technological skills and students see more senior nurses doing them while the health care assistants and auxiliaries are doing the basic skills. The technological skills assume more importance thus the comforting skills become less important and are therefore dismissed as menial. Older people require an array of nursing skills, but some of those skills are labelled basic, thus they are viewed as menial. The whole area then becomes somewhere that nurses can learn basic nursing skills, instead of examining the complex skills which are required to carry out good nursing practice. The blame cannot be laid solely on the shoulders of nurses in the acute areas especially when there are nurses in the care of older adults settings extolling the virtues of becoming more acute and technological.

A much more serious issue is associated with how older people in hospital are viewed. The evidence from this study suggests that ageing is being viewed as synonymous with decline especially with regard to incontinence. This is a major

concern in that nurses who work with older people are making the assumption that there are common problems associated with ageing. Myths such as this will therefore be perpetuated. There are also implications for the notion of evidence based learning in that nurses must keep up to date with changes in practice.

Myths and stereotypes which occur in the media must also be exposed for what they are. They have a negative effect on student nurses who are bringing those stereotypes in to nurse education. The work for the lecturers should then be aimed at dispelling those myths and stereotypes, but the problem may then be that they are replacing societal attitudes and beliefs with those of other nurses. Furthermore, there are significant intergroup differences between nurses who work with older adults and nurses who work in the acute areas. If nurses are not aware of how they are portraying older people or how they are nursing older people, then no wonder student nurses will not wish to return to care of older adults placements.

Nurse education also needs to start looking at how gerontological issues can be taught using innovative and creative methods. These issues must also be visible in the curriculum with committed lecturers teaching the subject. There must be a commitment to teaching evidence based practice and to stop apologising for liking the subject. Added to this nurses who work with older adults need to start publishing innovations which they have implemented within their areas. Nobody will know what is occurring in those settings unless the information is disseminated.

Finally there has to be a change in the way we view older people and talk about them from an organisational stance. They are deserving of best practice as are younger people and there is really no excuse for not providing it. Longevity as Sutherland (1999) said requires celebration not derogation.

9.7 Limitations of the research

The research was carried out in one area of Scotland and involved only one School of Nursing and Midwifery plus a number of hospitals surrounding the area. Thus it would be useful to widen out the research to other areas within Scotland if not the United Kingdom.

Six focus group interviews were carried out however it would have been useful to carry out at least two group interviews with each type of participant. The group interviews where the same type of participant were useful in that different data were gathered from each group.

The internal reliability decreased on each refinement of the questionnaire. The internal reliability was well within acceptable limits when the questionnaire was made up of 80 items, but dropped to an only adequate level by the third questionnaire. The reliability might have been improved by increasing the numbers of students who completed the questionnaire prior to principal components analysis. It would be worth repeating the distribution of the questionnaire when there were eighty items to a bigger population to evaluate whether sample size influenced the principal components analysis.

Differences for gender were not completed due to the skewed distribution of males in each of the samples. Random sampling may have improved distribution thus allowing intergroup comparisons to be made. Transcultural differences were also not explored due a very small minority of the populations being from multicultural backgrounds. It has already been acknowledged that the study took place in one region of Scotland which does not have an ethnically diverse population. However this is not typical of other areas in the United Kingdom. Therefore this issue needs to be taken into account when considering the generalisability of the results.

Only two student groups were used in the survey phase. It might have been useful to follow one group through over at least a period of a year to evaluate any changes within the one group, in other words to take a longitudinal approach.

9.8 Recommendations for further research

Further study using focus group interviews would enhance transferability.

Further testing and refinement of the questionnaire would improve reliability and validity

Further investigation into whether nurses who work in care of older adult settings are discriminated against when applying for employment out with the specialty.

Evaluating student nurses' attitudes and beliefs over a longer period of time especially in relation to the attitudes and beliefs of the clinical nurses in acute care and the clinical nurses in the care of older adult settings would have been useful. It would also be worth following them through to registration to investigate where they apply for employment and link this back to their attitudes.

Comparisons with other schools of nursing and midwifery in other areas across the United Kingdom would indicate whether there is a uniformity in attitudes and beliefs in different parts of the country.

Further investigation into the influence of gender and ethnicity and their effects on attitudes and beliefs towards caring for older people.

9.9 Contribution of the study to Gerontological Nursing in Scotland

This study raises an awareness to the ongoing problem of less than positive attitudes and beliefs towards working with older adults. There is little doubt that the findings indicate that ageism whether manifest or latent continues in nursing practice.

However this study has identified that both nurses who work with older people and lecturers who teach student nurses are positive about working with older people. This has not been identified in previous studies where nurses who work with older people have been viewed as less positive than student nurses. This has been a very useful finding as it indicates that nurses who are working with older people and lecturers who are teaching student nurses are portraying the appropriate attitudes and beliefs during the socialisation process. Obviously work still needs to be done in relation to this particular issue but at least attitudes and beliefs are heading in the right direction. The negative aspect of this is that nurses who are working in the acute areas are less positive. Student nurses who spend most of their time in the acute areas are therefore exposed to nurses with less positive attitudes and beliefs. There is no doubt that the vast majority of the patients in the acute areas are in the older age groups which calls into question their quality of care. This needs to be addressed and one way of tackling the apparent ageism in the acute areas is through the role of the gerontological nurse specialist. There is a need for nurses to acknowledge the care of older people as a speciality and one way of doing it is through this route.

The evidence from the study suggests that there are two sets of attitudes and beliefs towards older adults, those that student nurses bring in to nurse education, therefore society's beliefs, and those of nurses who work with older people. This is not surprising when attitudinal researchers suggest that attitudes are context dependent. This then adds to the body of gerontological nursing knowledge through the explication of nurses' attitudes and beliefs towards older people. This informs nurses and educators so that efforts are aimed at nullifying the relevant attitudes and beliefs as opposed to those of society.

Contrary to other studies, student nurses positively evaluate the learning experiences in the care of older adults areas. Nurses who work in those areas therefore deserve to take the credit for ensuring that the care of older adults areas are learning environments. They also need to try and move away from the concept

of being second class nurses and to celebrate their unique and valuable contribution to nursing practice.

9.10 Recommendations for promoting improvements in practice

It is recommended that:-

There is consolidation of partnerships between the Schools of Nursing and Midwifery and clinical experts in teaching the parts of the curriculum pertaining to older adults.

Schools of Nursing and Midwifery audit how education addresses the subject of older adults in the curriculum.

Nurse management ensures that there is further education for both clinical nurses in the acute areas and the care of older adults areas relating to their exploring their beliefs about older people. There also needs to be a concerted effort in helping nurses respect each other's speciality. The qualitative results certainly suggested that there was a lack of respect for the roles.

It is the responsibility of nurses to speak out when they become involved in ageist practice, thus they need the skills to be able to recognise and deal effectively with those incidents.

Nurses who work predominantly with older people share good practice relating to their work with other nurses in Scotland and indeed the United Kingdom.

Consideration is given by nurse management and policy makers whether gerontological nurse specialists have a role to play in the acute areas, in the same way that there are continence or cancer specialists. This study is suggesting that the nurses who work in the acute areas are more negative so the introduction of nurse specialists could be a way forward.

There is a need for policy makers to be honest about the issues of ageism as there is evidence within the research to suggest that there are negative attitudes among nurses about older adults.

The policy makers themselves need to consider the terms they use when talking about older people, in words in terms of resources, delayed discharges and burdens. There remains to be seen some evidence of policy makers celebrating old age.

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Appendices

- I Letter to managers seeking to recruit participants for focus group interviews
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- III 80 item questionnaire
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Appendix I

**Sample letter to managers seeking to recruit participants for focus
group interviews**

School of Nursing and Midwifery
University of Dundee
2/4/97

Dear

As you know I am a nursing lecturer at the school of Nursing and Midwifery, Dundee. At present, I am enrolled at the University of Abertay where I am undertaking a post graduate research degree.

The title of my research is "An investigation into the influence of professional socialisation on the attitudes, beliefs and values of student nurses towards the care of the elderly in hospital." I intend using focus group interviews to generate a questionnaire to distribute to students. The focus group interviews would normally require the attendance of six to eight people. The reason that I am writing to you is to ask for your permission to approach first level registered nurses in the Assessment Unit of (named hospital) to take part in the interviews.

The interviews would take the form of questions and discussion on attitudes to the elderly, influencing factors and also the impact that nurse teachers have on attitudes. The information given would be as anonymous as possible as only nurses willing to take part in the interviews would be used. There would also be no interference with the normal workload on the wards.

I look forward to hearing from you

Yours Sincerely

Mrs. Ella McLafferty

Appendix II

**Sample letter to potential recruits seeking participation in focus
group interviews**

School of Nursing and Midwifery

University of Dundee

10/9/97

Dear

As you will probably know, I am a nursing lecturer at the School of Nursing and Midwifery (previously Tayside College). I am attending the University of Abertay where I am carrying out a research degree. The aim of the research is to identify the effects of professional socialisation on student nurses' attitudes towards elderly people. To do this I am going to give the students a questionnaire at different stages of their training to try and measure the influence of socialisation. The questionnaire will be based on the information I obtain from a group interview.

This type of interview is called a focus group interview because we will be focussing on a number of issues associated with older people. There will be 4-6 people in the group. My role is to ask the questions and to ask for any explanations if required. Other than that I sit back and allow the group to talk about the issues. I am not supposed to show any bias and anything that is said within the group is not considered right or wrong. The interview will be taped using a video recorder but the only people who will see the tape will be myself and my supervisor and the information will be kept as confidential as possible.

The topics which I hope to cover are; how attitudes to the elderly are portrayed; how they affect working with older people, both in the care of elderly setting and the acute setting. I also want to talk about work in care of the elderly and how the staff who work there are perceived. Finally, I want to talk about how the elderly are portrayed by lecturers.

The interview will last approximately one hour and I intend to arrange it during an afternoon when everyone is able to attend. I am writing to ask if you would be willing to participate in the interview. I would be grateful if you could let me know as soon as possible if you would participate. Please reply using the enclosed envelope,

Yours Sincerely

Appendix III

80 item questionnaire

Questionnaire

Attitudes Towards Older Adults

Definitions

- Care of the Elderly:-** any in-patient areas where one of the criteria is that they must be over sixty to sixty five years old
- Acute/General Areas:-** Normally areas where people are admitted due to a disorder e.g. they require medical treatment or they require surgery
- Older Adults:-** Old age is regarded as starting at around sixty or sixty five years old. (Thompson, 1990)

Instructions

Please tick the box for each statement which is closest to your opinions and try to be as honest as possible

Once you have completed the questionnaire, will you return it to Ella McLafferty as soon as possible

All answers will be confidential.

Thank you very much for your cooperation in completing this questionnaire

Code.....

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
1. There are very few older adults on television					
2. Television normally portrays older adults as not being able to look after themselves					
3. B and Q have the right idea, employing older adults before younger adults					
4. Younger people nowadays have little time for older adults					
5. The media presents images of well and happy older adults					
6. Most younger people enjoy contact with older adults					
7. When we become older we are less able to do a days work					
8. Patience is a very important quality when working with older adults					
9. Nurses who work with older adults need to know the ageing process					
10. Patients come into care of the elderly with a wide variety of nursing problems					
11. Patience is important no matter where you nurse					

12. Nurses who work in care of the elderly require little more than basic nursing skills					
13. Nurses have to take more time looking after older adults as they are slow					
14. All general wards where there are older adults should have nurses who specialise in care of the elderly					
15. Any nurse with a bit of common sense can look after older adults					
16. To work in care of the elderly, nurses need a good knowledge of technology					
17. Care of the elderly is repetitive and boring					
18. Surgical is much more interesting than care of the elderly					
19. The less nursing attention older adults receive the more likely they are to become dependent					
20. There is as much nursing care on a surgical ward as there is on a care of the elderly ward					
21. Care of the elderly is no more than washing, toileting and feeding patients					
22. All wards, no matter their specialty can be repetitive and boring					

23. Working in care of the elderly is interesting					
24. Older adults in the acute wards are more likely to be ignored than younger adults					
25. It is easier for older adults to be nursed in side rooms in the acute areas rather than in the main wards					
26. When nurses are busy, priority for care should be given to younger adults					
27. Looking after older adults in the acute areas will encourage them to recover more quickly					
28. Older adults are entitled to the same level of care as younger adults					
29. Older people are treated as individuals in the acute areas					
30. Older adults are more prone to isolation if they are nursed in side rooms					
31. Looking after older adults means taking them for walks and playing with them					
32. Older adults in care of the elderly are treated as individuals					
33. Older adults in the acute areas take up beds for much longer periods of time than they need					
34. In care of the elderly patients are motivated to be independent					

35. Nurses in care of the elderly will encourage patients to self care					
36. Most patients in care of the elderly are incontinent of urine					
37. There is as much nursing care in a continuing care ward as there is in a medical ward					
38. Most patients in care of the elderly are unable to walk					
39. Older adults are treated as children as they become older					
40. Most older adults look similar					
41. Most older adults tend to use their age as a means of taking advantage of younger adults					
42. Most older adults have the same sense of humour they have always had					
43. Most older adults are cantankerous					
44. All older adults are different from each other					
45. Most older adults are patronised by nursing staff					
46. Most older adults have lost their sense of humour					
47. Personality remains the same as we grow older					

48. Most older adults lose their personality as they grow older					
49. Most student nurses have little idea what to expect in care of the elderly					
50. Most student nurses think care of the elderly is about basic nursing care					
51. Most student nurses are surprised that older adults are "normal"					
52. Most student nurses are pleasantly surprised at how many acutely ill patients there are in care of the elderly					
53. There is nothing to learn in care of the elderly					
54. Most student nurses are surprised that older adults can hold a sensible conversation					
55. Student nurses are well prepared for working in care of the elderly					
56. There is more to learn in care of the elderly than basic nursing skills					
57. It is interesting to talk to older adults					
58. Most nurses will take time to chat to older patients					
59. Communication skills are less important in care of the elderly than in other areas					

60. It is a myth that older adults dislike younger people					
61. Most nurses tend not to laugh and joke with the older adults					
62. Working in care of the elderly can really enhance communication skills					
63. Most nurses prefer to talk with younger adults					
64. Young people have a lot of time for older adults					
65. Once in care of the elderly, nurses will not get a job out of care of the elderly					
66. Most nurses who work in care of the elderly want to be there					
67. Most nurses who work in care of the elderly are not clever					
68. Most nurses who work in care of the elderly have excellent interpersonal skills					
69. Most nurses who work in care of the elderly will lose their nursing skills					
70. Most lecturers think care of the elderly is second rate					
71. Most lecturers will promote an interest in care of the elderly					
72. Only lecturers who are experts should teach care of the elderly					

73. Lecturers who teach about older adults should spend some time in care of the elderly					
74. Most lecturers are out of date with advances in care of the elderly					
75. Any lecturer can teach about older adults					
76. Most lecturers will be fully supportive of nurses who want to work with older adults					
77. Some staff nurses can be short tempered with older adults					
78. It is essential that staff nurses motivate students to feel positively about older adults					
79. Most staff nurses who work with older patients are enthusiastic about their work					
80. It is essential that staff nurses who work with older adults are good role models					

Demographic Information

Finally, will you complete the following information by circling the most appropriate answers. This information will aid analysis of the data.

1. Age;- 18-29

30-39

40-49

50-59

2. Sex:- Male

Female

3. If you are a student nurse, have you worked in any of the following environments prior to commencing nurse education? If you have worked in more than one of those areas, will you circle the most recent area

Hospital

Nursing Home

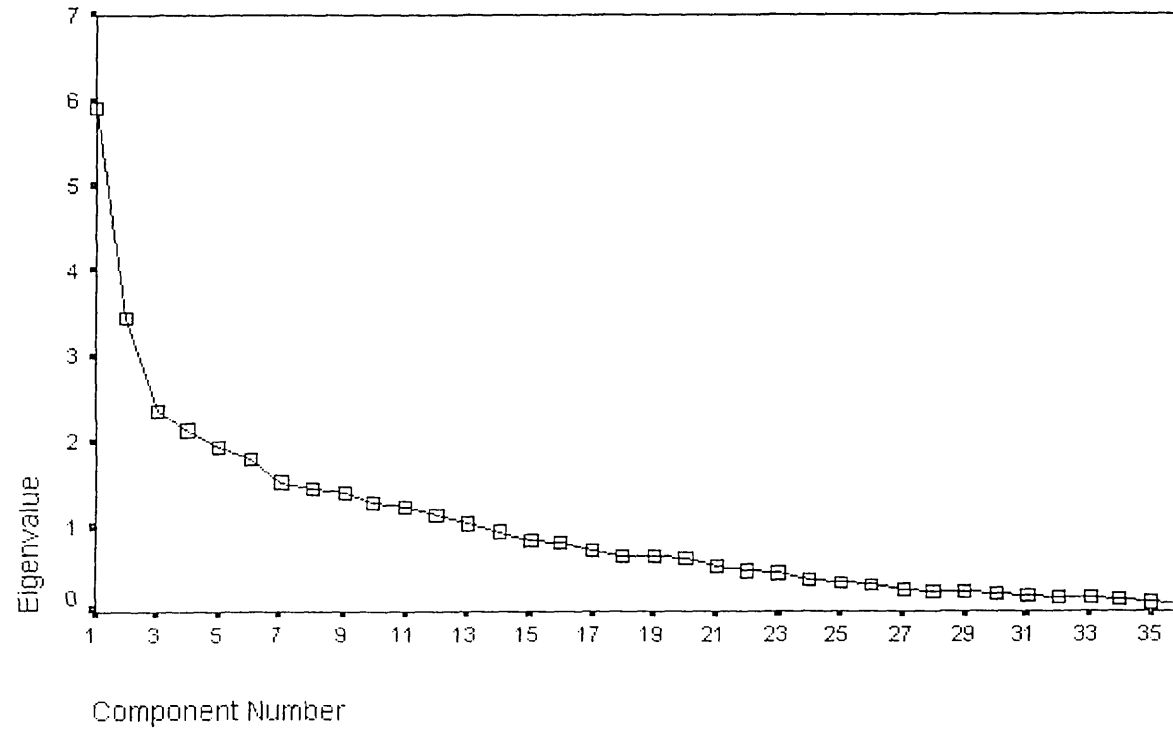
Residential Home

Community Nursing

Appendix IV

Scree plot from first principal components analysis

Scree Plot



Appendix V

36 item questionnaire

Questionnaire

Attitudes Towards Older Adults

Definitions

- Care of the Elderly:-** any in-patient areas where one of the criteria is that they must be over sixty to sixty five years old
- Acute/General Areas:-** Normally areas where people are admitted due to a disorder e.g. they require medical treatment or they require surgery
- Older Adults:-** Old age is regarded as starting at around sixty or sixty five years old. (Thompson, 1990)

Instructions

Please tick the box for each statement which is closest to your opinions and try to be as honest as possible

Once you have completed the questionnaire, will you return it to Ella McLafferty as soon as possible

All answers will be confidential.

Thank you very much for your cooperation in completing this questionnaire

Code.....

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
1. Most older adults tend to use their age as a means of taking advantage of younger people					
2. Most older adults are cantankerous					
3. Care of the elderly is repetitive and boring					
4. Nurses who work in care of the elderly require only basic nursing skills					
5. Nurses who are clever are not attracted to care of the elderly					
6. All older adults are different from each other					
7. Working in care of the elderly is interesting					
8. Most older adults are incontinent of urine.					
9. Most older adults have retained their sense of humour					
10. Older adults are entitled to the same level of care as younger adults.					
11. In care of the elderly older adults are motivated to be independent.					
12. There is as much nursing care on a continuing care ward as there is in a medical ward.					

13. When nurses are busy in an acute ward priority should be given to younger patients					
14. Looking after older adults in the acute areas, encourages them to recover more quickly					
15. Nurses in care of the elderly encourage patients to self care.					
16. Any nurse with a bit of common sense can look after older adults.					
17. Nurses have to take more time with older adults because they are so slow.					
18. It is interesting to talk to older adults.					
19. Any lecturer can teach about older adults.					
20. Care of the elderly is no more than washing, toileting and feeding patients					
21. Most nurses will take time to chat with older patients					
22. Only lecturers who are experts in the subject should teach care of the elderly					
23. Most nurses tend not to laugh and joke with older adults					
24. There is more to learn in care of the elderly than basic nursing skills.					

25. I have a lot of time for older adults.					
26. I was surprised to find that older adults are "normal"					
27. Once in care of the elderly, nurses will not get out of the area.					
28. Most lecturers promote an interest in care of the older adult					
29. Nurses who work with older adults are good role models.					
30. I was surprised that patients in care of the elderly can hold a normal conversation.					
31. Older adults are treated like children as they grow older.					
32. Most lecturers are out of date with the advances in care of the elderly					
33. Most lecturers think care of the elderly is second rate.					
34. Older adults lose their sense of humour as they grow older					
35. Most older adults are continent of urine					
36. Most older adults are unable to hold a normal conversation					

Demographic Information

Finally, will you complete the following information by circling the most appropriate answers. This information will aid analysis of the data.

1. Age;- 18-29

30-39

40-49

50-59

2. Sex:- Male

Female

3. If you are a student nurse, have you worked in any of the following environments prior to commencing nurse education? If you have worked in more than one of those areas, will you circle the most recent area

Hospital

Nursing Home

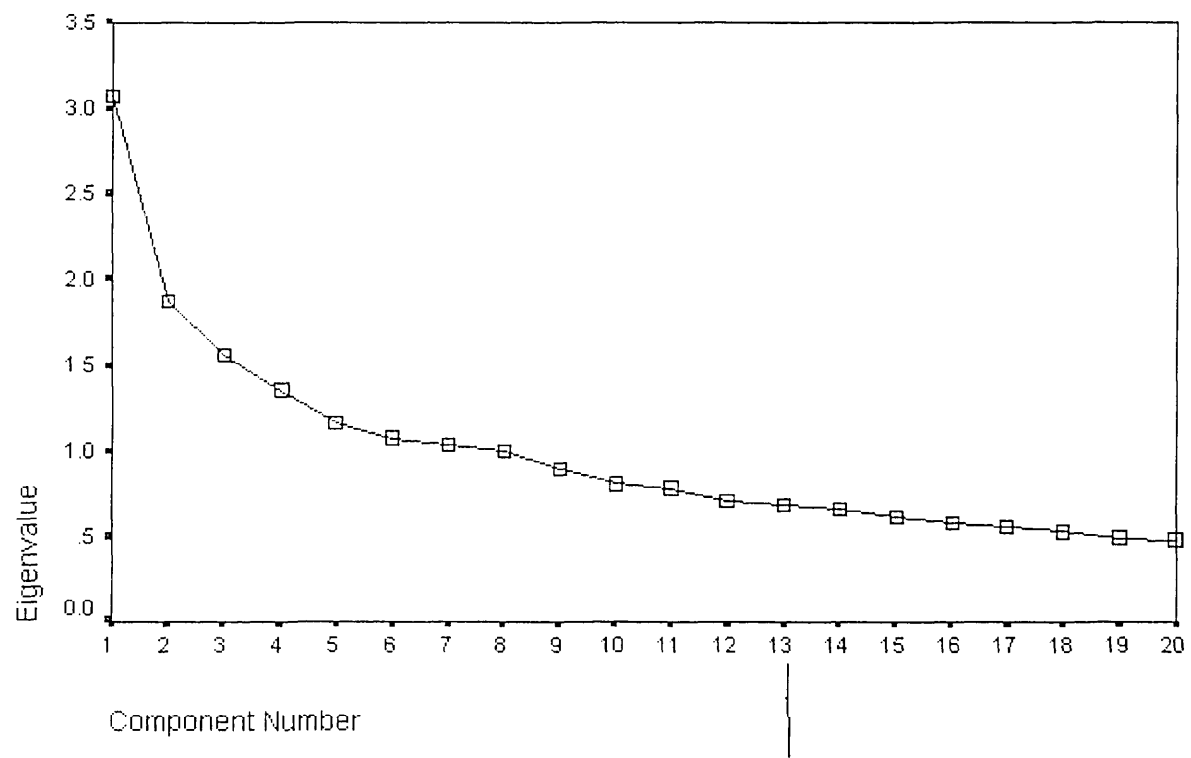
Residential Home

Community Nursing

Appendix VI

Scree plot from second principal components analysis

Scree Plot



Appendix VII

Final 20 item questionnaire

Questionnaire

Attitudes Towards Older Adults

Definitions

- Care of the Elderly:-** any in-patient areas where one of the criteria is that they must be over sixty to sixty five years old
- Acute/General Areas:-** Normally areas where people are admitted due to a disorder e.g. they require medical treatment or they require surgery
- Older Adults:-** Old age is regarded as starting at around sixty or sixty five years old. (Thompson, 1990)

Instructions

Please tick the box for each statement which is closest to your opinions and try to be as honest as possible

Once you have completed the questionnaire, will you return it to Ella McLafferty as soon as possible

All answers will be confidential.

Thank you very much for your cooperation in completing this questionnaire

Code.....

	Strongly agree	Agree	Unsure	Disagree	Strongly Disagree
1. Older adults tend to use their age as a means of taking advantage of younger people					
2. Working in care of the elderly is interesting.					
3. Nurses who work in care of the elderly require only basic nursing skills					
4. Only lecturers who are experts in the subject should teach care of the elderly					
5. When nurses are busy in an acute ward priority should be given to the younger patients					
6. Care of the elderly is no more than washing, feeding and toileting older adults					
7. Most older adults are continent of urine					
8. In care of the elderly, older adults are motivated to be independent					
9. It is interesting to talk with older adults					

	Strongly agree	Agree	Unsure	Disagree	Strongly Disagree
10. Most lecturers will promote an interest in care of the elderly					
11. Most nurses will take time to chat with older adults					
12. There is as much nursing care in a continuing care ward as there is in a medical ward					
13. Most older adults are able to hold a sensible conversation					
14. Nurses who work with older adults are usually good role models					
15. Most lecturers are out of date with advances in care of the elderly					
16. Once in care of the elderly, nurses find it difficult to find employment in the acute areas					
17. There is nothing to learn in care of the elderly.					
18. Nurses have to take more time with older adults as they are so slow					

	Strongly agree	Agree	Unsure	Disagree	Strongly Disagree
19. Patience is a more important quality in care of the elderly than in the acute areas					
20. Most nurses prefer to talk with younger adults.					

Once again, thank you very much for taking the time to complete this questionnaire

Demographic Information

Finally, will you complete the following information by circling the most appropriate answers. This information will aid analysis of the data.

1. Age;- 18-29

30-39

40-49

50-59

2. Sex:- Male

Female

3. If you are a student nurse, have you worked in any of the following environments prior to commencing nurse education? If you have worked in more than one of those areas, will you circle the most recent area

Hospital

Nursing Home

Residential Home

Community Nursing

Appendix VIII

**Sample letter to manager seeking permission to distribute
questionnaires**

School of Nursing and Midwifery

University of Dundee



Dear

You may be aware that I am in the process of completing a study into the influence of professional socialisation on student nurses' attitudes, beliefs and values towards working with older adults in the hospital setting.

The study is being carried out in two stages. Firstly views were sought from First Level nurses in both care of the elderly and in the acute general areas as well as nursing lecturers and third year student nurses in the form of Focus group interviews. From the Focus group interviews an instrument measuring attitudes to working with older adults has been developed. The measure has been piloted and is now ready for distribution to the same populations as for the focus group interviews. The aim of the second part of the study is to compare the responses given by the different populations and to evaluate for similarities and differences.

I am therefore writing to ask your permission to send out questionnaires to first level nurses in your directorate seeking their views on attitudes toward older adults. There would be no interference with the normal work of the area.

Yours Sincerely,

Ella McLafferty

Appendix IX

**Sample letter to potential recruits which accompanied the
questionnaire**

School of Nursing and Midwifery

University of Dundee



Dear

You may be aware that I am in the process of completing a study into the influence of professional socialisation on student nurses' attitudes, beliefs and values towards working with older adults in the hospital setting.

The study is being carried out in two stages. Firstly views were sought from First Level nurses in both care of the elderly and in the acute general areas as well as nursing lecturers and third year student nurses in the form of Focus group interviews. From the Focus group interviews an instrument measuring attitudes to working with older adults has been developed. The measure has been piloted and is now ready for distribution to the same populations as for the focus group interviews. The aim of the second part of the study is to compare the responses given by the different populations and to evaluate for similarities and differences

Therefore I am asking for your cooperation in the completion of the questionnaire which will take no more than five minutes. All information given will be confidential and I will be very grateful for the help. Please return the completed questionnaire in the envelope provided.

Yours Sincerely,

Mrs Ella McLafferty

Appendix X

**Table of means and standard deviation for each group in the final
questionnaire**

	C/E Mean SD	Lecc Mean SD	Stud.(1a) Mean SD	Stud.(1b) Mean SD	Stud.(2a) Mean SD	Stud.(2b) Mean SD	Acut Mean SD
1. Older adults tend to use their age as a means of taking advantage of younger people	3.905 .962	4.036 .816	3.561 .931	3.328 1.128	3.111 .949	3.380 .878	3.492 .982
2. Working in care of the elderly is interesting	4.333 .880	4.127 .721	3.902 .795	3.969 .689	3.901 .800	3.920 .724	3.381 1.038
3. Nurses who work in care of the elderly require only basic nursing skills	4.683 .668	4.673 .747	4.122 .908	4.031 1.054	4.198 .797	4.260 .853	4.143 .715
4. Only lecturers who are experts in the subject should teach care of the elderly	3.206 1.259	3.455 1.102	3.232 1.046	3.188 1.082	2.975 .948	2.760 .960	2.968 1.107
5. When nurses are busy in an acute ward priority should be given to younger patients	4.555 .616	4.745 .480	4.256 .644	4.266 .648	4.296 .715	4.220 .790	4.460 .643
6. Care of the elderly is no more than washing, feeding and toileting older adults	4.587 1.102	4.545 1.068	4.317 .844	4.250 .976	4.383 .815	4.560 .611	4.302 .944
7. Most older adults are continent of urine	3.254 1.319	3.782 1.384	2.988 .975	2.906 1.080	2.728 .908	2.900 1.055	3.302 1.116
8. In care of the elderly, older adults are motivated to be independent	4.000 1.063	3.327 1.037	3.268 .982	3.375 .672	3.605 .817	3.460 1.034	3.365 1.112
9. It is interesting to talk with older adults	4.571 .499	4.545 .689	4.354 .530	4.344 .511	4.383 .514	4.180 .748	4.349 .513
10. Most lecturers will promote an interest in care of the elderly	2.746 .879	2.800 1.026	3.451 .723	3.281 .806	3.420 .589	3.400 .670	3.063 .821
11. Most nurses will take time to chat with older adults	3.397 1.009	3.055 .951	3.000 .903	2.828 1.107	3.432 .774	3.100 .814	3.619 .974
12. There is as much nursing care in a continuing care ward as there is in a medical ward.	4.016 .975	4.400 .627	3.354 .807	3.438 1.037	3.395 .817	3.460 .734	3.730 .884
13. Most older adults are able to hold a sensible conversation	4.063 .896	4.436 .631	3.854 .833	3.813 .833	3.852 .709	4.020 .685	4.238 .615

	C/E Mean SD	Lecs Mean SD	Stud.(1a) Mean SD	Stud.(1b) Mean SD	Stud.(2a) Mean SD	Stud.(2b) Mean SD	Acut Mean SD
14. Nurses who work with older adults are usually good role models	3.556 .894	2.891 .832	2.915 .864	3.063 1.006	3.222 .725	3.220 .790	3.032 .647
15. Most lecturers are out of date with advances in care of the elderly	2.714 .906	2.727 .952	3.317 .718	3.297 .582	3.407 .543	3.560 .611	3.048 .884
16. Once in care of the elderly, nurses find it difficult to find employment in the acute areas	2.873 1.251	2.800 .890	2.927 .699	2.781 .786	3.074 .587	3.080 .488	2.333 .861
17. There is nothing to learn in care of the elderly	4.651 .901	4.691 .836	4.195 .808	4.266 .672	4.259 .919	4.460 .788	4.286 .658
18. Nurses have to take more time with older adults as they are so slow	3.143 1.229	3.182 1.038	3.049 1.164	2.938 1.153	2.926 1.046	3.020 1.078	3.175 1.056
19. Patience is a more important quality in care of the elderly than in the acute areas.	2.651 1.322	3.345 1.294	2.780 1.031	3.016 1.188	2.605 1.221	3.000 1.143	3.381 1.288
20. Most nurses prefer to talk with younger adult	3.524 1.120	3.073 1.052	3.268 .917	3.313 .941	3.395 .890	3.360 .921	3.841 .723

Appendix XI

ANOVA results for the factors using the subgroups as independent variables

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
F 1 Between groups	158.18	2	79.09	12.15	.000
Within groups	2219.53	341	6.51		
Total	2377.71	343			
F 2 Between groups	97.78	2	48.89	13.68	.000
Within groups	1219.10	341	3.57		
Total	1316.88	343			
F 3 Between groups	63.44	2	31.72	8.94	.000
Within groups	1209.86	341	3.55		
Total	1273.30	343			
F 4 Between groups	146.06	2	73.03	16.89	.000
Within groups	1474.06	341	4.32		
Total	1620.11	343			
F 5 Between groups	104.52	2	52.26	33.55	.000
Within groups	531.24	341	1.56		
Total	635.76	343			
F 6 Between groups	35.72	2	17.86	5.57	.004
Within groups	1093.28	341	3.21		
Total	1128.99	343			
F 7 Between groups	72.37	2	36.18	11.73	.000
Within groups	1051.40	341	3.08		
Total	1123.76	343			
F 8 Between groups	11.22	2	5.61	7.28	.001
Within groups	262.96	341	.77		
Total	274.18	343			

Appendix XII

**Results of the Kruskal-Wallis H test and ANOVA for the
independent variables of identity and age**

K-W /ANOVA	Identity			Age		
	Chi-Sq. F Ratio	D. F.	p F prob	Chi-Sq. F Ratio	D. F.	p F Prob
1. Older adults tend to use their age as a means of taking advantage of younger people	45.9405 7.4677	6	.0000 .0000	33.9957 17.2207	2	.0000 .0000
2. Working in care of the elderly is interesting	46.0454 7.8932	6	.0000 .0000	15.0061 7.0435	2	.0006 .0010
3. Nurses who work in care of the elderly require only basic nursing skills	54.5567 6.3587	6	.0000 .0000	28.8342 12.3626	2	.0000 .0000
4. Only lecturers who are experts in the subject should teach care of the elderly	15.4074 2.5415	6	.0173 .0198	4.8802 2.0865	2	.0872 .1253
5. When nurses are busy in an acute ward priority should be given to younger patients	35.452 5.2919	6	.0000 .0000	32.3657 12.2941	2	.0000 .0000
6. Care of the elderly is no more than washing, feeding and toileting older adults	27.4937 1.4310	6	.0001 .2010	23.5531 5.3160	2	.0000 .0052
7. Most older adults are continent of urine	38.8953 6.2110	6	.0000 .0000	16.9506 7.7619	2	.0002 .0005
8. In care of the elderly, older adults are motivated to be independent	25.3229 4.0047	6	.0003 .0006	3.4496 1.4481	2	.1782 .2361
9. It is interesting to talk with older adults	18.9159 3.0889	6	.0043 .0057	15.0061 6.2455	2	.0006 .0021
10. Most lecturers will promote an interest in care of the elderly	46.7198 9.2523	6	.0000 .0000	6.9628 3.7019	2	.0308 .0254
11. Most nurses will take time to chat with older adults	35.8096 6.2175	6	.0000 .0000	2.7932 1.55229	2	.2474 .2192
12. There is as much nursing care in a continuing care ward as there is in a medical ward.	75.4626 13.0126	6	.0000 .0000	37.0548 17.4473	2	.0000 .0000

K-W /ANOVA	Identity			Age		
13. Most older adults are able to hold a sensible conversation	40.8883 5.8182	6	.0000 .0000	29.3303 11.1020	2	.0000 .0000
14. Nurses who work with older adults are usually good role models	27.8479 4.9376	6	.0001 .0001	1.8087 .9150	2	.4048 .4013
15. Most lecturers are out of date with advances in care of the elderly	61.8093 13.2514	6	.0000 .0000	10.8440 7.1470	2	.0044 .0009
16. Once in care of the elderly, nurses find it difficult to find employment in the acute areas	39.0304 6.0613	6	.0000 .0000	1.5540 .5445	2	.4598 .5805
17. There is nothing to learn in care of the elderly	54.1987 3.9944	6	.0000 .0007	34.9315 11.6706	2	.0000 .0000
18. Nurses have to take more time with older adults as they are so slow	3.8497 .6144	6	.6970 .7189	3.3775 1.7090	2	.1847 .1822
19. Patience is a more important quality in care of the elderly than in the acute areas.	25.1704 4.3603	6	.0003 .0003	3.0000 1.4994	2	.2231 .2244
20. Most nurses prefer to talk with younger adults.	23.5359 3.9822	6	.0000 .0007	6.5747 4.2743	2	.0374 .0145

Appendix XIII

Significant results of the Mann-Whitney *U* tests and the unrelated *t* tests for the acute care staff and the care of older adults staff

Care of older adults staff/ acute care staff	Z stat. t value	p p
Older adults tend to use their age to take advantage of younger people	-2.5727 -2.38	.0101 .019
Nurses who work in care of the elderly require only basic nursing skills	-5.0284 -4.38	.0000 .000
Most nurses will take time to chat with older adults		$p > .05$ $P > .05$
Most older adults are continent of urine		$p > .05$ $P > .05$
Once in care of the elderly, nurses find it difficult to find employment in the acute areas	-2.5081 2.82	.0121 .006
Only lecturers who are experts in the subject should teach care of the elderly		$p > .05$ $P > .05$
It is interesting to talk with older adults	-2.3774 -2.46	.0174 .016
There is nothing to learn in care of the elderly	-4.6731 -2.60	.0000 .011
There is as much nursing care in a continuing care ward as there is in a medical ward	-2.1448	.0320 $p > .05$
Most lecturers are out of date with advances in care of the elderly	-2.3661 2.46	.0180 .015
Most nurses prefer to talk with younger adults		$p > .05$ $P > .05$
When nurses are busy in an acute ward priority should be given to younger patients		$p > .05$ $P > .05$
Care of the elderly is no more than washing, feeding and toileting older adults	-3.5177	.0004 $p > .05$
Working in care of the elderly is interesting	-5.4252 -5.55	.0000 .00
In care of the elderly older adults are motivated to be independent	-3.4221 -3.28	.0006 .001
Patience is a more important quality in care of the elderly than in the acute areas	-3.0339 3.14	.0024 .024
Nurses who work in care of the elderly are usually good role models	-3.6018 -3.77	.0003 .000
Most older adults are able to hold a sensible conversation		$p > .05$ $P > .05$