

Residents with mild cognitive decline and family members report health students ‘enhance capacity of care’ and bring ‘a new breath of life’ in two aged care facilities in Tasmania

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Abstract

Background Care provided by student doctors and nurses is well received by patients in hospital and primary care settings. Whether the same is true for aged care residents of nursing homes with mild cognitive decline and their family members is unknown.

Objective To investigate the perspectives of aged care residents with mild cognitive decline and their family members on interdisciplinary student placements in two residential aged care facilities (RACF) in Tasmania.

Design, setting and participants A mixed methods design was employed with both qualitative and quantitative data collected. All participants were interviewed and completed a questionnaire on residents’ quality of life, during or after a period of student placements in each facility (October–November, 2012). Qualitative data were coded for themes following a grounded theory approach, and quantitative data were analysed using SPSS.

Results Twenty-one participants (13 residents and 8 family members) were recruited. Four themes were identified from the qualitative data and included (i) increased social interaction and facility vibrancy; (ii) community service and personal development, (iii) vulnerability and sensitivity (learning to care) and (iv) increased capacity and the confidence of enhanced care. Residents’ quality of life was reported to be mostly good in the presence of the students, despite their high care needs.

Conclusion Residents with mild cognitive decline and their family members perceive a wide array of benefits of student provided care in RACFs including increased social interaction. Future

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quantitative research should focus on whether changes in care occur for residents as a result of student involvement.

Introduction

Quality care for people with dementia living in nursing homes is an international priority.¹ Cases of poor quality care are not uncommon in nursing homes in Australia and around the world.^{2,3} A combination of several factors are thought to contribute to such cases including high-level resident dependency,⁴ higher prevalence and severity of diseases (60% dementia⁵), and workforce challenges (recruitment and retention⁶). Placing tertiary health students in residential aged care facilities (RACFs) is a unique approach to capacity building in this sector seeking reform. The aim of this study is to address the issue of quality care by focusing on interdisciplinary student placements as a driver for quality outcomes for residents in nursing homes. While people with dementia more recently are seen as active users of services, rather than passive recipients of care,^{7,8} much of the research on health service evaluation has overlooked their opinions.^{9,10} To our knowledge, 'consumers' opinions on students training in RACFs have not previously been investigated. Therefore, this paper describes the perspectives of a select group of residents with mild cognitive decline and their family members on student doctors and nurses undertaking a programme of interdisciplinary placements in residential care settings.

Background

Much of the literature on consumers' views of health services delivered by trainee health professionals is based on medical students training to be doctors in primary care and hospital settings. A review of this literature for the general practice setting found patients mostly held positive attitudes and were highly satisfied with care provided by students (87–97%¹¹). In particular, Mol *et al.*¹¹ noted several benefits over and above usual care were mentioned by

consumers. These included a longer consultation, more thorough physical examination, better patient education and a second opinion.¹⁰ While less research is available on consumer interaction with nursing students delivering care, one study showed a similar pattern described above for medical students. Consumers are highly satisfied with nursing students in training, evident in a sample of patients reports from a community centre in the United States.¹² Much of the literature on care provided by students is based on primary and hospital settings, and whether the same is true for aged care residents of nursing homes, where a focus is on palliative care, is unknown.

Some consumers receiving care from trainee health professionals report not only a desire to be involved, but also a sense of responsibility towards student learning. A study included in the review by Mol *et al.*,¹¹ focused on senior medical students from Sweden, found a small proportion (22%) of consumers viewed their engagement with medical students as contributing to student learning.¹³ This occurred through the patient providing advice and feedback to the student, particularly about communication style and interpersonal interaction. In some cases, patients viewed themselves as experts on their condition, which included patients' experiences and feelings about their condition. This was relevant for a range of illnesses and also for conditions related to ageing. Similarly, Jackson, Blaxter and Levand-Hundt¹⁴ found consumers living in socially and economically disadvantaged areas in the United Kingdom reported they played an important role in educating medical students about the value of listening, and the emotional aspects of illness and disease. Older adults living in RACFs may experience similar responsibilities towards student learning; however, the research conducted on older adults in RACFs has generally focused on prevalence studies,¹⁵ end-of-life symptomatology,^{16,17} care needs¹⁰

and care delivery,^{18,19} and not on consumers experiences of student delivered care.

Despite the reported benefits of student delivered care, eight studies in a literature review by Mol *et al.*¹¹ consistently found there was some consumer reluctance to engage with student doctors about emotional problems, or problems of an intimate nature. Further, general practitioners are often reluctant to supervise student placements, stating concerns about their patients' low desire to engage with student learning.¹¹ This view of student health professional training is not uncommon, as similar reports exist in a palliative care setting, where staff can act as gate keepers for access to patients.²⁰ What remains unknown is whether older adults with dementia living in nursing homes and their family members have reservations about engaging with student doctors and nurses, as research about older adults and students generally focuses on student perceptions of working in geriatric care.²¹

Students from multiple disciplines often have little interest in gerontology, which may be representative of their training experiences,^{21,22} traditionally based in acute and primary care settings, rather than RACFs. Our study reports findings from the non-traditional student placement setting. As previously mentioned, older adult RACF populations have high dependency and severity of disease, and this study will explore whether these characteristics influence their perceived vulnerability and potential reluctance for student teaching and learning experiences. A small number of studies have been conducted with people with dementia and their carers, particularly investigating their opinions of care. The findings from these studies consistently mention the need for social interaction, social contact, social activities and company for people with dementia living in care homes.^{10,23–25} In most studies, there was a desire from the residents, staff and their family members to increase the opportunities that were available for residents to undertake social activities. Further, individually tailored activities that met residents' social and psychological needs were considered meaningful.²⁶ A review

of qualitative studies in residential aged care settings found social connectedness and involvement with others were essential for good care home life.²⁷ Whether tertiary health students have a role to play in social interaction for residents with mild cognitive decline in RACFs, to our knowledge, has not previously been investigated.

Desires for more social interaction for older adults in care homes are well founded, as social relationships influence the health outcomes of adults.^{28–30} A meta-analysis of published studies including 308,849 individuals, followed for an average of 7.5 years, found people with adequate social relationships have a 50% greater likelihood of survival than those with inadequate social relationships.²⁸ Holt-Lunstad *et al.*²⁸ argue that risk factors for mortality should therefore include social relationships, in much the same way as smoking and obesity are currently adopted as part of risk factor status for morbidity and mortality. While Holt-Lunstad *et al.*²⁸ conducted a comprehensive study, it was not focused on older adults living in RACFs. However, a retrospective cohort study on the social engagement of residents living in an RACF (based in the US, 725 beds²⁹) showed social engagement had a protective effect on mortality. Kiely *et al.*²⁹ showed that residents who did not engage socially were 1.4 times as likely to die during a four-year follow-up period than those residents who were the most socially engaged. Therefore, the implications of lack of access to social interaction for older adults living in RACFs can be dire.

Social activity has been found to be important not only for mortality, but also for morbidity and psychological symptoms. For example, a US-based study investigated the relationship between social engagement and psychological well-being for older adults living in RACFs.³⁰ Using hierarchical regression analysis, Park³⁰ found that friendliness (as perceived by residents and staff) was significantly associated with life satisfaction and depressive symptoms. Quality of life often includes an individual's social relationships, social interaction and engagement.^{31,32} A cross-sectional

study of 45 US long-term care facilities investigated the quality of life of residents with dementia and the care they received.³³ Residents' rated better quality of life when their facility encouraged social participation in activities.³³ Not providing opportunities for social interaction and activity for older adults living in nursing homes is neglectful, as evidence indicates a lack of social engagement can lead to physical and psychological decline.

One way to enhance social inclusion of people with dementia living in RACFs is by targeting change in the facility itself, to promote activities of social engagement. A programme of large-scale interprofessional student placements may promote a sense of social inclusion and be viewed as meeting residents unmet needs in this area. The aim of the study was to provide further understanding about an under researched area on the subjective experiences of residents with cognitive decline and their family members with student doctors and nurses. In particular, whether there was any reluctance by older adults to participate in student learning experience and whether student placements could drive quality care delivery to older adults with cognitive decline in RACFs. Thus, this paper reports the findings from a study that investigated consumers' views on student delivered care in two RACFs in Tasmania. Further, residents' quality of life of was reviewed to describe the sample.

Methods

Setting

Two RACFs, one in northern and one in southern Tasmania, participated in the study. At the time of recruitment, both facilities were participating in the Wicking Dementia Research and Education Centre's Teaching Aged Care Facility Program (TACFP). The Wicking TACFP implements an evidence-based model of interdisciplinary health student placements in residential aged care³⁴ and aims to improve learning outcomes for health students and enhance care for older adults through the

placement of trainee nurses and doctors. The facilities were both independently operated organizations with approximately 140 available beds (residents; north: 155; south: 139).

In total, 71 students participated in placements during this study. Student placements ranged between 1 (medical) and 2 (nursing) weeks duration (40–80 h per student). There were 33 students on placement in the northern RACF (10 first-year nursing, 10 sec-year nursing, and 13 fifth-year medicine). The southern RACF hosted 38 students (eight-first-year nursing, 10 sec-year nursing and 20 fifth-year medicine). The median age of student nurses was 23, and doctors was 24. As part of the placements, students were expected to work collaboratively to assess residents and make recommendations for improving their care (i.e., an interprofessional learning task). Student timetables were reviewed to provide an estimate of student time on this learning task, indicating approximately 16 h per resident was allocated to perform a collaborative assessment and recommendations.

Design

A cross-sectional and exploratory investigation was adopted in two RACFs. A mixed methods approach was employed to gain a detailed understanding of consumers' experiences of students training in RACFs. Data were collected from multiple sources and included qualitative data from interviews (with both residents and family members), socio-demographic and health information from resident files, quantitative data from questionnaires, organizational information about the facility, and student placement information. The study received written approval from the Tasmanian Human Research Ethics Committee (Ref No. H0012771).

Sample

Older adults who resided in one of two RACFs in Tasmania and their relatives were invited to participate (October to November, 2012). Participants were purposively selected by the

director of care and senior registered nurse at each facility based on their score on the Psychogeriatric Assessment Scale (PAS) and clinical judgement (including a review of records) about the residents' capacity to give consent and participate in a short interview (approximately 15 min). To be eligible for selection, residents were required to have a score on the PAS, Cognitive Decline Subscale, between 1 and 9, which indicates a low to moderate level of cognitive decline.³⁵ Prior to participation, a registered clinical psychologist reviewed each respondent's capacity to participate. A standardized evaluation was conducted on respondent's abilities to provide informed consent. Residents who consented to participate were asked whether a family member could be contacted for potential inclusion in the study. Potential respondents were excluded if they were not in Australia at the time of the study or if they could not communicate in English.

Measures

Quantitative and qualitative data were collected from both the organization and individual level, during and after student placements at each RACF. Data were collected via three modes to apply triangulation, which is a strategy used to manage threats to validity and is often adopted to enhance the rigour of research.³⁶ A quantitative, 13-item questionnaire was administered by a trained interviewer to collect information on resident quality of life (Quality-of-Life Alzheimer's Disease; QoL-AD; alphas 0.84–0.86; total score range 13–52³⁷). Resident files (held at each facility) were examined to obtain demographic details about participants and to look for evidence of changes in the care or condition of the residents during and after student placements. Qualitative data were collected from semi-structured interviews with residents and family members about student delivered care (see Table 1). A clinical psychologist (KE) conducted all interviews with residents (face-to-face) and family members (telephone).

Data analysis

Quantitative data from the questionnaire were entered into SPSS³⁸ and Syntax used to compute a total score. Scores were compared to normative comparison groups. Qualitative thematic analysis was used to evaluate the interview data and employed techniques that are common to the social sciences, including coding, memo development and theoretical saturation consistent with Glaserian grounded theory.^{39,40} Grounded theory is a well-validated approach to qualitative data analysis and a recent PubMed search, using the 'grounded theory' search term identified its application in 6922 publications. Themes were identified directly from the data. Analysis included coding of text from interview transcripts to identify preliminary data categories. Categories were then examined to identify recurring and meaningful ideas, which were regarded as the analytic codes. The analytic codes were then developed into memos, which provided the broad analytical overview of emerging ideas. Memos and exemplary respondent statements were then developed into themes. All qualitative data analyses were conducted using QSR Nvivo (version 10⁴¹) to enhance rigour, consistency and ensure analysis occurred in a timely manner.⁴² All interview and questionnaire data were collected by one researcher (KE) and then analysed by another researcher (MA) to reduce effects of interpretation bias. The coding analysis was then reviewed by the researcher who collected the data to confirm the veracity of the emergent themes. Analyses undertaken by two researchers revealed limited differences in the interpretation of the qualitative results. No changes were made to the results following these reviews. Both researchers had previous training and experience in qualitative analysis and Nvivo software.

Results

In total, 21 individuals participated in the study (13 residents and eight family members). Twenty-five residents were recruited in

Table 1 Semi-structured interview questions for participants

Participants	Semi-Structured Interview Questions
Residents	<p>Were you aware that students were working at this facility?</p> <p>Do you know what tasks, if any, the student/s undertook regarding your care?</p> <p>How did you find the care provided by students?</p> <p>What was different about having students providing care?</p> <p>What are the good things about having student/s providing care?</p> <p>What are the not so good things about having student/s providing care?</p> <p>Would you like students to come and work here again?</p>
Family members	<p>Were you aware that students were working at this facility?</p> <p>Do you know what tasks, if any, the student/s undertook regarding the care of your relative?</p> <p>Did the student/s provide you with any support or information regarding your relative?</p> <p>Did the care provided to your relative change while the student/s were working at this facility?</p> <p>Did your relative's emotional state appear to change as a result of the student/s involvement in their care?</p> <p>How did you find the care provided by students?</p> <p>What was different about having students providing care?</p> <p>What are the good things about having student/s providing care?</p> <p>What are the not so good things about having student/s providing care?</p>

collaboration with the director of care in each facility. Of these, two residents refused to participate and 10 were excluded for several reasons (refusal reasons included 'not interested', $n = 1$, and felt 'unwell', $n = 1$; whereas excluded reasons included away from the facility, $n = 1$; unable to hear, $n = 1$; no interaction with students, $n = 1$; or they could not provide informed consent, $n = 5$). The resident response rate was 52%. In total, 13 family members were approached by the researcher. Four could not be contacted and one refused to participate, stating they 'didn't have the time'. Excluding those who could not be contacted, 89% of family members approached agreed to participate in the research.

Most residents were female (F: $n = 10$; M: $n = 3$) and had a mean age of 85 years ($SD = 8.0$). The youngest resident was 70 years, whereas the eldest resident was 99 years. Regarding relationships status, most residents were widowed ($n = 8$) and fewer were married ($n = 3$) or divorced ($n = 2$). There was a wide range in the time since assessment of the PAS-Cog, which was conducted by a registered nurse, as recorded in the residents' files, which included between 6 and 23 months, with an average of 10 months since the assessment.

Residents had varying physical and psychological morbidities. Reasons for admission to the RACF included lack of appropriate care at home; deterioration of physical and or mental state; accident (e.g. fall); or medical event (e.g. stroke). Participants' records showed residents were diagnosed with comorbid chronic health conditions including cardiovascular disease, osteoporosis, diabetes, kidney disease, diverticulitis and rheumatic fever. Other physical disabilities such as sensory impairment (hearing/sight), amputation and spinal fracture were reported in resident files, as well as symptoms such as cognitive impairment, chronic pain and depression.

Table 2 summarizes the major characteristics of the sample. The scores on the QoL-AD from the current sample were comparative with a normative comparison group of people with dementia living in care homes or hospitals in United Kingdom; $N = 201$, mean age = 85.3 years ($SD = 7.0$) with residents' mean total score on the QoL-AD = 33.3, ($SD = 5.8$) and family members' mean total score on the QoL-AD = 33.1 ($SD = 5.3$).⁴³

Qualitative themes

A thematic analysis of the qualitative data identified four emergent themes among family

Table 2 Characteristics of sample

	N	Min	Max	Mean	SD
Age in years	13	70	99	85.38	(8.02)
Months of residence	13	12	94	37.00	(24.55)
PAS-Cog score	13	1	8	3.38	(2.10)
QoL-AD – R	13	28	45	36.08	(5.21)
QoL-AD – FM	8	20	37	28.54	(6.32)

SD, standard deviation; R, resident; FM, family member; PAS-Cog, Psychogeriatric Assessment Scale Cognitive Decline Subscale; QoL-AD – R, Quality-of-Life Alzheimer's Disease – R; QoL-AD – FM, Quality-of-Life Alzheimer's Disease FM.

members and residents of the aged care facilities: (i) increased interaction and facility vibrancy (ii) community service and personal development, (iii) vulnerability and sensitivity and (iv) increased capacity and the confidence of enhanced care. For the first three themes, exemplary quotes from family members are presented as evidence followed by resident statements. In the final theme, only resident data were obtained.

Increased interaction and facility vibrancy

Family members and residents recognized changes in the level of social interaction and atmosphere, and commented students were enthusiastic, which led to a vibrant environment. Comments included that students were naturally inquisitive and able to spend more time with older adults to engage in conversation, whereas care staff (regarded as highly competent) were often too busy to engage in meaningful social interactions.

I think that as far as the residents are concerned [the student placement] gives them a sense of being involved, a little bit of extra care and attention being given to them... as far as [my mother] is concerned, she appreciates that extra involvement (Family member 4)

[The student] had a bit more time to talk to [my father] than the paid staff, for sure... He had a bit of a chat, as I said, he was quite taken by one young lass who spent time with him (Family member 10)

The data show that residents valued the opportunity for interesting conversation with

young people. In congruence with the feedback from family members, residents reported that staff members were often too busy with their daily rounds to take the time to converse in a meaningful way. Residents also noted that the enthusiasm and energy of the students lifted the mood of the facility and created a positive atmosphere.

I've always found [the students] very pleasant and interesting to talk to. They bring a new element of inquiry into our lives which is sometimes needed very badly and, by and large, I thoroughly welcome their presence...It means a new breath of life coming into a place which is normally the province of the very old and sometimes the not very with it (Resident 14)

I was very pleased that they were happy to just talk to me because one of the needs I have of staff and students alike in the home is that I need to be made to feel important if you know what I mean (Resident 15)

Community service and personal development

Family members and residents considered they had an opportunity to provide a service to the aged care sector, by assisting in the development of health professionals. Family members identified a global perspective by recognizing the value of organizational and sector-wide change within what they viewed as a fragmented industry characterized by low-level qualifications. High standards of care were reported and these facilities were regarded as the best place for future health professionals to learn about the industry. In this context, family members were confident that resident and student needs could be balanced within the placement programme.

It's an absolutely marvellous experience for [the students] to see how a good home operates...getting them out to somewhere that has good activities for the residents and a wonderful atmosphere, happy staff, well-trained staff is invaluable... Organisational culture is something that a classroom can't teach (Family member 21)

I think [the students] all need to learn, and by actually physically doing it you get a better feel for what the job entails...You get a couple of

really good students. It's just nice to see them grow, and watch them, and help them (Family member 2)

Residents reported pride and satisfaction in their ability to assist in the learning process and impart their experiences of care to trainees. Some residents felt that they were well placed to help students understand how to approach individuals with complex health conditions, including dementia. Residents wanted to help students improve the level of care for future cohorts of older adults. In this regard, residents viewed themselves playing the role of a teacher or instructor rather than a patient. Residents felt they had the opportunity to pass on their knowledge or assist the learning of a younger person, which was valued by residents who may have comparatively few opportunities to provide meaningful assistance to others when they are in need of high levels of care themselves. Residents' views matched those of family members, as they too believed students needed to experience an aged care facility to prepare them well for their future careers.

I think [the students are] fine young people and I'd like to do anything I can to help them to become what they want to be...Plus, the fact that we know that they're training that they will, when we're not around, that they will care for others more fully (Resident 4)

In the course of conversation with [the students] you get some idea of what they're thinking and on occasions you make comments about whether they're either right or wrong in their ideas...It's, you know, you often have to show them the way, you know that things are usually done. Well, they've got to go somewhere to learn don't they (Resident 19).

Vulnerability and sensitivity (learning to care)

Family members and residents recognized a potential for discomfort and invasion of privacy. Family members were not always aware of activities associated with student placements and some were concerned about the vulnerability of their relatives as a result. Relatives felt facilities could do more to communicate effectively with family members about student

placements. However, family members showed trust and felt when students were supervised and were respectful, the benefits of the placement would outweigh the potential for harm.

... there's such a problem with people patronising residents ... things like tone of voice are so important, and using someone's honorific ... They're terribly important things. And that's different from physical care... I suppose there is potential for lots of things to go wrong... If there isn't adequate guidance and briefing from the staff of the home and adequate supervision from the university ... they need to be working to guidelines that show ... interpersonal relationships with the residents... (Family member 21)

[I have a concern] on my mothers' behalf: male students... privacy for female patients. It doesn't bother dad so much, having female students around because he's used to the female nurses, but I think my mum finds it a little bit difficult at times (Family member 7)

Residents were not concerned about their perceived vulnerability, but indicated that some students needed to display greater sensitivity and make more of an effort to build rapport. This is potentially significant for individuals who may typically have little interaction with young people or family members. Residents wanted students to understand the facility is their home and felt that students needed to respect this. Residents did not want to feel constantly on display or under examination. Some residents were also concerned that because they were in a high needs area where there is a greater burden of dementia, that students may make incorrect inferences about their lack of cognitive or communicative ability.

In some cases, residents did not feel comfortable participating in learning activities (e.g. assessments) if students did not initiate conversation. Residents wanted assessments and interactions to not be artificial or rushed (e.g. appearing to be undertaken solely for the purpose of assessing health and function). Residents requested that students be introduced to all members of the facility at the beginning of the placement and be encouraged to engage in more regular, even incidental, interactions.

Residents were concerned that if they were confined to their rooms by illness or mobility problems, students would not make an effort to interact.

Nobody cares for me in so many words. I've seen recently that students seem to like or to have been instructed to, as it were, adhere to one person taking them to meals and observing them while they ate (Resident 14)

Some [students] just stand there and look... Oh, I cottoned on they're not going to speak, so I don't speak to them. I'll speak to them if they speak to me (Resident 18)

Increased capacity and the confidence of enhanced care

While the perceptions of residents and family members were consistent across both facilities, only residents spoke of an increased capacity of care. Residents commented that the presence of students within the facility led to improved care and oversight. Student care ranged from the incidental (providing heat packs, talking to residents when stressed or preparing tea) to more significant (bathing residents, taking blood, reviewing medication, monitoring blood sugar, pain management and assuming the roles of health professionals when staff members were busy). Students were perceived by residents as eager to help and ready to listen. Student doctors were even able to provide additional diagnoses and influence the medication regimens of residents.

If you wanted a heat pack [the students] would get it for you. If you want a cup of tea they will get it for you. If you're in pain they will go and get somebody for you and talk to you when you were a bit stressed...They help with the giving out of your medications when they're here under the authority of a sister or an RN...it relieves the staff quite a lot and it gives us the confidence of more care...You know, you don't have to wait while the nurse attends to somebody else because while she's doing that the students will do what you want (Resident 4)

[The students] were good. The doctor [supervising the student] said they even found some different things she had overlooked. ... It was some

sort of a tablet they thought I was better to have...Yes, it was my medication (Resident 8)

The four qualitative themes identified during the analysis indicate that residents and family members value student placements when they are accompanied by appropriate supervision and meaningful engagement. There is a reported overarching benefit associated with increased social interaction, which may result in improved atmosphere, care and the capacity to contribute to the education of future generations of health professionals.

Discussion

Quality care for people with dementia is paramount and prioritized in national dementia action plans worldwide.^{1,44} Placing undergraduate students in nursing homes, where the incidence of dementia is high, is a unique approach to build capacity in a sector strained by workforce challenges. Long-term, it is envisaged that health students undertaking positive placements in aged care may choose geriatrics as a career. Short-term, students delivering supervised care in RACFs may offer unique contributions. Students have the potential to shift the focus of the RACF environment from managing workforce issues to learning. Key requirements of education including on-going and timely feedback on learning outcomes and supportive guidance through adequate supervision may transfer to the environment and have positive impact on consumers. Findings from this study offer preliminary support for this latter hypothesis, as consumers, for the majority, perceive a wide array of benefits of interdisciplinary student placements occurring in two RACFs in Tasmania, Australia.

The placement of student nurses and doctors in an RACF created *increased social interaction and facility vibrancy*. This finding is unique and to the best of our knowledge has not been reported elsewhere. The addition of students into an RACF is an uncertain endeavour as there is evidence to suggest that changes to the social or physical environment of people with dementia (over 50% of residents in the

participating facilities) can prompt increases in distress or confusion.⁴⁵ In this regard, the response of residents to the students could not be anticipated and was closely monitored by staff and supervisors during initial engagements. The implications of the findings for positive interactions and an improved facility atmosphere suggest our research contributes to further knowledge about how to respond to the known failings in the provision of aged care in Australia. In particular, there are limited opportunities for meaningful interpersonal connections, particularly with younger adults, considering those providing the majoring of care are on average 50 years old.⁴⁶ These findings relate to a perspective presented by King⁴⁷ where regulations and service requirements of RACFs have created a shift towards care delivery that is focused on the physical health needs more than the social and emotional care needs of patients and carers. RACFs and government funding bodies may be underestimating the significance of meaningful social interaction in the context of care provision.

Residents in our study reported their quality of life was mostly good, despite their high care needs. While family members were relatively distanced from the routine care that their relatives received, they were able to comment on their interactions with staff and family members after student placements. The level of interaction that family members had with their relatives may have influenced the inconsistent ratings on resident quality of life by some family members. The finding of overall good quality of life for residents may be related to the presence of students and increased opportunities for social interaction. Park³⁰ has identified a statistically significant relationship between the quality of social engagement within RACFs, life satisfaction and reduced rates of depression. Other studies have linked positive social environments in RACFs to significant reductions in mortality risk and increases in rates of survival.²⁸ Our findings and that of Park³⁰ and Holt-Lunstad *et al.*²⁸ suggest aged care settings may be able to increase the psychological well-being of residents through

initiatives that foster social engagement. In this context, student placements may represent an intervention that could potentially increase social interactions for residents. Further, educators should consider student placements in non-traditional settings, such as RACFs, especially the potential for specific learning tasks on developing students' interpersonal skills.⁴⁸ The RACF placement setting provides the opportunity to broaden health students experiences which are mainly focused on acute care, to include chronic conditions, such as dementias, which will be key presentations during students' future health engagements.

Our study found opportunities for *community service and personal development* were reported by consumers when participating in health students' placement experience. In particular, participants wanted to help improve the aged care sector and assert their knowledge. Residents perceived there was value in describing their experience of ageing, illness and disability, to assist students in their learning. Previous studies have reported similar results identifying health consumers often feel a sense of duty and altruism when interacting with students. Patients value the opportunity to personally contribute to students' educational outcomes with the aim to improve care for others.²⁰ Health consumers are experts in their personal experience of health problems,^{13,14} placing them in an ideal position to teach students about the subjective and emotional aspects of their illness. Our findings in combination with previous research highlight the nature of the relationship and meaning that has been ascribed by older adults to participate in student learning. Interacting with students in a learning environment may be an empowering experience for individuals who are often the recipients in health-related knowledge exchanges.

While the majority of the themes (three of four) in this study highlighted the positive aspects of health student placements in RACFs, some potential for negative outcomes was also found. If student supervision was inadequate, residents and their family members reported a

vulnerability and sensitivity for residents when providing care. The data identified as part of this theme suggested consumers acknowledged the learning status of students and the potential for care mistakes. This finding is similar to previous research by Arolker *et al.*²⁰ where staff working in a hospice setting held concerns about the burden of student involvement for their patients. Further, international studies have reported that health consumers are sometimes reluctant to interact with student doctors which is an obstacle to health services hosting student placements.¹¹ Finding a balance between consumers' desires, health professionals' protective approaches and student supervision requirements is likely to be an essential part of teaching RACFs. Unsupported student placement programmes in RACFs do not follow the guidelines⁴⁹ that model best practice in this area. The implications of our research findings for education and practice suggest that to maintain propriety and protect older adults, it will be necessary to ensure adequate clinical supervision and support throughout students' placements. This feat may be a challenge considering the current workforce climate and further highlights the importance of external stakeholder relationships (e.g. university partnerships) that supports equilibrium between adequate supervision and clinical excellence in teaching RACFs.

A noteworthy finding from our study is residents perceived student placements to *increase capacity and provide the confidence of enhanced care*. Residents reported students provided relief for staff and reviewed medication. This is supported by previous research demonstrating student doctors provide more thorough examination and a second opinion.¹¹ Placing supervised student nurses and doctors delivering care to older adults in nursing homes may create added capacity and drive quality care. This raises an ethical issue regarding when students are not undertaking placements in the RACF and the facility returns to its usual complement of staff. Additional positive clinical aspects of care (i.e. increased oversight) for older adults may not be addressed when students are absent. Teaching RACFs may offer continuing

student placements where students from multiple disciplines undertake practical experiences at overlapping times throughout the year to overcome ethical issues. However, students may not necessarily need to be present to drive quality care. Student recommendations may become part of routine care delivery, where the validity is checked by supervisors and RACF staff, which if deemed appropriate can be implemented and monitored. Research is currently underway with residents, family members and facility staff to explore resident health and quality of life both during and in the weeks following student placements.

Limitations of this study included variation in the timing of psychogeriatric assessment scores and the lack of member check on qualitative data to reduce interpretation bias. Residents may have also felt obliged to report positive findings, increasing the possibility of a 'halo' effect. Therefore, the data presented in this paper, which has a limited scope, are preliminary in nature and offer findings that must be further qualified by future research. Despite these limitations, the strength of this paper is how we start to bridge the wide gap in literature investigating older adults' opinions on students training in RACFs. By applying a qualitative focus, we described in depth the issues most relevant for consumers on students training in nursing homes. In this way, we offer pilot data for a new area of health service evaluation research in the residential aged care setting which our team and others can advance. Future research may be designed to determine the effects of an intervention of student groups into RACFs on resident health outcomes over time.

No diagnostic assessment on dementia was performed, which is a limitation of our study. Instead mild cognitive decline was determined by data collected from the facility based on an assessment that occurred at varying times for each participant. Therefore, participants may have levels of cognitive decline associated with normal ageing, and it is difficult to determine whether or not residents in the sample had a diagnosis of dementia. Future studies may

consider using a cognitive screening tool at the same time point for all participants. Despite the aforementioned limitations, the sample characteristics are similar to those reported in the aged care setting in Australia (mostly female and 85 years and over, average length of stay 2–5 years⁵⁰). Further, future research should determine ways to undertake assessments of satisfaction with student delivered care for persons with more advanced stages of dementia. For this proportion of residents, cognitive impairment and communication difficulties may influence consent and their ability to verbalize the nature of the care. Observational methodologies and interviews with care staff or family members may be considered appropriate for such future work.

Our research has a number of important implications. Firstly, student placements in two RACFs were perceived by consumers as creating a vibrant atmosphere thought to result in more opportunities for social interaction and benefit the well-being of older adults. An improved social environment may have important current and future consequences for resident quality of life, morbidity and survival. Secondly, residents' comments suggested they could contribute to the development the future generations of health practitioners and this involvement was a meaningful activity. Student placements can provide a rare opportunity for social inclusion of older adults often isolated from the community and from the evaluation of health services. Thirdly, the findings highlight the importance of adequate clinical supervision and oversight of students undertaking placements in RACFs, considering the potential vulnerability of older adults in these settings. The implications of our findings for practice and education suggest that highly supported placements where partnerships between tertiary educators and 'on the ground' clinicians are essential for consumer engagement and confidence. Finally, our research suggests student placements increase the level of clinical oversight and care for older adults. Developing learning environments in nursing homes, where student nurses and doctors deliver care, may

not only train a future workforce, but also contribute to enhanced capacity and the delivery of high quality care.

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