STUDENT NURSES' EXPERIENCE OF LEARNING TO CARE FOR OLDER PEOPLE IN ENRICHED ENVIRONMENTS: A CONSTRUCTIVIST INQUIRY

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SUMMARY

The unpopularity of gerontological nursing is well established and, although numerous studies have sought explanations for this, few have explored how work with older people can be promoted as a more fulfilling and challenging career choice. Underpinned by a constructivist methodology, this thesis provides new insights into how the experiences of student nurses during their training influence their predisposition to work with older people. Using a two stage approach, data were collected from longitudinal focus group interviews with student nurses from four schools of nursing over a period of eighteen months, together with case studies in seven clinical placement areas where students had identified a positive experience of learning to care for older people. The study was part of a larger national investigation funded by the English National Board for Nursing, Midwifery and Health Visiting.

Data analysis revealed that a positive experience of work with older people in a range of settings was key to determining whether gerontological nursing was seen as an interesting and exciting career option. Both 'impoverished' and 'enriched' environments of care were identified and analysed in terms of the 'Senses Framework' (Nolan et al 2001a). 'Enriched' environments ensured that students, staff and patients/carers each in their various ways experienced a sense of security, belonging, continuity, purpose, achievement and significance. The longitudinal nature of data collection also indicated that these senses varied in importance as students' experiences unfolded, and a number of foci for students' efforts emerged. These were: self as focus; course as focus; professional care as focus; patient as focus; and person as focus. Findings suggest that only in the most enriched environments will students have a vision of care that has the person as its focus.

Based on the interdependency implicit in the data, the thesis concludes by arguing that future policy, practice and education in gerontological nursing should be informed by relationship-centred care, as opposed to person-centred care.

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Education is not the filling of a pail but the lighting of a fire

William Butler Yeates (1865-1939)

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INTRODUCTION

Background and Context

The purpose of this introductory section is to provide the reader with an understanding of the background and context for the study upon which this thesis is based. This is necessary as the genesis of the study, and indeed the study itself, was complex and it is important to establish at the outset those elements of the overall study that constitute the unique contribution that this thesis makes. The study in question was termed the AGEIN (Advancing Gerontological Education in Nursing) project and it comprised a multi-method, multi-phase longitudinal investigation exploring a range of issues relating to the preparation of nurses to work with older people. AGEIN was funded by the English National Board for Nursing, Midwifery and Health Visiting (ENB hereafter), the body responsible, at that time, for overseeing professional education in these disciplines in England. It was won by a process of competitive tender, by a bid submitted jointly by the University of Sheffield and the University of Wales, Bangor. I was a named applicant on the submission to the ENB. In order for there to be transparency about the elements of the work upon which this thesis is based relative to AGEIN as a whole, this section will:

- provide a brief background to the ENB's goals in commissioning the study;
- succinctly describe the rationale upon which the successful tender was based;
- give an overview of the various phases of the AGEIN project;
- clearly identify those elements that constitute this thesis;
- describe the various chapters that comprise the thesis.

AGEIN: The Project Specification

As noted above, the AGEIN study was undertaken jointly by the University of Sheffield and the University of Wales, Bangor. It arose as a consequence of a tender submitted in response to the ENB's Project specification: Longitudinal Study of the Effectiveness of Educational Preparation to Meet the Needs of Older People and

their Carers. The Board commissioned this three and a half year project as one of a number exploring the changing face of health care within an increasingly multi-disciplinary and multi-agency context. The intention of this raft of projects was to consider the effectiveness of the educational preparation of nurses to meet the needs of a variety of key user groups, with AGEIN focusing on older people. In its project specification the Board noted that:

> *The project has at its centre a long term commitment to the continuing development of professional knowledge, skills and abilities, an epistemology of practice for practitioners involved in the care of the older population.*

In addressing this broad aim the Board stated that the study should:

> *Seek to identify the educational experiences which will promote the development of the professional nursing knowledge base of this vital area of health and social care.*

Such an aim was seen as particularly important in the light of the increasing difficulties of recruitment and retention in gerontological nursing.

The AGEIN project was one of the longest ever commissioned by the Board and was explicitly longitudinal in attempting to explore how attitudes, knowledge and competence develop over time across both pre-registration and post-registration programmes of preparation. The more specific aims included a consideration of:

- learning outcomes and teaching/learning strategies across a range of curricula;
- ways in which both pre- and post-registration students/practitioners develop a concept of ageing and how knowledge, skills and attitudes towards older people are acquired and develop over time;
- pre- and post-registration education for the care of older people in a multi-professional, multi-agency context;
- how professional knowledge can be developed through education and practice;
- the effectiveness of current educational provision and the implications of the study for educational and practice development.

Responding to the Board's Specification: The Arguments Underpinning the Tender

In interpreting and responding to the above aims the project team, of which I was a member, submitted a proposal predicated upon three central premises:

- Current nursing practice with older people and their carers was deficient across a range of fronts. In many cases it was antithetical both to the policy rhetoric and the expressed values of practitioners.

- Current understanding of the needs of older people and their carers was inadequate to provide a sound basis for practice and there was a need for a constructively critical appraisal of a number of assumptions that were taken for granted. In other words, there did not currently exist an adequate epistemology of practice and therefore it was not possible to articulate clearly *the knowledge, skills and attitudes essential in the care of older people* (ENB Project Specification).

- Current education, both generic and specialist in nature, and at pre- and post-registration levels, failed adequately to prepare practitioners to deliver high quality care. Extensive analyses of curricula, conducted independently by members of the Sheffield team for the ENB during two earlier projects, suggested a lack of structure, cohesion and consistency in most programmes (Davies et al 1997, Nolan et al 1997).

Building upon these premises the proposal argued that nursing in particular, and health and social care in general, lacked a sound rationale for the care of older people, especially frail older people, and the project team challenged the validity of a number of assumptions such as community care being inherently superior to institutional care, and autonomy and independence being necessarily always the most appropriate goals of care. It was our contention, much as Barker et al (1997) had asserted with respect to psychiatric nursing, that gerontological nursing had yet to establish its proper focus. In providing a rationale for the project we proposed to

chart the emergence of new cultures of care in a variety of contexts such as dementia care (Kitwood 1997), long-term care (Henderson and Vesperi 1995), and rehabilitation (Nolan et al 1997), arguing that such cultures had yet to be fully described and that consequently it was not clear how they could be achieved. In suggesting a way forward it was our contention that there was a need to develop an epistemology of practice and a complementary epistemology of education, as well as to identify the range of factors which might predispose nurses to work in gerontological care.

In building on these arguments we suggested that not only did gerontological practice lack a clear direction and focus, but also that educational preparation, particularly within the health care disciplines, paid scant attention to the needs of older people and continued to prioritise the hi-tech areas of care, perpetuating negative beliefs and attitudes about older people (Davies et al 1997, Nolan et al 1997). Compounding these difficulties, the espoused commitment to the relational aspects of nursing (Fagermoen 1997, Mulrooney 1997) similarly received little coverage in curricula, which instead demonstrated a continued biomedical dominance (Davies et al 1997, Nolan et al 1997).

Such issues are of particular relevance to frail older people where curative (medical) or restorative (rehabilitative) models may not meet the needs of many of the most dependent older people. We consequently argued that there was a need to give greater consideration to the carative, as opposed to the curative, components of nursing if an appropriate framework (a term we preferred to epistemology), for both the practice of nursing with older people and the educational preparation of practitioners, was to emerge.

In interpreting the project specification provided by the ENB we proposed that the AGEIN study should address four key questions:

- How do nurses acquire and sustain their perceptions of, and predispositions to work, with older people?

- How, over time, do nurses develop their theoretical and practice frameworks for work with older people?

- What is the nature of the students' educational experience, and how does this impact on their perceptions, predispositions and theoretical and practical frameworks in relation to older people?

- What other factors may influence students' perceptions, predispositions and theoretical/practical frameworks?

As noted by the ENB, the study was to consider both pre-qualification and post-qualification students and practitioners. However, this thesis is concerned only with those elements of AGEIN that relate to pre-qualifying student nurses.

Operationalising AGEIN

In meeting the complex aims of AGEIN a multi-method, multi-phase design was proposed, which in essence comprised two phases, some elements of which ran concurrently, and some consecutively. Briefly, these phases were:

- A conceptual phase – the aim being to provide a comprehensive synthesis of current knowledge in relation to caring for older people and their families.

- An empirical phase – comprising two components:
  - an extensive component
  - an intensive component

(Lathlean et al 1986, Owen et al 1999)

The conceptual phase consisted of six in-depth reviews of the extant literature in the following areas:

- Acute and rehabilitative care
- Primary care
- Continuing care

- Mental health in older age
- Learning disabilities in older age
- Palliative care and end of life issues in older age

Each review began with a comprehensive synthesis of the existing and emerging literature, in nursing in particular, but also including wider professional, policy, and gerontological sources. This resulted in the identification of key themes and concepts. Complementing these reviews, which focused on largely discrete but nevertheless overlapping areas of care, were two more generic reviews that considered quality of life and quality of care in relation to older age, and a wide range of literatures considering the nature of relationships and sources of knowledge that might inform work with older people. I played a particular role in these two reviews, especially the latter. All of the major themes from these reviews were then brought together in an effort to identify a potentially unifying framework that might encapsulate the emerging rhetoric around person-centred care (see Chapter 1). The results of this activity were subsequently presented as an interim report to the Board and later published by the Open University Press in a book entitled *Working with Older People and Their Families: Key Issues in Policy and Practice* (Nolan et al 2001a).

The empirical phase of the project was divided into an intensive and an extensive component. The intensive component was undertaken using in-depth qualitative methods in four main case study sites (see Chapter 2 for a description of how these sites were selected, and Appendix I for an overview of their characteristics). One element of the intensive component explored the perceptions of post-registration students enrolled on specialist community courses or courses for those working with older people. This focused on their concept of ageing and their perceived competencies in a number of domains. The main form of data collection was telephone interviews with a small number of individuals, supplemented by questionnaires sent to a large random sample. Data collection was repeated at four points in time: before the start of the course, and at 6 months, 12 months and 18 months. Further details of this element of the AGEIN project are not considered

here and interested readers are referred to the original study report (Nolan et al 2002).

The second component of the intensive component expressly focused on the experiences of pre-registration students. It was this phase of the study for which I had lead responsibility, and it is this phase that constitutes the central plank of the present thesis. Briefly, this component employed longitudinal focus groups, held over 30 months with groups of students in the selected case study sites (see Chapter 3), together with in-depth case studies of practice placements (see Chapter 4).

Philosophically the study as a whole, but the intensive phase in particular, adopted a broadly constructivist approach to research following Rodwell (1998) (see Chapter 2 for a detailed account). Underpinning such an approach is the belief that there are multiple constructed realities and that the aims of inquiry are to seek a degree of consensus on how important elements are understood. Consequently, research designs are emergent and results are negotiated via a series of iterative dialogues rather than being determined primarily by the researchers themselves.

The longitudinal focus groups not only permitted an understanding of students' perceptions and predispositions over time to emerge, but also allowed an iterative dialogue to occur and enabled the identification of a range of factors that helped to create either **impoverished** or **enriched** learning environments (see Chapter 3). Consistent with the study's emergent design, the next phase of the intensive component sought to elaborate further upon the nature of an impoverished or enriched environment. In order to do so, in-depth case studies were undertaken in seven practice placements (see Chapter 2 for a methodological description and Chapter 4 for the results of this phase). It is the results of these focus groups and case studies that lie at the heart of the thesis.

While the intensive phase was intended to allow for a detailed consideration of factors operating in specific locations, the extensive phase was designed to consider issues on a much wider basis, with far larger samples. Briefly, this phase involved postal surveys with large samples of both pre-qualifying students and qualified nurses that explored both their knowledge about older people and their views of

work with older people. Although this element is not reported in detail here, specific issues are considered in the next chapter, as they provide an essential context for interpreting some of the later results.

Summary

In summary, therefore, this thesis is concerned with those specific elements of a larger project (the AGEIN project), which sought to address four key questions in respect of pre-registration student nurses (see page 4).

In addressing these questions the primary data drawn upon will be those collected in a series of longitudinal focus groups and in-depth case studies. However, it is important to remember that the study was intended as an integrated whole and that it is not possible fully to interpret the results of the intensive component involving pre-registration students without some reference at least to the conclusions of the conceptual phase, and to those aspects of the extensive (survey) phase that relate to pre-registration students. These are outlined in Chapter 1.

The thesis contains the following chapters:

Chapter 1 presents an overview of the conceptual phase, with a particular focus on the emergence of a potential theoretical framework – the **Senses Framework** (Nolan 1997, Davies et al 1999), which was subsequently tested and developed further in the intensive phase with pre-registration students. This chapter also briefly considers those elements of the survey that involved student nurses, and identifies two very important issues that informed, and were tested further, in the remainder of the study. The first was the overriding influence of student placements, as opposed to their classroom/university experience, on their predisposition to work with older people, and the second was the emergence of the concept of an impoverished environment of care/education.

Chapter 2 gives a detailed account of the methodology for the study, justifying the chosen constructivist approach, and describing how it was operationalised. Issues of ethics, analysis and quality criteria are also considered.

Chapter 3 provides an in-depth account of the results from the longitudinal focus groups, which elaborated further upon the nature of impoverished and enriched environments, and how these might be created (or not) in relation to the Senses Framework. Analysis of the data also suggested that, as they progress through their training, students tend to focus upon particular issues at certain points in time. These **foci** are a useful device for better understanding the temporal nature of the student experience.

Chapter 4 concerns itself with the results of the in-depth case studies, and provides a more detailed account of the Senses, and particularly of the foci, as they impact on placements at various stages of the students' training. The role of the ward leader, and especially the mentor, figure prominently here.

Chapter 5 draws the thesis together and pays particular attention to the quality of the study, the extent to which it addressed the original questions, and its contribution to advancing thinking in respect of better preparing students to both want to work with, and successfully meet the needs of, frail older people. This chapter builds on the notion of **relationship-centred care** (Tresolini and the Pew Fetzer Task Force 1994, Nolan et al 2001a, 2004), and argues that this framework may provide a way of reconciling a number of longstanding tensions and debates as to what constitutes the proper focus of gerontological nursing. The thesis concludes with a series of recommendations for action, and identifies areas for further research.

CHAPTER 1
THE AGEIN PROJECT: A SELECTIVE OVERVIEW OF THE CONCEPTUAL AND EXTENSIVE PHASES

Introduction

The introductory section of this thesis provided the background and context to the study upon which the thesis is based and outlined the four key questions in respect of student nurses that the AGEIN study sought to address. This chapter provides a selective overview of both the conceptual phase of the AGEIN project and the extensive phase, with particular reference to those elements most relevant to the thesis. The conceptual phase comprised an exploration of the then existing literature in relation to what older people see as important to their overall quality of life and the quality of care they might receive; and was, as noted in the introduction to this thesis published as *Working with Older People and Their Families: Key Issues in Policy and Practice* (Nolan et al 2001a). The overview presented here focuses in particular on the origins of an emerging theoretical framework – the Senses Framework (Nolan 1997, Davies et al 1999) that was subsequently subjected to empirical inquiry and developed further by myself in the intensive phase of the AGEIN project with pre-registration students (see Chapters 3 and 4).

The second part of this chapter considers those elements of the extensive survey element of the AGEIN project that involved student nurses. It identifies two very significant issues that informed the direction of, and were further elaborated upon in the remainder of the study. These were:

- The overriding influence that the students' practical placements, as opposed to their classroom/university experience, exerted on their views of, and predispositions to work with, older people.
- The identification and initial description of an impoverished environment of care and education, raising the possibility that there might exist its opposite in the form of an enriched environment.

The chapter begins with the overview of the conceptual phase of AGEIN and a brief summary of the methods used in the literature review.

The Conceptual Phase of the AGEIN Project

The aim and scope of the review

The intention of the literature review was to identify areas of commonality and potential divergence in six key areas that might begin to form the basis for an epistemology or framework of practice with older people. The six areas were seen to represent the major environments of care in which nurses might be involved with older people. They were:

- Acute/rehabilitative care
- Primary care
- Continuing care
- Care of older people with mental health problems
- Care of older people with learning disabilities
- Palliative and end of life care for older people

The review focused on the theoretical as well as policy and practice literatures in relation to older people. The aim of the review was to explore the ways in which nursing could contribute to the well-being of older people and the competencies they required, especially in the less tangible relational and interpersonal dimensions of care. In addition to the above six specific reviews, generic overviews of issues impacting on quality of life and quality of care for older people, and the varying forms of knowledge that might inform the care of older people, were also undertaken. As noted in the introductory chapter, I played a particular role in these two generic reviews, especially the latter, and the results of these reviews comprise the first part of this chapter. However, before presenting the review a brief description of the methods used is provided.

Summary of methods used in the literature review for the conceptual phase of the AGEIN project

The identification of literature sources was rigorous and the guiding principle behind the review was that it should be systematic, explicit and reproducible (Nolan et al 1997). In order to produce a synthesis of knowledge across six distinct areas of practice with older people, and two generic domains, it was important that the review was carried out in a consistent manner across these boundaries, thus allowing it to be regularly updated. Work produced in the period 1988–98 provided the initial focus for the search, however, key references identified from the retrieved sources which were published before this period were also included. The review was updated as new items were published.

Search terms were identified for each of the six discrete areas (see above) from a range of bibliographic sources (including Cinahl, Medline, Psychlit, AgeIfo, Bids and HMIC; see Appendix II for details). When these terms were collated it became apparent that many of the themes and concepts were common to all six areas (quality of life and quality of care, for example) and these formed the focus of the two generic reviews. Search terms specific to each field of practice were also subsequently identified (see Appendix II). Initially more than 22,000 references were identified, most of which were academic papers in peer reviewed journals, with books and reports contributing approximately 5% of the total. Material that was obviously not relevant was eliminated after scrutiny of the abstracts, and the remaining references were then prioritised in order to produce a more manageable volume of literature for review; this process resulted in the identification of approximately 200–300 items for each field. These were retrieved, reviewed and grouped thematically to provide a structure for each chapter of the resulting book (see Nolan et al 2001a).

In reviewing each reference, a broad three-stage iterative process was followed. Initially each reference was read and notes identifying and summarising key themes were made. Subsequently, the notes from this first-order analysis were scrutinized in detail to distil the core dimensions of the key themes. This formed the second-order analysis. Finally, in the third-order analysis, comparisons were made within

and between themes to explore the conceptual links and achieve an element of synthesis. Thus the analysis of the literature was informed by the principles of constant comparison in which each reference obtained was treated as a source of data (see Nolan et al 1997 for a more detailed description).

As previously noted, the completed review was subsequently published as a book (see Nolan et al 2001a). The book was structured so that the two generic reviews formed the introductory chapters, followed by the six specific reviews. The final chapter sought to bring together the key themes from the earlier chapters and identified the Senses Framework (Nolan 1997, Davies et al 1999) as a potential means of providing purpose and direction to the care of older people, and the education of practitioners. The first two chapters and the final synthesis are described in some detail here, as they were particularly important in informing the analysis of the data from the intensive phase of the empirical component of the AGEIN project reported in this thesis. Readers interested in the remaining chapters are referred to the original source (Nolan et al 2001a).

The first two chapters of the book (Nolan et al 2001b, Brown et al 2001) sought to bring together the literature on quality of life and quality of care for older people and the varying types of knowledge that might underpin such care. Particular emphasis was placed on the interpersonal and relational domains. At the time the AGEIN project began, quality of life was rapidly being established as a key concept in the delivery of health and social care (see, for example, Bowling 1995). However, our consideration of the literature suggested that it was a complex and contested issue. Certainly, with greater recognition that prolonging life at any cost is less important than the quality of life lived (Clark 1995), increasing attention has been given to the way in which quality of life is defined and measured (Brown et al 1996, Renwick et al 1996, Haas 1999). Indeed, at the time of the review, quality of life had emerged as one of the most important outcomes of health and social care, particularly when cure was no longer an option (Martlew 1996, O'Boyle 1997). This is particularly relevant to the care of older people.

However, although Renwick et al (1996) suggest that quality of life may provide a potentially unifying concept in gerontology, there is little agreement as to what it

really means (Bowling 1995, Farquhar 1995, Hanestad 1996, Haas 1999), especially when applied to older people. Although the literature suggested widespread agreement that the concept is complex and involves both objective and subjective elements (Farquhar 1995, O'Boyle 1997, Powell-Lawton 1997, Woodend et al 1997, Haas 1999), existing definitions were often founded on the views of younger people (Stoats et al 1993, O'Boyle 1997, Reed and Clarke 1999) and based on assumptions such as the value of autonomy and independence (Farquhar 1995), the relevance of which for older people is increasingly questioned (see Steverink et al 1998). Despite this, autonomy and independence comprise key elements of an emerging vision of successful ageing, largely characterised by high levels of physical and cognitive functioning (Coleman 1997), often measured using proxy indicators such as activities of daily living (ADL). Therefore, although the literature recognised the importance of both objective and subjective domains of quality of life, the objective criteria, usually professionally derived, appear to carry the most weight in the fields of health and social care (Farquhar 1995, Wistow 1995, O'Boyle 1997, Haas 1999). To compound difficulties, even when subjective elements are included in an appreciation of quality of life, these are often based on the views of researchers (Day and Jankey 1996), with patients' and carers' perceptions rarely being adequately addressed (Chesson et al 1996).

However, while the above represented the dominant view, the review also identified a number of dissenting voices, who argued that existing measures of quality of life lose the human being (Kivnick and Murray 1997), signalling a need to move beyond 'statistical sophistication (Bowling 1995) towards a model of quality of life that engages the older person as a full partner (O'Boyle 1997). For older people in particular, attempts to capture the more subjective dimensions of life should include attention to their life history and biography (Clark 1996) in order to provide a better understanding of their past, present and future (O'Boyle 1997). Moreover, the focus should not be primarily on the problems of ageing; a more balanced approach should be adopted that recognises both the limitations and potential that ageing presents (Clark 1995, Fontana 1995, Kivnick and Murray 1997, Wenger 1997, Thorne and Paterson 1998). As a result it was suggested that a more sophisticated and rounded understanding of what constitutes successful ageing will emerge (Baltes and Carstensen 1996, Wenger 1997), together with a better appreciation of what makes

for a meaningful life, even in the presence of the increasing frailty that often accompanies advanced older age.

Studies indicate that most older people manage to sustain a positive view of their quality of life, despite their frailty. Such findings represent an empirical and conceptual puzzle as to why, despite their objectively adverse situation, older people often do not perceive their quality of life in negative terms (Brändstädter et al 1994). If we are to better understand such a paradox, authors such as Minkler (1996) argue that we need to focus on meaning in later life in order to appreciate how older people adapt positively to the limitations of ageing (Loew and Rapin 1994, O'Boyle 1997, Wenger 1997). A number of theories that existed at the time of the review offered potential explanations, highlighting in particular the role of subjective perceptions and interpretations (see, for example, Stewart et al 1993, Brändstädter et al 1994, Baltes and Carstensen 1996, Renwick and Brown et al 1996, Johnson and Barber 1997, Nilsson et al 1998). Based on a synthesis of these theories (see Nolan et al 2001b for a fuller account) it was concluded that there was an emerging consensus as to what quality of life comprises and that it:

- is a complex concept involving many elements;
- comprises both objective and subjective elements, the relative importance of which vary depending upon personal and cultural values and beliefs;
- is dynamic and changes according to the stage of the life course;
- is ultimately a subjective and individual experience.

Given the then current emphasis on developing services that reflect the wishes of users and carers (DoH 1997, DoH 1998), it was argued that attempts to measure quality of care should pay greater attention to individual values and perceptions.

However, it was also argued that while it is essential to consider what matters for older people and their family carers, a good quality of care is unlikely to be achieved and sustained unless paid carers also enjoy and value their work (Nolan et al 2001b). The literature clearly indicated that ageist attitudes and the devaluing of work with older people are still all too apparent in both health and social care (HAS 2000

1998). Therefore, we proposed that in order to be useful, a framework for promoting quality of life and quality of care for older people must also incorporate staff perceptions and suggest ways that work with older people can be accorded greater status and value.

One such potential framework had been proposed by Nolan (1997) who, concerned about the lack of direction and purpose for work in long-term settings with older people, had identified six **Senses**[1] that he believed might provide a therapeutic rationale for staff and both improve the care that older people received, and the job satisfaction that staff experienced (see Table 1.1). The term Sense was chosen to reflect the subjective and perceptual nature of the important determinants of care for both older people and staff. AGEIN argued that, although in need of further refinement and empirical testing, the Senses Framework might have application beyond long-term care settings and be transferable to a range of care environments (Nolan et al 2002).

Coincidentally, the opportunity to further test and elaborate upon the potential usefulness of the Senses Framework arose independently of, but concurrent with, the AGEIN project. In response to the Not Because they are Old report (HAS 2000 1998), which had identified a series of deficits in the care of older people in acute hospital setting, Help the Aged and the Order of St John's Trust commissioned a team of researchers from the School of Nursing and Midwifery at the University of Sheffield to explore the characteristics of hospital environments in which older people considered that they had received good or excellent care. Once again I was a member of this research team and played a key role in the project, the report of which was called *Dignity on the Ward* (Davies et al 1999).

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[1] The term 'sense' or 'senses' when used to refer to the model developed by Nolan (1997) Page: 16 will generally be presented with a capital letter and no quotation marks (eg Sense) for clarification and ease of reading

Table 1.1: The six Senses as originally conceived by Nolan (1997)

A sense of security	
For older people	Attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort.
For staff	To feel free from physical threat, rebuke or censure. To have secure conditions of employment. To have the emotional demand of work recognised and to work within a supportive culture.
A sense of continuity	
For older people	Recognition and recognition and value of personal biography. Skilful use of knowledge of the past to help contextualise present and future.
For staff	Positive experience of work with older people from an early stage of career, exposure to role models and good environments of care
A sense of belonging	
For older people	Opportunities to form meaningful relationships, to feel part of a community or group as desired.
For staff	To have a sense of therapeutic direction, a clear set of goals to aspire to.
A sense of purpose	
For older people	Opportunities to engage in purposeful activity facilitating the constructive passage of time, to be able to identify and pursue goals and challenges, to exercise discretionary choice.
For staff	To have a sense of therapeutic direction, a clear set of goals to which to aspire.
A sense of fulfilment	
For older people	Opportunities to meet meaningful and valued goals, to feel satisfied with ones efforts.
For staff	To be able to provide good care, to feel satisfied with one's efforts.
A sense of significance	
For older people	To feel recognised and valued as a person of worth, that one's actions and existence is of importance, that you 'matter'.
For staff	To feel that gerontological practice is valued and important, that your work and efforts 'matter'.

(Based on Nolan 1997)

Following a review of the literature and detailed empirical case studies, Davies et al (1999) identified four key principles that appeared to underpin good practice with older people. These were:

- **Valuing fundamental practice** by giving priority to the essential care needs of older people such as help with personal hygiene, nutrition and toileting, and involving senior staff in such direct care delivery.
- **Fostering a stable environment of care** in which staff are nevertheless encouraged to challenge the way that care is delivered.
- **Establishing clear and equitable therapeutic goal(s)** by ensuring that older people have the same access to services as younger people, and that clear goals are established in consultation with older people and family carers. Such goals should be regularly reviewed by all individuals in care delivery.
- **Having an explicit and shared set of values** and an agreed philosophy of care that clearly identifies the standards of care expected for both patients and staff.

In synthesising those factors which shape the experience of care for older people, their family carers and staff, Davies et al (1999) adapted the six Senses, and in applying these to the acute care context they identified how such Senses might be created and sustained. Their suggestions are summarised in Table 1.2, and the dynamic and reciprocal relationships between those factors necessary to promote the Senses and to achieve a positive culture of care for older people in acute care settings are captured in Figure 1.1.

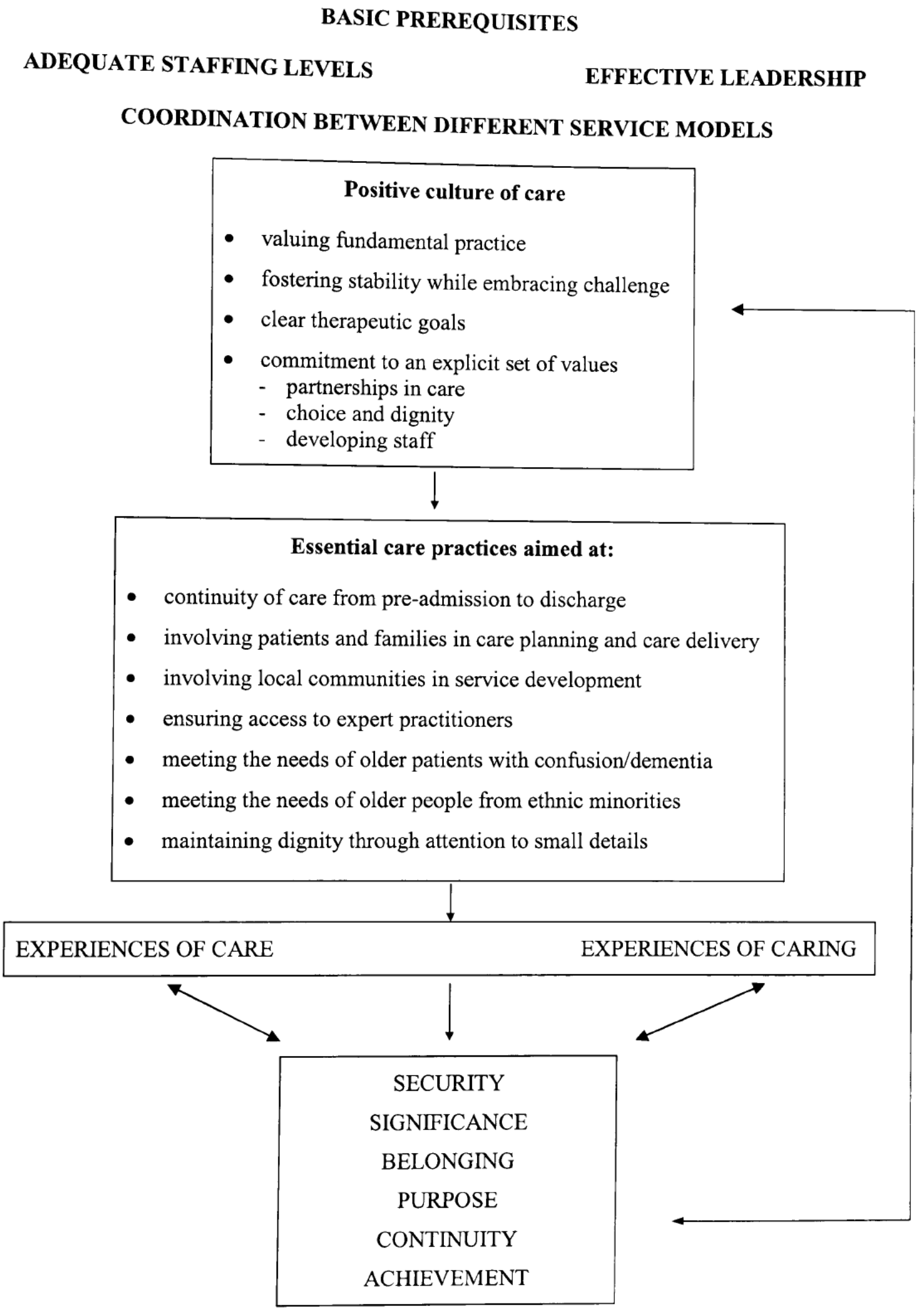
As a result of the extensive empirical data collection from the Dignity project (Davies et al 1999) the potential validity of the Senses Framework in helping to understand the relational dimensions of care for older people had been demonstrated. Moreover, the framework itself had been refined, with a Sense of 'fulfilment' being replaced by a Sense of 'achievement', and some of the factors that might help to create the Senses being identified. The Senses raise a number of questions about the interactions between staff and patients/or carers in health care environments, and an exploration of these interactions formed the substance of the second chapter of the OUP book (Brown et al 2001).

Table 1.2: Examples of factors shaping the experience of care for older people, their families and staff

Factors creating a Sense of	For older people and their families	For staff
	• Access to experts such as medical consultants and clinical nurse specialists • Rapid access to a hospital bed when needed • Support after discharge, eg telephone calls, discharge support	• Experienced staff available for role-modelling and problem-solving • Freedom to challenge poor practice without censure • Known boundaries within which to operate • Having clear and explicit goals
Belonging	• Families encouraged to participate in care as appropriate • Refreshments available for patients and visitors • Recognition of importance of relationships with other patients	• Core team of stable staff • Clear sense of belonging to a team • Strategies for keeping staff informed eg team briefing, computerised information system
Continuity	• Team nursing/named nursing as the system for organising care • Wards having designated therapy staff • Staff taking time to get to know the older person	• Team nursing/named nursing as the system for organising care • Integrated multidisciplinary team documentation – continuity of communication
Purpose	• Regular meetings with staff • Self medication programmes • Being a genuine partner in planning and evaluation of care	• Clear therapeutic rationale for care • Investing resources in effective leadership • All staff encouraged to review practice and suggest improvements
Achievement	• Evaluation carried out with the older person • Feedback • Care plans and progress sheets accessible	• Recognition of effort eg award schemes • Designating additional responsibility eg link nurse role • Being able to give the best possible care
Significance	• Equity of access to medical/therapy care • Being involved in care planning and evaluation eg bedside handover, biographical assessment • Resources invested in making the environment comfortable and attractive	• Investment in personal professional development • Opinions valued and listened to • Adequate equipment to carry out role • Work with older people valued and recognised as important

(From Davies et al 1999)

Figure 1.1: Factors necessary to promote the Senses and to achieve a positive culture of care for older people in acute care settings



(From Davies et al 1999)

The policy review conducted as part of the work described in Chapter 1 of the OUP book (Nolan et al 2001b) noted that empowerment and participation figured prominently in the policy rhetoric and practice literatures, reflecting drives towards developing a quality framework that captured user and carer experiences of health and social care. Moreover, the increasing focus on understanding subjective quality of life from a biographical perspective highlighted the fact that it is essential that service providers in some way know the older person. For this to happen there is a need for a common language, with definitions being shared by both lay people and professionals (McFadyn and Farrington 1997), yet this is rarely the case in professional and lay interactions (Clark 1995, 1996). Consequently, we argued that while person-centred care may be high on the policy agenda, reflecting a new ethos of service which places the individual, and not the provider, at the centre (Williams and Grant 1998), realising such an ethos required a reorientation of professional practice (Clark 1995, 1996, Williams and Grant 1998). Therefore, despite much talk of new cultures of care in diverse areas of practice such as dementia care (Kitwood 1997), rehabilitation (Nolan et al 1997), and long-term care (Henderson and Vesperi 1995), that placed considerable emphasis on relationships (Pincombe et al 1996, Fagermoen 1997, Mulrooney 1997) as being fundamental to high quality care (Fossbinder 1994, Clark 1996, Janes et al 1997, Halldorsdottir 1997, Williams and Grant 1998), the potential tensions that may arise between different cultures – one professional and the other based primarily on lived experience (Cassell 1991, Clark 1996, Williams and Grant 1998) – were not fully articulated. We argued that this required a reconsideration of who is the expert? (Brown et al 2001). We began our review with one of the most complete accounts from the professional literature, that provided by Eraut (1994).

In a detailed analysis of the basis of professional knowledge, Eraut (1994) argues that the essence of professionalism is power based on claims to specialist expertise, and that the more unique the expertise the greater the power. Such power is traditionally based on theoretical and propositional knowledge. However, recently other types of knowledge, variously termed intuition, experiential or tacit knowledge, are increasingly acknowledged and seen by some to be equally important to traditional forms of propositional knowledge, especially in practice disciplines such as teaching, social work, nursing and medicine (Benner 1984,

Schon 1987, Cassell 1991, Thompson 1995). This has led to an often heated debate about the value of experiential knowledge and its relationship to expertise (Dreyfuss and Dreyfuss 1986, Schon 1987, Benner and Wrübel 1989). Such debates have also served to promote greater recognition of lay expertise by:

- challenging the belief that professional expertise is inherently superior;
- highlighting the need, even in medicine, to complement science, that part of practice to do with managing the disease, with art or those elements of practice to do with caring for a patient as an individual (Cassell 1991);
- legitimising lay individuals' claims to possess a different but equally important form of expertise (Nolan 1996).

This latter point in particular suggests the need for a considerable reorientation of professional practice and education, which currently provides little incentive to take account of lay knowledge (Kleinmann 1995). Indeed, some go as far as to suggest that the goal should be for **professional involvement** in **patient decision-making** rather than **patient involvement** in **professional decision-making** (Tuckett et al 1985). This has clear implications for a project such as AGEIN and its search for a framework to guide both education and practice. We therefore argued that there was a need for a more sophisticated understanding of the types of knowledge and experience held by older people and their carers (Brown et al 2001). The literature on chronic illness provided some potentially important insights.

From the accounts of individual experiences of chronic illness/disability three themes emerge which, although distinct, share a degree of overlap suggesting an interactive and dynamic relationship between the 'existential, biographical, and temporal' dimensions of illness/disability (Nolan et al 1997). From an existential perspective loss of self has long been recognised as one of the most devastating effects of illness and disability (Blaxter 1976, Bury 1982, Charmaz 1983, Corbin and Strauss 1988, Robinson 1988, Corbin and Strauss 1991, Beckmann and Ditlev 1992, Carricaburu and Pierret 1995), and reconstructing a new and equally valued identity is one of the key tasks in adapting to chronic illness (Charmaz 1983, 1987, Robinson 1988). However, there is relatively little acknowledgement of such

existential factors in the professional literature, as professionals tend to thrive on 'dramatic results' (Barnard 1995), and their educational preparation often overlooks the need to develop skills such as 'empathetic witnessing' that help people transcend illness to restore a sense of leading a valuable life (Gerhardt 1990, Milz 1992, Marris 1996).

Two complementary concepts, also necessary for a more complete understanding of illness or disability from a personal perspective, are biography and temporality (Nolan et al 1997). Reconstructing a sense of 'I' (Beckmann and Ditlev 1992, Peters 1995) is not possible without reference to both the past and also to a number of potential futures (Gerhardt 1990). One of the most significant effects of chronic illness is that it separates the past from the present, and the present from the future, thereby making biography discontinuous (Corbin and Strauss 1988). Biography in this context serves to unite the existential and the temporal dimensions of illness and disability. We argued that there is a clear overlap between many of the ideas in the literatures on chronic illness and disability, and on ageing, particularly the importance of understanding subjective meanings from a temporal or biographical perspective (Brown et al 2001). This reinforces the need to 'know the person' if the policy rhetoric of person-centred care is to become a reality.

'Knowing the person'

In considering the rationale for interventions with frail older people, Kivnick and Murray (1997) contend that there is a need for a more holistic focus that enables older people to contribute more actively, so that the interactions between older people and professionals are based on 'interpersonal mutuality'. Others similarly contend that person-centred care requires knowledge of people as individuals (Williams and Grant 1998). Mulrooney (1997) usefully extends the criteria for person-centred care and identifies three attributes:

- Respect for personhood
- Valuing interdependence
- Investing in caregiving as a choice

We contended that these dimensions capture the dynamic and reciprocal nature of person-centred care, and mandate a reconsideration of the place of such concepts in the preparation and practice of professionals, especially nurses (Brown et al 2001). At the time of the review probably the most detailed consideration of person-centred care was to be found in the nursing literature (Fossbinder 1994, Benner and Gordon 1996, Benner et al 1996, Tanner et al 1996, Halldorsdottir 1997, Janes et al 1997, Liaschenko 1997). However, Liaschenko (1997) argues that most of these authors focus on knowing the patient rather than the person, and adopt a largely biomedical perspective in which the goal of knowing the patient is mainly to understand their response to illness. While recognising the usefulness of such knowledge, Liaschenko (1997) believes that other forms of knowledge are required, especially in longer-term health care relationships. She identifies three broad types of knowledge that she contends can inform health care practice:

- **Case knowledge** – biomedical knowledge of a particular condition, such as stroke.
- **Patient knowledge** – information about a person's social circumstances, level of support, etc. to provide a better understanding of the impact of their condition.
- **Person knowledge** – based on understanding 'biographical life' which includes the capacity to instigate meaningful action, understand individual patterns of life, and appreciate how the individual relates to their physical, social and political environments so as to create a sense of belonging somewhere.

Liaschenko (1997) argues that patient knowledge and person knowledge are different, and that for nurses person knowledge, while not appropriate in all contexts, is often essential to promoting and maintaining individual integrity. However, she also believes that such knowledge is often not valued in professional practice. Consequently, it does not figure in the educational preparation of practitioners, which still focuses predominantly on the technical aspects of care delivery.

Affirming the value of 'person knowledge'

Halldorsdottir (1997) contends that there is a separation in health care practice between **competence** – the delivery of complex technical care given by professionals, and **caring** – an affective process often seen to be the domain of people other than professionals. For care to improve she argues that competence must be combined with caring. This requires a model of competence that goes beyond the delivery of excellent technical care, to one which is based on a sophisticated understanding of the skills required for a person-centred approach. In order to implement such a model practitioners require interpersonal competence, which Fossbinder (1994) summarises as comprising:

- Translating – informing, explaining, introducing, teaching
- Getting to know you – personal sharing, humour, being friendly
- Establishing trust – creating confidence in ability to provide competent care
- Being in charge – knowing what to do
- Anticipating need
- Following through – delivering care as promised
- Enjoying the job
- Going the extra mile.

(after Fossbinder 1994)

However, extensive analysis of nursing curricula conducted just prior to AGEIN had suggested that such aspects rarely figured prominently in courses at either pre-registration or post-registration levels (Davies et al 1997, Nolan et al 1997). It was therefore argued that on the basis of the literature review for AGEIN and the Dignity project (Davies et al 1999) that the Senses Framework might offer a potential means of ensuring greater attention to these important areas (Nolan et al 2001b).

The generic reviews relating both to quality of life and the differing forms of knowledge that potentially inform health and social care had reinforced the importance of subjective and perceptual dimensions, highlighting the centrality of relationships to the delivery of high quality care. On this basis we argued that the

Senses Framework had the potential to unite differing strands in the extant literature. The six specific reviews on: acute/rehabilitative care (Nolan M 2001); community care (Nolan J 2001); continuing care (Davies 2001), care of older people with mental health problems (Ferguson and Keady 2001); care of older people with learning disabilities (Grant 2001); and palliative and end of life care for older people (Seymour and Hanson 2001) further reinforced such conclusions. Consequently, the final chapter of the book entitled 'Integrating perspectives' sought to consolidate the major themes emerging from the review (Nolan et al 2001c).

Integrating Perspectives

On the basis of the eight reviews, Nolan et al (2001c) argued that if the current situation was to improve then there was a need to appreciate that:

- Good care should reflect the perspectives of all the stakeholders involved, so that the views of no one group are privileged. As Brechin (1998) notes, care is centred round interpersonal relationships which impact on the identity and sense of self of everyone involved. Good care should therefore reinforce rather than detract from personal identity (Coyle 1999, Kendig and Brooke 1999). This is as true for those giving care as for those receiving it, whether they are family or professional carers.

- There is a pressing need to articulate more clearly how care work (Davies and Nolan 1998) can be made more satisfying and rewarding, particularly in continuing care environments and increasingly in the community. As Grant (2001) highlights, care outcomes are enhanced where there is a development-orientated attitude among care staff, with Davies (2001) vividly describing the need to consider how older people, staff and family carers can work together to improve quality of life, quality of care, and job satisfaction.

- Good care means recognising and valuing differing forms of expertise so that none is privileged above another. Professional carers must therefore value the expertise that older people and family carers possess, but this does not mean

devaluing the central role of the 'outsider' expert. It must be appreciated therefore that an empowered client or carer is potentially very threatening to professional carers (Brown et al 2001).

- Treatment without care is poor and often ineffective (Fitzgerald 1999) and the importance of combining proficient technical care, considerate fundamental care, and good interpersonal care were consistent themes throughout the reviews. In combination these elements can elevate safe care to good or even excellent care (Davies et al 1999), and it is such care that is highly regarded by older people and their family carers. However, to provide good care the recipient has in some way to matter and there is a need to 'value the person in the present with all their disabilities and restrictions' (Adams 1998). Equally important is that both the care given and the caregiver are valued and seen to matter (Adams 1998, Davies and Nolan 1998).

We therefore argued that, without imposing it on the study, the Senses Framework would be useful in identifying the type of 'foreshadowed questions' (Rodwell 1998) that would inform the empirical element of the AGEIN project. Having provided a brief overview of the conclusions of the conceptual phase of the project, attention now turns to the extensive component.

Overview of the Extensive Component of the AGEIN Project

As described earlier, the empirical elements of the AGEIN project comprised both an intensive and an extensive phase. The case study component of the intensive phase is described within this thesis, but in order to fully understand these case studies it is necessary to have an appreciation of the extensive surveys that were conducted. These are briefly described here, beginning with a rationale for the surveys and what they were intended to achieve.

As previously described, the literature synthesis had identified a definition of person-centred care provided by Mulrooney (1997), that comprised three elements:

- Respect for personhood (in this case older people)

- Valuing interdependence (such interdependence was, we argued, potentially captured by the Senses Framework)
- Investing in caregiving as a choice

In the conclusion to the reviews (Nolan et al 2001c) it was suggested that the Senses Framework might help to unite the views of older people, their carers and service providers. Early empirical testing of the Senses Framework in the Dignity on the Ward project (Davies et al 1999) highlighted concrete ways of creating a Sense of security, belonging, continuity, purpose, achievement and significance, for older people and health care professionals. On the basis of the extensive reviews undertaken for the conceptual phase of the AGEIN project, Nolan et al (2001c) argued that there was substantial convergence between the Senses Framework and both the existing theoretical literature and policy/empirical studies. This was summarised in the form of a table reproduced here as Table 1.3. Moreover, the original Senses Framework was expanded to include family carers, as well as older people and paid carers (see Table 1.4).

One goal of the AGEIN project was therefore to consider the extent to which there was empirical support for the Senses Framework in respect of student nurses. This comprises one of the major goals of this thesis.

Another major goal of AGEIN was to explore how students develop their predispositions to work with older people. This was considered especially important in the light of Mulrooney's (1997) conclusion that a prerequisite of quality caregiving is that professional carers (in this case nurses) actively choose to work with older people (Mulrooney 1997). However, as early as 1969 Delora and Moses described how unfavourably 'geriatrics' was viewed in comparison to other nursing specialities. Many subsequent studies have demonstrated the general reluctance of nurses to specialise in working with older people (Campbell 1971, Hooper 1979, Robb 1979, Tagliareni and Boring 1988), therefore the goal of the extensive survey component of AGEIN was to explore students' views and experiences of older people using a large sample.

Table 1.3: Theoretical and empirical support for the Senses

	Theoretical Frameworks					Service Delivery			
	Chapter 1	**Chapter 1**	**Chapter 1**	**Chapter 2**	**Chapter 3**	**Chapter 3**	**Chapter 4**	**Chapter 5**	**Chapter 5**
		Nilsson et al 1998	Renwick and Brown 1996a	Liaschenko 1996	Redfern and Norman 1999	Davies et al 1999	Easterbrook 1999, Farrell et al 1999	Bowsher 1994	Davies 2001
Security	Comfort (Physical well being)			Space	Keep promises; trust/confidence; monitor care.	Visibility of staff. Access to experts as needed.	Confidence in staff, competent and safe care		Reduce vulnerability/ powerlessness
Belonging	Affection (Social well being)	Personal relationships	Belonging	Space	Homely ward atmosphere. Use of affection and humour.	Recognise important relationships with other patients. Treated as family.	Person-centred care delivered by person-centred workers. Focus on interpersonal relationships.	Develop/ maintain positive social networks/ climates	Create a sense of community
Continuity		Positive links between past and present	Being	Temporality	Maintenance of important routines. Continuity of care.	Named/team nursing. Post-discharge follow up.	Single point of contact. Continuity of carer. Integrated services. Understanding of life history.	Generate interesting stories about lives	Maintain links with family/ community
Purpose	Stimulation (Physical well being)	Activity	Becoming	Agency	Provide activity to reduce boredom	Mutually agreed goals.	Clarity of goals and purpose	Develop competencies	Shared activities to create a community
Achievement	Behavioural confirmation (Social well being)	Activity	Becoming	Agency	Opportunities to achieve goals	Regular feedback on progress, being included in review.	Involve older people	Attain important/ valued goals	Maintain identity
Significance	Status (Social well being)	Strong personal beliefs	Being – psychological and spiritual identity		Reinforce identity and personhood	Equity of access to care. Fully involved in care.	Listen to expertise and voice. Value older people.	Experience satisfaction and positive affect	Maintain identity

(Nolan et al 2001c, p174)

Table 1.4: The six Senses in the context of caring relationships

A Sense of security

- For older people: Attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort. To receive competent and sensitive care.
- For staff: To feel free from physical threat, rebuke or censure. To have secure conditions of employment. To have the emotional demands of work recognised and to work within a supportive but challenging culture.
- For family carers: To feel confident in knowledge and ability to provide good care (To do caring well – Schumacher et al 1998) without detriment to personal well being. To have adequate support networks and timely help when required. To be able to relinquish care when appropriate.

A Sense of continuity

- For older people: Recognition and value of personal biography; Skilful use of knowledge of the past to help contextualise present and future. Seamless, consistent care delivered within an established relationship by known people.
- For staff: Positive experience of work with older people from an early stage of career, exposure to good role models and environments of care. Expectations and standards of care communicated clearly and consistently.
- For family carers: To maintain shared pleasures/pursuits with the care recipient. To be able to provide competent standards of care, whether delivered by self or others, to ensure that personal standards of care are maintained by others, to maintain involvement in care across care environments as desired/appropriate.

A Sense of belonging

- For older people: Opportunities to maintain and/or form meaningful and reciprocal relationships, to feel part of a community or group as desired.
- For staff: To feel part of a team with a recognised and valued contribution, to belong to a peer group, a community of gerontological practitioners.
- For family carers: To be able to maintain/improve valued relationships, to be able to confide in trusted individuals to feel that you're not in this alone.

A Sense of purpose

- For older people: Opportunities to engage in purposeful activity facilitating the constructive passage of time, to be able to identify and pursue goals and challenges, to exercise discretionary choice.
- For staff: To have a sense of therapeutic direction, a clear set of goals to which to aspire.
- For family carers: To maintain the dignity and integrity, well being and personhood of the care recipient, to pursue (re)constructive/reciprocal care (Nolan and Caldrock 1996).

A Sense of achievement

- For older people: Opportunities to meet meaningful and valued goals, to feel satisfied with ones efforts, to make a recognised and valued contribution, to make progress towards therapeutic goals as appropriate.
- For staff: To be able to provide good care, to feel satisfied with ones efforts, to contribute towards therapeutic goals as appropriate, to use skills and ability to the full.
- For family carers: To feel that you have provided the best possible care, to know you've done your best, to meet challenges successfully, to develop new skills and abilities.

A Sense of significance

- For older people: To feel recognised and valued as a person of worth, that one's actions and existence are of importance, that you matter.
- For staff: To feel that gerontological practice is valued and important, that your work and efforts matter.
- For family carers: To feel that one's caring efforts are valued and appreciated, to experience an enhanced sense of self.

(Developed from Nolan 1997, 2001 and Davies et al 1999)

This survey was designed and undertaken concurrently with the early stages of the intensive phase (see Chapter 3), and data generated here informed the content of the questionnaires used in the survey. The AGEIN project adopted an emergent design in which students played a critical role in co-constructing the results (see Chapter 2 for a detailed description). Concurrent with the literature reviews described above, ongoing early focus groups with student nurses (in the intensive phase of the study) were beginning to generate ideas that would inform a national survey of students, as well as providing a direction for the more detailed intensive phase (see Chapters 3 and 4 for details). Analysis of these early data suggested that it was the nature of the students' practice placements, rather than their educational experience in the school of nursing, that was most influential in informing their views of work with older people. The surveys were designed to explore these early qualitative results using a much larger sample.

National surveys were therefore undertaken with both students and qualified nurses, with two primary aims: firstly, to provide insights into the knowledge of older people held by student nurses and qualified staff, and secondly, to explore the influences that might predispose them to seek, or not to seek, work with older people as a career move.

The questionnaire therefore comprised two new instruments. The first, a knowledge quiz (see Appendix III), tapped into the knowledge that nurses possess about the circumstances of older people. This was developed using up-to-date facts about the situation of older people in the UK taken from two primary sources: The Age File 99 (Leather 1999), and the Health Education Authority Fact Sheet 1: Older People in the Population (Health Education Authority 1998). The quiz contained items relating to the demographic profile of older people, their living circumstances, their employment and expenditure, their need for help, support and use of services. Details of the results of this questionnaire are not provided here, but can be found in Nolan et al (2002).

The second instrument: the perceptions quiz (see Appendix IV for a copy of the quiz and Nolan et al 2002 for further details) was developed from data obtained during the early focus groups undertaken by myself with student nurses at the four case

study schools of nursing (see Chapter 3). This quiz explored students' and qualified staffs' perceptions of working with older people (as opposed simply to their attitudes towards older people) in three broad areas: working with older people in general; the respondents' intentions to work with older people; and the perceived consequences of working with older people either in terms of future career prospects or job satisfaction. Items were modified as appropriate for students and qualified staff.

In addition to the above two instruments, the questionnaire for students contained sections exploring their experiences of working with older people prior to starting their training and whether they still worked with older people outside of their training programme. Students were asked to provide details of the type of work that they had undertaken and whether they found this a positive or negative experience. The questionnaires also contained space for further comment and a range of demographic and other data including age, gender and ethnicity, as well as qualifications and branch of nursing. Two separate surveys, one for students and one for qualified staff, were carried out. Only the results from the student sample are presented here.

In order to capture key transition points during training, data collection focused on two groups of students, those starting their 'common foundation programme' (CFP) and those at the point of transfer to their chosen branch (18 months into the three year course). In this way data were collected from 718 students across four sites (for a detailed account of sampling and overall results in relation to groups other than student nurses see Nolan et al 2002). Overviews of the findings from the student surveys drawing on both quantitative and qualitative data are presented below.

Findings from surveys of student nurses: students' perceptions of work with older people

Before considering the ways in which students perceive work with older people, it is important briefly to describe the nature of the sample. The main demographic details are given in Table 1.5 and, as can be seen, the students constituted a diverse group. All of these variables provide important contextual data; however, what is probably most interesting in the present context is the number of students who had

prior experience of work with older people before starting their training; 63% of respondents had worked with older people in some formal context, and almost all (94%) had some contact, such as caring for a family member (one in three) to voluntary or school experience. The potential influence of this prior contact on students' attitudes to working with older people is particularly important in the context of this thesis, and is considered later.

As noted above, students' perceptions of working with older people were explored in three broad areas: work with older people in general; personal disposition to work with older people; and perceived consequences of working with older people. The results are presented below.

Work with older people in general

Students' general perceptions of work with older people painted a very positive overall picture. For example, 8 out of 10 students (82%) disagreed that nursing older people comprises only basic care and does not require much skill. Similarly, the majority of respondents considered that nursing older people was interesting (69%) and provided a challenge (64%). There was virtually no agreement with the statement that nurses' work with older people because they cannot cope with hi-tech care (5%).

Overall these responses suggest that the students in the sample were generally favourably disposed towards work with older people. However, relatively large percentages were undecided whether: older people would be interesting to nurse (22%); such work would challenging or be stimulating (25%); or if nursing older people required high levels of skill (31%). These data suggest two immediate challenges for educational programmes. One is to maintain the positive disposition towards work with older people displayed by the majority of students, and the other is to convince those that are undecided that working with older people can indeed be interesting, challenging, stimulating and skilful. The factors which influence this were explored in detail in the case studies (see Chapters 3 and 4). However, as will be highlighted shortly, both prior and current experience of caring for older people exerted a considerable influence.

Table 1.5: Sample characteristics of student nurse respondents to the AGEIN questionnaire (n=718)

Gender	%	Ethnic Origin	%	Age	%
Female	83	White	82	Under 30	59
Male	17	Black	12	30-39	28
		Asian	3	40+	13
		Other	3		

Branch	%	Qualifications – highest level	%
Adult	61	NVQ/Access course	22
Child	8	'O' level/GCSE	21
Learning disability	5	'A' level	25
Mental health	25	City & Guild/HNC	4
		Diploma	12
		Degree	9
		Higher Degree	1
		Other	7

Work experience with older people (not mutually exclusive)	%	Other experience of older people	%
Residential/nursing home	42	Caring for family member	36
Hospital	31	Voluntary work	15
In older peoples homes	19	School experience	14
Day centre	9	No experience	6
Other work environments	16	Percentage currently working with older people	34
Percentage with some prior work experience	63		

Personal disposition to work with older people

The positive tone of the first broad set of perceptions was further reinforced in the remainder of the data. However, once again many of the students were undecided. For instance, only 17% stated that working with older people did not appeal to them at all and 4 out of 10 (40%) would definitely consider working with older people when they qualified. However, nearly a quarter (23%) were undecided as to the appeal of working with older people and a third (34%) did not know if they would consider such work upon qualification. Although the latter figure might be anticipated, as for many respondents it would be too early to decide if they wanted to work in any particular field, the fact that a quarter of the sample were not sure of the appeal of nursing older people does suggests that there is much that could be done to make this area of work more attractive. The data also highlight the importance of careful preparation for placements; with there being quite high levels of anticipatory anxiety in evidence, with 1 in 6 students confessing to high levels of anxiety about placements with older people. Furthermore, 4 out of 10 of the respondents (39%) were either uncertain about, or were sure that, they were **not** looking forward to their first placement with older people. Again, as will become clear, such data are particularly important given the influence of the practice placement on students' feelings about work with older people.

Perceived consequences of working with older people

The final set of questions on the perceptions quiz were all broadly concerned with the possible future consequences of working with older people, such as the impact on careers, job satisfaction and the perceived status of gerontological nursing. Consistent with the previous section, the overall impression was that respondents viewed work with older people in a largely favourable light. The impact on future career prospects was seen as limited (only 4% thought that working with older people was a dead-end job, only 6% thought that it was not a good career move, and only 10% felt that once you work with older people it would be difficult to get a job elsewhere). Eight out of 10 respondents disagreed that it is difficult to gain satisfaction from working with older people. However, the one area of the questionnaire that suggested an important factor militating against work with older

people was its perceived status. Only 12% of students thought that work in this area had a high status, half felt that it did not (49%) and 4 out of 10 (38%) were uncertain.

Overall, the above data suggested that the student nurses in the sample did not have negative predispositions towards work with older people. However, the data, both quantitative and qualitative, from the remainder of the questionnaire highlighted the pervasive influence of students' experience of caring for older people.

Exploring the influence of a positive or negative experience of working with older people

A number of telling insights about the way that students perceive work with older people emerged from both the quantitative and qualitative data, with both reinforcing the importance of the students' prior and current experience of work with older people and their exposure to what we termed **impoverished environments**. The quantitative data gave a clear indication of the influence of positive experiences of work with older people and the qualitative data elaborated upon the type of experiences that expose students to impoverished environments.

From the quantitative data it emerged that:

- Those students who have had positive prior or current experience of working with older people were far more likely to see such work as interesting (79% vs 33%, $p < .00000$) and challenging/stimulating (73% vs 33%, $p < .001$).

- This positive view was also apparent when predispositions to work with older people were considered. Students who saw their experience of work with older people as positive were far more likely to consider working with older people when they qualified (49% vs 10%, $p < .00000$) and to look forward to their first placement (50% vs 15%, $p < .00000$), and were far less likely to agree that work with older people did not appeal to them (8% vs 58%, $P < .00000$).

- This trend continued when the perceived impact of work with older people was addressed, with those students having a positive experience being far less likely to agree that it is difficult to get a job elsewhere once you have worked with older people (7% vs 28%, $p < .0005$) and also far more likely to disagree that work with older people is a dead-end job (89% vs 63%, $p < .00000$) (Nolan et al 2002).

In the context of the AGEIN project these results can be seen as encouraging, but they also pose a number of challenges. If students enter the profession fairly inclined, or at least not in large numbers, disinclined, to work with older people it is essential that their training reinforces these perceptions and also persuades those students who are undecided that gerontological nursing is indeed a potentially challenging, skilful and rewarding area of practice. This suggests that placements should be carefully planned with this in mind. A critical variable, however, is likely to be the perceived status of the work. Having identified some key messages from the quantitative data, attention is now turned to the important elements of the qualitative comments made in the questionnaire.

Hearing the students' voices: messages from the qualitative data in the student surveys

Sixty percent of students added further comments to the questionnaire, and these were often extensive. These data were subject to a detailed content analysis that identified a number of themes, providing valuable insights and adding a further layer of interpretation to the quantitative analysis (see Nolan et al 2002 for a full account). Despite their disparate nature, one issue served to link the themes and to reinforce the impression from the quantitative analysis; that is, whether or not students wished to work with older people, their views of older people themselves were on the whole very positive. However, what was particularly relevant in the present context was that, notwithstanding these largely positive attitudes, the experiences students had when working with older people, whether prior or current, often either put them off work in the area when they qualified, or created doubts in their minds. As will be illustrated, the tensions resulting from these dilemmas were frequently borne out of concern about the standards of care that students witnessed older people receiving.

This highlights the fact that the type and range of experiences to which students are exposed, whether as part of their studies or not, may erode the positive perceptions of older people apparent in the quantitative data.

However, it is important to recognise at the outset that some respondents had no desire to work with older people. This was not necessarily because of negative views or experiences, but simply because other areas of work are more appealing. This was reflected in two themes from the qualitative data: **not for me** and **pastures new**.

Not for me

The title of this theme is largely self-explanatory, indicating that for certain students work with older people simply was not for them. This was unrelated to negative predispositions towards older people themselves but rather reflected students' desire to work in other areas. Many of the respondents providing such responses were studying towards a qualification in children's nursing and as such had, de facto, demonstrated their preferred area of practice.

Pastures new

As noted above, one striking feature of the data was the large numbers of students who had worked with older people previously (63%), many for several (10+) years. While such individuals usually indicated that they had enjoyed this experience, indeed for many it had provided the motivation to commence their training, some clearly felt that a change of scene was in order. Therefore upon qualification they intended to expand their horizons and work with other clients, thereby moving to pastures new.

For both of the above groups neither the academic component of the course nor their experiences in the clinical environment would be likely to influence their future career trajectory. On the other hand, some respondents did not wish to work with older people because they could see no obvious source of job satisfaction or reward, or because they thought that the work would be difficult or depressing:

> *I did not look forward to my first placement working with older adults, however, once there I enjoyed it and became fond of my patients. However, it is not an area I would like to go into – not because it is not challenging or stimulating, but because I find it a bit depressing. Three patients died in a month and I don't think I would like to be in that environment. I like to be more focused on people getting better. That is not to say that a great deal of satisfaction can't be gained from nursing people at the end of their life as I feel it could be very rewarding. I do not think it is for me.*

However, despite their reservations, none of these respondents had as yet entirely ruled out working with older people when they qualified. As these individuals were as yet 'uncertain' of their future careers, this provides opportunities to 'turn around' their views. As will be demonstrated shortly, the key to this would appear to be the degree to which work with older people can be perceived of as rewarding, rather than 'hard' or 'depressing'.

As noted above, for a variety of reasons some respondents had determined that working with older people was not a future career option. However, even amongst those who had decided that they definitely wanted to work with older people, such work was still perceived as 'hard':

> *I enjoy talking to older people, reminiscence, and the feeling of job satisfaction in being able to build a caring relationship and caring for them in the time before they die. Emotional and draining at times, but I really love the work.*

The pivotal point seems to be whether it is possible for students to perceive work with older people as 'hard but rewarding' or simply 'hard'. That is, students who could conceive of some purpose or satisfaction from what they did either in terms of making a difference to the lives of older people, or in terms of personal satisfaction, or both, were far more inclined to want to pursue a career in the field. Those who could not create such an image had already determined that such work was 'not for me':

> *Before commencing my placements* [with older people] *I tried to approach the experience from a non-judgemental and objective point of view. However, ... I find nursing the aged degrading in terms of*

having to clean them. I find the conversation with them unstimulating and not challenging. You can argue as much as you like in terms of ethics and caring issues – I did not come into this profession for this side of nursing.

[Older people] *were bored, frustrated, unstimulated so all they could do was moan. I hated, and still do, the thought that I may end up like that, so it is better that I do not work with them as I get very negative and down.*

... I also find that many elderly people don't have quality to their lives and therefore find this upsetting and feel that although I'm helping them, really I'm just prolonging their 'quality-less' life.

As the above quotations illustrate, the use of words such as 'heavy demanding work', 'depressing', 'degrading', 'bored', 'frustrating', 'unstimulating', 'not challenging' convey a very negative perception of working with older people. What is perhaps most telling of all is the idea of a 'quality-less' life and the absence of 'any form of life apart from sleeping and sitting in a chair'. It would seem that for students a great deal turns on the belief, or otherwise, that they can have some kind of positive impact. That is, at the end of the day, is it 'worth it'? This was succinctly captured in the following quote:

The work is often very labour intensive and often unpleasant. Sometimes 'it's worth it' when you've made a difference to someone's life. Sometimes it's a thankless task with no element of gratitude or achievement.

The contrast between the above views and those that follow could not be starker, and illustrates the often diametrically opposed sentiments relating to work with older people that emerged from the survey. Those who had already had a positive experience of working with older people, or could conceive of it as stimulating and rewarding, provided a much more optimistic view:

I have enjoyed working with older people in the past and have found it quite rewarding. I would consider working with older people when I can really make a difference to the care this age group receive.

Quite clearly the idea of being able to make a difference is an important one and the following comments illustrate that this often hinges on small but subtle factors.

Moreover, it seems that some respondents were able to relate to older people, even those with a degree of cognitive frailty, on an interpersonal level. Consequently, their relationship was not seen as one-sided but rather reciprocal, with both gaining from the interaction:

> *Working with older people is a challenging experience regardless of their illness or state of mind. I have worked with this client group for some time* [6 years] *and have nursed elderly people on both sides of the scale, ie people who are just physically or mentally ill and those who are less fortunate like people with Alzheimer's disease and those who have other problems. I feel you can learn a great deal with taking time out and talking to people, trying to empathise and understand what it is like to be in that position, looking for a way forward for that particular individual and promote them to live their life to the best of their potential, with either help, advice or regular interventions.*

The positive and reciprocal relationships that are reflected in these sentiments provide evidence that many students can, and do, find work with older people rewarding and stimulating, and this stands in marked contrast to the perception of the work as 'boring', 'depressing', 'unstimulating' and so on. However, even amongst these students there was an awareness that the 'system' did not always promote the sort of care that they saw as important, and therefore vigilance was needed to ensure that standards were maintained:

> *The elderly have so much to offer in terms of wisdom and life experience. I enjoy their sense of humour and stoicism. I find it easy to become close to the elderly and hold them in genuine affection and respect. As a student RMN* [registered mental health nurse] *I have found that much elderly psychiatric inpatient care tends to be physically focussed and task orientated. From personal reading I found Kitwood's approaches fresh and innovative and hope to bring some of this enthusiasm to future practice.*

The discussion so far has focused mainly on two distinct groups: those students who had made their minds up that work with older people was 'not for me', and at the opposite end of the spectrum those who, at this point in their training at least, held the converse view. However, many respondents sat somewhere in between these extremes and still had an open mind about where their future might lie. Therefore, one of the challenges for the providers of education is to ensure that the educational

experience to which students are exposed builds on and sustains the enthusiasm amongst those who see a future in working with older people and wins the hearts and minds of those who are still uncertain. In other words, how is it possible to overcome prejudice, boredom, fear and create instead a view that this is a field in which it is indeed possible to make a difference. Although the data from the survey do not provide any definitive answers, they nevertheless give some potentially telling insights. These were encapsulated in a number of key themes discussed below:

- Ageism is alive and well
- In my experience
- Impoverished environments

Ageism is alive and well

Broadly speaking the students identified ageism as operating at three levels, the first two explicit and the third more implicit. At the most general level many respondents commented on the ageist attitudes of society at large:

> *I think that British society undervalues the elderly in a way that is unacceptable. I hope that my mind does not change when I go out into practice. At the moment I am fascinated about the problems related to an ageing society and would be very happy to be a part of the continuing care of older people.*

> *I think a lot of people have misconceptions about elderly people, seeing them all as being disabled or stupid; they are less valued by society. Most elderly people have a good quality of life, good pensions, holidays, go out socially, but this is seldom acknowledged.*

The above sentiments indicate a high level of awareness and a quite subtle appreciation of the ways in which society undervalues older people. However, this did not seem to have prejudiced such respondents against work in the area, in fact quite the contrary. On the other hand, it seemed that a decision to work in the field could be influenced one way or the other by the experience to which students were exposed. The following quotes are therefore a cause for concern

for they indicate that students often see ageism manifest both in the care that older people receive and in the way in which gerontological nursing is viewed within the profession itself:

> *Older people are very undervalued both in society and in the medical profession. There are older people who need more care than others but that doesn't mean they should be any less valued. Personally I feel that the majority of older people have a lot to offer, both socially and personally, and I would be more than willing to work with older people and would definitely heed advice given by an older person, as I have already done in many situations. Just because someone is over 65 doesn't mean they should be written off at the first signs of ageing or illness, or disregarded for treatment.*

The very positive attitudes towards work with older people captured in these sentiments are encouraging, but conversely other respondents suggested that, notwithstanding their own regard for older people, this was not always reflected either in the care that older people received from others, or in the value and status accorded to gerontological nursing:

> *I have noticed a lack of recently qualified staff working with older people. Many of the staff seem to have been around the block for many years and have ended up working with older people because they do not have a relevant, recent education to work with younger people, and many believe that nursing older people requires basic care with no skill.*

> *I feel that due to the nature of many profit-making nursing homes and care homes the standard of care is often poor and that this attitude filters down from the management and therefore attracts poor quality staff. Any nursing can be interesting if it is carried out well. However, standards when caring for the elderly appear to be lower, this doesn't attract fresh blood.*

From the two comments above it is quite clear that many respondents were aware of the difficulties of attracting staff to work with older people, and that despite their own positive attitudes this was a factor that might ultimately influence their own career decisions:

> *Many have commented that working with older people is job suicide and I have noticed that there does not seem to be the same job*

opportunities. However, from recent placements it has been noted that things appear to be improving with the development of areas such as memory clinics and the introduction of admin nurses. However, until the situation improves to a level where opportunities with older people are the same as working within the general adult population, it is still very off-putting

I have worked with older people during placements as a student nurse. I found working with older people interesting and quite rewarding but am very aware that nurses who work with the elderly are given less status than those working in other areas. I have also been informed that there aren't the promotion opportunities in elderly care that there are in other areas, as staff turnover in elderly care is apparently very low – which means it would not offer a student nurse about to qualify good career prospects. Saying that though, I do enjoy working with the elderly and would not rule it out as a career in the future – after probably working in other areas.

It is interesting to note that comments such as these further reinforce the role and influence of the students' own experience in shaping their predispositions to work with older people. All of the data considered so far point to a high level of awareness among students of the manifestations of ageism, but despite this most continued to value work with older people. As noted earlier, many respondents had previous experience of such work, and it was quite clear that these experiences were important influences. For those with less experience, or individuals who had previous negative experience of older people, the data also suggested that a positive placement could do much to reverse such feelings. Conversely, a negative placement could have the opposite effect. This is captured in the theme 'in my experience'.

In my experience

As noted above, this theme is concerned with the effects, positive or negative, of students working with older people during their training. Once again the data below provide telling insights into the importance of a positive placement experience. The first comment is from a respondent who, according to the more structured section of the questionnaire, was definitely not looking forward to her first placement with older people. However, a positive experience had transformed her perceptions so that she subsequently strongly agreed that nursing older people was stimulating and

challenging, was a highly skilled job, and that older people were really interesting to nurse:

> *Originally I had very negative thoughts about working with older people but after a recent placement on an older adult ward for three months it I changed my view totally. In fact it is an area I am considering pursuing when I qualify. I found it a stimulating challenge and I really enjoyed my time there.*

Similar transformative experiences are reflected below:

> *I must admit when I started my job 3 years ago I was very nervous and didn't know how I would handle working with older clients, as I always had a very low rapport with them, but this has changed a great deal – I love it.*

> *Although I was not looking forward to working on an elderly mental health ward I found the placement very interesting, extremely rewarding, and one of the best learning experiences of my training so far.*

However, not all experiences were so positive, and whilst for some students this did not necessarily 'put them off' working in the area, for others it had precisely this effect:

> *Prior to commencing the Dip HE in Nursing I thoroughly enjoyed working with the elderly. However, ... I do not wish to work with the elderly when I qualify because of the poor practice in health care settings I have experienced throughout my practical placements.*

> *My negative experience was based on my placement on a ward, which was like going back to the turn of the century. The placement gave me a very negative picture of working with the elderly, due to the way the ward was run, the attitudes of the staff* [not all were negative however], *the layout of the ward. However, since then I have had another placement on an elderly ward which was a much more positive experience due to the dynamic attitude of the ward manager and his staff.*

Although several respondents who recounted such experiences had indicated that this had convinced them that work with older people was 'not for me', the final comment above reinforces the variability of experience and highlights the major

influence that a dynamic attitude can exert. Unfortunately the final theme here, that of impoverished environments, provides compelling evidence that students, whether as a result of placements during their course or because of working in care settings to supplement their bursary, were often exposed to standards of care and environments so poor that the deleterious effects are hard to over state.

Impoverished environments

As can be seen, the survey generated extensive volumes of qualitative data, and nowhere was this more apparent than in those comments that reflect what we termed impoverished environments. Both the volume of data on this topic, and its content, clearly indicated that students were deeply affected by some of the conditions, attitudes and standards of care to which they were exposed:

> *The staff were overworked, underappreciated and underpaid. Their contribution wasn't valued so consequently patient care suffered. Therapeutic touch and communication was limited by trained staff, carers just saw to their physical needs.*

> *It was like they came there to end their days peacefully, even though dignity and respect were at the bottom of the pile with regards to skills.*

> *I thoroughly enjoy working with the elderly; I find it very easy to communicate with them. However, not all nurses who work with the elderly share my thoughts. I have seen some awful treatments towards the elderly. During one of my placements I had to inform the sister of bad practice by two health care assistants. I would inform on any person who ill-treated any patient.*

> *Sometimes they have long periods alone between meals and routine rounds etc. If there are too many patients requiring help with feeding it is difficult to give enough time to each one. I think more training is required for auxiliary staff, as handling can be rough.*

> *I have felt quite disturbed by the length of time some elderly patients* [who have refused drinks] *are left before given rehydration therapy or intravenous fluids.*

Some of the nurses who do work with older people that I came into contact with had negative views of older patients and this was expressed in the way they treated them.

There are often not enough nurses on each shift to cover the heavy workload so any additional care, eg emotional care, cannot be done because of time constraints.

I view working with older people as a privilege and have enjoyed all the nursing of older people I have done, but working with older people is made more difficult by other staff members' attitudes. I have come across many HCAs [health care assistants] *and nurses who consider nursing older people to be a dead-end job and have worked with many people who are disillusioned by the work and make no effort with the patients at all, to the extent that at times staff are rude, forceful and bordering on abusive. I think this is because staff lack the ability to empathise with older people and to consider them as normal human beings – they are often considered to be difficult and are treated like children .... Perhaps nursing and HCA training needs to include more about understanding and respecting older people and learning to empathise with all patients and be much less judgemental.*

My experience in the nursing home was an eye-opener. Staff were given no training whatsoever, not even on infection control, yet there were three patients there with MRSA! Corners were cut all the time by the manager to save money. I hope this isn't typical of nursing homes for older people but unfortunately I think many are like this.

No one had training in moving and handling. The stair-lift didn't go right to the top of the stairs, lifting of residents was essential to get to the top of the stairs. One resident out of nine couldn't bear their own weight. No hoist, slide sheets, pat slides. Bathrooms were not big enough to fit wheelchairs in them. Toileting was done in the front bedroom. Doorways not big enough for wheelchairs. Lounge doors had drops to the level of the corridors. Basically the home was not safe. Most of the residents had bruising around the legs and arms caused by wheelchairs knocking into them. You couldn't go a month without someone falling. The accident book was full and we started a new one in the time I was there. Manger was supposed to be on 24 hour call – you could never get hold of her. Medication was given out without training. Decisions were made at the home about whether people needed the doctor/ambulance without nursing advice. The residents were not given the care they were needing.

Lack of knowledge and nursing skills means cross-infection passed easily among staff and residents from poor hygiene [plus lack of cleaning resources], *shared creams and equipment. Surely if*

residents classed as needing nursing care are allowed to stay in a residential home, then they should be receiving just as good nursing care as those living elsewhere.

The comments highlighted several elements of an impoverished environment, including:

- an inadequate physical environment;
- lack of resources and equipment;
- staff who lack appropriate knowledge and skills;
- little or no investment in staff training;
- lack of consistency and dynamic leadership;
- poor communication skills;
- poor pay and conditions for staff working with older people;
- poor staffing levels.

Most concerning, however, were the attitudes of staff towards older people and the poor standards of care.

It was clear from the qualitative data that student nurses found some environments better than others, and that experience of impoverished environments could have a serious detrimental effect on their intentions to work in the area when they qualified.

Summary

This chapter has provided an overview of the conceptual phase of the AGEIN project through the reviews of the literatures, and provided an outline of the survey results from which several common themes emerged:

- Quality of life is an important reflection of quality of care, but existing measures tend to rely primarily on objective features that fail to reflect important subjective dimensions. Numerous authors have called for the development of more sensitive indicators that take into account biography and the importance of the past and the future for older people and their carers.

- Family carers are frequently marginalised figures whose skills and expertise are not recognised, and who do not feel valued or listened to.

- Ageism is evident throughout the health care system.

- Care work is undervalued and accorded little status and worth.

- Staff often have negative views of work with older people, and lack the necessary skills and knowledge, and an explicit framework for practice.

- There is a need for a reorientation of professional practice towards one of working in partnership with older people and their families so that expertise is pooled. This requires a greater focus on the relational aspects of care.

Based on the extensive review of the literature undertaken for AGEIN and the empirical work from a separate project (Davies et al 1999), we argued that the Senses Framework (Nolan 1997, Davies et al 1999) could serve to unite the views of older people, their carers and service providers. Early testing of the Senses Framework (Nolan 1997) in the 'Dignity on the Ward' project (Davies et al 1999) highlighted concrete ways of creating a Sense of security, belonging, continuity, purpose, achievement and significance, for older people and health care professionals. The reviews further reinforced the fact that in order to provide good care both the recipient and the provider of care have in some way to matter.

One major goal of the intensive case studies reported in this thesis was therefore to expose the Senses Framework to further scrutiny and to determine if it had relevance to the students' experience, and therefore the potential to provide a framework for education and practice.

The latter part of this chapter focused on the students' responses to the survey. The major messages to emerge here were that students are generally favourably predisposed towards work with older people but that the nature of their prior and current experience are key influences. The notion of an impoverished environment

emerged as a major factor. Consequently, the second major goal of the intensive case study was to try and identify what comprises an enriched environment in which to learn to care for older people, and whether or not the Senses Framework might shed any light on the characteristics of a good learning and care environment.

Before the results of the case studies are presented, the next chapter turns attention to the methodology adopted.

CHAPTER 2
METHODOLOGY

Introduction

The previous chapter presented an overview of the conceptual phase of the AGEIN project and summarised those findings from the survey of student nurses (the extensive component of AGEIN) relevant to this thesis. This chapter gives a detailed account of how the intensive component of the research, the mainstay of this thesis, was operationalised in order to answer the four initial research questions identified in Chapter 1.

Based on an extensive consideration of the available literature, and the results of a large-scale survey with student nurses, there was strong evidence to suggest that, rather than students' educational experience being a major factor, it was their experience of older people in the practical setting that was the main influence. The notion of an impoverished environment emerged in this context. Moreover, it was suggested the Senses Framework (Davies et al 1999, Nolan et al 2001c) might provide a means of understanding the students' experience. Therefore, in order to address the four initial questions, the intensive component of the study with pre-registration students sought to further explore the potential relevance of the Senses Framework and to consider if there might exist the opposite of an impoverished environment, and what this might look like.

It was not the intention to impose the Senses Framework on the study but rather, based on its relevance to work with older people as established from earlier studies and the conceptual phase of AGEIN, to use this to identify potential sensitising concepts to inform the empirical work (Rodwell 1998, see later). This chapter describes the way in which the study was conducted.

The body of the chapter is divided into four sections; the first discusses the reasons why qualitative methods seemed the most appropriate way of exploring the above issues, and the second justifies the constructivist approach subsequently chosen. The third section describes the two main approaches to data collection, focus groups

and case studies; consideration is given to why these methods were adopted, how they were operationalised, ethical issues and data analysis. The final section explores quality criteria as they apply to the process of undertaking the research upon which this thesis is based.

Choosing a Qualitative Approach

> *The choice of research practices depend upon the questions that are asked, and the questions depend on their context.*
>
> (Nelson et al 1992: 2)

The quotation above suggests it is the questions that a study seeks to address that are the main driver of decisions about which approach to adopt. However, while in principle researchers are free to choose from any of the myriad of available approaches, in reality these choices are limited by influences such as organisational constraints and practical considerations (Miller 1997). A decision was made within the AGEIN project as a whole to adopt an approach in which participants themselves were key players in shaping the findings of the study. As the work undertaken for this thesis was an integral part of the overall project, it needed to be consistent with the philosophy of AGEIN. For the intensive case study element of the project reported here a qualitative approach was considered appropriate because of:

- the wide-ranging nature of the questions initially guiding the study;
- the broad range of possible factors influencing student nurses' perceptions of working with older people, as identified in the preceding chapter;
- the need to use a longitudinal approach to explore how such perceptions are derived and develop over time.

As Denzin and Lincoln (1994) observe, qualitative research does not comprise a single approach:

> *Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings,*

> *attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interview, observational, historical interactional and visual texts – that describe routine problematic moments and meaning in individuals' lives. Accordingly, qualitative researchers deploy a wide range of interconnected methods, hoping always to get a better fix on the subject matter in hand.*
>
> (Denzin and Lincoln 1994: 2)

Despite the diversity of qualitative approaches, and the fact that qualitative research privileges no single methodology, nor does it have a distinct set of methods, there are certain shared characteristics, including an emphasis on:

- process and meaning;
- the socially constructed nature of reality;
- the intimate relationship between the researcher and what is studied;
- the situational constraints that shape inquiry.

Qualitative research therefore primarily seeks to answer questions about how experience is created and given meaning. The focus is normally exploratory and descriptive, and there is no intention to generalise the findings but rather to gain a deeper understanding of experience from the perspective of the participants selected for the study (Maykut and Morehouse 1994). This means that qualitative methods are particularly appropriate when relatively little is known about the area of interest (Brink and Woods 1988) and the aim is to understand how phenomena are experienced over time. Hence a qualitative approach was entirely consistent with the original aims and objectives of the intensive component of the AGEIN project. Although deciding the broad methodological approach to be adopted was relatively unproblematic, it was still necessary to determine which of the many potential qualitative methods would be used.

Finding a Perspective

The field of qualitative research is complex, representing '*a series of essential tensions, contradictions, and hesitations*' (Denzin and Lincoln 1994: ix) from which

the researcher must select a research paradigm, approach and strategy by which to operationalise the study. Having decided to use a qualitative approach, it then becomes important to determine the processes of the research. Denzin and Lincoln (1994: 11) recognise three interconnected concerns that define the qualitative research process, arguing that the:

> *... researcher approaches the world with a set of ideas, a framework (theory, ontology), that specifies a set of questions (epistemology), that are then examined (methodology, analysis) in specific ways.*
> (Denzin and Lincoln 1994: 11)

In other words, the descriptions of reality constructed by qualitative researchers and the interpretations of those descriptions will vary depending on the life experience and the philosophical stance adopted by the researcher. The combination of the researchers' ontological, epistemological and methodological premises is termed the 'paradigm' or interpretive framework that comprises the '*basic set of beliefs that guides action*' (Guba 1990: 17). Differences in paradigmatic assumptions cannot be dismissed as mere '*philosophical artefacts*' (Guba and Lincoln 1994); implicitly or explicitly, these positions have important consequences for the practical conduct of inquiry, as well as for the interpretation of findings. Guba and Lincoln (1994) identify four major interpretive paradigms that comprise qualitative research: positivist; post-positivist; constructivist-interpretive; critical theory and related positions. They provide a comparison of the basic beliefs of each and of their varying positions with regard to practical issues (Table 2.1).

It appears that the aim of inquiry for both positivist and post-positivist paradigms is explanation and ultimately prediction and control of phenomena. The inquirer is cast in the role of 'expert' and 'disinterested scientist', implying a privileged vantage point from which to view the 'problem'. Knowledge is considered to be (probable) fact or law, which accumulates via generalizations or links between cause and effect. Values are specifically excluded as confounding variables that cannot be allowed in an objective inquiry.

Table 2.1: A comparison of four major interpretive paradigms adapted from Guba and Lincoln (1994: 112)

	Positivism	**Post-positivism**	**Critical theory**	**Constructivist/Interpretive**
Ontology	Naive realism – 'real' reality but apprehendable	Critical realism – 'real' reality but only imperfectly apprehendable	Historical realism – virtual reality shaped by social, political, cultural, economic, ethnic, and gender values; crystallised over time	Relativism – local and specific constructed realities
Epistemology	Objectivist; findings true	Modified objectivist; critical tradition findings probably true	Subjectivist; value mediated findings	Subjectivist; created findings
Methodology	Experimental verification of hypotheses; chiefly quantitative methods	Modified experimental falsification of hypotheses may include quantitative methods	Dialogic/dialectical	Hermeneutic/dialectical
Inquiry aim	Explanation, prediction and control		Critique and transformation; restitution and emancipation	Understanding; reconstruction
Nature of knowledge	Verified hypothesis established as facts or laws	Non falsified hypotheses that are probable facts or laws	Structural/historical insights	Individual reconstructions coalescing around consensus
Knowledge accumulation	Adding to the 'edifice of knowledge'; generalisation cause and effect linkages		Historical revisionism; generalisation by similarity	More informed and sophisticated reconstructions; vicarious experience
Goodness or quality criteria	Conventional benchmarks of 'rigour': internal and external validity, reliability and objectivity		Historical situatedness; erosion of ignorance	More informed and sophisticated reconstructions; vicarious experience
Values	Excluded – influence denied		Included and formative	
Ethics	Extrinsic; tilt towards deception		Intrinsic, moral tilt towards revelation	Intrinsic; process tilt towards revelation; special problems
Voice	Excluded – influence denied		Included and formative	

The nature of the research questions being posed in the intensive component of the AGEIN study, specifically the wish to explore the student experience, whilst involving students in the research process as experts in their own experience, precluded the researcher adopting a role as **the** expert. Moreover, as little was known about the area under investigation, it was inappropriate to test predetermined hypotheses. Furthermore, the longitudinal element of this study also required prolonged involvement. Taking all these factors into consideration it was considered entirely inappropriate to adopt a positivist or post-positivist paradigm.

An alternative paradigm, critical theory, has the goal of *critique and transformation of social, political, cultural, economic, ethnic and gender structures' by engaging in confrontation or even conflict* (Guba and Lincoln 1994: 113), with the overall aim of enduring restitution and emancipation. Advocacy and activism are key concepts, with the researcher acting in an authoritative role as instigator and facilitator. This tends to imply an a-priori understanding of what changes are needed. Knowledge in this paradigm consists of a series of structural/historical insights that are transformed as time passes. These transformations occur when '*ignorance or misapprehensions give way to more informed insights by means of dialectical interaction*' (Guba and Lincoln 1994: 113).

While, unlike positivism, both critical theory and constructivism (see below) hold values as being central to shaping the findings of the research, the focus of critical theory is to provide a stimulus for action and to transform existing structures. This implies that an understanding of the correct action to take already exists and also that without that direct action the research has little meaning. As noted in the preceding chapter, what 'should be done' in the context of this study was unclear and would remain so until the nature of the student experience and the ways in which this experience influences perceptions and theoretical and practical frameworks were more fully articulated. Consequently, a critical theory approach was also seen as unsuitable.

A Constructivist Approach

The final paradigm discussed by Guba and Lincoln (1994) is constructivism, where the aim of the inquiry is to understand the personal constructions/reality that people, including the researcher, hold in relation to the study topic. The aim of a constructivist inquiry is to move towards consensus, while at the same time being open to new interpretations as information and discussion develops (Guba and Lincoln 1994: 113). The main criterion for success is that, over time, participants formulate more informed and sophisticated constructions and become more aware of the competing constructions held by others. Knowledge consists of those constructions about which there is relative consensus, and that can be potentially transferred from one setting to another by case study reports that provide the reader with vicarious experience (Guba and Lincoln 1994: 114). Here the researcher is cast in the role of participant and facilitator whose voice is one of passionate participant (Lincoln 1991). However, while change may occur as reconstructions emerge and individuals are stimulated to act on them, this is not integral to constructivism. Consequently, this approach seemed to be particularly suited to AGEIN.

Once constructivism had been identified as a potentially valuable approach, it was necessary to be clearer as to the premises on which it is based. As AGEIN was moving into its empirical phase, Rodwell (1998) published a text on constructivist research, which greatly influenced the project team and the study as a whole. Rodwell (1998), a researcher with a background in social work, promoted constructivist inquiry as a way of engaging practitioners in the generation of knowledge while producing knowledge of practical relevance. Her approach informed AGEIN, and much of what follows draws on this text.

Rodwell (1998) summarises some of the basic tenets of constructivism in the following way:

- Constructivism starts with the assumption that research is value bound, therefore what constitutes an appropriate method, or admissible knowledge, depends on the situation.

- Reality is multiple and each individual will construct his or her own understanding of experience and action. Consequently, even individuals having the same experience may use different interpretive frameworks so that the number of potential interpretations may match the number of individuals having the experience. This means that constructivists are interested in the structure of the *cognitive maps* that allow individuals to impose meaning on their personal experiences (Rodwell 1998: 26). The researcher seeks to understand the realities and rationales of others involved in the situation being explored from an emic (insider) perspective, rather than adopting the role of stranger or outsider (etic perspective). Realities are explored and constructed through a dialectic process and the researcher's goal is to achieve consensus, or at least to generate constructions that seem reasonable and make sense to participants.

- In constructivist research the inquirer and the object of inquiry interact to influence one another to such a degree that *the knower and the known are inseparable*, and all participants are changed by the process.

- Generalisation is not possible and all findings are tentative. The aim of the final report is to provide sufficient richness so that readers can decide on the relevance of the work for their own context; that is it should provide readers with vicarious experience.

In addition to Rodwell's (1998) endorsement of constructivism as well suited for practice disciplines, it was deemed particularly appropriate for the present study, since as a relativist ontology which accepts that there are multiple realities, it allowed the research to focus on a range of experiences within different educational contexts. Moreover, the subjective epistemology would enable participants and the researcher to jointly create understanding, allowing the students' personal reality of learning to care for older people to be heard. Furthermore, a naturalistic methodology involving an ongoing dialectic between the investigator and participants generates a grounded theory that reveals the values, beliefs, attitudes, prejudices and biases of all participants (Rodwell 1998: 59).

Rodwell (1998) contends that a constructivist approach can be adopted to suit most types of research question, provided that the aims of the study are consistent with the above assumptions, but she believes that it is most appropriate when:

> *The question of interest is a value embedded one, with complex dimensions suggesting no cause..., if understanding all of these aspects is of interest then it is likely that a constructivist approach is appropriate.*
>
> (Rodwell 1998: 42)

In the context of this study the main purpose of the inquiry was to produce new insights into the ways in which student nurses experience learning to work with older people and to enhance individual nurses' abilities to make informed choices about working with older people as a career choice. These aims were seen as entirely consistent with a constructivist approach.

Operationalisation of a Constructivist Approach

Having decided upon the general approach, it was important to consider how it would be operationalised in order to answer the research questions, and also reflect the emergent design that is central to a constructivist study. However, an emergent design does not mean an absence of structure, and Rodwell (1998) provides a detailed account that identifies the broad methodological requirements and assertions for the various phases of a constructivist inquiry. These are:

Entry

- The research is conducted in a natural setting, because reality cannot be understood in isolation from the context that gives it meaning.
- Tacit or prior knowledge is required to understand nuances and should be used in addition to propositional knowledge to communicate meaning.

Research Design

- Purposive sampling increases the scope and range of data collection

Data collection

- The researcher, as the 'human instrument', undertakes the primary data collection, as this is the only instrument that is able to grasp the meaning in interaction.
- Qualitative methods are preferred as they are better able to capture multiple and potentially disparate realities.
- Multiple realities, the individual interpretation of experiences by participants, shape and define the research focus and boundaries of the emergent study.
- Tacit or prior knowledge is required to understand nuances.

Emergent Design

- The boundaries of the study are determined by the issues.
- The research design emerges as the study progresses, rather than being developed in advance of data collection. This is because no inquirer can fully appreciate the possible range of individual interpretations that may inhabit a particular context.

Data analysis

- Raw units of information are subsumed into categories in inductive data analysis to make sense of the context of the investigation.
- Grounded theory emerges from the study because an a-priori theory would not reflect the detail of the individual interpretations of participants in a specific context.

Products

- Meanings, interpretations and final products are negotiated with participants, who retain ownership of the data.
- Findings are generally reported in case study format as this better captures multiple realities and makes the results more accessible to participants.
- While findings may have relevance for other contexts, any application must be tentative and negotiated.
- Research rigour is judged in terms of criteria for trustworthiness and authenticity.

(Based on Rodwell 1998)

Rodwell (1998) also provides a flow chart for a constructivist inquiry that broadly mirrors the progress of the present study (Figure 2.1). However, as a longitudinal study with an emergent design, it was necessary to adapt this approach as the study progressed. How this was achieved is the subject of the next section of this chapter, which begins with an overview of the methods adopted before discussing those methods in greater detail.

Research Design

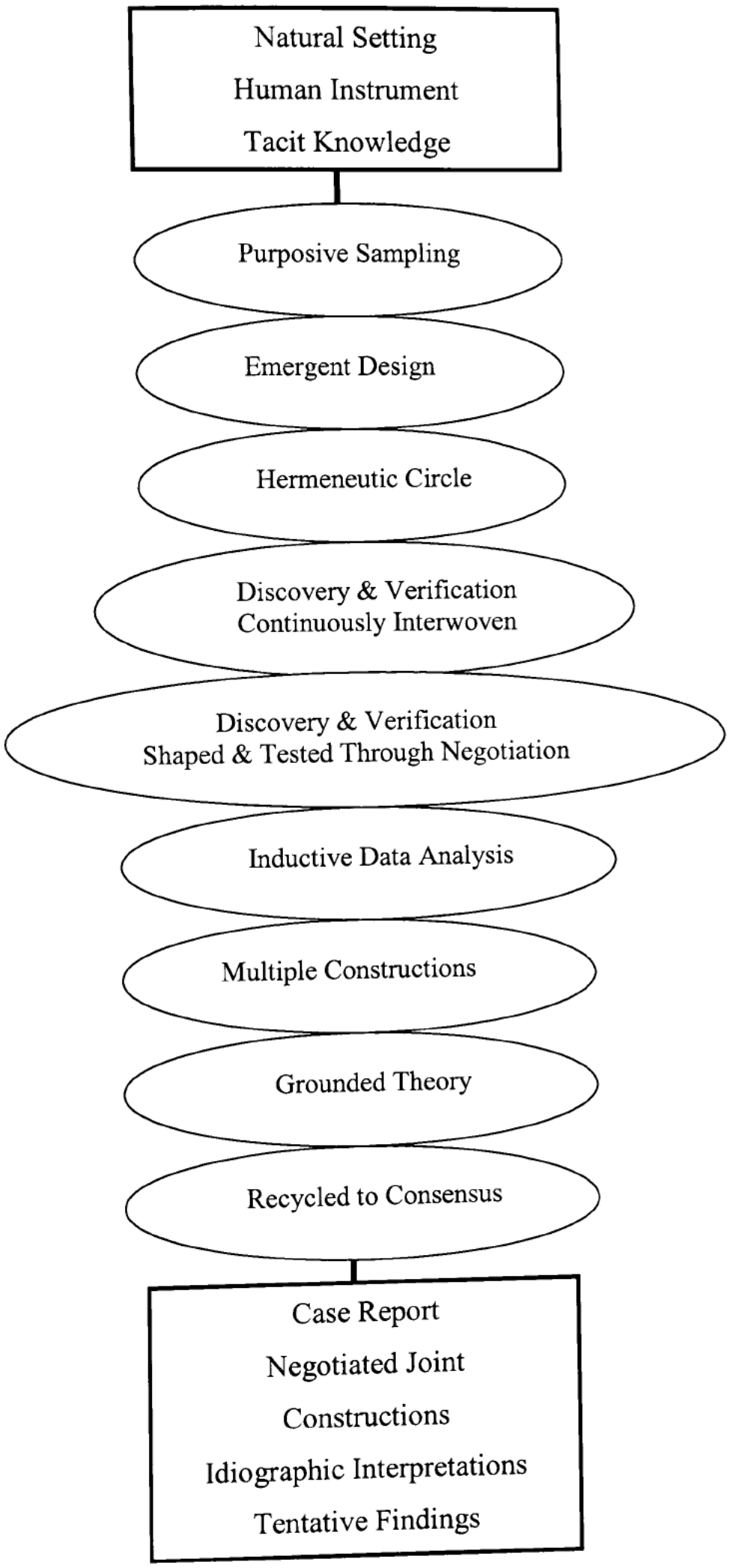
Overview of methods

In order to address the research questions outlined at the beginning of this chapter, the intensive component of the study evolved in two related phases organised within an overall constructivist framework (see Table 2.2).

Table 2.2: The two related phases of the intensive component of this study

The Intensive Phase	**Developing a new culture of education**			
Phase 1	18 MONTH DATA COLLECTION			
Focus Groups with pre-registration nursing students in four Schools of Nursing	Focus Group 1	Focus Group 2	Focus Group 3	Focus Group 4
Phase 2	33 one-day reconnaissance visits to clinical placements in preparation for 7 in-depth case studies of practice placements			

Figure 2.1: The form of constructivist inquiry



(Modified from Rodwell 1998)

The first phase involved a detailed exploration of students' views about their experience of learning to care for older people, gathered by longitudinal iterative focus groups which took place over an 18 month period in four schools of nursing in England. Participants were student nurses who, through their respective programmes (adult, mental health and learning disabilities), were learning to care for older people. Focus groups comprised members of the same student cohort, who, as data collection began, were either within the first months of the course or just beginning the branch programme some 18 months into their training.

Early focus group interviews followed a relatively open agenda thereby allowing students to articulate their own experiences of working with older people, both before commencing their training and during the course to date. Themes emerging from the analysis of early focus groups were presented in subsequent focus groups, consistent with the dialectic/hermeneutic process, and initial findings also fed into the national survey of student nurses, as discussed in Chapter 1. The intention was to begin to create a joint understanding, shared by the participants and the researcher, of students' experiences of learning to care for older people. This broad brush approach was intended to inform a more focused exploration within the specific contexts of the school of nursing and the practice arena.

A number of consistent and striking themes emerged in the early focus groups (see Chapter 3 for a full account), which were corroborated by data from the student survey, and mirrored those from the conceptual phase. Consistent with an emergent design, these themes were explored further in the second phase of the study. Of particular significance was the importance of the practice environment in relation to student learning. In order to more fully understand the influence of the practice environment, students were asked to identify placement areas where they felt that they had a positive learning experience in relation to older people. The participants recommended a total of 51 placements, 33 of which were the subject of short visits by members of the research team. This reconnaissance stage was undertaken at the beginning of phase II of the study in preparation for the in-depth case study of six practice areas chosen as being typical of the range of recommended practice placements. Data collection within the case study practice placements focused on interviews with placement leaders, mentors, staff and students, combined with some

informal observations. The intention was to explore the ways in which these recommended practice placements met the needs of students learning to care for older people, thus contextualising and illuminating the experiences identified in phase I of the intensive study. Having broadly described the two main empirical phases of the intensive component, the following sections consider these in more detail.

Phase I: Longitudinal Focus Groups

Why use focus groups?

Kreuger (1994: 44) identifies two circumstances in which focus groups are particularly relevant:

- when there is a communication or understanding gap between two groups of people;
- when insights are needed into complicated topics with multifaceted concerns.

The way in which students learn to care for older people is an uncharted and complex issue involving matters relating to the student, to academia, and to the practice arena. The key elements that make up those areas are as yet unidentified, and the relationship and interactions between the school, the student and clinical practice in relation to learning to care for older people remain unarticulated. Therefore using focus groups in this study was considered the most appropriate way of gathering the data required.

Focus groups also had additional advantages for the AGEIN project; they offered the potential to capture individual experiences of learning to care for older people, as well as participants' perceptions of the shared experience of belonging to a cohort of student nurses. Importantly, therefore, they are an excellent way of operationalising a hermeneutic dialectic. Hermeneutic dialectic propels the inquiry forward through comparison and contrast of participants' views, with the goal of mutual education and deepened awareness. Using focus groups helped to achieve the longitudinal

element of the study, by involving a number of the same individuals over time. As the concept of group discussion is familiar to student nurses, where the method is used to promote reflection, for example, it was potentially less threatening than some other methods. The presence of peer group members also offered support to people who might have been a little anxious about participating. Furthermore, from a pragmatic point of view focus groups offered a way of increasing the number of participants in the study in a cost- and time-effective way. Attention is now turned to the methodological literature on the use of focus groups, and how they were applied in the current study.

Focus group methodology in principle

Kitzinger (1994) defines focus groups as *group discussions organised to explore a specific set of issues*. The traditional focus group occurs when the inquirer acts as group leader and uses group dynamics and communication skills to manage a conversation with six to twelve people for about one hour (Morgan 1988). These discussions take place in a social setting and generate descriptive or explanatory information (McDaniel and Bach 1996). Focus groups are considered a powerful tool that have the potential to bring the researcher closer to the topic of interest through a direct and intense encounter with key individuals (Clarke 1999), in which the perspectives of all participants can be changed (Rodwell 1998). Rodwell (1998) promotes the use of focus groups in constructivist inquiry, particularly as noted above, because they provide an ideal way of developing a hermeneutic approach:

> *Mutual shaping does occur as participants' ideas are sparked off one another. In this 'sparking', communication and self-disclosure are stimulated. Participants do influence each other in meaning making. In this regard, focus group processes are consistent with the hermeneutic dialectic of meaning. It might be said that a well-developed focus group can actually become a face-to-face hermeneutic circle.*
>
> (Rodwell 1998: 128)

Various authors suggest that in focus groups participants are stimulated to challenge each other's perceptions in the following ways:

- The 'multi-vocality' of the participants limits the control of the researcher who has less power over the group than over a single individual (Holstein and Gubrium 1995, Wilkinson 1998).

- Focus groups involve not only vertical interaction, that is between the researcher and the participants, but also horizontal interaction among group members (Rodwell 1998).

- The group situation ensures that precedence is given to the participants' hierarchies of importance, their own words and language and frameworks they use to describe their own experiences (Kitzinger 1994).

- By asking questions of each other, participants challenge the beliefs of others, and debate with other participants. Such sharing helps create the social construction of meaning (Holstein and Gubrium 1995).

While the human instrument (Rodwell 1998) is the principle data collection tool in constructivist inquiry, the data collection process needs a degree of structure and form in order to produce meaningful results (Rodwell 1998). Focus groups, like interviews, vary in their degree of organisation, from structured groups in which there is a standard order and form of questions, to the relatively unstructured, dependent upon the purpose of the group (Fontana and Frey 2000). In focus groups the usefulness of the information is gauged by the ability to draw valid conclusions about the topic under discussion rather than the ability to replicate findings across many groups, so a less structured interview schedule may be most appropriate (Stewart and Shamdasani 1990: 75). The aims of the present study, to provide a rich description of what it is to learn to care for older people, favoured this less structured approach.

Focus groups in the context of this study

Operationalising the focus groups began by gaining access to participants via schools of nursing. A constructivist approach demands that the research must be mounted in the *natural setting* of the phenomenon under investigation.

> *The wholeness of what is real is only understood when attention is given to the factors that shape the environment, the patterns of influence that exist, the values that are accepted, and so forth.*
>
> (Rodwell 1998: 55)

As student nurses spend approximately 50% of their time on the programme within the school of nursing, this was deemed to be a natural setting in which to begin data collection. In recruiting potential case study sites to the AGEIN project, heads of schools of nursing offering pre-registration programmes in adult, mental health and learning disabilities branches of nursing in England, were approached to take part in the study. There were 51 in total at the time of the study, of whom 34 expressed an interest, and the case study sites were identified from among this number.

In constructivist studies the purpose of sampling is to include the broadest scope of information, therefore purposive sampling is the method of choice (Guba and Lincoln 1989, Erlandson et al 1993, Rodwell 1998). In the context of this study participants needed to be recruited in such a way as to include experiences from a range of schools of nursing. Practical considerations relating to the resources available to collect data longitudinally dictated that the sampling should be limited to four schools of nursing. However, an attempt was made to gain the broadest perspective when selecting the four schools, which were chosen for:

- **Geographical spread** – case study sites were spread throughout England and included schools that were based in both predominantly urban and rural areas.
- **Variety of programmes** – centres were chosen that offered Dip HE in nursing in all branches of interest, adult, mental health and learning disabilities, with some offering a graduate programme.
- **Expertise** – It was decided to incorporate one institution that was acknowledged as a centre of gerontological expertise, offering a masters programme in gerontology.
- **Fresh research sites** – it was also thought important that the schools of nursing chosen had not been over-researched in other educational studies.

Table 2.3 shows the general features of each school of nursing; for a more detailed description of each, see Appendix I.

Once the sampling decisions had been made, the head of each school was approached with a pack of more detailed information regarding the project and permission was sought to recruit students to the study. The need to secure individual school ethics committee approval was anticipated. However, in the event this was not required at any site.

Finding participants

To gain insight from as broad a spectrum as possible, students who intended to qualify in adult, mental health or learning disabilities branches of nursing were recruited to the study from all four case study sites. To obtain the views of students at all points during their course, participants were recruited from cohorts either at the beginning of their nurse training or from groups who were just entering the branch programme, 18 months into the three-year course.

Meetings with groups of students from the case study sites were arranged at which they were invited to participate in the study. Those who signalled an interest were given a pack containing an explanation and full written information including a consent form, reply slip and prepaid envelope. Initial responses from students were very positive. However, there were still many gatekeepers to negotiate before data collection could begin, as Guba and Lincoln (1989) note:

> *Each stakeholder group (in this case student nurses) and often sub groups (individual cohorts) within – will have their own gatekeepers. Each gatekeeper requires a separate negotiation... Each gatekeeper will have essentially the same questions (often related to the purpose of the study, the risks to which the particular stakeholder group will be exposed, and the possible payoffs to the group that make participation desirable)... The task may seem unending, since new gatekeepers are likely to be uncovered everyday as new stakeholders are identified, to be sure, but also because each venture onto new 'turf' is likely to turn up a new gatekeeper.*
>
> Guba and Lincoln (1989: 199)

Table 2.3: Characteristics of the Schools of Nursing which focus group participants attended

Case study site	Site location	Number of students per year	Number of lecturers	Branch students	Nursing older people theory	Nursing older people practice	Type of qualification on offer
Site 1	Midlands Urban	260	39	Adult Mental Health Learning Disabilities	Integrated into a module about the adult	Only for 'adult' branch students	Parallel running Dip HE and BSc (Hons)
Site 2	South West Urban and rural	526	119	Adult Mental Health Learning Disabilities	Threaded through the curriculum	One specific placement focusing on older people for degree students only	Parallel running Dip HE and BSc (Hons)
Site 3	South Urban	340	45	Adult Mental Health Learning Disabilities	Threaded through the curriculum	Three short placements during the course of 1 or 2 weeks	Course with dual outcome of BSc (Hons) and Dip HE
Site 4	North Urban and rural	250	38	Adult Mental Health Learning Disabilities	Integrated into a module about the adult	All students during CFP – four weeks duration	Parallel running Dip HE and BSc (Hons)

Arranging focus groups in four different schools of nursing throughout the country required negotiation with many such gatekeepers. The possession of organisational permission to undertake the research and personal commitment from students to participate in the research did not ensure access. Each cohort of students had a programme leader or year tutor who needed to be consulted. As each focus group was held following a class run by a different teacher, negotiation for access to the cohort had to be undertaken on a group by group basis, with full explanations and reassurances being given each time. In addition, in order to ensure that focus groups were organised at times of greatest convenience for the participants, for example, not just before or just after an examination, or when only half the group was in school, negotiation with a gatekeeper to the timetable was also required. Furthermore, to ensure that the focus group had somewhere to meet, negotiation with a room-booking gatekeeper was necessary. A second matter that required early attention was that of negotiating the fully informed consent to participate that ethical inquiry requires.

Participant consent

Absolute informed consent and research accountability that attends to rights of privacy, confidentiality and freedom from coercion (Fetterman et al 1996) must be central to any research study; but guaranteeing these issues is problematic in an emergent design (Rodwell 1998: 221). Indeed, Behi and Nolan (1995) have stated that problems and uncertainties arise because of the difficulty in defining informed consent and knowing when it has genuinely been achieved. Munhall (1991) describes qualitative research as an ongoing, dynamic, changing process in which risks and benefits may not be obvious, predictable or expected, and suggests that informed consent as classically understood is a *past tense concept*. As an alternative he provides a proposal for *process consent* in qualitative research. Process consent fits well within a constructivist framework as:

> *The idea of process consent seems to exemplify a negotiated view of not only the 'phenomenon' but also of the study itself.*
>
> (Munhall 1988)

Process consent encourages mutual participation and mutual *affirmation* for both the participants (Munhall 1991: 267) and the researcher, and should be developed with the research participants' input, ideas and suggestions. Process consent should include agreement on several issues, which are reflected in relation to this study in Table 2.4. Behi (1995) advises that best practice would be to provide a combination of informed and process consent, and indeed this is how consent proceeded in this study. Initially potential participants consented to be part of the study from an informed standpoint, and once an 'informant community' was established a more negotiated form of process consent was used.

Table 2.4: Issues in process consent

How will data be kept anonymous and confidential?
How will you ensure accurate portrayal?
How will the researcher share the information?
Where are the findings to go?
On what grounds will information be included or excluded?
What will happen to secrets, confidential material and unanticipated findings?
What happens to the findings?
How often will the focus groups take place, and how long will they last?
Where will the focus groups be held and when?

(Adapted from Munhall 1991: 268)

These issues are now each considered in relation to the current study.

Informed consent

Information is one of the keys to 'informed' and 'process' consent, and people are entitled to sufficient truthful and relevant information to help them decide whether to participate or not (Behi 1995). In pursuit of this aim a verbal explanation of the project, with the opportunities to ask questions, was given at an initial meeting. In addition, an information pack was left with students. This pack provided sufficient information to allow students to consider the implications of the study and what participation would require (see Appendix V). At the same time, contact details for

the researcher were included if the students wanted further clarification. Information about the study adopted a question and answer format for clarity and this reduced the amount of written text in each section of the document, increasing readability. Attention was also paid to the language used and attempts were made to avoid jargon and not to assume knowledge, but without being potentially patronising.

As the researcher was also a teacher there was a need to consider a number of further issues. Firstly, it was important not to underestimate the power differential between a teacher and student, even from different institutions, and it was considered essential that the students did not feel under pressure to participate in the research. Similarly, it was important that people were aware that their organisation had agreed to the study being undertaken and for them to be approached, but it was equally essential not to give students the impression that their organisation expected them to take part. Therefore visits to students to introduce the research were undertaken without a member of faculty staff present, and information packs with contact details were left as opposed to taking names on the day in order to allow a cooling-off period for the students to consult with others if they wanted before agreeing to take part. Secondly, it was crucial to ensure that students did not feel that their continued participation would have any effect on their academic progress.

Those who responded to the invitation to take part in the study gave their names and addresses and permission to continue to contact them directly in future was sought. Therefore, students were written to personally with details of focus group meetings rather than asking the school to maintain contact. It was made clear to the students that their faculty would not be given the names of those who were contributing to the study, nor of those who chose to discontinue their participation. This approach made it easier for students to decline to take part in the study, thereby meeting the canons of informed consent. Once this initial consent had been obtained, ongoing process consent began.

Process consent

As illustrated in Table 2.4, process consent requires that a number of issues are addressed.

How will data be kept anonymous and confidential?

During data collection using qualitative research methods, it is usual at the start of an interview to assure participants that the focus group data will remain anonymous and/or confidential. This is particularly important if the research topic is of a sensitive nature. For example, student participants may feel that remarks attributable to them could affect their progress on the programme. To prevent this:

- Students were assured that the researcher was independent of individual institutions and that no individual, other than the project team, nor institution would have direct access to raw data.

- Participants were made aware that the proposed inclusion of verbatim quotes from the transcripts in publications made the total confidentiality of data unachievable.

- However, it was stressed that a relative degree of anonymity was afforded by protecting the identity of participants and their institutions. It was also pointed out that the content or context of some comments meant that individual students (or their close associates) might recognise themselves or their institution.

The naming of tapes and transcripts and access to the data was raised within the groups. It was agreed that:

- The researcher and other members of the research team, for example the person undertaking transcription, should be the only people to have access to untranscribed tapes, which should be named only by cohort and coded school, for example Group: Spring 2002 Site - 1.

- Data would be kept in a locked cupboard.

How will you ensure accurate portrayal?

The concept of an iterative dialogue was introduced and discussed with the groups. Participant reflections on specific issues were analysed by the researcher to identify themes, which guided subsequent rounds of data collection in a hermeneutic circle. Participants were provided with a brief summary of the points raised in the previous meeting and invited to agree or challenge that interpretation or the themes subsequently identified by the researcher.

How will the researcher share the information and where will the findings go?

It was explained to participants that their input would contribute to a formal report in which the findings from the data collection process as a whole would be presented initially to the research commissioners, the English National Board, and subsequently more widely throughout the nursing profession through professional journals and conference presentations. Students were also made aware that their data would be contributing to this thesis.

On what grounds will information be included or excluded and what will happen to secrets, confidential material and unanticipated findings?

It was stated that all data obtained would be part of the study. In other words, 'secrets' and 'stories' were to be discouraged if they could not be included in the study. It was explained to participants that some 'secrets' or 'stories' pose a dilemma for the researcher who as a nurse is concerned for patient well-being, and as a teacher is equally concerned for student well-being. It was therefore agreed that, should such a difficult issue arise, the participant would be encouraged to discuss this with a tutor in the first instance. Failing this the researcher would ensure that, with the student's consent, the appropriate person was informed.

Where will the focus groups be held, and when? How often will the focus groups take place, and how long will they last?

The participants, some of whom lived many miles apart, and who were unable to meet when not in school because of shift patterns on practice placements, chose to have the focus groups in the school of nursing during the lunch break. This seemed appropriate, as using participants' familiar spaces helped to diffuse the power of the researcher. Following an initial meeting and focus group, participants discussed with the researcher when was the most appropriate date to meet again taking into consideration examinations, assignments, holidays, and so on. The duration of the focus groups was limited to some degree by their timing in the day. However, in most instances (when focus groups met promptly without interruptions) an hour appeared to be an adequate length of time to cover a range of issues. All subsequent meetings took place in schools of nursing at lunchtime. The room was arranged as informally as possible by the researcher, who also provided lunch.

The number of participants in each focus group varied from 3 to 16, with the average number at each focus group being 7. In order to track the experience of students longitudinally from commencement of training, cohorts from each of the branches of interest (adult, mental health and learning disabilities) were selected who were entering the branch programme together with groups just beginning the course at the common foundation programme (CFP). Fifty-six focus groups were undertaken in total (some cohorts were interviewed together especially during CFP). Two rounds of focus groups were held at two of the study sites, three at another and four at the final site; see Table 2.5.

After introductions and an explanation of the study, participants were reminded that the discussions would be audio-taped. The need for the content of the meetings to be confidential was stressed, and it was reiterated that participants could leave the study at any time without giving an explanation. Process consent issues were followed as outlined above.

Table 2.5: Overview of focus groups and the point on the course (in months) when they occurred

Cohort and branch	Focus Group One	Focus Group Two	Focus Group Three	Focus Group Four
Point on the course in months →	Months	Months	Months	Months
SITE 1				
Autumn 1998 CFP	17	Became branch cohorts		
Autumn 1999 Adult group A	6	11	19	24
Autumn 1999 Adult group B	6	11	19	24
Autumn 1997 Adult	29	36		
Autumn 1999 Mental health	6	19	27	
Autumn 1997 Mental health	29	36		
Autumn 1998 Mental health	15	23	29	33
Autumn 1999 Learning Disabilities	6	11	19	24
Autumn 1997 Learning Disabilities	29	36		
SITE 2				
Spring 1999 Adult	16	27		
Autumn 1999 Adult group A	10	16		
Autumn 1999 Adult group B	10	16		
Spring 2000 Adult	5	12		
SITE 3				
Spring 1998 Adult group A	24	30		
Spring 1998 Adult group B	24	30		
Autumn 1998 Adult	21	33		
Spring 1999 Adult	5	17		
Spring 1998 Mental health group A	24			
Spring 1998 Mental health group B	24			
Autumn 1998 Mental health	21	33		
Spring 1998 Learning Disabilities group A	24			
Spring 1998 Learning Disabilities group B	24			
Autumn 1998 Learning Disabilities	21	33		
SITE 4				
Spring 1997 Adult	30	35		
Spring 1998 Adult	11	13	17	
Spring 1999 CFP	11	Became branch cohorts		
Spring 1999 Adult	9	24	30	
Spring 1999 Mental health	9	24	30	
Spring 1997 Mental health	30	35		
Autumn 1998 Mental health	13	20	24	

Facilitating focus groups in this study

The human instrument is the principle data collection tool in constructivist inquiry (Rodwell 1998), and the enhancement of that instrument requires the development of skills. The skills that are required to conduct a focus group are not significantly different from those needed for individual interviews. The interviewer must be flexible, objective, empathetic, persuasive and a good listener (Fontana and Frey 2000). Although I had assisted in facilitating a focus group in a previous study I had not undertaken any alone. During the early phases of this study, I therefore assisted an experienced researcher, who conducted the group while I observed and took detailed notes. Following this, I then practised the skills I had observed with a group of local students before taking on the role of group moderator myself. However, some specific challenges remain:

- The interviewer must keep one person, or group of people, from dominating the group.

- The interviewer must encourage reluctant participants to 'have a say'.

- The interviewer must try to obtain responses from the entire group to ensure the fullest coverage of the topic.

(Merton et al 1990)

In short, the group interviewer must simultaneously worry about the script of the questions and be sensitive to the evolving patterns of group interaction (Fontana and Frey 2000). As a teacher and researcher with experience of other types of interviewing I felt that I had some skills that would assist me in facilitating a productive group.

Each focus group involved participants from the same university cohort and was held at the students' own school of nursing at a time and date of their choosing. This was potentially empowering for students who were familiar with the surroundings and each other and ensured a less dominant role for the facilitator, who

came to the group as an outsider. Students were used to holding discussions within these groups and there were very few incidents of individual students dominating. I purposely ensured that all members of the group had the opportunity to speak and, few, if any, seemed reluctant to do so. However, this willingness to respond may have been due to the self-selection process in which people with formed or strong views on the topic area may have been more likely to put themselves forward to participate in the study.

My experience as a teacher, while providing useful skills in facilitating the groups, may have led the students to give the responses that they thought I wanted to hear. Little is known about how the effects of social desirability and conformity influences the expression of views in focus groups (Fitzpatrick and Boulton 1994) and participants may have been tempted, for example, to express extreme views with a mind to shock an academic out of her supposed ivory tower with examples from the real world.

However, there was little evidence of this in the early focus group interviews which followed a relatively open agenda with initial questions such as 'Have you ever cared for an older person? Can you tell me about it?' Such questions allowed students to articulate their own experiences of working with older people, both before commencing their training and during their training to date. The interview then proceeded in a conversational manner with me responding to and developing points raised by participants. The focus groups closed with a summing up of the issues raised, decisions about the next meeting and discussion around what the students would be experiencing in terms of placements, modules assignments and so on, before we next met.

Data from focus groups were analysed using a constant comparative approach (see below), with analysis of main themes being completed after each focus group. These were then fed into later groups towards the end of each discussion as part of the evolving hermeneutic cycle. This allowed me both to 'check out' meanings while also looking for similarities and differences across sites. It also facilitated the development of shared knowledge and understanding essential to a constructivist model of working (Rodwell 1998). As noted earlier, it is a basic premise of

constructivist research, and indeed several qualitative methods more generally, that a-priori theoretical frameworks are not used. Therefore the intention is not to test existing theories but rather to generate insights and constructions that emerge from the data. However, as Rodwell (1998) suggests, it is appropriate to use 'sensitising concepts' or 'foreshadowed questions', from the literature or prior experience, to provide some direction and purpose. As will now be apparent, AGEIN was a complex project with a number of phases, some running concurrently, some consecutively: the early focus groups were taking place at the same time as the conceptual phase review of the literature. This again is a potentially contentious issue, with some qualitative researchers arguing that the literature should not be consulted until after data collection has been completed. However, as noted in Chapter 1, the literature in AGEIN was seen as another form of data, and the project adopted the principle, articulated by Morse (1994), that as much of the literature as possible should be consulted to avoid the research simply reinventing the wheel, and to help the researcher to *'recognise leads without being led'*.

Based on the emerging consensus from the conceptual component, the Senses Framework was therefore used as a broad 'sensitising concept' during the initial focus groups. However, the importance of the practice environment emerged very early in the focus groups (a factor later reaffirmed by the survey data), and the students often talked about the placement experience using terms directly relevant to the Senses, sometimes even using the same words. So, for example, participants would talk about the need to feel that they 'belonged' in a placement team, and that they wanted to be a useful member of that team (Sense of purpose), or about their wish to feel safe (Sense of security). For example, one student said:

> *I really just want to feel that I belong there* [placement] *and that I'm some use to them when I am there!* Focus group participant

Another commented:

> *You want to feel safe when you are doing things to a patient, you don't want to make a mess of it.* Focus group participant

Consequently, the Senses were introduced to the students in subsequent focus groups and they were asked to critique the Senses Framework in relation to their own experience. As the study progressed participants were also asked to consider the definition of the Senses and to think about how their experiences mapped (or failed to map) onto the Senses Framework (for more detail see below and Chapters 3 and 4).

Similarly, the concept of an impoverished environment was introduced to students for their critical scrutiny and refinement.

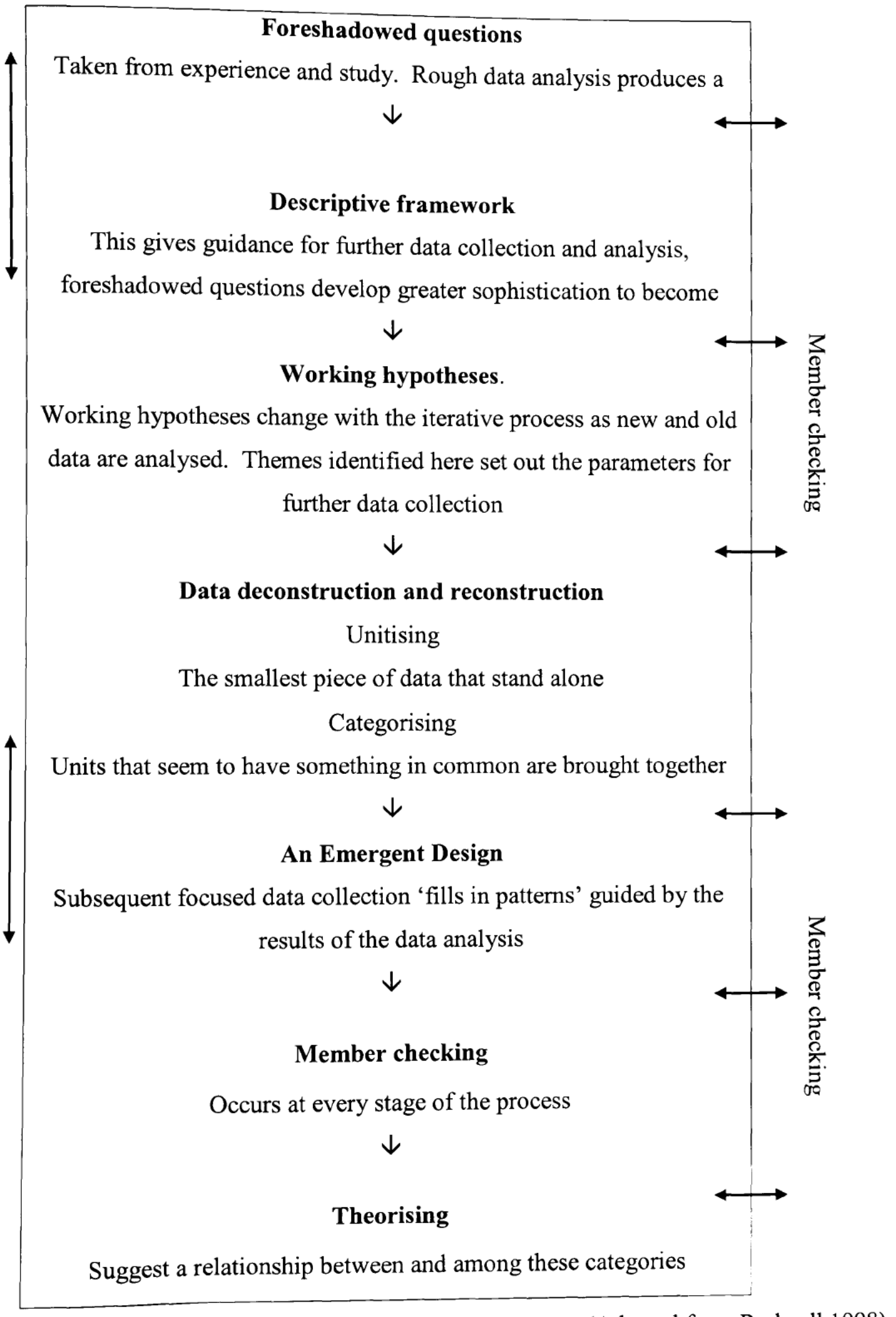
Data analysis in principle

The large volumes of rich data collected in a project of this size and complexity require a planned and disciplined approach to analysis. Data analysis is further complicated by the fact that, unlike quantitative analysis, there are few well established and widely accepted rules in qualitative data analysis. Many would argue that this is the way it should be – qualitative research is an interpretative and subjective exercise, and the researcher is intimately involved in the process, not aloof from it (Pope and Mays 1996). There are several potential theoretical approaches to choose from, but within a constructivist inquiry (see Figure 2.2) data analysis proceeds in parallel with data collection. As noted earlier, the inquirer begins by shaping foreshadowed questions (McMillan and Schumacher 1993) defined by Rodwell (1998) as:

> *Those issues that the inquirer brings to the inquiry from their own experience or from study that serve as the conceptual framework not only in the initial stages of the research but also for the data analysis that begins early in the process.*
>
> (Rodwell 1998: 148)

At this stage preliminary data analysis generates a **descriptive framework** (Rodwell 1998: 149) providing guidance for further data collection and analysis. As analysis proceeds, foreshadowed questions become **working hypotheses**. Rodwell (1998) sees hypotheses as a way of describing factors that are unique to a context or event, thereby providing tentative descriptions about reality that can be investigated further.

Figure 2.2: Analytic framework for constructivist inquiry



(Adapted from Rodwell 1998)

> *In constructivism, working hypotheses tentatively guide the data collection and are finally fashioned at the completion of the inquiry process in the form of 'lessons to be learned'.*
>
> (Rodwell 1998: 152)

Because constructivist inquiry is primarily an inductive process building on particulars that are discovered, working hypotheses change as new and old data are analysed. At this stage of analysis important elements are being identified (or mapped), but complete details of the elements and their relationships have yet to be fully constructed. This occurs during the formal process of data deconstruction and reconstruction. It is at this stage that the techniques of grounded theory building are most apparent (Rodwell 1998: 154). In constructivist studies the process of creating a grounded theory involves 'unitising', as part of the deconstruction process, 'categorising' and 'reconstruction' in a **constant comparative approach.**

Unitising involves identifying the smallest piece of information that can stand alone and be understood by someone with minimal knowledge of the subject, and then assigning a code to it so that it can be tracked back to its original data source. Codes are built from foreshadowed questions, and the working hypotheses. This is the most time-consuming part of data collection and analysis.

Once all the units are prepared, each is compared to the others to identify relevant themes and categories and the units that seem to have something in common are brought together into provisional categories by a process of categorising (Lincoln and Guba 1985). As the constant comparison progresses some units may not appear to fit into any category. However, these are not discarded but returned to later in the process. Once the categories begin to develop they are then defined to make the inclusion and exclusion criteria clear and examined to determine which if any, are subcategories of another. This process continues until possible relationships between categories begin to emerge.

> *Data have been deconstructed into units and are being reconstructed into categories with greater and greater degrees of abstraction. Overarching categories with clear relationships is the goal of the reconstruction.*
>
> (Rodwell 1998: 159)

As data analysis progresses, more focused data collection may be necessary to fill in patterns after the deconstruction and reconstruction. There is constant feedback to and from participants at this stage as it is important to check whether or not the reconstructions have captured the participant's experience. Rodwell (1998: 162) suggests that to enhance trustworthiness and increase the quality of the hermeneutic circle the inquirer asks participants:

- Do the concepts and the definitions make sense?

- Does the ordering of the categories and sub-categories seem reasonable?

Finally, having reduced the data to its major categories the next stage is to suggest relationships between and among these categories (Rodwell 1998: 163) and to seek understanding of the network of relationships involved with the phenomenon under investigation, that is **theorising** (Morse 1994).

Both Guba and Lincoln (1989) and Rodwell (1998) suggest grounded theory as an appropriate method of analysis within a constructivist approach. In light of this, the way in which data analysis was undertaken in this study is more fully described below.

Analysing the focus group data

The aim of analysis of the focus group interviews was to identify a broad range of experiences of learning to care for older people and their families that might help inform nursing educational practice. However I was also aware of the need to analyse and present the data in a way that would have the potential to both empower and inform student nurses themselves.

The initial questions posed to participants were intentionally very broad ('Have you ever cared for an older person? Can you tell me about it?'), in order to allow participants to direct the course of discussion. Initial analysis of each focus group

was undertaken promptly after its conclusion in order that the constructions could be fed back into the next focus group, in line with the initial process of data analysis suggested by Lincoln and Guba (1985) and Rodwell (1998) (see above). As noted earlier, whilst the Senses Framework was used to identify sensitising concepts (and later a descriptive framework) it quickly became apparent from what participants were saying that there were clear links between the data and the Senses. Therefore, in agreement with the participants, the boundaries of the Senses and their relevance to their experience were explored more fully so as to determine:

- what it means to experience (or not) the Senses during practice placements;
- what consequences the creation (or not) of the Senses had on students' learning with older people;
- to articulate what constitutes the Senses for student nurses learning to care for older people.

In this way the Senses Framework provided the **working hypotheses** for data analysis. This enabled me and the participants to begin to outline the breadth and diversity of experience of learning to care for older people for students in three branches of nursing, and in three different years of training across four schools of nursing.

As the number of completed focus groups grew it became apparent that some strategies for managing the amount of data generated would be needed. The computer software QSR*NUDIST (Non-numerical, Unstructured, Data: Indexing, Searching and Theorising) data analysis program was used to assist with this. This program has several advantages:

- It allows the researcher to access large volumes of data quickly and efficiently, and by having this facility on a laptop computer, anywhere at any time.

- It is able to search for words and phrases quickly.

- It supports the constructions of hierarchies of codes and categories.

- It has the facility to create memos creation and linking these to segments of text or codes.

The use of QSR*NUDIST (1997) aided the process of retrieving and coding and allowed me to follow hunches, amend the framework and gain insights more readily. In analysing the first interviews units of text were coded largely in a descriptive manner using codes to represent the meaning of each unit. Some clearly fitted into the Senses Framework, but no attempt was made to force a fragment into a code or the code into the framework. Where a fragment did not fit into an existing code, a new one was created. This process resulted in the generation of over 600 separate codes.

As data analysis progressed, categories were then grouped under a series of headings and subheadings that further developed and gave greater depth to the categories. The analysis might therefore be visually represented as a tree with each of the Senses (security, belonging, continuity, purpose, achievement and significance) being the main branches. The categories that related to each branch were then grouped under subheadings (forming the smaller branches) that related to how a particular Sense was created or the factors that militated against the creation of a Sense. Subjective responses to the creation or otherwise of each Sense were also grouped together, and in this way it was possible to map, often very minutely, the factors which contributed to, or militated against, the creation of the Senses. This enabled the key dimensions or characteristics of an enriched, as opposed to an impoverished, learning environment to be established.

Feedback to focus group participants (or **member checking**) of the analysis as it progressed was also key. Participants were given definitions of the Senses as they developed and asked to comment on whether they were understandable and if they made sense. They were given examples of the content and ordering of the categories and sub-categories and asked if these seemed reasonable. Most importantly, participants were asked to consider whether they could identify their own experience in the growing construction. The concept of the Senses Framework resonated strongly with participants from the outset, and students could see how a

Sense of belonging or security, for example, had been important to them in their experience of placements. Moreover, when given unitised data the students attributed those data to the same categories and subcategories as the researcher, thereby adding to a shared construction. When given examples of how each of the Senses might be created or inhibited, participants contributed to this process by providing examples from their own experience (see Appendix VI).

As data from each focus group were categorised, the key categories created were used to examine participants' contributions in various ways. Matrices were created that gathered responses from all participants in terms of:

- Branches of nursing – responses from each branch (adult, mental health and learning disabilities) were charted together. This allowed me to look for issues, themes and concepts that were shared or specific to each branch.

- School of nursing – charts were created for each of each of the four schools of nursing, helping me to look at contextual differences that may have affected participant responses.

- Year of study – participants' responses were charted by year of study, allowing me to examine responses in terms of experience on the programme.

The value of an emergent design was amply demonstrated when a discussion with a participant at the end of a third round of focus groups prompted me to undertake a reanalysis of the data from both the focus groups and the practice placements. This student had earlier recommended a practice placement as a case study site and asked if I had yet visited the placement. I indicated that I had, and the student appeared dismayed at this. When I asked her why, she explained that she had been to the area for a second time and following this experience had decided that the placement was in fact not a good area to learn to care for older people. I asked the student what had changed since her last visit, and she replied that nothing about the placement had changed but rather she had. This led me to wonder if students' need for the Senses varied over time. I therefore re-analysed the data, looking for any evidence of

changing needs from other study participants in both the focus groups and practice placements.

This resulted in the concept of the foci emerging (see Chapters 3 and 4), which suggested that there was a temporal dimension to the student experience and that the Senses varied in importance at differing points in their training. This analysis enabled me to identify varying key dimensions of the 'life history' of a student in terms of the different foci they adopted as they progressed through the programme (see Chapters 3 and 4). By plotting participants' foci or personal drivers and the Senses along two dimensions it was possible to construct a typology which illustrated the need for the Senses to be created throughout nurse training, with the importance of each Senses varying at certain points in training (see Figure 3.1)

This process is characteristic of an **emergent design,** led by the data. Using this approach it soon became apparent both from the focus groups and from the survey data that a full understanding of the students' learning could not be obtained without a detailed consideration of their placement experience.

The importance of the placement experience

As the original intention of the study was to explore student learning with regard to older people in both the school and the practice placement environment, I had envisaged sitting in on classroom teaching, interviewing teachers and examining the curriculum as well as visiting some practice placements. However, as the study progressed, the far greater influence that the practice environment had on participants' learning clearly emerged. While many participants spoke of both positive and negative experiences, they were adamant that the vast majority of their learning about older people took place in the practice arena. Participants were keen to identify features and attributes that enhanced their learning and contributed to the creation of what was eventually termed an enriched environment. In such a setting the relationships students developed with older patients, their family carers and placement staff, specifically the mentor, emerged as a major influence. It was therefore considered essential to gain a better understanding of the factors that contributed to the creation of an enriched environment that might contrast with the

impoverished environment that had been identified in the survey data. In light of the emerging constructions from the data the original research questions were therefore reconsidered. These were:

- How do nurses acquire and sustain their perceptions of, and predispositions to, work with older people?

- How, over time, do nurses develop their theoretical and practical frameworks for work with older people?

- What is the nature of the students' educational experience, and how does this impact on their perceptions, predispositions and theoretical and practical frameworks in relation to older people?

- What other factors may influence students' perceptions, predispositions and theoretical/practical frameworks?

While the questions remained relevant, it was evident that it was the experience to which students were exposed in the practice arena that exerted the main influences. It therefore seemed that, if the above questions were to be adequately addressed, data collection needed to occur in placement areas.

Consequently, in order to fill in the gaps (Rodwell 1998), I asked participants if they could recommend areas where they had enjoyed a positive experience of learning to care for older people. They identified 51 practice placements were identified in all (see Table 2.6), 33 of which were given reconnaissance visits in order to get a feel for the range of placements and their characteristics, and to ask if they would be willing to take part as a more detailed case study.

Table 2.6: Type and number of practice environments visited during reconnaissance visits to clinical placement areas

Type of practice environment recommended	Number of recommendations	Number visited
Acute medical and surgical wards	9	7
Specialist stroke units	3	2
Rehabilitation wards	8	6
Nursing homes	5	4
District nursing teams	3	2
Community mental health teams	4	2
Day hospitals	4	2
Learning disability group homes	2	1
Elderly mentally infirm (EMI) units	6	3
Mental health assessment units for older people	5	2
Emergency admissions units	2	2
Total	**51**	**33**

Why undertake reconnaissance visits?

I had been persuaded of the value of short (one-day) visits to clinical areas for sensitising the researcher to potential issues of interest while taking part in the *Dignity on the Ward* study (Davies et al 1999), where the research team undertook intensive one-day visits to acute care settings for older people. The experience taught me that a number of short visits to clinical areas were helpful in:

- allowing researchers to gain a broad overview of issues in a number of settings;
- giving researchers a feel for similarities and differences in differing contexts;
- highlighting issues that seemed central to all environments;

- allowing for the exploration of differing work approaches and styles, for example, leadership and mentorship.

These visits also helped to inform the sampling for the more detailed case studies.

Phase II: Case Studies of Practice Placements

Why use a case study approach?

After conducting the one-day reconnaissance visits it was decided to select a smaller number for detailed case study as this would provide:

- the opportunity to explore a complex environment such as a clinical placement in some depth;
- the prospect of talking to other stakeholders such as placement staff, who could potentially illuminate different facets of a good learning environment;
- the opportunity to see how group dynamics between older people, their family carers, staff and students worked within that environment;
- the chance to observe whether a placement identified as a good learning environment by students was also a good environment for older people, their carers and staff;
- the prospect of exploring ways in which a good learning culture could be transferred to other areas.

Case study methodology in principle

A case study is a methodological approach useful for investigating complex issues where the boundaries between the phenomena (a positive experience of learning to care for older people for student nurses) and context (practice placements) are not clearly evident (Yin 1994). Stake (1995) suggests congruence between constructivism and case study methodology when he states that:

> *Case study research shares the burden of clarifying descriptions and sophisticating interpretations.*
>
> (Stake 1995: 102)

Stake identifies three types of case study: intrinsic, instrumental and collective. The main aim of an intrinsic case study is to develop greater understanding of a single case (an individual practice placement for example). The single case is seen as being inherently interesting, rather than because studying it might say anything about similar cases. Conversely, instrumental case studies may examine one or a limited number of cases to understand something more than the particular case, and to identify a broader set of phenomena. A collective case study involves a wider number of cases in order to enhance the range of inferences made. For the present study my interests lay, not in a single practice placement, but rather what the study of recommended practice placements might say about creating a positive environment in which to learn to care for older people. This clearly indicated the use of an instrumental or collective case study. Stake suggests that evidence for case studies may come from five different sources: documents, archival records, interviews, observation and physical artefacts. In the present study the main data collection methods used were interviewing and, to a lesser extent, observation. These methods are considered in the next section.

Case studies in the context of this study - selection of the case study sites

Stake (1995) holds that the first aim in the selection of case study sites should be to maximise what we can learn:

> *Of course we need to carefully consider the uniqueness and contexts of the alternative selections, for these may aid or restrict our learning. But many of us caseworkers feel that good case study does not depend on being able to defend the typicality (of a case).*
>
> Stake (1995: 4)

The practice placements, each acting as a case, were selected purposely to incorporate:

- the different types of placement recommended by the participants in phase I;
- the types of placement visited as reconnaissance areas;
- the different branches of nursing under consideration;
- geographical spread incorporating placements from each of the four schools of nursing from which participants from phase I of the study were drawn.

Moreover, ensuring balance and variety in the chosen sites was important so that in exploring the case study sites I had some opportunity to reflect upon all of the focus group data from phase I of the study. With these considerations in mind, eight practice placements were originally selected for a more in-depth exploration (Table 2.7).

Constructivist inquiry requires that the research be undertaken in the natural setting of the phenomena in question (Guba and Lincoln 1989, Rodwell 1998), and Erlandson et al (1993) emphasise the importance of establishing a rapport with community leaders, in this case placement leaders. All of the placements selected for exploration had been visited during the reconnaissance stage of this phase of the study. Expressions of interest in participating in more in-depth study were sought from all the placement leaders and none declined. Consequently when the final selection was made much of the early ground-work in terms of establishing interest and building up relationships with placement leaders had already begun. However, I contacted each placement leader by telephone explaining the research again and what participation at this level would involve. This was followed up with written information and a reply slip. All the placement leaders were willing to participate in the study. Following a positive reply I contacted senior managers for permission to access the practice placement. Frequently placement leaders had already discussed the project with line managers. Once the permission of a manager had been granted, I then sought approval from the local research ethics committee (Appendix IX). Once outline approval to undertake the research had been given, participation and consent was negotiated with individual students and members of staff on the placements.

Table 2.7: In depth case study placements selected from the reconnaissance visits

Placement		School of Nursing (see Appendix I for full description)	Location	Branch
A	Psychiatric community services, day hospital and assessment unit for elderly people	4	Geographically isolated post industrial coastal area in the north-east of England	Common Foundation Programme/ Mental Health
B	District nursing team	2	Inner city community divided into older terrace properties and 1970's flat-roofed houses and high rise flats	Adult
C	Orthopaedic rehabilitation ward	2	Located and on the outskirts of a large conurbation in the south west of England which it served	Common Foundation Programme/ Adult
D	Acute mental health assessment unit for the elderly	1	In the suburbs of a large city in the Midlands.	Common Foundation Programme/ Mental Health
E	Medical admissions unit	2	Commuter town in the south east of England. Mixed housing, majority close by Victorian villas	Adult
F	Stroke unit	1	In a large hospital serving a major Midlands conurbation in England	Common Foundation Programme/ Adult
G	Care home	4	Small commuter village serving two towns in the north-east of England	Common Foundation Programme
H	Learning disability group home	3	Large house and gardens built in the 1950's in a residential area of a large conurbation in the south of England, close to all amenities	Learning Disability

One placement, a learning disability home for older deaf clients, had recently been assimilated into a new Trust. Contacting the ethics committee of this Trust was time-consuming as initially they felt that the placement fell outside their jurisdiction. Following protracted discussions, complicated by summer holidays and staff sickness, the ethics committee approved the research. However, they were concerned that the residents of the home would be caused anxiety and required that researchers should be able to communicate using sign language. Unfortunately by this time it was not feasible for me to learn sign language nor to select and approach another placement. Therefore seven practice placements became case study sites.

The intention of the case studies was to explore the styles of mentorship and placement leadership in the case study sites, and the ways in which they influenced student experiences of learning to care for older people, and the creation of a positive learning environment in relation to the needs of older people and their families. The principle data collection method was interview. I undertook one-to-one interviews with the students at the beginning and the end of their placements. I also interviewed mentors, placement leaders, care assistants and occasionally older patients themselves. Contextual information was gathered by observation. I conducted 1–4 days of observation in each placement over a period of 4–6 weeks. I observed some caregiving, mentoring and other related activities.

Undertaking interviews

Within constructivist research the interview is the primary data collection tool (Rodwell 1998). The interview is seen as a context – embedded conversation with a purpose where both the purpose and the context shape what will be said. Interviews are not neutral tools of data collection, but require active interaction between two or more people leading to negotiated, contextually based results (Kahn and Cannell 1957: 149). Interviews vary in structure from the highly structured statistical interview, through semi-structured to unstructured interviews. The varying types of interviews can be conceived of as different points on a continuum (Rose 1994):

- The **structured interview** is a highly controlled encounter in which the interview schedule takes the form of preformatted questions asked in a set order (Rubin and Rubin 1995).

- The **semi-structured interview** is one where the interviewer asks certain major questions in the same way each time but is free to alter their sequence and probe for more information (Fielding 1994) allowing the researcher to use prior knowledge to help them in the process. At the same time the informant retains the freedom to address the issues that they deem important and to talk about them in a way that they choose.

- The **unstructured interview** is said to be unorganised as opposed to disorganised (Rose 1994). The interviewer has a list of topics they want participants to talk about but is free to phrase the questions as they wish, to ask them in any order that seems sensible at the time and even join in by discussing what they think of the topic (Fielding 1994).

Rodwell (1998) proposes that the interview schedule in a constructivist inquiry should take the form of foreshadowed questions and sensitising concepts. This suggests a semi-structured approach. Fielding (1994) contends that there are two principles that inform research interviews. Firstly, questions should be relatively open in order to allow participants to contribute as fully as possible to the construction, and secondly, questioning techniques should encourage participants to communicate underlying attitudes, beliefs and values rather than give glib answers. Consequently, setting the tone of the interview is important and Rodwell (1998) recommends the use of a grand tour question, (a term derived originally from ethnographic research, meaning a broad universal question (Spradley 1979) used to give the participant practice in the process. The initial questions should also create a relaxed atmosphere and help the individual to provide thoughtful information (Rodwell 1998). More specific questions should be introduced as the interview progresses in order to achieve greater clarity and to develop points. Rose (1994) points out that while it is sometimes implied that anything that participants say is valuable data, in practice researchers (and frequently busy participants) are

constrained by time and the needs of the research project. It is therefore important to offer guidance to participants during the interview. As Rodwell puts it:

> *In short, the inquirer dialogues, inquires, sustains the conversation, becomes a partner in meaning generation, and finally, terminates and closes the activity.*
>
> (Rodwell 1998: 126)

In concluding the interview the researcher should summarise what they believe has been said at the close of the interview while asking the participant to verify, amend, and extend the constructions of the researcher (Rodwell 1998). It is important to be honest, recognise mistakes and learn from them. May (1991) suggests that systematic preparation for each interview can help achieve balance and this includes reviewing field notes from previous interviews and taking stock throughout the interview to judge whether additional questions might be needed.

Undertaking interviews in this study

Seven case studies of practice placements were undertaken with the aim of identifying the cultural and organisational factors that influenced the student experience. One-to-one interviews with students were undertaken at the beginning and where possible, the end of their placements. Sometimes students had already been on placement for some time when data collection commenced and in these circumstances one interview was undertaken. In other situations, despite having made arrangements to see them, students were not available for a second interview, either because they were off sick or off duty, this latter having been changed before my arrival. However, I found that many mentors had made their students aware of the project and wherever possible I interviewed both the students and their personal mentor (separately) in order to gain a deeper insight into the dynamics of this important relationship. In total 56 interviews were undertaken as illustrated in Table 2.8.

Table 2.8: The numbers of student, mentor and placement leader interviews undertaken in the case study sites of recommended practice placements

Placement	Placement leaders	Student numbers visit one	Mentor numbers	Student numbers visit two	Older people
A Psychiatric community services, day hospital and assessment unit for elderly people	2	4	2	4	0
B District nursing team	1	1	2	1	1
C Orthopaedic rehabilitation ward	1	3	2	3	1
D Acute mental health assessment unit for the elderly	1	2	1	1	0
E Medical admissions unit	1	2	2	2	1
F Stroke unit	1	4	2	2	0
G Care home	0	2	1	2	2

The interviews were conducted in the practice placement setting in private areas wherever possible, such as a resource or interview room. Participants were assured that no member of the placement staff or the school of nursing staff would be given direct access to their comments, and students were assured that taking part would have no effect on their practice assessment, although, as described earlier, the possibility of direct quotes being recognised by the participant or their associates was raised. The interviews began with a broad question, which allowed both participant and researcher to settle. For example, students were asked to reflect upon their experiences of caring for older people to date and this was followed by general questions asking them to describe the characteristics of their ideal mentor and to talk about their expectations of their placement (see Appendix VII). The interviews lasted between 30 and 60 minutes. I concluded the interview with a summary of what had been discussed and, in the case of the students, arrangements were made to meet again to discuss the placement experience.

After each interview I wrote individually to the students thanking them for their participation and mentioning when the next interview was planned. I telephoned before the second interview to establish that participants wished to continue with the project. The second interview with the students built on the first, with topics raised and views expressed explored in light of the placement experience. Moreover, towards the end of the interview issues raised in the focus groups during phase I of the study were introduced for consideration and evolving definitions of elements of the Senses Framework were also shown to the students for comment and feedback in keeping with the constructivist approach.

In interviewing mentors I asked them for their views relating to the care of older people in their clinical area. Other questions addressed mentors' perceptions of students' learning needs. I also asked mentors for their opinions of the nursing curriculum. Wherever possible, questioning encouraged mentors to give practical examples of the ways in which they met students' learning needs. Placement leaders were asked about the importance of students and their learning to the clinical environment. Other questions related to their understanding of and beliefs about nurse education, and their approach to mentorship.

While Rodwell (1998) proposes interviewing as the primary method for constructivist inquiry, she concedes that observation can complement the information available from interviews alone. I therefore decided that it would be beneficial to use some very limited observation in addition to the interviews.

Observation in principle

Observation has been described as 'listening with the eye and ear' (Kadushin 1990), and ranges along a continuum from complete participation with no data collection, to complete observation with no participation and only data collection. Either type of observation can complement interviews in the constructivist paradigm, not for validation purposes but as a form of further information gathering. Rodwell (1998: 127) holds that participant observation includes '*weaving a process of looking, listening, watching, and asking into the natural context of the observation*'. Lofland and Lofland (1995) see a 'mutuality' between participant observations and

interviewing as in many cases the details of the social situation that are being observed only make sense after an intense interview.

Data collection in observation should be subject to some systematic organisation. Rodwell (1998: 128) maintains that observation should be undertaken in a way that parallels the interview process used in a study. The form of observation may vary depending upon the stage of the study, however, as the study becomes more focused so too does the observation. Data from the observation are not entered into the raw data to be unitised for analysis but rather are used as '*background to extend depth and scope in the meaning making and reconstruction*'. Rodwell (1998: 128)

Observation in this study

The purpose of my observations on the recommended practice placements were:

- To develop vicarious experiences for the reader (Stake 1995, Rodwell 1998), to give them a sense of being there. To do this the physical environment of each practice placement was detailed and the client group described in order to give readers an understanding of the clinical and nursing context (see Appendix VIII).

- To further illuminate the students' experience and to help the researcher to develop the constructions of the stakeholders (students, mentors, placement leaders and staff) the elements of a typical placement day were recorded (see Appendix VIII).

- To explore the practical ways in which these recommended placements met the needs of students, as recounted in the focus groups.

Rodwell (1998) recommends participant observation as the method of choice, where data is created in a relationship with participants and the researcher can check for '*meaning in the moment'* (Rodwell 1998, p127). However, my level of participation was limited primarily because of time constraints. This meant that I was unable to engage in prolonged periods of observation during each case study placement. I

actually spent between one and four days in each area, spread over two visits, and therefore was unable to build in-depth relationships with participants. Consequently, I chose primarily to observe the mentors, students and placement leaders in activities relating to student learning. The process of using observation as '*background*' (Rodwell 1998) seemed particularly relevant to this study, as I wished to deepen my understanding of the context of the student placements with older people.

Analysis of the case study data

The aim of undertaking this part of the study was to explore the ways in which the recommended practice placements met (or otherwise) the needs of students learning to care for older people, thus contextualising and illuminating the experiences identified in the focus groups.

Analysis of the case study data was concurrent with data collection and emerging themes were supplemented and clarified at each visit. Analysis of the interview data proceeded in the same way as in the focus groups.

Once data collection at each of the six sites was concluded detailed analysis of the case study was undertaken in three stages:

- Analysis of data from each practice placement – within-case study
- Analysis of the data across practice placements – cross-case analysis
- Integration of the case study data with the longitudinal focus group data from phase one of the study.

Case researchers seek both what is common and what is particular about the case (Stake 1995). With this in mind I created parallel accounts of the philosophy, structures and processes influencing the experiences of student nurses within the individual practice placements. The placements were very different in terms of

environment, client group, branch and geographical setting, and it felt important to capture the essence of each individually (the *particular*) as well as what was *common* (see Appendix I).

Reading and rereading the data in various forms from both the focus groups and the case studies began to once again reinforce the relevance of the Senses Framework and to consolidate the foci that had been identified during the focus groups. In this way it was possible to further elaborate upon how the Senses were relevant to the student experience and the ways in which they exerted differing influences over time as reflected in the foci. In particular, the case studies illustrated the characteristics of an enriched environment for students and the factors that operated to create and sustain such an environment. The results of both the longitudinal focus groups and the case studies are presented in the following two chapters. However, before this, attention is briefly turned to quality in constructivist inquiry.

Quality in constructivist inquiry

The issue of judging the quality of constructivist studies has yet to be fully resolved (Guba and Lincoln 1994, Rodwell 1998) and remains a contested area. However, two broad sets of criteria are generally applied, one relating to the so called trustworthiness of a study and the other to the study's authenticity.

In their early writings Lincoln and Guba (1985) were concerned that their emerging naturalistic (constructivist) inquiry paradigm would be seen by other more traditional scientific (positivist) researchers as being undisciplined and merely subjective with no appropriate criteria to judge the rigour of a study. They saw the basic issue as relating to the trustworthiness of an inquiry, with the key question being *'How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?'* (Lincoln and Guba 1985: 290). In order to address this question they proposed a set of so-called 'parallel' criteria that they saw as mirroring the commonly accepted quality canons of positivist service, namely: internal validity; external validity; reliability and objectivity. The way in which these parallel criteria are defined is captured below in Table 2.9.

Table 2.9: Parallel quality criteria and their key concerns

Traditional criteria	Constructed criteria	Key concern
Internal validity	Credibility	Is there a full understanding of the scope and depth of the issues under study?
External validity	Transferability	Can the information created and lessons learned have meaning and usefulness in another context?
Reliability	Dependability	Are the procedures used to collect, analyse and interpret data consistent with the expectations of a constructivist inquiry?
Objectivity	Confirmability	Are the results as reported linked to the data, can the logic of the development of working hypothesis be followed?

(After Rodwell 1998)

Various strategies are suggested for addressing the above criteria and these will be considered with respect to the present study shortly.

However, it was widely recognised, both by Guba and Lincoln (1989) themselves, and by others (Rodwell 1998) that the creation of the parallel criteria was a direct response to criticisms from within positivism, and that there was a largely pragmatic

reason for doing so – that of convincing funding bodies that constructivism was indeed robust.

Consequently, Guba and Lincoln (1989) expressed their dissatisfaction with the parallel criteria, as they were primarily methodological and largely addressed issues of process. They therefore discussed an additional set of criteria that they termed the 'authenticity criteria', which they believed more clearly reflect the principles upon which constructivism is based. As Rodwell (1998) notes, *'Authenticity captures the value pluralism, multiple perspectives and qualitative change focus of constructivist inquiry'*. However, it is the parallel trustworthiness criteria that have become the best known and most widely applied, often being used as quality criteria for qualitative research more generally. The extent to which the present study might be said to have met the parallel criteria is considered here, with a reflection on the authenticity criteria being provided in Chapter 5 once the results have been presented.

The way in which the present study sought to address the trustworthiness criteria is outlined below, starting with credibility.

Credibility

As noted in Table 2.9 credibility attests to the '*process and product accuracy in understanding the depth and scope of the issues under study*' (Rodwell 1998: 98). The intention is to promote clarity on the part of the stakeholders and prevent misinterpretation on the part of the researcher. The most important point is that the analysis and interpretations of the researcher are believable to those who participated in the construction of reality represented in the final report.

Lincoln and Guba (1985) recommend a variety of activities to increase the probability of credible findings, including prolonged engagement, participant observation, triangulation, peer debriefing and member checks, all of which were applied to a greater or lesser extent in the present study.

Prolonged engagement involves lengthy purposive contact with the context and the stakeholders connected to the issue of interest (Rodwell 1998: 98). In this study interaction with participants in phase I took place over an 18-month period, allowing me to build up a relationship with them and to gain their trust. Moreover, it gave me the opportunity to go back to participants over time to ensure that my understanding of what was being said was accurate. However, the engagement in the case study sites was much shorter and feedback was therefore necessarily reduced, but by including a second interview with the students every effort was made to maximise the period of engagement.

It is through **persistent observation** of the issues of interest with the stakeholders that emerging themes become familiar enough to be understood and appreciated, or rejected as irrelevant for the purposes of this inquiry (Atkinson and Hammersley 1994). Repeatedly discussing developing and emerging understanding of the Senses Framework as it related to student nurses with participants allowed for a distillation of ideas and offered different perspectives, as the student participants also underwent some changes as the course progressed. This longitudinal element of the study significantly enhanced opportunities for both prolonged engagement and persistent observation.

Triangulation occurs when one data source is compared with another (Denzin 1978 referred to by Rodwell 1998: 98). Guba and Lincoln (1989) moved away from triangulation as a credibility check, suggesting that its overtones are too positivistic, but they did advocate **cross-checking**. The general idea of cross-checking is central to the hermeneutic process and Rodwell (1998: 99) suggests that it helps us to gain full understanding of the reality in construction. Cross-checking of ideas was facilitated throughout the present study. Methodological cross-checking was facilitated as early working hypotheses generated in the initial focus groups were subjected to wider scrutiny through a national survey of student nurses, which were then further cross-checked in the later focus groups. Subsequently developments in the ongoing construction were advanced and tested with students and mentors in the case studies in phase II and fed back into further focus groups through the hermeneutic cycle. Researcher cross-checking was achieved as members of the AGEIN research team contributed to and commented on the work of colleagues in

the team. The extensive literature review and synthesis, together with a consideration of the existing empirical studies, allowed for the Senses to be subjected to considerable theoretical cross-checking (see Table 1.3).

Peer debriefing involves working with someone uninvolved in the inquiry process but who is in a position to ask difficult questions, explore next steps, support and listen. '*The peer reviewer gives advice, adds perspective, offers technical assistance, and helps to process the strong feelings, anxieties, and stresses that naturally result from such a complicated, intense process so that it does not negatively affect the inquiry*' (Rodwell 1998: 99). In a study of this nature this role was undertaken primarily by my supervisors. However, it might legitimately be argued that they are too close to the study to undertake this role as described above. But, as most of the study was also a part of the AGEIN project, the role of peer debriefing was also undertaken by the project Advisory Group. This comprised mainly individuals who had neither been involved in commissioning the study, nor were involved in conducting the research; all, however, had expertise in the field. It is therefore suggested that my supervisors provided one element of peer debriefing which was complemented by that provided by the Advisory Group.

Member checking was an extensive feature of this study, with formal and informal checking of information with participants being undertaken through the hermeneutic circle set up with the focus group members in phase I of the study and facilitated by prolonged engagement with study participants

Dependability

Dependability is about ensuring that all procedures used to collect, analyse and interpret data fall within the constructivist umbrella. Changes prompted by the emergent design in this study have been accounted for and supported by the data and feedback from the focus groups in phase I, and the case study data from phase II, and have been clearly articulated in this chapter. Triangulation or cross-checking (see above), which is used to establish credibility, also helps to establish dependability. Ultimately, however, the dependability of a study can only be judged by readers. In respect of this thesis it is hoped that sufficient detail has been

provided for the reader to make judgements as to whether the collection, analysis and interpretation of data are consistent with good constructivist research.

Confirmability

Confirmability is about asserting the reasonableness of the inferences and the logic of the theory that evolved from the data (Rodwell 1998: 100). In other words, do the results as reported link clearly to the data? Given the same data another researcher may construct something different, but this is not an issue; what is important is that an outside reader is able to discover and follow the logic that took the inquirer from the initial raw data to the final product (Rodwell 1998: 100). In this study confirmability involved good record-keeping and offering the reader insight into the analytic decisions made during the process of construction. Claiming confirmability also means that the researcher is confident that the results reflect the voices of all participants and are related to the context from which they were gained, and are not just a reflection of the researcher's *'cognitive processes of meaning making'* (Rodwell 1998: 101). Once again triangulation and member checking play a role in ensuring confirmability, and as will be apparent, every effort was made to try and ensure the full engagement of participants in the present study.

Transferability

Transferability (not to be confused with generalisability) allows for the possibility of information created in one context having meaning and usefulness in another (Rodwell 1998: 101). While there is a belief within constructivism that every context and every experience is unique, there is also recognition that tentative findings in one context may have some applicability in another. However, in this study, as with all others, the decision about usefulness in other environments remains with the reader of this thesis, or the publications that come from it. The aim here has been to provide sufficient information to allow the reader to determine if transfer of all or some part of the findings is possible.

Transferability is therefore still a matter of judgement, but such a judgement is assisted if the reader is provided with a '*thick description*' of the time, place, context

and culture in which the data were collected (Guba and Lincoln 1989). As Rodwell (1998) asserts, the account should be *'richly descriptive enough to impact vicarious experience of the setting, the problem and the findings'*. Inevitably, in a thesis that is subject to a word limit, such a thick description has limitations. However, it is hoped that the account provided here, supplemented by detail in various appendices, is sufficient for the reader to make a reasonably informed judgement as to the transferability of the study to other contexts.

Having paid attention to the issue of the trustworthiness of the study, I now proceed to present the results of the longitudinal focus groups.

CHAPTER 3
FINDINGS FROM THE LONGITUDINAL FOCUS GROUPS AND RECONNAISSANCE VISITS TO PRACTICE PLACEMENTS

This chapter presents the results from the analysis of the longitudinal focus group data, and the reflections from the reconnaissance visits. As described in the preceding chapter, originally the Senses Framework was used to generate a series of sensitising concepts that provided a very loose structure for the data collection and analysis. However, it rapidly became apparent that the Senses had great relevance to the student experience and provided a potentially very useful device to begin to articulate some of the characteristics of an enriched environment from a student perspective. Consequently, in conjunction with the students, the Senses were explored more explicitly and the results of these analyses are therefore presented with respect to them, and in particular:

- the positive consequence of each Sense – that is informants' descriptions of how they felt when they experienced each Sense in a positive way;
- the negative consequence of each Sense – that is informants' descriptions of how they felt when the Sense was not present or was experienced in its antithesis;
- the factors that helped to create each Sense;
- the factors that militated against the creation of the Sense.

In the latter part of the chapter attention is turned to the various foci that were identified. These help to understand how students' needs for the Senses change over time throughout their training.

Reflecting the main research questions, participants' views of their experience of learning to care for older people were consistently sought. However, students found it difficult to separate such experiences from their overall experience of learning to care. Therefore, it soon became clear that many of the issues raised by informants transcended a specific client group and had wider applicability and relevance across the student experience as a whole. This is significant because for participants in this study, work with older people per se was not unpopular, rather it was their particular

experience of such work that exerted the greatest influence on their future career options. This was summed up by one participant as follows:

> *I think I would definitely work with older people but I don't want to work in a setting like I have just been. It's not really the client group that determines if you like working in a place, it's about facilities, the environment, the staff.*

This reinforces the usefulness of the concept of an enriched or an impoverished environment. In exploring what 'determines if you like working in a place' the findings from this phase of the study begin with an overview of the Senses as they were described by the study participants, together with a detailed account of each Sense and the ways in which they are either created or inhibited by factors operating in the practice environment. Informants were also asked to reflect upon their career intentions, and the factors that might influence these intentions. Their responses were considered alongside the data gathered from the reconnaissance visits to practice placements. On this basis it emerged that, although all the Senses were important to students throughout their training, their relative influence varied over time as the course unfolded. Consequently, this chapter considers how the Senses differed as students focused on differing aspects of their course. The foci that emerge map in a longitudinal fashion the subtle shift in emphasis from **self as focus** through to **person as focus**. The findings begin with an overview of the Senses as perceived by students.

Overview of the Senses as Perceived by Student Nurses

As noted earlier, the relevance of the Senses to a better understanding of the students' experiences became apparent in the very early focus groups, with students often spontaneously using the same words and phrases adopted by the team. For example, one student said *'I want to feel safe and secure'*. Therefore, as part of the ongoing 'construction' of knowledge, the Senses were explored more explicitly in subsequent rounds of data collection and students were presented with, and invited to challenge, a number of ways in which the Senses were conceptualised in order to arrive at a shared definition of each Sense, which could then be explored in greater detail. This section of the chapter presents an overview of each Sense in terms of its

broad definition, together with how the Sense was experienced and those factors which either facilitated or inhibited it.

The Senses as they were originally conceptualised, and later refined (Nolan 1997, Davies et al 1999, Nolan et al 2001b, c), were not intended to be hierarchical, but to interrelate and exert a mutually reinforcing and reciprocal effect. Therefore, although the Senses are discrete they also overlap. However, it emerged from the student data that there was an element of temporal ordering to the Senses, with some being more prominent at early stages in the pre-registration nursing programme, to be superseded in importance later, only to emerge to the fore again subsequently. For example, as might be anticipated, during their early placements a Sense of security and belonging were highly significant, possibly reflecting some of the anticipatory anxiety students feel (see survey data). At this point it was important for students to feel safe and welcome on the placement. Later, however, as they became more confident, safety and belonging were rather taken for granted and students wanted clear and valued goals to which they could aspire, reflecting a Sense of purpose and achievement. Interestingly, as students neared qualification and realised that they would soon leave the comparative safety and security of student status, the need to feel secure and to belong once again become overriding concerns. This would suggest that there is likely to be a temporal ordering to the Senses of which it is important to take account.

The data from the reconnaissance visits to practice placements also suggested that students needed to feel safe and secure before the other Senses could be experienced. Therefore, in presenting the results the Senses will be considered in the following order: security, belonging, continuity, purpose, achievement and significance.

A Sense of Security

Factors that contribute to fostering a Sense of security

As might be anticipated, given the variety of practice placements that students experience, and the need to change placements throughout their training, feeling safe

and secure within a given environment was of considerable importance. It is not surprising, therefore, that a Sense of security surfaced as key at several points in data collection, particularly at the beginning and towards the end of training. However, feeling safe did not equate with being constrained, and students also wanted to feel safe to practice their developing skills in a secure environment. Security for students might therefore be encapsulated by the term *freedom within boundaries*. As students progressed it was important that these boundaries became more flexible, but not entirely permeable. Early in their training, however, more basic considerations applied and students did not want to feel or look foolish or incompetent but neither did they wish for harm to befall patients if they were left to perform tasks for which they felt unprepared. Students also wanted to feel that they could express their needs without feeling inadequate, and to have the emotional and physical demands of their role recognised. Essentially, what students wanted, was to be free to learn and to 'be a student', while simultaneously being allowed to explore what it meant to 'be a nurse'.

A Sense of security might therefore be defined as:

> *The freedom to learn and explore roles and competencies within a supportive but enabling environment which recognises the physical and emotional vulnerabilities of being a student.*

This notion of recognising vulnerability (or potential vulnerability), while at the same time promoting confidence, was an important balancing act that was a characteristic of the best learning environments. Indeed, for students, knowing that they had someone to turn to if things were not going well, or when they had been exposed to poor practice, was an essential attribute of a 'secure' environment, and the role of the mentor was crucial (see later). However, fostering of a Sense of security was not just a facet of the practice environment and although relatively little reference was made to the school or university, the need for careful preparation for placements was very important.

Several factors therefore contributed to fostering a Sense of security and central to these were:

- Being well prepared
- Feeling supported
- Having help to 'talk things through'

Being well prepared

The majority of students who participated in the focus groups had experienced prior contact with older people, often in some formal work capacity as a care assistant or a similar role. To a degree, therefore, many students were already 'prepared'. However, not all such experience was necessarily positive and some of the early focus groups identified students who, because of their prior experience, were very apprehensive about the prospect of their placement with older people. Furthermore, even for informants with considerable experience of work with older people, their change of role and their new 'student' status meant that most felt the need to be well prepared for their placements. Many wanted to feel equipped with the clinical skills that they anticipated using, whereas for others the focus was on a better understanding of the relevant theory needed to make the most of their placement in academic terms. The best type of preparation helped students to begin to make connections between theory and practice, and also to alert them to the demands and expectations of being a student:

> *I found one of the tutors used to use practical examples and he really made it very interesting. He put theory and practice together. He was really interested in it and gave you a much broader perspective on health care... I mean we could do with more practical experience but the academic, I have found personally has been very helpful in helping me to understand how I feel about nursing.*

Feeling supported

No matter how well prepared students were prior to their placement, this counted for little if they did not get the support that they felt they needed while 'out there' on placement. This support could come from a variety of sources and might include link tutors from the university. It was also important that there was positive leadership in the clinical area and that 'boundaries' were clearly communicated. However, the role of the mentor was probably the single biggest influence:

> *If you've got a good mentor then you usually have a good placement. They want to teach you their knowledge as well. They discuss the objectives. They are supportive. Someone who facilitates, makes you feel part of the team. You are free to ask questions.*

As this quote suggests, the role of the mentor was multi-faceted and key, not only in providing an initial feeling of being safe, but subsequently in creating a learning environment where students felt free to challenge without threatening their status as 'part of the team'. This notion of being 'part of the team' falls more clearly into the Sense of belonging but is useful here as it illustrates how the Senses interact in a mutually reinforcing way.

It is also important to recognise that students did not only get support from what might be termed 'formal sources'; older student nurses, family and friends were also significant.

Help to 'talk things through'

Some focus group members described vividly the characteristics of what was termed impoverished environments (see Chapter 1), and it would be naive to assume that the students in focus groups were exempt from such influences. Of course in the 'better' placements' one would not anticipate exposure to seriously compromised standards of care, and indeed some of the best placements demonstrated that it was not the 'physical environment' that was the key determinant but more the ethos of care, as encapsulated by the Senses. Nevertheless, throughout their training students encountered incidents that fundamentally challenged their notion of acceptable care, and even in the better areas sometimes came across practices which they would question. A secure environment would acknowledge this, creating an atmosphere in which students felt safe to raise concerns and also help to 'talk things through' so that an appreciation of 'other' perspectives might be gained:

> *While I sit there pulling my hair out about placements, saying are they really allowed to talk to people like that, he will explain how they* [nurses] *came to be talking like that in the first place. He will give me their perspective and my perspective and he finds the bit in the middle.*

It should also be remembered that, especially during their early placements, it is not just poor or questionable care that students find challenging, but also some of the emotionally stressful moments to which they are exposed. There also needs to be a secure place in which to explore and 'think through' these issues:

> *On my last day it was very emotional. Someone* [an older person] *had cancer. It was my first experience of my hearing someone telling someone they had cancer. Knowing they are living with it, it was so touching, I couldn't take it I had to go out, it is difficult to accept.*

Although the above section may contain little data referring directly to older people per se, creating a Sense of security appeared to be essential to the way that students developed their perceptions and predispositions to work with older people. Firstly, until they felt secure, students were not able to focus on the needs of any client group, whether they be older or not. Secondly, and perhaps more importantly, those wards that created a Sense of security for students were also far more likely to do so both for other staff and for patients. As will be apparent later, these are the very sorts of environments that are more likely to provide good, or even excellent, care (Davies et al 1999).

Feeling secure

It was often difficult for students to capture in their own words what it was like to feel secure; perhaps the word itself is descriptive enough. However, many found it all too easy to describe what it was like to work in an environment which did not promote a Sense of security. An indication of the range of disparate emotions that resulted is provided below:

- Feeling paranoid, emotionally unprepared
- Feeling unsupported
- Feeling intimidated
- Feeling of too much responsibility or not knowing who to turn to
- Not wanting to go back
- Feeling like going off sick

- Feeling anxious, apprehensive, terrified, scared or alone
- You feel worried
- Feeling shocked

It is obviously important to be able to provide positive examples of the way that a Sense of security can be created, given the above extensive (but by no means exhaustive) range of emotions, but it is also essential to recognise those factors that militate against it.

Factors inhibiting a Sense of security

Perhaps not surprisingly, many of the factors that made it difficult to achieve a Sense of security were mirror images of the circumstances in which such a feeling was promoted. These included:

- Feeling unprepared
- Feeling unsupported
- Feeling that staff lacked the requisite knowledge and skill.

Feeling unprepared

The issue of preparation was particularly important with respect to caring for older people, especially for students who had no prior experience, or whose prior experience had been negative. Some students already had a potentially negative view, either based on prior experience or underpinned by misconceptions about older people:

> *If we are going in with this perception ... oh no it's the elderly placement coming up again, then it's not going to teach us, it's not showing us that it's not just all cleaning bums.*

Unfortunately the data suggested that there were few concerted efforts to portray a more positive view of older people. Many students had difficulty discussing the theoretical content of their course relating to older people that they had received in the classroom, or in identifying how theory was applied in practice settings. When

pressed, some students could identify isolated sessions (frequently around elder abuse), often given by a particular person who was enthusiastic about the care of older people. However, for the majority it seemed that the care of older people was 'touched on' within classroom sessions when other topics such as diabetes were discussed. This is consistent with the study sites that adopted an integrated approach to teaching the care of older people (see Appendix I and Table 2.3).

Lack of preparation was not limited to theoretical content, and early in the course students had a real sense of not being sufficiently prepared clinically before going on placements. Having limited opportunities to practice their skills in the clinical area compounded this feeling. More senior students talked of this lack of preparation in relation to being qualified:

> *But then you are going out into the workplace and if you have spent the last three years learning basically nothing, you are on your own, then on your head be it.*

However, it was those students anticipating their first placement for whom a perceived lack of preparation had the biggest impact. The following comment is particularly insightful, suggesting that older people are not like 'regular people' and that some students without prior experience are unprepared for the levels of dependency that they might encounter:

> *I expected to see a big wide range of adults. Just like regular people. Not just people that should be in old peoples' homes – just people that can't be looked after at home.*

Feeling unsupported

The vital role played by the mentor was one of the key factors that helped to provide students with an all-important Sense of security once on the wards. Moreover, as has already been discussed, being secure helped students to feel free to challenge care and to explore their role without threat of censure, rebuke or appearing foolish. Unfortunately, this experience was by no means universal, and several students were allocated a mentor with whom they had little contact through illness, shift patterns or holidays. In such circumstances emotions such as feeling 'alone', 'scared',

'overwhelmed' or 'not knowing who to turn to' surfaced. For others there was the feeling that their mentor was not interested in teaching and this threatened one of the fundamental elements of a Sense of security, being able to take 'safe risks':

> *You don't feel safe when your mentor isn't interested in teaching you. If I can't make a mistake when I am a student, when can I make a mistake, but if I haven't got somebody watching me, how can I take that risk now.*

The idea of a 'safe risk' might appear to be an oxymoron but it is essential to a full appreciation of students' need to 'stretch their wings', secure in the knowledge that there was a safety net, both for themselves and – crucially – for the patient. This issue was of particular importance in relation to completing assessment documentation, as students wanted to feel that they had been assessed as 'competent' by someone who was fully aware of their skills and abilities and therefore had a firm basis on which to make a decision. Most students, however, felt that mentorship was rather like a lottery, yet it could 'make' or 'break' a placement.

In the present context the presence of a good mentor served another important purpose, as without the guidance of an 'old hand' who could talk them through the needs of older patients, students often failed to grasp the complexity of gerontological nursing and struggled to envision a picture of holistic care and practice. This often tended to dampen their enthusiasm:

> *I was ignored or sent out of handover everyday because the room wasn't big enough and they refused to hold it anywhere else. So subsequently I never heard the full details for every patient throughout the whole placement, which completely spoilt it because I didn't know their history and I couldn't get interested.*

Feeling that staff lack the requisite knowledge and skills

One critical attribute of a 'safe' environment is that students feel they are working with staff who not only have a passion for their area of practice but are also skilled practitioners. While this was evident in the 'better' placements, students often questioned the ability of staff, especially as they became more experienced, knowledgeable and confident themselves. Particular problems were identified in

relation to older people with organic mental health or cognitive deficits, and those with challenging behaviour. Students frequently expressed concerns that staff tended to focus on 'containing' patients rather than using a more therapeutic approach:

> *... She has a problem, she walks all the time, we have to tell her to sit down and take a break. But when she went to the nursing home they said 'oh she's wandering around all over the place'. I thought, good God we're used to this. As nurses aren't they supposed to be trained to do these things? They are supposed to be professionally trained. They haven't got any experience at all in dementia.*

Students usually appreciated that qualified staff sometimes faced situations which they were not trained to handle and that, especially in the private sector, opportunities to update were limited. Such sensitivity, however, did little to alleviate their own feelings of insecurity. In other instances some students felt that the practices they witnessed were an affront to their own 'professional' standards, yet they might have no one to turn to in order to 'talk it through'. It was in such circumstances that some of the most extensive negative emotions surfaced, with words like 'nightmare', 'shocked' and 'scared' being used. Unfortunately, several of these instances related to the care of older people, providing yet further examples of the effects that an 'impoverished environment' can have. Nevertheless, it was heartening to hear students describe areas in which they achieved a real Sense of security for themselves, and witnessed a good standard of care for older people.

Allied to a Sense of security, notably for students in their early placements, was the need for students to feel 'part of the team', that they in some way 'belonged'.

A Sense of Belonging

Factors that contribute to fostering a Sense of belonging

Given the need for students to change placements on a regular basis, the ability to 'fit into' different environments, while at the same time feeling part of something, was another key indicator of a quality placement. Therefore, following the creation of a Sense of security it was important for students to feel that they 'belonged'.

Although students 'belong' to several groups, some more permanent, such as their branch cohort, and others, especially on the wards and clinical areas, more transient, it was the latter in which the need to 'belong' was seen as paramount, especially at the beginning of each new placement. A 'Sense of belonging' can therefore be defined as:

> *... feeling part of a defined group with a clear and valued role to play, mainly, but not exclusively, within the clinical area. Identifying with a community of peers, belonging to a cohort of students.*

Given the diversity of clinical placements, students needed to adapt quickly to differing cultures and expectations. However, beneath this heterogeneity there were certain attributes that inevitably helped to create a Sense of belonging. These were:

- Being made to feel welcome
- Accessing the 'team spirit'
- Clear leadership
- Playing your part
- Identifying with older people

Being made to feel welcome

The old adage 'first impressions count' is particularly apt here, as students' first perceptions of their placement often set the 'tone' for the duration.

Students who felt that they were expected and were made to feel welcome from the outset settled in much more quickly. The role of the mentor, both during the early phases and throughout the placement, was again pivotal. Consequently, the degree to which students felt they belonged or not was in large part dependent on whether their mentor 'brokered' their relationships with other members of the ward team. Simple ways in which this could be achieved included mentors waiting for students in changing areas so that they could go on duty together, and introducing students to other members of the multi-disciplinary team:

They straightaway make you part of the team. I know it sounds stupid but with things like, 'make sure you don't go for your dinner on your own'. I know it sounds daft, but when you are a stranger ...

However, mentors were not the only people who helped students to feel that they belonged, and respondents also identified the role of senior nurses and the willingness of auxiliaries to involve students. Older people and their carers also had an important role to play in making students feel part of things. Indeed, informants often felt that older people saw students as less intimidating, more approachable and as having more time to talk to them. This, as will be noted later, was often key to students' being able to identify with older people.

Accessing the 'team spirit'

It may seem self-evident, but students who felt that they were going to an area in which morale was high and in which there was cohesion, but without 'cliques', immediately tended to feel more at home. Therefore 'joining a happy crew' was another important criterion. Students were often very adept at picking up quite subtle cues and were able to sense themselves the type of atmosphere that pervaded the placement:

I think it was the staff and relatives were quite happy with the care and that gave it a good atmosphere. It was good.

Being made to feel welcome and a happy atmosphere are not 'chance' happenings, but rather part of the 'culture' of the unit. Culture is of course multi-faceted and subject to many influences, but a 'positive culture of care' is characteristic of areas that provide good quality care for older people (Davies et al 1999), with the role and influence of the placement leader being crucial. If students are to be made to feel welcome, that they belong, and are part of a well-functioning team, then good leadership is essential, and a leader who creates both a Sense of security and belonging for all members of the ward team not only facilitates a good atmosphere, but also an effective one:

You are going in to work happy, the staff were all great, having a laugh, getting on with the job.

As argued with respect to a 'Sense of security' the vulnerability of students, especially in their early placements, is such that they need to feel secure and that they belong before they are able to focus on other aspects of their clinical work. However, once students feel safe and a part of things they more readily turn attention to their role in the wider 'scheme of things', and to the needs of their patients. *'Playing your part'* captures students' feelings of taking some responsibility for maintaining and sustaining the 'atmosphere' in the ward, and also of making a valid and important contribution to care. The latter topic is considered more fully later under the Senses of purpose and of achievement but is cited here as a further indication of the subtle interplay between these factors. In the context of creating a Sense of belonging students talked about *'only getting out of the placement what you put in'* and recognised that as well as 'rights' that they also had 'responsibilities', including a willingness to learn and the ability to adapt flexibly to the changing demands of the clinical setting.

In terms of the ways in which students develop their concepts of older people, and those factors which might predispose them towards working in gerontological nursing, being able to identify with older people was a key part of the jigsaw. The ability to see older people as other human beings on the ward helped students to feel that they belonged in such an area, and they were consequently more likely to feel that they would like to specialise in this type of work upon qualification:

> *I mean I'm older than quite a few other people* [on the course] *so I have got older relatives and I could see my Mum, I could see my Grandma in these people.*

The cumulative effect of the above factors in creating a Sense of belonging often made a deep and lasting impression on students who talked about feeling 'brilliant', 'trusted', 'part of the team', 'accepted', sentiments which most people would see as positive descriptors. Indeed for students, leaving a good placement could be quite difficult:

> *You belong on a ward when you start to feel bad when you are leaving.*

Factors inhibiting a Sense of belonging

Unfortunately, not all students were helped to feel that they belonged on their placements and the deleterious effects of this were simply, but eloquently, captured by a student who noted:

> *The hardest thing about being a student nurse is being a stranger, that first day feeling, it never leaves you. You can't even be yourself.*

As was the case with a Sense of security, the positive attributes and consequences of feeling you 'belonged' were often summed up in a few words. However, the effects of feeling like a 'stranger' engendered a gamut of responses, as the focus groups revealed:

- Feeling like a lone voice, feeling like a spare part
- Feeling like you don't fit in, not feeling part of the team
- Feeling resentment or annoyance from others
- Feeling you are in the wrong place
- Feeling you are attached to the wrong people
- Feeling like a stranger, feeling like an outsider
- Feeling anxious

As with a Sense of security, 'feeling like a stranger', was often due to the absence of those factors that created a Sense of belonging. This unwanted feeling was particularly likely when students were not made welcome, or were welcomed by some parts of the ward team but not others. Sometimes trained staff could appear distant and aloof, and in such cases it was often care assistants to whom students turned in order to survive and learn the culture of the ward:

> *You are not overly welcomed by the trained staff. I think that nursing assistants make up, you feel more welcome to the place rather than the trained staff. Because they have all the knowledge of the ward.*

Another important factor that often reduced a Sense of belonging is captured by what is termed here *'being treated like a pair of hands'*. In this case students felt that they were accepted and seen as useful only when 'filling in the gaps', created, for example, by staff shortages or when they contributed to sustaining a ward 'routine', which was often not conducive to individualised care but rather to ensuring that things 'got done' on time. This is particularly important in relation to older people and is comparable to the idea of 'good geriatric care' suggested by Reed and Bond (1991). These authors argued that in the absence of any real therapeutic direction (see a Sense of purpose later), good care is equated with 'getting things done' and creating a 'neat and orderly ward':

> *You become significant when they are short staffed but not in the way you want. On my last placement you were significant if they got everybody up in time.*

The idea of feeling 'significant' is an important one and this will be discussed in greater detail when creating a Sense of significance is considered.

Up until now the main emphasis has been placed on students' feelings of 'belonging' while in the clinical areas. This reflects the majority of the data gathered in the focus groups. However, students also 'belong' to other groups. The data suggested that they often have a very strong Sense of belonging to their cohort, and particularly the branch cohort of which they were part, but that for a variety of reasons they rarely felt that they 'belonged' to the wider student body, or that they were really 'part' of the university.

'Belonging' to a community of student nurses related primarily to the branch rather than the body of student nurses per se:

> *I feel part of the mental health group*
>
> Do you feel part of the school of nursing?
>
> *More so the group I think, because of the divide between adult nursing and mental health. It's unfortunate, but there it is.*

It is easy to appreciate why such bonds are formed, but the role they play in sustaining 'tribalism' within the profession is more difficult to determine.

Quite the reverse happened when the student body as a whole was considered. Student nurses did not really associate themselves fully with the university, nor did they feel that they belonged in any real sense. This was manifest in a number of ways, with informants from all sites describing reduced library, canteen, and transport services during 'university' vacations when nursing students still attended college. Opportunities to participate in many of the normal student activities, such as 'Freshers' Week' were also denied to some nursing students. Moreover, informants not only felt discriminated against by the university but also by other health care professionals, with examples being given of medical and nursing students being segregated in halls of residence and of doctors failing to include nursing students in teaching.

> *There is that divide between student nurse and medical students, as soon as you are on the ward there is that divide ... Even on campus, like where we live, medical students are separated from nurses.*

The need to belong is important, but nursing students sometimes felt as though they belonged nowhere. They were not traditional university students, they lacked the academic status of degree course students, and they were not employed by the Trusts who provided their practice placements. Supernumerary status safeguards their learning opportunities to some extent but can militate against a genuine Sense of feeling part of something.

A Sense of Continuity: Forging Connections

The nursing literature is replete with talk of the 'theory–practice gap', and the 'distance' that exists between what students are taught 'in the school' and what they experience 'out on the wards'. The hoped-for 'seamless' transition of theory to practice is rarely apparent, and given the importance of the practice arena and the subtle but powerful influences to which students are exposed, it is little wonder that it is often the ward view of 'how things get done' that prevails. Perhaps this was strongest for students who had previous experience. However, such prior

experiences are in some ways 'random' in that they are not part of a 'structured' programme and therefore individuals interpret and respond to stimuli in their own way. It might be expected that the experience as students on a programme of training would be less 'random' and that their theory/practice encounters would be designed with clear and shared goals in mind. In other words, it would be reasonable to expect an element of continuity or connection between theoretical inputs and practical experiences, which would help to forge a coherent Sense of what constitutes 'nursing', especially with respect to nursing older people.

Unfortunately this was not always the case, and students recounted numerous instances where they experienced anything but a Sense of continuity. Participants identified continuity as being important in three main areas:

- Between theory and practice based on a shared understanding between the 'school' and the ward.
- Continuity of relationships within the ward environment.
- Experiencing a consistent standard of care based on a clear philosophy.

A Sense of continuity might therefore be broadly defined as:

> *Being enabled to forge connections and make links between nursing as taught and nursing as witnessed, having consistent relationships and advice, experiencing good standards of care based on a clear and agreed philosophy.*

In many ways a Sense of continuity pervades the Senses Framework itself, as the Senses are interlinked and in part interdependent. For example, students are unlikely to feel totally secure if they do not feel that they belong, nor, as will be seen later, can a Sense of purpose be entirely divorced from a Sense of achievement. In this respect for the participants of this study a Sense of continuity, as the name reflects, was the thread that served to link the other Senses. The reverse also applied; a feeling of discontinuity was seen as potentially threatening or undermining of the other Senses. The data suggested that the inability to forge the links and connections essential to a Sense of continuity often undermined the students' experiences of their training. Continuity might therefore be seen as the

'piece of string' that students could grasp if they felt that they were losing their way, and follow it back to places that they know. Students who did not experience continuity described a range of emotions such as feeling:

- Frustrated
- Losing interest
- Worried
- Like giving up
- Like being on a production line
- Isolated
- In the dark

Attention to three broad areas in which continuity is seen to be important, school/ward; relationships and philosophy of care, provides a useful way of thinking about how connections could be forged.

One obvious and increasingly popular way to help students make links between theory and practice is for practitioners to provide some of the theoretical input. Students often appreciated this, as there was more immediacy and impact when lectures were delivered by those still working in the clinical area. This often reinforced what the students had been taught elsewhere, making theory 'get real':

> *Qualified nurses coming in and making the links, everybody I think would agree that that had been good.*

However, numerous factors militated against students' ability to span the theory–practice gap, with several feeling that the programme itself was disjointed and that there was little in the way of shared understanding between nursing as taught and nursing as witnessed. Often students formed the impression that ward staff did not value theory or that the theory taught bore little resemblance to what went on during placements. Such feelings of 'disconnection' were exacerbated when the timing of the theoretical input did not coincide with the practice placement. Moreover, as has already been noted, the fact that by and large any theoretical input relating to older people was interspersed throughout the course meant that many students did not relate it to their placement. It could be argued that designing the course in this way,

with the input on older people being 'threaded' through the programme, would enhance continuity. On the other hand, if this input is too well 'hidden' then students find it difficult to identify with.

A 'disconnection' between 'school' and 'ward' was not only apparent with respect to theory–practice issues but also related to a lack of a shared understanding about the course as a whole and its relationship to the placement. For some participants their 'teachers' appeared to have lost touch with the reality of the clinical areas, and conversely it sometimes seemed that staff in their placements had little or no understanding of the course and how students' learning was sequenced.

Limited communication between the university and the placement was seen as problematic by some students. In some cases students found themselves acting as mediators between the two parties, having to explain the intentions of the one to the other. This lack of understanding could leave students feeling dissatisfied with their experience and the grade that they achieved:

> *They didn't have link tutors to the university either and so there was nothing I could do and I got what I thought was not a very good mark. There's a lack of communication between the nursing home staff and the university, because they have no idea of what to expect in the first place. I was told that we were there to work with the auxiliary nurses four days a week and the other day with the qualified staff, and they genuinely believed it.*

Sometimes placement staff relied on students to assist them in completing assessment documentation; while in other instances the relevance of the learning outcomes presented by the university was questioned, undermining their credibility with students:

> *I have had people say "forget these for now we will sort them out at the end, let's just try and see it we can teach you something while you are here that's actually relevant".*

Although such instances were by no means in the majority, neither were they isolated. At the opposite end of the spectrum were the placements characterised by excellent communication between school and ward, where the links and connections

were made explicit. Most placements, however, fell somewhere in between and there is little doubt that greater clarity and communication would have done much to improve the continuity that students experienced.

The other two central elements of a Sense of continuity, consistent relationships and exposure to a clear philosophy of care, together form bridges to the other Senses, the former to a Sense of belonging, and the latter to a Sense of purpose. The mentor is a key figure in creating both a Sense of security and of belonging and therefore it is hardly surprising that students who had consistent contact with a mentor were able to make 'links and connections' more effectively than those who did not. Similarly, in placements where there was a clear and agreed philosophy of care, which was actually 'enacted' rather than just 'looking good on paper', students experienced a Sense of security (as boundaries were defined) but also of continuity, particularly if the philosophy was a 'living thing'. The idea of a 'living philosophy' in many ways underpins a Sense of purpose, which, with respect to older people, is perhaps one of the most critical Senses of all.

Having Something to Aim For: Creating a Sense of Purpose

The survey data suggested that work with older people was often seen as 'hard' (see Chapter 1). However, whether it is viewed as hard but also interesting, stimulating and challenging, or 'just hard', often turned on subtle feelings of being able to 'make a difference'. Therefore it is important to be able to conceive of nursing care as contributing to an improved quality of life for older people.

Following the work with the Senses Framework in acute care settings (Davies et al 1999), a Sense of purpose for qualified staff was defined as *'a Sense of therapeutic direction, a clear set of goals to which to aspire'*. The student data would support this, as for them purpose meant largely 'having something to aim for'. This Sense of purpose was linked to an agreed set of goals both for older people and for students. It is interesting to note that this marks a subtle change in emphasis, where the focus shifts from being primarily on the student and more firmly locates the older person centre stage. Therefore the early Senses of security and belonging which students sought referred mainly to their own need to feel safe and to be part of things. At one

level this was the overriding 'purpose' of early placements, and was essential in helping students to settle into their role and to begin to explore what it means to be a 'nurse'. As noted above, the best environments created these 'Senses' rapidly, thereby allowing students to shift their focus towards the patients' needs.

Once students felt safe and secure they were better able to define a Sense of purpose in terms of patients' needs. Although having a Sense of purpose for themselves as students was still a key consideration, it gradually faded in importance to be replaced by the desire to have a clear Sense of purpose with respect to the care given to older people.

The type of care that most impressed students focused on the older person rather than the convenience of the ward or the institution, for example, fostering independence when this was appropriate:

> *They were encouraged to wash themselves and given a choice about whether they wanted to do it, what they wanted to wear. They were encouraged to be independent.*

Students recounted instances when treating older people within a person-centred model had left a lasting impression:

> *The sort of thing that would impress me is if you got a ward, nursing home or unit where the patients, no matter what their cognitive state, they are doing something and are being treated as ordinary people. For instance where I work we have residents closing curtains, putting knives and forks out, it's only something simple. Whereas you don't want to be patronising, for someone that might be a challenge or something they have always done and something they want to continue doing, you know.*

It was during these placements, often with the subtle guidance of staff, that students began to appreciate and value small, often seemingly inconsequential goals, based on relationships and interactions:

> *I have worked in rehabilitation where it was not the same every day but the key was forging relationships with people, therapeutic*

relationships where you were seeing tiny small goals. Where it is not going to work out that people get better and go home.

Similarly, students came to realise that it was possible to make a difference to the lives of people with incurable disease and also important to support carers:

People with the organic [mental health] *problems, yes you could see deterioration but you could help with that, you couldn't stop it but at least you could help and you could see how it was giving their carers respite as well.*

The realisation that they could 'make a difference', even in the absence of cure or functional recovery, began to dawn on many students. It is difficult to capture the almost imperceptible ways in which such a realisation occurs, or the influences that bring about such a change. The work in acute care settings (Davies et al 1999) suggested that the 'ward sister' (or equivalent) was a very influential figure and, as will be seen shortly, this was equally true for students. However, even more important was the 'space' created for students within the best practice placements for them to 'get to know' older people. For some this had a profound, almost existential, effect not only on their perception of what constitutes nursing, but also about who they are as people:

For me it was the values that the old people I work with have that made me change the way I feel about nursing because of the way they treated me. The way they valued me was more based on what I did for them and who I was rather than the kind of things I am accustomed to being valued for. You know, they didn't value me because I was young, they didn't value me because of my looks or because of any other personal attributes... They didn't care what school I had been to and whether I was rich or not. They didn't judge me on the kind of shallow materialistic principles that I am used to and that made me change the way I thought about them, because they were interested in me as a human being.

Of course such dramatic or such eloquently phrased 'transformations' were in the minority but it is true to say that for many students some placements either reinforced and awakened a desire to work with older people (or at least to see it as a career option), or had the opposite effect.

Positive placements rarely just 'happened' but rather reflected a philosophy of care which valued older people, and in which the 'little things' were seen as important and accorded status. It is here that the role of the placement leader emerged. For students a good placement leader had a passion for the work and led by example. Some leaders had demonstrated their 'passion' by making an active choice to work with older people:

> *This changed some of my feelings, that she gave up her high status job in ITU to go and work in a nursing home. Because doctors tend to regard older people as less exciting and they can't do much with them. There is this general autonomy so you get more control over the care, so you get to actually do the planning and the implementing of the caring person.*

Other less tangible ways of showing enthusiasm also exerted a powerful effect on students. These often turned on day-to-day interactions and the fact that the ward sister actually delivered care. Such enthusiasm appeared contagious:

> *The rapport that she had with some of the people on the ward was brilliant, and every day she was fascinated by each person and she would point it out to us.*
>
> *She'd always be out there. She was a very good role model to us.*
>
> *Her staff were so motivated and enthusiastic and really, really genuine.*

Being 'genuine', conveying the importance of caring, and reinforcing the individuality of older people, were all keenly identified with by students:

> *It is important for this profession that you want to belong to a profession that cares, because you want to do your best.*
>
> *The sister and ward manager have to be seen to be caring for the elderly patients not just for that patient but for the whole consensus of elderly care.*

Interestingly, and again reflecting the results of work with qualified staff in acute care settings (Davies et al 1999), it was not essential that there was a written philosophy of care, although if this existed and was applied then this helped. Nor

was it necessary for staff to be consistently reminded of what was required, a truly living philosophy seemed to permeate all aspects of the ward environment:

> *I never saw her going on the ward and shouting at people and being nasty but everybody knew what was to be done.*

Creating and sustaining such a culture was crucial but was dependent to some degree upon the availability of adequate resources in order to be maximally effective. If the creation of the Senses for older patients, staff and students leads to an enriched environment, failure to create the Senses leads to the creation of an impoverished environment. This impoverishment can be felt at a number of different levels. Probably the most devastating form of impoverishment is the absence of a positive culture, but this may in part be created and sustained by an environment devoid of basic equipment and essential items. Students recognised the need to invest in the care of older people, not only financially, but also in terms of giving time:

> *The big change was because they have just got a load of money. They could start doing things like setting up memory clinics.*
>
> *What you need is to be able to give older people time.*

It was not just time for older people that students recognised as being important, as there was also a growing realisation that relatives were also key 'players':

> *For me I find that I spend a long time talking to relatives, not because they want anything from you but so that I can find out what I need to know. They can give you explanations sometimes for behaviours.*

However, it was not just a focus on older people and their carers that provided a true Sense of purpose for students, as their own needs also figured prominently.

As students gained a Sense of security and belonging the focus shifted more towards the concerns of the patients, but participants still indicated that they wanted to be seen as an important part of the 'ward team' (part of belonging). One way in which this could be achieved was by having a clear Sense of purpose, that is knowing what their role was, and by staff acknowledging and giving some priority to their needs as

a student. This could be achieved in several ways and students particularly appreciated it when they were not simply seen as a 'pair of hands' and where, despite staff shortages or other potential constraints, ward staff attended to their learning needs:

> *I had a fantastic time ... They sent me all over the hospital, any procedures I wanted to see I got priority. Even though I had a positive experience they were still understaffed, they still kept their chin up and they were very good, yeah.*

Once again the mentor emerged as playing a significant role. Effective mentors were integral to helping students identify and maintain their Sense of purpose. Students saw a good mentor as setting placement objectives, understanding assessment documentation, facilitating learning opportunities, while also having a 'feel for' the level of input needed by individual students, thus helping students to link theory and practice:

> *My mentor was superb in so far as she was able to appreciate that I was a first year and almost dumb everything down to my level and start introducing new ideas at the right pace.*

As students became more confident and able they also began to appreciate the importance of their work being underpinned by the appropriate theory:

> *I noticed with the care assistants, they know the practical side of things but they did not understand about the theoretical side of things. Like why you turn people, they know they have to do that but they don't seem to know why.*

At a point further down the line students wanted to be able to demonstrate their growing skills, and part of feeling secure was to work in an environment where challenge was not just permitted but also encouraged. Even in some of the better environments students were able to question practice, and this added a further layer to their Sense of purpose:

> *But I did try and do it in a nice way you know. I made the sister actually come and look at his bottom, and she looked and she couldn't deny the fact that he was re. She said 'we have been putting*

cream on' and I said that research would say it's the worst thing to put on his bottom.

For students, having a Sense of purpose enhanced their learning experience and, importantly, helped them to construct a positive view of older people and gerontological nursing. Feeling impressed with the care, motivated to learn further, or simply describing the experience as *'brilliant'*, *'amazing'* or *'wonderful'* aptly reflect some of the positive consequences.

Conversely, as with all the Senses, not all placements were able to provide a Sense of purpose and this generated a range of emotional responses, almost the antithesis of the above. These included:

- Feeling frustrated, feeling annoyed
- Feeling exploited
- Feeling shocked at the lack of resources
- Feeling undermined, annoyed and confused
- Feeling sidelined and unsupported
- Dreading it
- Feeling intimidated and confused
- Feeling as though you are wasting your time, wondering what is the point

If a placement generated such emotions it is easy to see how it might put students off work with older people. It is therefore important to be able to identify factors that militate against the positive therapeutic culture, which were pervasive in some of the placements. Once again factors reducing a Sense of purpose were usually mirror images of those that helped to create it.

In this respect students described many characteristics of an impoverished environment, particularly staff not treating older people as individuals, and thereby effectively reducing choice even in the most mundane aspects of life, with staff being seen to foster dependence and infantilise older people:

I was surprised actually just in that older people do not decide or choose to sit in the lounge ... It was a bit like going back to infant school. They were treated like children.

An encouraging sign was that, as students became more discerning themselves, they were able to discriminate between levels of care and they recognised that specialist wards for older people were often better able to determine needs and respond appropriately:

On an elderly ward they can tell if they can feed themselves or if its that they don't want to or that they need help to get their dietary intake. Whereas on a general ward that doesn't happen, they assume that that person can do it.

Unfortunately, this was not always the case and in some wards students felt that staff had become disenchanted and complacent about the care that they were giving and indeed had lost their own 'Sense of purpose':

They become numb to what's going on really. They have been in the job so long that I think they have become obsolete.

This lack of purpose could be demonstrated in a number of areas, most notably with respect to the absence of a clear direction of care for patients and older people. However, such staff also often lacked a clear Sense of purpose with students, and in their relationships with other members of the multi-disciplinary team.

This lack of direction and enthusiasm in some practice areas reinforced the impression that working with older people had a low status, confirming the suspicions of some students that it required little skill. Some informants therefore talked of 'elderly wards' as being *'the end of the line'* or *'holding bays'*, and of caring for people with dementia as *'baby-sitting'*. Others, however, pointed to a lack of shared understanding and philosophy between staff and students in relation to the care of older people. Focus group participants gave a variety of examples of this, such as staff not considering talking to patients as legitimate work, and students being concerned about the lack of support for family members and carers.

> *I think you tend to feel undermined if you work with a team that 'doesn't have the same attitudes as you. Your head is saying 'I am going to stick to my guns and do it this way' and they are saying ... and you feel you don't want to work with that team any more.*

A lack of purpose in patient care was often reflected in the student experience: for example, when staff relied on task allocation, and students were left unsupervised or used as a pair of hands, while qualified staff spent the majority of their time in the office. This made students feel *'exploited'* and *'frustrated'*. Indeed on some, albeit relatively rare, occasions students were not even necessarily expected to be present at the placement:

> *Each time it just seems as if we were the only ones interested. Each time* (the mentor) *was saying you don't have to come. What am I supposed to do? She said, I don't expect to see you here ... She said 'come back when I need to sign your book'.*

In such circumstances students struggled to develop or maintain their own Sense of purpose, especially if staff did not understand what was expected of students, and it was difficult for them to maintain their motivation, or to see the point of the placement. Furthermore, students could themselves become socialised into the predominant placement culture of assuming that there was no point in questioning things, as they were impossible to change.

This lack of guidance on the ward was compounded for some informants by their lack of preparation. What was often missing was an opportunity to 'talk through' their expectations of their placement with older people and to explore some of the anxieties that they might have. This was a missed opportunity to allay unnecessary fears and to reduce the 'dread' which some students experienced.

Participants frequently found it difficult to articulate their objectives to ward staff and often felt out of their depth, for example, when dealing with relatives of dying patients. While it might be expected that students would use the learning outcomes set by the school of nursing to guide them during difficult periods, this was not always the case. Some students could not see the relevance of the outcomes, with the wording being perceived as vague and too abstract. Indeed, some informants spoke of the outcomes as a constraining influence. Knowing that the outcomes had

to be achieved meant concentrating on the minutiae and producing evidence that objectives had been met. In doing so some students felt they missed opportunities and failed to see the 'bigger picture' of care.

In reality most practice elements were neither 'all good' nor 'all bad', but usually sat somewhere in between. Moreover, students recognised that there was also an element of 'you get out of the placement' what you put in'. They were also conscious of the fact that as 'transient' members of the team they needed to 'fit in' and could not really afford to rock the boat too much. Therefore, as students progressed through their training they often acquired the skill of *'managing the placement'*. This involved a degree of proactivity and comprised a number of strategies, many of which revolved around managing relationships. Those students who had a good mentor experienced few difficulties in this regard, but for others there was a need to carefully cultivate those staff, whether trained or not, who they thought could help them to meet their objectives and get the most from the placement. Therefore, sometimes rather than developing a focus on the needs of the older person, students defined their objective largely in terms of 'passing the placement'.

Students used a number of tactics of 'placement management', such as trying to fit in, using humour to change practice, getting to know staff, and learning how to approach them in order to achieve their goals. These tactics related both to their needs as students, but importantly as students matured, also to the needs of older people. However, despite their best efforts, students sometimes found it difficult to change things and this could reinforce the futility of work in some environments.

> *I said can't they wait until they have eaten their pudding before they have their drugs. "Well then they all disappear" And I said they are not going to go far* [laughter]. *So anyway, there were a couple of ladies* [patients] *having a bit of a laugh you know. And I said to them 'oh for goodness sake, get them pills down and then you can get your pudding down you' so they did, you know, but I just felt it was so sad.*

When informants felt that their management techniques were failing they resorted to more radical measures such as going off sick, or refusing to go back to an unsatisfactory placement.

The idea of 'placement management' is closely linked to a Sense of purpose on a number of levels. In the best areas students had no need to resort to such measures, as staff were aware of their needs and the placement was structured, not only to ensure that their clinical objectives were met, but importantly so that they were exposed to positive and affirming experiences of work with older people. In the worse case scenario 'placement management' was a matter of survival, with students directing their efforts to meeting their course objectives with the least difficulty and disruption so that, at a minimum, they 'achieved' the required objectives. This was essential to pass the programme, but little else could be achieved in the 'impoverished environments' to which some students were exposed. However, at the opposite end of the continuum some students were able to achieve so much more and it is how to create such a Sense of achievement that is now considered.

'Am I Getting Anywhere?': Experiencing a Sense of Achievement

Knowing where you would like to go (as encapsulated in a Sense of purpose) and being able to get there are not necessarily one and the same thing. For students the feeling of 'getting somewhere', that is experiencing a Sense of achievement, can be considered at numerous levels. Perhaps most fundamentally of all in their role as students the essential achievement was to 'pass the course' and qualify as nurses. However, for most students this was accompanied by the desire to 'make a difference' in some way, and therefore simply qualifying without at the same time feeling that things had improved for patients (older people in this context) becomes something of a hollow achievement. These two types of achievement are therefore intertwined, and in extreme cases students might prefer not to qualify (ie to leave nursing) if they think that they cannot make a difference or, if in order to qualify, they have to condone or collude in practices that were not acceptable to them.

Although this scenario was by no means unique it was not the 'norm' and most students tended to be able to 'manage' their training, much in the way that they 'manage' their placements, by qualifying, developing and maintaining their own 'standards'. However, it is the influence that their training has on these standards that is important and, particularly with respect to older people, whether their training

creates and sustains a positive perception of such work, or reinforces an existing negative one. In addition to these two major forms of achievement are more personal goals and aspirations and how meeting these, or otherwise, helps students to reappraise their perception of themselves as a person.

Informants spoke of a number of ways in which they experienced achievement, such as contributing to the care of individual patients, in demonstrating their knowledge on placements, or by passing an assignment for example. A Sense of achievement in the clinical arena was especially important if students were to enjoy working with older people as a client group. In this respect achievement might be defined as:

> *... being able to realise personal and professionally orientated goals, particularly in relation to developing competence as a nurse, in a way that is consistent with self and others' definitions of what constitutes good care. Being able to feel that you have made a difference.*

In the final analysis one of the key elements of achievement for students was to feel good about themselves in relation to what they had done, and to perceive that they had actually 'made a difference'. This provided a strong motivation for students and, if they got a Sense of achievement from working with older people, they were more likely to be inclined towards work in this area. Obtaining such a Sense of achievement on the wards was the result of a combination of factors, at the heart of which lay a Sense of purpose, together with other factors such as feelings of security and belonging:

> *The care was good and the staff were good and I got on with the patients really well. I just like working with that client group* [older people].

The impact of such an experience should not be underestimated, as it often left a powerful and enduring impression:

> *... and I have also had a good placement that was completely inspiring.*

Such inspiring placements were the antithesis of the impoverished environment, and where areas in which older people received the highest standards of care, delivered by knowledgeable and skilled staff who themselves got a Sense of achievement from their work that they communicated to students. Students generally recognised that such work was never easy, with the notion of 'hard but rewarding' being very much to the fore, underpinned by the belief that you could indeed 'make a difference'. For example, seeing an older person achieve something when the student has been involved in their care and being able to challenge and influence care made students feel *'trusted'* and *'satisfied'*.

> *Seeing them achieve things themselves. Especially if you have been part of that in motivating them, you can get someone who otherwise would be sat there in a vegetative state, doing something it can just give you a huge kick. It's a slight ego trip isn't it?*

From comments such as these it was apparent that such achievements were intrinsically rewarding. However, they also helped to cement students' feelings of making a positive contribution, especially when their role was recognised by other staff, patients and their relatives. This reaffirms the notion of feeling good about yourself, not in an egotistical or self-centred way, but rather because of more altruistic concerns. Having your contribution recognised did not necessarily require overt thanks, and the reactions of patients with dementia were seen as being particularly satisfying:

> *Yes, you get pleasure from them when you can make contact with them* [older people with dementia]. *After a period of time there is a flicker of recognition.*

Staff also played a key part and students were encouraged to achieve by working with empathetic staff who were prepared to share their knowledge and by senior nurses who were approachable. Informants saw quality mentoring as important in facilitating their learning, making them feel they had the skills needed to do well, thereby helping them to develop a positive self-image:

> *When we got there the first day our supervisor knew what we were supposed to do so he made an agenda. We were going there every day and every day we had different things to do and we had to feed*

back on, you know, how we are doing and stuff. He planned everything here and he was guiding us.

Although the major form of achievement that emerged related mainly to the clinical areas, this was by no means the only source of reward, and for some students, particularly the mature ones, doing well on the academic side of the course was also very affirming:

Me coming in as a mature student with a family, my basic study skills were not perhaps what younger people's would have been. For me to pass all my assignments, that has been a real Sense of achievement for me. That is something I have built on and developed.

Whatever its source, a Sense of achievement resulted in a range of positive outcomes with students feeling that they could contribute in a meaningful way, that they liked working with older people, and could see the work as rewarding, although it was often still described as being hard. Those students who had very strong feelings of achievement often used words such as *'amazing'* or *'inspiring'* to capture their experience. However, as with all the other Senses, achievement was by no means universal and there were a range of factors which inhibited or reduced students' feelings of being able to achieve. Several areas of difficulty could be identified broadly relating to factors operating either in the placements or in the school setting. Although there were more comments relating to the school environment here than for any of the Senses so far, nevertheless it was still the ward area that predominated.

As might be anticipated, given the importance that students attached to being able to deliver high quality care, a Sense of achievement was seriously diminished when standards of care were seen as being poor. This was often compounded when there were indications that older people themselves were not seen as important and that systems operated mainly for the benefit of the institution rather than the patient:

I was on the outpatient clinics and I found that the elderly had early appointments and they [staff] *knew full well that they would be waiting for ambulances. The appointments would be at 10:00 and they still hadn't been seen by 12:30 the ambulance would come at 11:45 and they wouldn't wait. So you had to rebook it and then they*

> *are sitting there till 6:00 at night, they are sitting in the wheelchairs and have no food ... They only usually see to people who are diabetic, there isn't enough nursing staff to go out to the area to check on them. They are just left there. You find they start to get upset. Especially if it's their first appointment they think they have been forgotten. It's only when the clinics have closed that they say 'oh you're still here'.*

Many other students had witnessed standards of care that left them feeling *'distressed'* or *'terrified'*, with some care being described as *'barbaric'*. Such care included older people being shouted at, and even occasionally staff stealing from patients. As might be anticipated, this left students feeling confused and uncertain of what to do, and it clearly put several students off work in the area:

> *They were waking these old ladies up at sometimes 5 o'clock in the morning to get a percentage of them up and dressed and wheeled in front of the television in the lounge. I was so horrified I haven't worked in elderly care since.*

Several students had begun to develop a sense of their own professional standards and were able to make judgements that some of the care that they witnessed clearly fell below that which they would hope to provide themselves.

Students did not wish to be associated with such practices and distanced themselves from them as far as they could. Such care only further reinforced the perception that work with older people was not important, and represented a 'backwater'. Unfortunately, this type of care was witnessed more often in the private sector than in other settings:

> *Working in that sort of nursing home compromises how you would care, properly care for a person. At the end of the day I spoke to a few of the care assistants and they said 'I'm only here for the money' and that's the way they feel. But when you are training and you're nursing at the same time its a compromise on what you believe and what you would do as you train.*

The other main aspect of the ward environment that reduced a Sense of achievement was when there was no culture of learning for the qualified staff or others on the ward. Most of the better learning environments for students also created

opportunities for all staff on the ward to learn and develop. Where this was absent then students felt that they had little to learn from the ward, but at the same time could not demonstrate their own knowledge for fear of being seen as a threat to the staff on the unit. Conversely, others felt that they brought new insights to the ward and that the presence of students helped to maintain standards:

> *But it is very difficult for them: because they don't work in an environment that keeps up to date they can't teach you a lot. And it's good that we go in and you know, keep the standard up almost.*

However, the lack of a student-centred culture on the wards was often reflected by the fact that staff had little appreciation of what the students learned or how they could be helped to get the most from their placement. Although the following example does not relate to older people, it nevertheless highlights the difficulties that many students faced:

> *My classic example was as a student in mental health going on a maternity placement. I was made to feel by midwives very inadequate because I couldn't do a blood pressure, which is fair enough. But it seems so far removed from what we have done at college. One week you are in college doing about politics or whatever and the next week, you are supposed to know how to do a blood pressure and that gives you no Sense of achievement, you feel quite inadequate.*

In addition to the ward placements there were two main aspects of the university experience that could make it difficult for students to feel that they had the breadth and range of skills needed. One was the seemingly endless demand of the academic component, with the need to complete several assignments, making students feel *'stressed'* or *'pressured'*. The perceived need to complete assignments often meant that students did not feel that they were able to get the most from their placements. Some felt as if this was a deliberate ploy by the university to see if they could cope with the pressure:

> *They give you the pressure to see if you will crumble. They pile it all on and watch people fall away. It's almost as if they do it consciously, and lots of people didn't survive. I have taken it that that is the reason we are almost being tested, to see can you work under pressure.*

Although this may well be an erroneous impression it does highlight the multiple demands that students can face. For some this meant that they rarely focused on anything other than 'passing' the course.

The second area that caused students some concern was the balance within the curriculum and the need, for example, for students undertaking mental health training to have insights into the physical needs of older people, and vice versa:

> *I think that you need to have a broad knowledge base of every client group because mental health doesn't discriminate, does it. I think our adult input has been very minimal. I have done no medical or surgical wards at all but nursing on an elderly psychiatric ward you often have diabetics, you often have pressure care, ulcers to look after. You have a range of physiological problems as well as psychological problems.*

While all the above factors influenced the students' Sense of achievement, the most important components related to the feeling that they could 'make a difference' to the quality of care that older people received. Central, therefore, to whether work with older people was seen as a positive choice or not was the need to feel that it mattered, that is, the extent to which it was seen as significant.

A Sense of Significance: 'Do I Matter?'

For students a Sense of significance existed at several levels, not only, nor even necessarily, primarily relating to quality of care. Therefore, although the need to give good care was central to a Sense of purpose and achievement, and figured prominently in terms of creating a Sense of significance, for most students the primary need, especially at the start of their training, was for them to feel that they mattered. That is, that they were not viewed simply as a pair of hands but as individuals with needs and expectations of their own. Feeling significant hinged largely on students being made to feel that they had a valued contribution to make and that they contributed to the ward, rather than just being seen as a drain on ward resources. Students themselves need to feel *'cared for'* and *'valued'*. Without this it was difficult for them to feel significant:

> *There is nobody there for us, nobody to teach us. You say 'oh, this wound has deteriorated', you tell somebody and they get the tissue viability nurse. She comes on to the ward, and is a student nurse there? No, we are doing the work.*

Feeling significant therefore is about being valued and being seen to matter, that you make a valued contribution, and that what you do 'makes a difference'. Although most students had their own sense of 'mattering' it was also important that this was reinforced by significant others in both the clinical and university settings. However, as students moved through their training there was a subtle shift in emphasis so that while their own needs still mattered, those of patients also figured more prominently. A Sense of significance might therefore be defined as:

> *A perception that you matter as a person and as a student, and that what you do is recognised as making a valuable contribution which is acknowledged by significant others, individually and collectively. Fundamentally that you are able to develop a belief that nursing and patient care matters, and is accorded status.*

In this context significant others include ward staff, patients and relatives, as well as tutors and lecturers. Students who saw themselves as significant described a range of positive, affirming emotions such as:

- Feeling the staff are interested in you
- Feeling cared for
- Getting a buzz
- Feeling you have something to offer the staff
- It feels fantastic
- Feeling noticed by relatives

As has been noted repeatedly throughout this account, it was the nature of the practice experience that was pre-eminent in influencing students' perceptions that work with older people is *'important'* and *'significant'*. However, the perception that students matter as individuals is also important, particularly the respect that they feel they were given by ward staff:

> *You were made to feel really welcome, you were given some responsibility, you were given some power over what you were doing*

yourself with the clients and it was like they respect me, they can see how far my training is and how developed it is.

Importantly, the ways in which older people were presented in the academic context could also help to further sustain the belief that work with such individuals was indeed significant:

On the course to date we have been encouraged not to classify people with regard to their appearance their age or whatever. My experience, and I have found it to be true, is that people are different. People may all look elderly but they don't all act the same, but the training we have had to date has underlined that principle.

In many respects, therefore, a Sense of significance arose from a combination of all the other Senses interacting in such a way as to create and maintain the belief that what students did 'mattered'. It is difficult, if not impossible, to divorce this from the feeling that older people matter, as do the staff who work with them. This reinforces the reciprocal and dynamic way that the Senses interact.

Conversely, even a carefully constructed Sense of significance could be reduced or threatened in several ways, and often a poor experience could do considerable damage. Students cited several examples of ageism that they had encountered, some demonstrated by society as a whole, some evident in the environments in which they had worked with older people, and some held by the staff with whom they worked:

It's a part of society in general: if you're old you've had your time, thank you very much, and we just put you to one side, this is just a general part of society that they don't get the care that it is given to someone younger ... Society as a whole views the elderly as second-class citizens.

Students felt that such general attitudes towards the needs of older people were also reflected by the lack of resources, and in the ways in which staff referred to some older patients:

They haven't got sufficient rehabilitation, occupational therapy, physiotherapy. Not enough has been given to these, because elderly is not being treated as a speciality any more.

> *When I went to hand over in the morning I couldn't believe the way they talked about them* [older people]. *After 6 months here learning about ethical practice and I sat there and the sister was saying 'the nutter at bed 8', 'that nut case over there', you know. I just sat there and I thought 'is this real life?*

Not surprisingly the latter lamentable practices, together with the overall lack of resources that many students encountered, collectively characterise what have been termed here impoverished environments, a fact that was not lost on students themselves:

> *A shocking environment to be in and to think, you know, that we could all end up like that.*

Although the above lack of resources were a component of impoverished environments, their major characteristic was reflected in the attitudes of staff. Students believed some staff talked to older people as if they were stupid, using inappropriate terms of endearment, and belittled or humiliated older people by the use of pejorative terms such as 'old bed blockers'. This served to create and sustain a lasting impression that such work was not valued, and that standards were so low as to be immune to change.

Although such sentiments were not reinforced within the academic component of the course, the fact that students often considered that those elements relating to older people were 'tagged on' to other sessions, almost as an afterthought, did little to directly counter or reverse negative perceptions.

Regardless of their experiences of working with older people, some students considered that they themselves were not fully valued, both because ward staff might not see the 'new' training as relevant, and due to the fact that, as student nurses, they did not really feel that they fitted in well with the university:

> *I think because we have an academic base to our training the difference in the more traditionally trained nurses that stands against us. It's been said, not directly but by implication, that your training is not worth anything, ours was a lot better.*

> *I didn't feel welcome at university at all. I felt like an outsider – I felt like nursing students were not like proper students, if you know what I mean. There is this sort of degree thing that if you come to university you have to do a degree and we are not. We are doing a diploma and we are like this little add-on bit that is sort of stuck on the side.*

The above factors provided a potent mix of negative influences, influences to which all students had to some extent been exposed. However, despite this most informants were able to sustain a belief that nursing was significant, that they had a significant contribution to make and that notwithstanding the difficulties they faced, that work with older people was also potentially interesting and rewarding.

Participants provided explicit evidence that exposure to positive experiences of older people was one of the key influences determining that such work: was interesting and exciting; was a positive future career option; and was an area that students would consider when they qualified. So, for example, repeated exposure to positive environments was more likely to predispose someone to want to work with older people:

> *From what I have seen now, maybe I have changed. I suppose very ignorantly I had the idea of old people who weren't going home again and were just having quite a sad life in hospital until they die ... Coming on this course has made me feel a lot more of an inclination towards the elderly and I actually want to try and do something about that, even if that means while I'm on the ward just giving them the best possible care I can. And I noticed it on my first placement but it came home to me in my second and because of the reading around it that I have done for various assessments.*

For some of those informants who were perhaps as yet undecided about where to work upon qualification, working with older people was seen to provide good preparation for work elsewhere, either as a student, or as the first ward after qualifying:

> *If you can manage on an elderly care ward, you can manage anywhere. You've got all your problems that you would get on any specialist wards. You have got all your specialities on one ward.*

> *I would* [work with older people]. *I was always told when you qualify get yourself 6 months to 12 months on elderly care because then you will pick up all the nursing skills you will need.*

For other informants the image of work with older people was not so positive, and it was seen to comprise only basic care. Moreover, the perceived lack of status or kudos associated with gerontological nursing, combined with a view that pay, working conditions and remuneration were all poor relative to other settings, all exerted a negative influence. This was often particularly noticeable with respect to nursing homes:

> *What I have noticed a lot with the elderly is that there doesn't seem to be the job promotions at all. They don't seem to move around the same, so there aren't the openings. They didn't seem to get the same pay.*

> *The private nursing homes they are just not going to pay, are they. You get D grades on £3.50 an hour.*

What was interesting to note was, largely irrespective of which client group students wanted to work with upon qualification, the re-emergence of a Sense of security and a Sense of belonging as important elements of the students' psyche, especially as qualification neared. Several students therefore opted to seek employment in areas where they had a prior positive experience, and felt that they belonged and would feel safe as a newly qualified practitioner:

> *I have worked with that team in the past and I want to work with that team again, and working with older people just came as a bonus.*

Analyses of the data suggested that those clinical areas that had provided a good learning experience for students also tended to be those that were aware of the needs of newly qualified staff. They were therefore conscious of the importance of helping new staff to feel safe and secure, and to create a Sense of belonging in order to optimise their chances of settling in as quickly as possible:

> *My mentor had come here as newly qualified, she said that they were great, they supported her in that role, gave her space to grow but kept an eye on her, and that's what I want.*

The varying importance of the differing Senses as students progressed through their training prompted a re-analysis of data to see if it were possible to identify a temporal framework that might help to explain the way that students develop both a concept of ageing, and the knowledge, skills and attitudes needed to work with older people.

The Foci

As noted earlier, a fuller understanding of how students develop their perceptions towards older people cannot be divorced from the ways in which their attitudes towards caring in general developed. From the re-analysis of the data a temporal ordering emerged, making it possible to identify a number of broad areas of focus which become prominent, at various points in time. Although these foci are not discrete or separate, they do exert relatively more or less influence at differing stages of training, and help to explain how the Senses apparently wax and wane. These foci were defined as follows:

- Self as focus
- Course as focus
- Professional care as focus
- Patient as focus
- Person as focus.

Self as focus

Self as focus is pre-eminent during the early stages of training and reflects students' needs to adapt to the new environment in which they find themselves. At this time a Sense of security and a Sense of belonging are therefore to the fore. Students are forging relationships and need to begin to feel 'a part' of something and to 'find their feet'. This applies both to the university context and to the clinical environment. Initially the university is the main focus and, as noted earlier, there are numerous barriers to student nurses feeling that they 'belong' in the university as a whole. Their main allegiance therefore is towards fellow nursing students,

particularly those in the branch of which they are part. This feeling of branch affiliation is evident throughout the first year of the nursing course, known as the common foundation programme (CFP) when students studying all branches are taught together, and is reinforced as students move to their own branch programme.

Moreover, notwithstanding the fact that many students had prior experience of care, for most there was still a degree of anticipatory anxiety about their initial placements. Indeed, if their previous experience with older people was negative then the first placement could be approached with some trepidation, not to say dread in some instances.

However, as the majority of informants began to feel more confident and forged at least initial sets of relationships, then the focus shifted away from 'self' to wider horizons, initially about the course. For some students who had a wealth of previous health care experience this self as focus stage was brief and related essentially to the new experience of seeing oneself as a student. Conversely, if students constantly experienced environments in which they did not feel safe, or did not belong, then self as focus, or the need to survive, remained to the fore.

Course as focus

The diversity and heterogeneity of the student body was evident from the demographics found in the focus groups. Gone are the days when the majority of students are 18 year old young women with five GCSEs (Rafferty and Solano 1999). Now, at least within the case studies, student nurses are very diverse in terms of age, gender, qualification and, to a lesser extent, ethnicity. Many of the mature students in particular had not studied for several years, and the demanding nature of the course was alluded to a number of times. Given the way that most Project 2000 courses were structured, with the relative emphasis in the early period being on the theoretical element, it is therefore not surprising that for many students course as focus was next to emerge. Early on in the course many students were all too aware of their relative lack of knowledge and were anxious when lecturers assumed that they had a more extensive grasp of the academic elements of the programme than they really did.

Many students had little idea of what to expect from their training, and some were taken aback at the amount of academic work that it entailed. Some admitted to maintaining a pretence of understanding and consequently often felt under pressure to keep up with their peers. They therefore focused primarily on their assignments, fearful that they might expose their academic limitations. This was often exacerbated by the mixed abilities of students, with some having higher degrees before starting training, whilst others had no formal qualifications.

Therefore, even though they might feel relatively secure in terms of their relationships with peers, the course itself posed a threat for several, and their Sense of purpose and achievement was defined largely in terms of needing to pass assignments. For some this remained an overriding concern throughout their training.

Professional care as focus

At a point later in their training, particularly when practice placements became more frequent, longer and more focused, most students generally experienced another change in focus, often around the point of transfer to branch. Now they were beginning to develop their own professional self-image and standards for practice, and would increasingly question what they perceived to be poor care.

During their early placements the relative insecurity of being the 'new kid on the block' understandably made all but the most confident and determined of students reluctant to challenge care. They recognised their vulnerability as students, particularly with regard to the importance of their 'ward assessment report'. As noted above, this was characteristic of the course as focus phase, when the need to have a purpose and to achieve revolved largely around the demands of the course:

> *You can't say to the sister 'excuse me I don't think this is very right'. As a student I don't think this is good. It can come back on you and they might give you a bad report.*

This conveys a powerful impression of the perceived need for students to 'know their place', fearful that being seen as 'pushy' or 'too clever' would adversely affect their report. Some students never really developed much beyond this, particularly if their placement experiences did not allow them to feel safe and secure in challenging care.

Most, however, developed their own sense of what was good and bad care as part of their growing professional awareness. They began to notice and challenge poor care, not just in terms of a gut reaction, but also by reviewing the evidence. Some also began to raise their concerns with others:

> *I couldn't believe no one else had seen it going on. I got a bit worried about that but I went to my tutor and it was all done confidentially.*

Naturally, in the best environments, there was little need to question overt bad practice, as it was not encountered. However, even here students might see instances when, for example, the latest research was not being applied and, provided that they felt relatively safe, they would voice their opinions without fear of threat or censure.

As students' own sense of professional competence and standards matured, another change of focus was apparent in the data: many students became less concerned with the professional aspects of nursing for their own sake, and more interested in the importance of good professional care because of the way that it impacted on patients. A subtle change in emphasis occurred, with the patient as focus emerging to the fore.

Patient as focus

Most nurses would admit to entering the profession because they see caring in its broadest sense as being important. Therefore it might be argued that the patient as focus is always present and, to some extent, this is true as the 'patient as focus' is often the primary motivator for becoming a nurse in the first instance. Indeed, as noted several times above, the feeling that you can make a difference is one of the

main sources of job satisfaction and reward in nursing. In its absence the significance of nursing is diminished. At an intuitive level, therefore, the patient is always the driving force behind good care.

However, the patient as focus is still largely rooted in a biomedical view of nursing, in which cure or restoration of function are the overriding aims. For example, students feel the need to understand how to care for the patient with a myocardial infarction, or an insulin-dependent diabetic with an infection. Of course this is appropriate in many instances, but for a growing number of older people such a vision of 'success' condemns those who cannot meet such criteria as failures. Moreover, even within a curative, acute environment, good care can only become excellent when a wider view is adopted, that locates the person outside their condition and views them in the context of their broader life. This is particularly relevant to the care of older people, and students who were most likely to work in this area developed a growing sense that patient as focus was not sufficient.

Person as focus

For some students seeing the needs of the 'person' behind the 'patient' would always be prominent, whereas for others this emerged only when they became comfortable with their knowledge of the care of patients in terms of their condition.

Those students who worked in placement areas where they felt safe, that they belonged and so on, were also more likely to witness patients receiving person-centred care. Consequently, such individuals were more likely to develop a conception of care based on the person as focus rather than the patient or the professional care as focus. This person as focus may well predispose them to choose this area of practice when they qualify.

Conversely, students who are exposed to impoverished environments struggled to move beyond self or course as focus, and seemed less likely to be able to construct an enduring feeling of safety and belonging from which to challenge poor care practices.

Interestingly, our data also suggest that as they neared qualification students tend to revert, temporarily at least, to self as focus, and needed to feel secure and that they belonged in their new role as qualified nurse if they are to deliver good care as rapidly as possible (see Figure 3.1).

Achieving person as focus

It is important to reiterate at this point, in proposing these five foci and their temporal sequencing, that they are not seen as being discrete, nor is each one entirely superseded as the next focus emerges. Indeed, it is suggested that all the foci will continue to exert an influence and will resurface in various combinations over time. Furthermore, it is not suggested that they operate in a simple linear fashion, nor even that they are necessary or sufficient conditions for a given individual to realise person as focus. There are undoubtedly individuals who, despite exposure to impoverished environments, will still wish to go on and work with older people and will develop a concept of care based on the person as focus. Conversely, there will be those who experience only positive care environments but who may never grasp the subtle factors that help promote a person as focus approach to care.

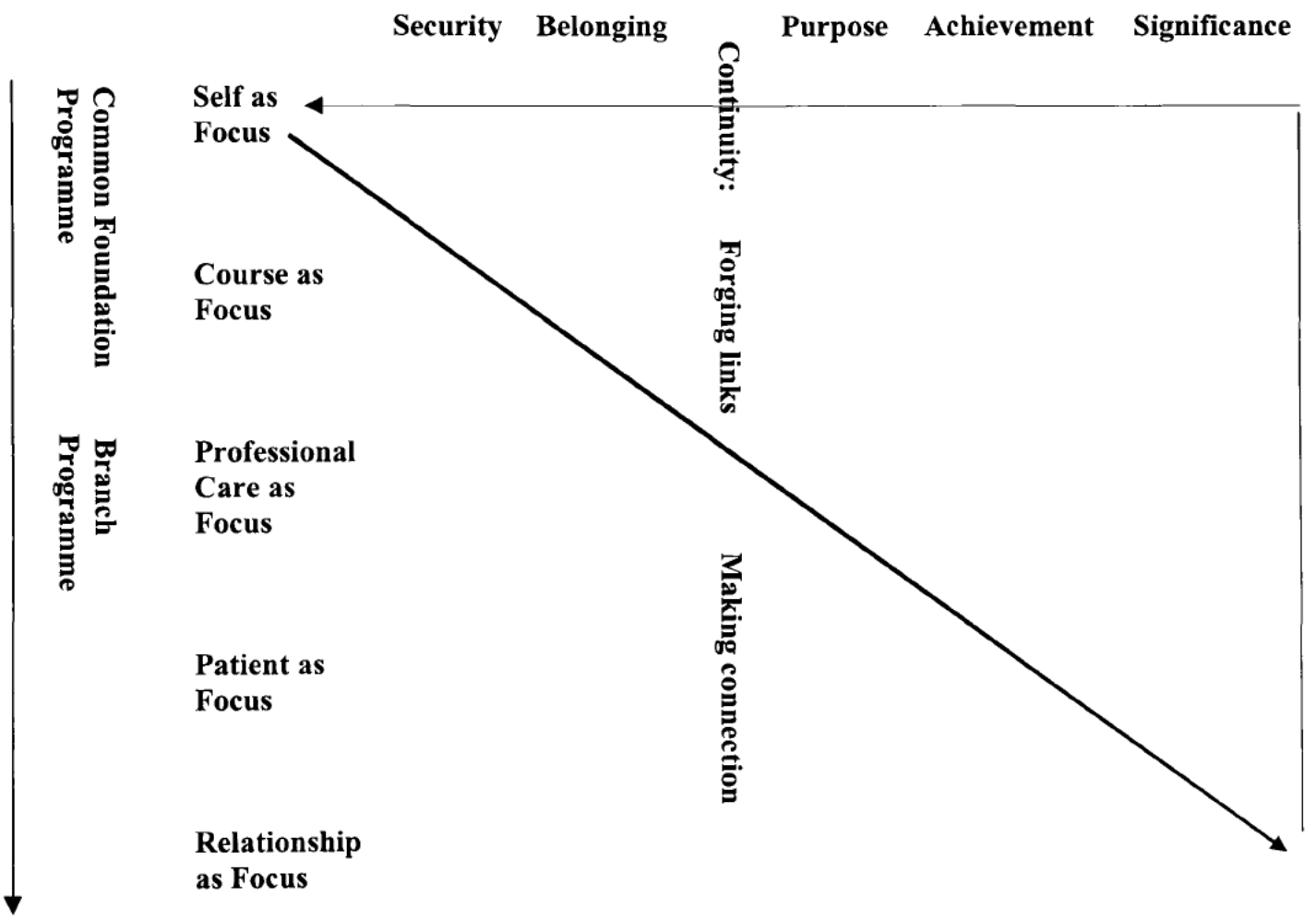
What is proposed, however, is that the various foci, when interpreted relative to the Senses and considered longitudinally over time, provide a very useful device through which to begin better to understand the various factors likely to influence the emergence of person as focus and predispose students to want to go and work with older people. This is outlined in Figure 3.1.

Summary

This chapter has provided an in-depth longitudinal account of the influence of the Senses on students' experiences of their training, and suggested the development of a holistic view of care based on person as focus is far more likely to happen if students experience the Senses during their training. It has also been argued at various points that enriched, as opposed to impoverished, environments create the Senses not only for students, but also for staff, patients and carers. In order to gain

deeper insights into the factors that create an enriched environment, participants in the longitudinal focus groups were asked to recommend placement areas where they had enjoyed a positive experience of learning to care for older people. The next chapter will explore the data from the seven in-depth placement case studies.

Figure 3.1: Influence of the Senses on student focus



CHAPTER 4
FINDINGS FROM THE IN-DEPTH CASE STUDIES

Introduction

In the previous chapter the findings of focus groups conducted with student nurses in phase I of the study were presented. The chapter began with an overview of the Senses (security, belonging, continuity, purpose, achievement and significance) as they were described by the study participants, together with a detailed account of each of the Senses and the ways in which they were either created or inhibited by factors in the practice environment. Analysis showed that although all the Senses were important to the students throughout their training, their relative influence varied over time as the course progressed. An attempt was made to relate the Senses to the ways in which students adopt differing foci for their efforts over the course of their training. This mapped longitudinally a subtle shift in emphasis from **self as focus**, through **course**, **professional care**, **patient** and finally **person as focus**. As phase I unfolded it became increasingly apparent that the ways in which the Senses were created and achieved for students was grounded overwhelmingly in their experiences of practice placements and their interactions with staff, patients and relatives. Thus it felt important to gain a deeper understanding and insight into the practical ways in which the more enriched clinical practice environments created and sustained the Senses. This was the overall aim of phase II of the study.

Focus group participants from phase I were asked to recommend practice placements where they felt they had enjoyed a positive experience of learning to care for older people. A total of 51 practice placements were suggested, eight of which were chosen for in-depth case study in phase II. Because of problems of delayed ethical approval in one site (see Chapter 2), seven practice placements were eventually used as case studies. These sites were selected because:

- They reflected the variety of placements recommended.

- They were geographically diverse. Practice areas were chosen which served each of the four schools of nursing attended by participants in phase I of the study.

Table 4.1 gives an overview of the key characteristics of the case study placements, full details of which can be found in Appendix VII.

Data collection focused on individual interviews with students, mentors, placement leaders, and other staff. Student nurses who were assigned to the practice area at the time of data collection but who had not themselves recommended it also took part in the study. The students were interviewed at the beginning of their placement to gain an understanding of their beliefs and expectations, and again at the end of their placement to explore with them their experiences of learning in that environment. Contextual information was gathered during limited observation in the practice placement environment. All the interviews followed a relatively open agenda, thereby allowing participants to articulate their own views and experiences.

Interviews with placement leaders, mentors and staff largely featured discussions around their beliefs and practices in relation to student learning, and their philosophy for working with older people. Attempts were made to explore how features interacted to create a foci. Interviews with student nurses initially encouraged them to describe characteristics of the best types of mentorship and support for them, as well as discussing their beliefs and expectations about working with older people. The second interview explored the practice experience and how it reflected their initial expectations of the placement and the client group.

The overall aims of phase II were to:

- gain a deeper understanding into the practical ways in which the more enriched environments created and sustained the Senses;
- further explore and articulate the temporal sequencing of the Senses through the foci.

Table 4.1: Overview of the key characteristics of the case study placements

Key: CFP - Common foundation programme – the first 18 months of the course
MH - Mental health branch programme – last 18 months of the course
AD - Adult nursing branch programme – last 18 months of the course

Practice Placement		Course	Main clinical focus of the placement	Location	Environment	Beds
A	Psychiatric Community services, day hospital and assessment unit for elderly people	CFP MH	Assessment and treatment of older people with mental health problems	Geographically isolated post industrial coastal area in the north east of England	A first floor ward in an old Victorian Hospital that had been internally modernised	25
B	District nursing team	AD	Caring for adults [mainly older people] in their own homes	Inner city community divided into older terrace properties and 1970s flat roofed houses and high rise flats	Office in a single storied flat roofed health centre also used by GP's, health visitors etc	N/A
C	Orthopaedic rehabilitation ward	CFP AD	Caring for adults [mainly older people] following the acute phase of orthopaedic surgery	Located and on the outskirts of a large conurbation in the south west of England which it served	A ward within a modern purpose built orthopaedic unit in the grounds of a large teaching hospital based	27
D	Acute mental health assessment unit for the elderly	CFP MH	Assessment and short term treatment of older people with mental health problems	On the suburbs of a large city in the Midlands	In the grounds of a large old psychiatric hospital in the Midlands. Ground floor of a purpose built unit	18
E	Medical admissions unit	AD	Short stay [24-48 hour] medical unit stabilises seriously ill adult patients before sending to appropriate ward for further treatment	Commuter town in the south east of England. Mixed housing, majority close by Victorian villas	Second floor of a modern district general hospital	25
F	Stroke unit	CFP AD	Specialising in the treatment of adults [mostly older people] following stroke	In a large hospital serving a major Midlands conurbation in England	Second floor of a modern extension to a Victorian hospital	24
G	Care home	CFP	Offers nursing care to frail older people in a continuing care setting	Small commuter village serving two towns in the north east of England	Modern extension to an old house standing in its own grounds	20

During the analysis of the data from phase II it became apparent that, as in phase I, students on case study placements who were at different stages of their courses placed emphasis on different Senses in respect of their learning. This reflected the students' stage of training and mirrored the temporal sequencing outlined in the preceding chapter. For example, students near the beginning of their course in placement G (see Table 4.1) valued the family atmosphere and the Sense of belonging that the staff created for them. Conversely, some more senior students questioned the relevance of this placement to their learning needs. For more senior students the creation of a Sense of belonging and security, although still important, had been superseded by the need to create a Sense of purpose and achievement. However, in the better placements staff appeared sensitive to the unique needs of students and tried to tailor the experience to ensure that these were met.

Analysis also suggested that students moved through the foci, not only at a macro level throughout their course, but also at a micro level during each placement. Therefore, students moved from self as focus with security and belonging to the fore at the very beginning of the placement, through professional care and patient as focus to eventually person as focus in the better environments. Finally the students returned to self as focus as they anticipated the placement report and disengaging from the placement. Each clinical practice experience could therefore be seen as a microcosm of the course itself. This chapter presents the practical ways that placements created the Senses with reference to the foci. Placements begin, as does the course as a whole, with students focusing primarily on their own needs.

Self as Focus

At the beginning of the placement, as with the beginning of the course, students tended to be most concerned with self as focus, which is most strongly associated with the creation of Senses of security and belonging. As might be anticipated, given the variety of practice placements that students experience and the necessity of having to change placements throughout their training, feeling safe and secure within a given environment was of considerable importance. Many students experienced anticipatory anxiety at the prospect of beginning a placement, and could feel insecure and conscious of themselves as outsiders:

I mean it's frightening when you first go on a ward because you don't know what to expect. You don't know any of the staff, you don't know any of the patients, they all know each other, the patients, the staff and you're new and it's really strange. Student, placement A

When I came it was so overwhelming and everyone seemed so busy, there were so many people round the [nurses'] *station I thought how am I going to achieve my outcomes here? I'll just be getting in the way.* Student, placement C

More enriched placements were aware of these anxieties and had begun to address them even before the students arrived. For example, some placements sent letters of welcome with details of mentors, off duty and other issues of interest. Others, attempting to counter the fear of the unknown, encouraged students to visit the ward before the placement began:

All students are given an induction and we go out of our way to spend a lot of time on that induction. We do like students to come up [to the ward] *before* [the placement], *but not everybody does. ... I like people to just sort of get a feel for the place; you know, get to know everybody, get an idea of where things are and then work on things after that. I think that when you can get your student relaxed and feel part of it then I think you get more from them.* Mentor, placement A

This mentor clearly recognised the importance of swiftly allaying students' fears by creating a Sense of security and belonging in order that students got the most from their placement. This required the investment of time and effort on the part of the mentor to help students to settle into the placement as quickly as possible. In addition, placements made efforts to provide students with the type of specialist information they needed about the placements in order that they could maximise the learning opportunities available. This helped to shift the focus from 'self' towards that of meeting the learning outcomes, that is, course as focus:

We have introductory booklets that we either send them or give them when they come onto the ward ... and we have specific ones on cardiac drugs and drugs generally used on the unit and the side effects and contraindications. Mentor, placement E

As noted in the preceding chapter, schools of nursing also have a part to play in preparing students for forthcoming placements, and whilst there was evidence of this, some students in phase II had received no such preparation. This tended to limit the benefits they perceived, as it reduced the Sense of continuity necessary to make the links between theory and practice:

> *We have two placements straight after each other which means that our elderly theory module actually comes after our placement, which seems a bit mad.* Student, placement D

Other factors outside the context of the placement were also important, especially during the first placement. For some students, fitting in and not standing out from the crowd was an important part of belonging. Early in their course a number of students spent time defining for themselves what a 'student nurse' is and how and where they fit into the university and health care systems. One student saw her uniform as integral to her self-perception as a new student nurse and this was important in helping her to become part of the team:

> *This is your first chance to get your uniform on. Yeah, I didn't even have to wear it, I wasn't wearing it, but I thought no, I'm going to wear it. I want to know how it feels to be a student nurse and I want to feel part of the team here.* Student, placement A

Wearing the uniform gave this student a feeling of legitimacy (creating security) and helped her to fit in with other staff and students, thereby helping to create a Sense of belonging.

However, it was the sensitivity of the placement areas and their use of tactics such as letters of welcome, invitations to visit the placement, and introductory booklets that were the most important factors creating a Sense of security and belonging, thus helping to move students through self as focus even before they started the placement.

Once students began a placement in an enriched environment, staff further anticipated their anxiety and vulnerability and attempted to reduce it by ensuring that students were expected and welcomed personally, preferably by the mentor or placement

leader. One student described how her greeting on the ward had helped to create a Sense of significance and set the tone for the placement:

> *When I walked on the ward and said I was the new student they said, 'Rene* [Sister] *is expecting you'. She showed me all round herself and she introduced me to Fran and said, 'this is going to be your mentor', and it was really sort of a positive introduction. You know she was like saying this is my colleague and I trust her; it made me feel important I suppose.* Student, placement C

Being expected helped students to establish key relationships early in the placement. One placement leader acknowledged the importance of good personal relationships in creating a Sense of security for patients and students:

> *Personally I always try and treat anybody as I would wish to be treated myself and that goes right across from patients to students. I think that you can't underestimate how important that is because right from the minute somebody walks through the door the way that they're treated has a bearing on how comfortable they feel and how they feel they could ask you questions.* Leader, placement A

The welcome received in the practice placements was not only central to addressing students' initial anxieties, but also in helping them to focus on their learning needs at an early stage, as the following quote illustrates:

> *Yeah, getting to know the staff was important because then I feel like I can turn to them if I have got any problems. I feel I can turn to them a lot easier, because they are really, really nice on this ward as well, it's great and I'm enjoying it ... I feel that I can talk to them about my placement pack and what I need to do now I know they are ok about me coming to the ward. Me and Abby* [mentor] *are going to talk about my objectives ... but she has already said if there is anything that you want to do just come and tell me because you're one of the team.* Student, placement A

It is clear that if security and belonging are addressed early then students are ready to 'move on' and to consider their learning needs, with the course requirements becoming their main focus.

Summary

Students initially approach a new placement with self as focus. In enriched environments where students' vulnerabilities and anxieties are recognised, positive early steps are taken to begin to create a Sense of belonging and security for students. These include, for example:

- sending a letter of welcome with an invitation to visit the ward before the beginning of the placement;
- ensuring that students are expected and welcomed to the ward;
- establishing important relationships with the mentor and placement leader early in the placement;
- allowing time for staff to induct students and for students to get to know the staff and clinical area.

In enriched environments with well-established structures in place students can begin to move through self as focus even before the placement begins and move beyond it in the very first days of a placement. Once students have established themselves (beginning to feel a Sense of belonging) and they feel secure, they are ready to consider issues relating to the course and achieving their placement outcomes.

Course as Focus

It might be anticipated that course as focus and academic concerns would be less evident in practice placements than the other foci. However, all the students came to placements with learning objectives and frequently with additional course work to complete. Even the most academically able students had to consider how they were going to meet these objectives in a particular environment, with the Senses most to the fore here being purpose and achievement in relation to the course itself. Therefore, until students felt that they would be able to achieve their objectives, they were not able to focus their attention elsewhere.

The main person assisting students to address course requirements and clinical learning while on placement was their mentor. Early allocation of, and meeting with,

the mentor, as discussed earlier, was key to creating a Sense of security and belonging for students. However, once this had been achieved, mentors in enriched environments wanted to ensure that students could address their course objectives as quickly as possible. Mentors began this process by assessing students' learning needs.

In the more enriched environments this assessment took place at a number of levels. All the mentors in the recommended practice placements asked students about their stage of training in order to gain an appreciation of the level of support they needed. However, some mentors also tried to get to know students as individuals and tailored their input to provide for the needs of the individual student:

> *We get a feel for where they are, not only where they are in their training but also what their attitudes are and their experience. And because you often get more than one student at a time you have to change that induction depending on who you're actually talking to.*
> Mentor, placement A

Although all students came to the placements with predetermined objectives relevant to their stage of training, mentors in more enriched environments not only explored students' personal objectives for the placement, but also encouraged them to develop self-reliance and to use their own initiative:

> *We like to find out what they would like to get – their personal objectives. Obviously they have some set objectives and we discuss how we are going to manage those ... We encourage them to arrange their own time to go and see other people* [health professionals] *instead of doing it all for them. So give them a bit of ownership of that. It's easy to mollycoddle people too much, even though you have to make them feel supported and for yourself to be approachable.*
> Mentor, placement B

This mentor was helping the student to build a Sense of purpose and achievement by encouraging her to take responsibility for her own learning. Another mentor helped junior students to become increasingly independent learners by pairing them up with a more senior student and giving both complementary tasks

appropriate to their learning needs which encouraged shared learning between the students:

> *I get them to share learning, in a learning set they are both set something to learn and feedback to me on a related subject, we all learn. I have had that work very well. It encourages them to talk to each other. I have used it with students at different stages and they really seemed to enjoy it ... For example, I get the junior one to look at an assessment tool that we use and I get the senior one to talk about the importance of patient assessment.* Mentor, placement C

The students were given a 'real' problem to work through, giving them a Sense of purpose beyond simply meeting the prerequisites of the course. This mentor also acknowledged that she could learn from the work the students prepared together. In this way students could feel that they were making a genuine contribution to a placement, further enhancing their Sense of achievement and significance.

Another mentor described how she tailored the placement experience to meet individual learning needs. By getting to know the student and personalising the placement experience mentors were better able to assess the 'focus' of the student and plan the placement accordingly:

> *I really try to assess where the students are in their learning, thinking about what they need from this experience here. So I can frame the experience, use it like a surgical placement or an orthopaedic placement or as a general medical one as well. Sort of choose the glasses that the student will see it through really.* Mentor, placement C

Many of the students valued the relationship they had with their mentor and appreciated the role they played in their learning:

> *I feel that I can approach her* [mentor], *and ask her if I can do new things to meet my outcomes. She has contributed over half of my learning on her own.* Student, placement F

> *I must say she's* [mentor] *just opened everything up really. Made it, you know, not seem so difficult as I was told and it's just been smooth I think.* Student, placement E

The importance of a quality relationship between the mentor and the student to student learning was illustrated very clearly on placement D where two mature second-year mental health students were placed on a ward specialising in the assessment and care of older people with mental health problems. Neither of them had worked with older people before, nor had they received any pre-placement academic preparation (a module relating to older people was scheduled to take place after the placement). At our first interview both expressed some anticipatory anxiety about working with older people:

> *I was telling my mentor actually it sounds awful when you say it but I have never been into old people that much and I wasn't looking forward to my elderly placement. My grandparents passed away when I was quite young and so I haven't had anything to do with old people.* Student, placement D

When I returned to undertake second interviews it was apparent that both students had very different experiences of mentorship on the ward. The first student had been inspired by his experience, and clearly would now consider working in such an environment:

> *It was a bit of a culture shock coming to this ward. It just felt strange – all of a sudden I am here on a ward and there are twenty elderly people and I am caring for them – but after a day or two with Pat's help* [mentor] *I settled in quite nicely and started to really enjoy it. Pat has been a wonderful mentor, inspirational ... She is just the sort of nurse I want to be ... The staff are great here, everyone has been very supportive, everyone has taken an interest in me. I would come and work here, yes, I have learned so much here, assessment is not just about measuring things or being judgmental but its about getting to know the whole person, all the influences on them.* Student 1, placement D

With the help of his mentor and other members of the team this student appears to have been able to move through all the foci very rapidly from pre-placement anxiety, self as focus through professional care and patient as focus through to viewing older

people as human beings, person as focus. All the Senses (security, belonging, continuity, purpose, achievement and significance) seem to have been met. In marked contrast, the second student appeared to have been devastated by his experience on the ward, with some initial insensitivity on the part of his mentor setting the tone from the outset:

> *To be quite honest with you I was a bit shocked the first day I came because I had never done any elderly before. The first morning after handover my mentor said 'right, come with me and get yourself an apron and gloves' and I thought what is going on? So we went to a patient's bedroom. We had to wake the old lady and get her washed and changed in bed, which I have never done in my life before or even seen. To be honest it was frustrating; to start with I haven't seen an old lady ill in bed before, and now it is someone I have never seen before, never met. The first time I am going to see that person and we are going to do all these intimate things so it was a big hurdle for me really ... I didn't expect that in psychiatric nursing ... Just to jump into it when you don't know anything about it can be a bit shocking or put you off, stressing – very, very much stressing.* Student 2, placement D

With no time to settle onto the ward, no assessment of his learning needs and no opportunity to talk to his mentor, the student was plunged into a situation for which he was totally unprepared. This experience challenged his Sense of security to such an extent that there was little opportunity for creating any of the other Senses for the student in this environment. As a second-year student he had developed his own understanding of psychiatric patient care as part of his growing professional awareness. This experience severely challenged his Sense of professional care. His concept of the role of a psychiatric nurse did not include the physical care of a frail elderly person. The student was both shocked and affronted by the experience, which not only threatened his Sense of security but also left him with very negative views of the speciality. Consequently, he found it difficult to identify what the placement had to offer him:

> *I haven't seen much change in the health of patients here really. They are physically unwell as well as mentally unwell but I don't see much of the mental illness here to be quite honest with you. Maybe one or two get a bit high or low and sometimes shout a bit and sometimes make a bit of nonsense and inappropriate actions and talk and things like that. There's not much strong mental health issues going on here*

> *... And when they say assessment I haven't seen much assessment going on. They are assessed when they come onto the ward, like on any other ward, and that's it.* Student 2, placement D

The experience so affected this student that far from wanting to belong to this team he questioned the appropriateness of classifying these older patients as being in need of psychiatric care. He was unable to progress beyond this incident and expressed his unhappiness by failing to complete the last two weeks of the placement. Clearly, despite being in the same ward, the differing approach of the two mentors was pivotal in shaping the way the placement was experienced by these students.

However, the quality of mentorship is not always the responsibility of individual mentors and students. For example, a student on placement F experienced discontinuity, despite having been allocated two mentors:

> *They gave me initially two supervisors and I haven't really worked with either of them. The one I have worked with mainly I have probably worked about three shifts with her the whole of the time. She has been on courses, she has been off sick, and she's been having annual leave, the other one's been sick and all sorts of things. It's been pretty tough for me .... It's a good job this isn't my first ward, I wouldn't have known what to do ... You have to set your priorities and what you want to get out of it because no one else is going to. I mean we are just not a priority at all on the ward; no one is going to say 'oh, make sure you do this, or make sure you do that'. No one is going to make sure that you get what you need to complete your* [assessment] *booklet.* Student, placement F

Because of her previous placement experiences this student was still able to get beyond self as focus and set her own priorities. However, it was evident that a lack of supportive mentorship had left her with little Sense of belonging or significance. Another student whose mentor was taken ill also felt insecure and found the lack of continuity difficult:

> *The hardest part is not having been guided and not having time to sit down with someone who can say 'we have done this and we have got this left and lets concentrate on this, let's work towards that'. Each person that I have been working with has been very, very good and supportive in that short time that I have been with them but it's the continuity that has been missing.* Student, placement E

These examples demonstrate the way in which key relationships between students and mentors require stability and a Sense of continuity in order to be most effective. In the more enriched environments continuity was maintained with students having the same mentor throughout, frequently shadowing the working patterns of their mentors and working within the same team of nurses and/or with the same groups of patients. Moreover, in the most enriched environments, when circumstances caused disruption to their relationship a second mentor was always allocated.

The majority of students in the case study placements had positive experiences and many found that their mentors could help them to meet their placement objectives and to move beyond these. However, for some students, even in enriched environments, the academic demands of the course itself appeared to pose a threat. For these students their Sense of purpose and achievement was defined largely in terms of needing to pass the placement and associated assignments. Where this was the case, placement staff sometimes felt that students were so preoccupied with 'course as focus' that they were left with no alternative but to allow them to focus their effort on their assignments:

> *Sometimes all they're bothered about is getting their assignment in. All they say is 'I've got to do it' and that's fine, but what about learning about mental illness, that's what you're here for, and in a way I can see it, I do understand. I must say sometimes I've actually had to say 'well, look, you're so stressed up with this, get on with it, just do it.* Leader, placement A

The placement leader was concerned that, in concentrating on passing an academic assignment, some students failed to fully appreciate the purpose of their placement or to take full advantage of the experience on offer. However, he was sensitive enough to recognise that unless this stress was resolved for the student little other learning would take place. Therefore, for some students the perceived pressure of academic work overshadowed the practice experience and such students did not move beyond course as focus throughout the placement. One student, who was coming to the end of the first year of the course, described the problem from her perspective:

> *I'm having a lot of problems with my assignments at the moment, I'm frightened I'll fail. And it's like, should I do that or should I be*

> *following that patient down to scan? The thing is, if I don't pass my assignments I won't be here to see any scans!* Student, placement F

Some students found such concerns receded as they were helped to appreciate the links between theory and practice. Better placements attempted to help students meet their course requirements, while also assisting them to broaden their perspective. A mentor described her approach:

> *For trans-cultural* [an assignment around trans-cultural nursing issues] *for example, they're looking for things like ethnic minorities that we don't really have so we always work on things like age, you know, the culture and the age differences. We help them to think wider, you know think outside the box to find answers.* Mentor, placement A

Summary

Comprehensive assessment of students' learning needs enabled mentors to ensure that the placement experience was maximally effective. Some mentors were innovative in their teaching strategies and helped students become increasingly independent learners. To achieve this continuity in the student–mentor relationship was a key consideration. Consequently, the majority of students in the case study placements had a positive experience and managed to move beyond self as focus and overcome their concerns relating to passing the placement and other course requirements. Therefore, they were able to observe more closely the nursing that was taking place on the ward, and in doing so they began to develop their own sense of what constituted good and bad care as part of their growing professional awareness. This marked a move toward having professional care as the focus of their attention.

Professional Care as Focus

Data from phase I of the study indicated that students on placements at the beginning of nursing programmes started to explore and map out for themselves their own vision of what constitutes nursing and the standards that they would set for themselves. As students experienced more clinical placements they naturally started to refine their views on nursing and to make comparisons between the ways in which various nurses worked and interacted with patients and family carers. In this way they began to

shape a personal philosophy of nursing care and their professional self-image. They also increasingly questioned what they perceived to be poor care and to test how far they could go in changing things if necessary. The more enriched practice environments recognised that encouraging students to question and to challenge practice was an important part of learning and this was promoted from the outset. This helped to make students feel significant and valued, as one student recalled:

> *It was nice to be made to feel relaxed, and I think that they are quite proactive here. For somebody to say that the ward is changing all the time and be critical now that's really good. For somebody to say 'be open and critical, if you think there's something please say'. To hear that from the manager himself is great.* Student, placement A

Staff understood the value of acknowledging and recognising the contribution students could make, and the impact this could have on the development of self-esteem and Sense of significance:

> *That's good for the student, isn't it, because they feel valued, you know able to give a comment or feedback, you know that's going to be listened to even though you may disagree or whatever ...* Mentor, placement A

Unsurprisingly, in the best environments, there was little need to question overt bad practice. However, even here students might see instances when, for example, the latest research was not being applied and providing that they felt relatively safe they would voice their opinions without fear of censure:

> *Well, I listen* [to what the nurse says], *and if it makes sense then I do it. But it wasn't* [sense] *and I felt that I needed to challenge it ... The cuff on the machine was the wrong size too, and I said 'no, I refuse to do it'. And she was sort of getting really frustrated because she was being put under pressure by her manager to do something and I was following the guidelines, not doing like she wanted ... it's like the pressure that people are under that I've found on some wards has been unbelievable.* Student, placement A

This first-year student was aware of the guidelines and felt prepared to challenge qualified staff and hold the care they gave up to scrutiny, based upon her own knowledge and understanding. The student had a strong sense of what was right and

proper in terms of undertaking individual elements of care, but she was also beginning to realise some of the pressures under which qualified staff had to operate. The important thing here was that she, even as a first-year student, felt secure enough to challenge practice, safe in the knowledge that the response from the placement would be a measured one.

A more senior student who had experienced a range of clinical placements and had come to appreciate the roles and responsibilities of the nurse, demonstrated in her comments a more mature understanding of some of the constraints placed upon qualified staff:

> *It seems that the staff nurse on here is responsible for everything, absolutely everything. The health and safety of every person that steps foot on the ward, the nutrition of the patients, everything. Training of everyone around the families, the carers, the health care assistants. How on earth we are supposed to do this I have no idea at all. I think that is why we have to make such decisions about prioritising what we can do in the time available. You can understand why people choose not to be in it* [nursing]. *It's almost saying 'you have got an impossible task and we have these massive expectations'.* Student, placement E

Students may feel overwhelmed in contemplating the enormity of the responsibilities of a staff nurse, and the seemingly impossible task of fulfilling the role while maintaining standards of care. Fortunately, these two students both felt able to challenge the nursing care they observed. Exposure to this type of environment can only assist students in developing appropriate strategies to manage the demands that qualified staff face. However, even though students may question and challenge practice they remain vulnerable, and need intensive support and the opportunity to discuss concerns throughout the course. The mentor has a key role in supplying that support.

Those leaders and mentors in the case study placements who encouraged students to question and challenge practice also understood that even in the most facilitative environments constraints on free speech still existed. One of the main barriers to students voicing their opinions were their concerns about how this might influence the marks or comments made in their placement assessment document. One placement attempted to overcome this barrier by holding debriefing sessions at the end of the

placement following completion of the student practice assessment. This allowed students to maintain a Sense of significance, purpose and security, and enabled them to speak openly without fear of censure:

> *I see them at the end of the placement and we debrief. If there's anything that's been a problem that they've not been able to discuss at the time or they feel that they can give you a parting shot you know, that's not going to effect how they're looked at then ... I feel that that's really what we've got to have, we have to be able to be challenged and I have to justify what I'm doing, it doesn't matter to whom.* Leader, placement A

Although encouraging challenge is sound in principle, maintaining such a culture requires commitment and determination. Students were quick to note when espoused sentiments were simply rhetoric:

> *You can tell quickly. You can spot it whether what's been said meets with what's actually being done.* Student, placement G

Moreover, placement leaders who were committed to creating such an environment were under no illusions that being open to challenge was not always an easy thing to accept:

> *I think the people are fairly welcoming here, and I think we do challenge one another and do encourage people to challenge one another. I encourage people to challenge me, that's important ... and its not something I like really, as a person, do you know what I mean. Because I actually can get a bit kind of ... I hate it!* Leader, placement A

While placement leaders endeavoured to remain open to challenge from staff, students and patients, they also realised the problems involved in sustaining this culture of challenge:

> *I must say that sometimes it's an easy culture to get into, what you're told to do you do, and even though you keep on trying to say 'well, just challenge whatever you see, challenge it', it's much easier not to.* Leader, placement A

One way of maintaining a culture of challenge is to lead by example. A placement leader recalled an incident in which an older person had asked to have their medication at the time they were used to taking it at home and he had refused. He spoke of how he felt about being challenged on this point by a nursing assistant:

> *And although I felt challenged, and I felt quite got at, at the time, after I thought about it, I realised I'm at fault and we'd better change our practice.* Leader, placement A

The leader subsequently discussed the issue and his feelings about it with the care assistant. This honesty and openness is indicative of a professional who is reflective and self aware, demonstrating a mature concept of working relationships in which the contributions of all staff are valued. While challenge was accepted on several of the practice placements and encouraged on some, the position of the leader was still recognised and respected. Leaders in the more enriched environments balanced accepting and acting on challenges with firm direction and control. The leader from placement A recounted how he had addressed a problem of a patient who had felt that a member of staff was being unsupportive. The patient had been made to feel uncomfortable and rushed by the body language of a nursing assistant:

> *I had to have a big lecture about non-verbal communication. So we had a big thing on that, a really big . I was giving lectures every morning on it, well just discussing it, but I felt it was important that we recognised it and everyone knew where they stood.* Leader, placement A

By making it clear that this behaviour was unacceptable he was able to ensure that *'everyone knew where they stood'* and the boundaries of acceptable care were made clear. While the ability to question and challenge bad practice is important it was also essential that students and staff could see that action or at least discussion, followed helping to create a Sense of significance, achievement and continuity:

> *Jean, the matron, is lovely. She's straight, and for us. Any problems straight to her and its sorted out she doesn't let discontent build up, she nips things in the bud. She's good with us.* Carer, placement G

As well as valuing the freedom to question the practice of others students also wished to be challenged themselves:

> *They have to show me things and they also have to be challenging and they don't just show me the task and give me the rationale and then do it themselves, they do one and then actually watch me do it, a sort of continuity and building on experience.* Student, placement E

This student had a distinct vision of the type of experience that she wanted. An important aspect of 'professional care as focus' was the way in which it allowed students to gain an appreciation of, not only the professional identity of themselves as a nurse, but also of the clinical skills required. This was the case on a number of the placements but figured most prominently on a placement with community nurses.

On this placement staff attempted to strike a balance between making students feel safe and secure while at the same time encouraging them to take responsibility and to work on their own initiative. The method they used gave students the experience of delivering professional care, but in a secure, supportive environment. Early in the placement the students accompanied their mentor on their visits to observe the care given. They then progressed, under the supervision of a qualified nurse, to giving care to patients in their homes. If the mentor considered them to be competent and safe in their practice, students went on to make independent visits to two or three patients. This graded responsibility was a challenge for the students, as one student describes:

> *Well, it was great to go round with Kay to patients' houses, but watching day in and day out can wear a bit thin. But when she said 'you better pay attention because you are going to do the next one' it really made me sit up. When I had done dressings on a couple of people a few times with her watching, she asked me what I thought. I had just said that I thought I had got the hang of it when she said 'good, you can do Mr Smith and Mrs Jones on your own tomorrow morning and then check on Fred on your way back to base'. I thought whoo, this is amazing, then the responsibility of what she said hit me.* Student, placement B
>
> *Were you worried about what she had asked you to do?* Researcher

No, I thought she wouldn't have asked me to do it if she thought I wasn't up to it .... I really enjoyed it and it was good because it gave me a taste of what it is like to be qualified. I mean, I know it's not the same but ... It was safe I had a mobile phone and I could have got in touch with any of them and they would have come round straight away, so I felt safe. And when we met up at base I gave a report. But I had seen patients every day this week so I knew what to expect, I knew what to look for. Student, placement B

The mentor had assessed this student's abilities and challenged her to take the responsibility of working alone. The student felt secure in the knowledge that her mentor thought she was '*up to it*' and safe knowing that contact with her mentor was only a phone call away. Being challenged to take responsibility broadened the student's horizons (purpose) giving her an insight into '*what it is like to be qualified*' (achievement) and made her feel that she contributed to the work of the team (significance and belonging).

In the same placement the leader also challenged staff to push the boundaries of their own practice to take on more responsibility and to move outside their comfort zone within a framework of support and a strong sense of teamwork:

And in a way that's the same for the staff really, I like them to have ownership, I encourage them to take on responsibilities such as going to meetings and reporting back. I want them to feel that they are practitioners in their own right, that they can lead and direct care, but at the same time I want them to feel that they are part of a supportive team and that I am the most supportive person in that. Leader, placement B

The staff were aware of the leader's philosophy and gave examples of how it was put into practice:

At the moment Penny [leader] *is very keen for us to take on an area that we are interested each, such as diabetes, I am very interested in that. And Penny is very good at not taking ownership of everything; she sort of hands it out through the team. I go to meetings on Clinical Governance to bring it back to everybody. It's not just Penny going to all of them and telling all of us, she actually makes us take ownership and that makes me feel good.* Mentor, placement B

This nurtured the Senses of significance, purpose and achievement among staff. Data suggested that in the more enriched environments a positive learning culture existed for staff as well as students.

Professional care as focus not only saw students questioning and challenging practice but also gave placement staff who specialised in the care of older people the opportunity to challenge what they saw as student misconceptions about working in their speciality:

> *I would suggest that most people have a preconceived idea anyway, but it's amazing that when they are here and when they go their attitudes have changed because they realise just how committed we are all to it and they didn't realise what it was about.* Mentor 1, placement A

> *Maybe care of the elderly is an area where it would be easy for people to misconstrue what its like. When they come here they've had a positive experience – I like to think that their misconceptions are challenged.* Mentor 2, placement A

> *So I think because they have that preconception that they are not going to enjoy it, it makes you more determined to make sure they do enjoy it, or do see bits that they were not expecting to see.* Mentor 1, placement A

> *That's very true actually and that's significant, isn't it, that once people have been and had an experience and seen it as a positive thing they want to come and work here. We get them through the door and then they can't believe it.* Mentor 3, placement A

These mentors felt it was important to communicate their passion for their speciality and to highlight the therapeutic potential of working with older people. Indeed, for some students to see skilled nurses working with older people was a revelation:

> *I wasn't expecting it to be like this, I was dreading it. Don't get me wrong, the work is still heavy but I don't know, it's the way they* [the staff] *are with each other about their work ... They are really supportive and caring.* Student, placement E

Students seemed almost surprised to discover that nurses working with older people could be skilled. It was clear that they valued the skills these nurses possessed:

> *It was great working with Emma,* [mentor] *she did so much, and seemed to really know what she was doing. She even assessed peoples' swallowing when they were admitted and she decided what they could eat and drink and she showed me everything ... It goes against the grain ... You are led to think that there is nothing but toileting to care of the elderly and to be honest I have worked on wards where that's true. But here there seems to be so much to learn, even just being able to talk about all the different types of stroke there are, I had no idea.* Student, placement F

The realisation that nurses caring for older people were both skilled and knowledgeable gave some students an appreciation of the significance of the speciality. The growing belief that these nurses were highly skilled professionals was endorsed for the students by the fact that other colleagues valued the knowledge and skills of the ward staff:

> *The nurses seemed to have more respect here than they did on the other elderly ward I have been on. People seem to listen to what they say. What happens to the patients on here seems to be really important, it doesn't matter that they are old. My mentor was worried how many tablets one lady was on, she suggested cutting some out to the doctor and changing some others. They had a talk about it and changed some things. I know this happens everywhere but I could see that he was really interested in what she* [mentor] *had to say, it was a discussion between two professionals not the little nurse asking the big wise doctor like it seems to be on other wards.* Student, placement F

Staff appreciated that not all students would want to work in the field, however, more enriched environments took the view that ensuring students had a positive experience which addressed their preconceptions was investing in the future care of older people:

> *We always say to students, 'if you don't get anything else out of it then just try and remember how complex it is when you are actually discharging people into the community'. Because we have some terrible trouble, don't we? And if we keep going like that investing in the students, helping them appreciate the problems, with all the students, then in a couple of years it will be all turned round.* Mentor, placement B

> *But I like to get them* [students and staff] *away from this idea that we float down the ward on castors administering to the sick, you know. I like to get them to realise that the clients, the patients, older people whatever we've been calling them, pay us to look after them and we have a duty to deliver a service just the same as if we were a checkout at Sainsbury's, it's the same thing, we have that duty.* Leader, placement A

> *One of the things that we try to get over to people is that there will be one of our clients on every ward in every hospital, and it's usually the little old lady in the corner with the cold tea. So we try and get that over and we try to get the students to see that it's not in isolation, what they learn here is invaluable, contrary sometimes to popular belief ... So we go out of our way to make sure that they see the placement as more valuable than any other placement and that's something that we work very hard at.* Mentor, placement D

Summary

With professional care as focus students begin to explore and refine their vision of nursing and to question standards of care. A number of the placements accepted students and staff questioning practice, and a few encouraged it. Where students or staff challenged nursing actions it was important that explanation, discussion or action followed.

However, even in environments where challenge was readily accepted, potential barriers remained, such as the completion of practice assessment documentation for students. In more enriched environments leaders embraced challenge whilst maintaining clear boundaries of practice, ensuring that everyone knew where they stood. However, in contributing to students' maturing vision of nursing, staff in enriched environments also challenged their preconceptions about working with older people. Staff felt that helping students to appreciate the complexities involved, and the skills needed to nurse older people, was an important investment in the future care of older people.

If students can move swiftly through self and course as focus and spend some time exploring their vision of professional nursing in a supportive environment that encourages them to question and challenge, they are more likely to appreciate the needs of patients.

Patient as Focus

As students gained a deeper understanding of the nature of professional competence and standards of care, another subtle change in their focus could be observed. They became less concerned with the professional aspects of nursing for their own sake, and were more interested in the importance of good professional care because of the way that it impacted on patients. However, patient as focus, as described in Chapter 3, was still largely rooted in a biomedical view of nursing, in which cure or restoration of function were the overriding aims. Students in phase II, with patient as focus, were also operating with a biomedical model, as manifested in their desire to acquire and master clinical skills:

> *Theory is less important now, I know that if I need to revisit then I can just go back to my book but the practical you have got to know it, you cannot pretend you know it. If you cannot do someone's blood pressure then you cannot do it. You need to practice and lay your hands on. Dealing with the patient is my concern now, getting to do things with the patient.* Student, placement C

Once again the way in which the foci act as a continuum became evident. Just as junior students began to appreciate that their skills, such as taking a blood pressure, could impact on patient care, the more senior students were aware that skilled nursing consists of more than the ability to undertake individual elements of care in a proficient manner. They wanted to be able to make links between, signs, symptoms, investigations, diagnosis and treatment and to understand these in relation to nursing actions. In this way they were able to produce an internal blueprint of the typical care a patient with certain condition would require:

> *I am hoping that this placement will help me be able to put two and two together more, like if someone has got diabetes, whatever, that I am getting to be more thinking in medical ways. Could this be because of that? Could that be because of this? You know, rather than it dawning on me two days later. I'm not quick at putting things together yet. Start to think in terms of cause and effect. Like a diabetic with an infection, it scares me to death, I need like a week to work it out and I want to be able to do it like these nurses can.* Student, placement D

The idea of *'putting things together'* and seeing the overall patterns in nursing care was a theme that was repeated across the placements among senior students:

> *I know I have got the theory now but then I want to nurse a patient in that situation, putting it all together. Just getting the confidence, I'm a bit scared that I am near the end and you are going to be on your own. You are not going to be on your own but then a lot will be expected from you – if somebody wants a nurse you are not going to transfer the call or the question because you will be expected to be in charge at some stage.* Student, placement F

> *It's a very busy area and I have enjoyed it for that, really. We have seen a real mixture of conditions coming up from A&E and then we send them off the most appropriate ward once they are diagnosed and stabilised ... The interesting thing was seeing the frequency of certain conditions coming in like chest pain, breathing difficulties and prioritising the treatment regime for them.* Student, placement E

Many staff also valued variety in their work and, in such acute environments, building and sustaining relationships with patients was perhaps understandably of less importance. However, this often seemed to be at the expense of seeing the patient as a person

> *Students like it here because we have a quick turnover, you don't get any grannies on three months rehab* [rehabilitation] *and if we do, we ship them straight out, no messing.* Mentor, placement E

In acute care settings a biomedical model may be considered as appropriate. However, some students in the study recognised that acute clinical areas were often unable to adequately meet the needs of older people with multiple pathology and complex care requirements:

> *Whenever they had anyone coming in with either dementia, confused or psychiatric or in any way needed perhaps more attention, they were absolutely furious because they just didn't have the staff. People were just falling over, falling down, slipping on the floor, walking away attached to everything. Simply because they didn't have anyone, they couldn't observe them or manage them to the extent that they needed.* Student, placement E

It might be anticipated that some clinical areas struggle to provide the most appropriate care for older people with complex needs. However, sometimes older patients were seen as the cause of the problem rather than as people having to endure inappropriate care services. Students were quick to pick up on negative views of older patients in areas where these had become internalised as part of the ward culture:

> *There was an older man with learning disabilities and staff were saying 'he's a schizo* [schizophrenic], *and there was a kind of fear and stigma and a worry that they would not be able to cope. You got the impression that they were frightened of anyone that needed a little more because we were just getting by looking after patients who demanded nothing ... They kept saying 'he is in the wrong place, he shouldn't be here', and every effort was made to get him moved or discharged that same day.* Student, placement E

By implication, this student's comments suggested that there was a lack of skills on the part of the qualified staff and a lack of resources to meet patients' needs. Indeed the same student commented on the frustrations that built up where resources were short:

> *One of the frustrating parts of this whole experience has been the shortage of resources there, equipment, anything that should be in the clean utility room. I am just walking around and around and they say 'try this ward, try that ward, go here, go there' just to find what you need. It has a really bad effect on the staff. Its just a little thing that you are missing but each time it happens the cumulative effect of that is very, very frustrating and demoralising ...* Student, placement C

However, older people could also be quiescent and appreciative, and this was valued by some staff who rarely felt that they received thanks for the care provided:

> *Older people didn't demand anything and therefore were easier patients in a sense to have around for the staff. I think they were absolutely welcomed and eaten up by the staff if they ever said anything like thank you, just a little response of appreciation was so appreciated by the staff simply because it's not a place where you get a pat on the back or any rewards other than knowing you have done a good job or a patient is simply comfortable or said thank you. And certainly appreciated for not making demands because it was*

something that would just blow, the final straw really. Student, placement C

For some students this helped to shift the focus from older people as patients to older people as unique individuals: person as focus.

Summary

The case study placements had been recommended by participants in phase I of the study because they were seen to be good places to learn to care for older people. On the basis of the above data it could be argued that some of the areas were not ideal environments for meeting the complex needs of some older people. However, what was seen as being a good learning environment was very much dependent on the overall focus of a particular student, at a certain stage of their training. If a student was at a point where they had a strong patient focus with a need to make the links between symptoms, treatment and nursing action, then an acute environment with a high turnover of patients might be seen as an ideal place to learn about a variety of conditions that older patients present with. Although some students preferred to work in such a setting, others recognised that within an acute biomedical environment, good care can only become excellent care when a wider view is adopted, which sees the older person in the context of their lives outside the hospital environment. Such students developed a growing sense that patient as focus was not sufficient.

Person as Focus

Data from phase I of the study indicated that in placements where students were more likely to be experience the Senses, person as focus rather than patient as focus was the dominant model. In phase II of the study some care environments of appeared to be more or less patient- or person-focused in their philosophy. For example, placement E, a medical admissions unit, had a very strong sense of patient as focus, with its purpose being to assess, investigate and diagnose patients prior to transferring them to the most appropriate clinical environment within 48 hours. Conversely, on placement A, a mental health assessment unit, considerable time was spent in valuing the individual and developing relationships between patients, staff and students. Here a

strong person as focus philosophy was in evidence. As students became experienced, they were readily able to identify the focus of placements:

> *The whole ward is geared around the patients and the staff and the students are incidental, and you have to do the best you can and get what you can from that situation, but it's not geared towards giving you a good training its very hit and miss really. And when I say it's geared around the patients it is, but only in terms of the chest pain in bed four, not dealing with her and the cat she has left at home. And yet they still send us here.* Student, placement C

> *I can see that it's nursing in a sense but it's not that hands-on stuff. And I think when I have seen what passes as hands-on stuff on this ward I realise it has a lot to do with organs, hearts, lungs, and very little to do with people.* Student, placement E

This student was asked if an acute admissions unit had been a good environment to learn to care for older people:

> *Not as the primary objective I would say, because in a sense the clients are almost incidental when they are working at that pitch and that turnover.* Student, placement E

Data from phase I of the study indicated that some students would always see the needs of the person behind the patient, while for others this emerged only when they became comfortable with their knowledge about patients in terms of their condition. It was also dependent upon the values they observed in the staff around them. Students who persistently experienced placements where older people were not a priority for staff struggled to develop a sense of person as focus. However, even in environments that did not promote person-focused care, those students who held a personal philosophy, or had experienced placements in a number of enriched environments, were better able to identify the importance of personal relationships for older people:

> *And you can see what the patients are looking for. They are looking for something familiar, they are looking for something comfortable, they are looking for anything that's going to be making a bond between you and them, getting that relationship going. And in some ways we are trying to sort of meet that need in them and yet explain to*

> *them that they are going to be very quickly through and we are not able to engage with them.* Student, placement E

This student was able to appreciate the benefits for the patient when they were moved to a unit that was better suited to meet their needs for a more person-focused environment:

> *Yes, I can see the difference when I have taken a patient to the most appropriate ward for them. It's a completely different situation there. They have everything ready, they have someone waiting at the bed, and they are explaining things to them straight away. They are making that relationship that they* [older patients] *really, really want to feel that they are being looked after and that someone is interested. You can see the relief in the patient when they can see that they are going to be looked after and they are not going to be left without any information in a strange corridor not knowing anything.* Student, placement E

However, even where students held person as focus they struggled to maintain that focus in an environment with an alternative philosophy:

> *And when patients are calling out, I have learnt this myself and I'm ashamed to say it, but you sort of turn a deaf ear because you have so much to do. You think 'if I respond to that the rest of the morning is gone'. And then I think, what am I here for if it's not to engage with these people.* Student, placement E

The enriched environments helped students to gain an appreciation of the patient as focus by explicitly incorporating this within placement objectives:

> *With patient and students I'm the same. I look at the person as a whole from birth, I like to find out, you know, what kind of person they are, what relationships they have had, where they have been in their life ... and I encourage the students to do that too.* Mentor, placement D

This mentor worked on the placement where, as discussed earlier, two psychiatric student nurses had very contrasting experiences of learning to care for older people. The student she worked with was left with a very positive attitude and was

well able to express his move to person as focus, as not only integral to his vision of nursing, but to himself as a person:

> *I have learned so much here, assessment is not just about measuring things or being judgmental but it's about getting to know the whole person, all the influences on them. You have to try to view their lives from their standpoint as well as the professional standpoint. Since I have been on this placement it has really changed my attitude and perception towards them* [older people]. *I do now realise that they are human beings and their lives have been so full of experiences, ... I have learnt a lot about older people. I realised that people at 65 and 70 still fall in love and they still get depressed and worry about the bills, they worry about their kids. Not all old people are settled and financially secure ... I think that I am learning as much about myself as I am about older people, its been interesting.* Student, placement D

Being able to relate the experiences of older people to their own lives was the key to some students viewing older patients as people. Students who experienced an enriched environment found that they were not simply learning about technical care and skills but also about themselves as practitioners and people. They tended to view older people in a markedly different way following their placement; as one put it *'It was like seeing them* [older people] *for the first time'*. Students were helped in this process by observing how mentors and other members of the multidisciplinary team had a much more holistic vision of what their placement was about:

> *One lady was due for dressing practice. On other wards the nurses would have been rubbing their hands in glee because that was one less to wash in a morning. But here we worked together, the lady* [patient], *the occupational therapist and the nurse and me. When we had done the physio popped in to see how well she was standing unaided. The others didn't leave, they all stood there and gave the patient their full attention.* Student, placement F

> *They invited Mrs Brown* [patient] *and her daughter to come to the meeting* [case conference]. *I don't think that I have ever seen that before.* Student, placement F

Assisting students to fully appreciate the importance of the individual to the multi-disciplinary team and their work was essential if they were to appreciate the significance of older people as a client group. In some settings patients also

contributed to student learning and this further reinforced the view of them as a significant person:

> *It was nice to see people and get to know them in their home, they seem more like people, does that sound awful, you know what I mean more like .... But when Mandy said 'you visit on your own tomorrow' I really understood how important it was that I knew them* [the patients] *and they knew me. They* [the patients] *looked after me and gave me tips and that was great.*
>
> *What kind of tips?* Researcher
>
> *Oh, you know, one chap told me to leave my waste bag and he burnt it on his fire, little things like that.* Student, placement B

Mentors often saw the benefits of older people and students working closely together, and actively encouraged this:

> *You know the patients that like a student. You know that a particular patient will get on with a particular student, and you can ask them to help you with the students. They are usually very pleased to be asked and very helpful, they keep a special eye on the student and it gives them someone else to chat to. It works both ways, for the student and the older person.* Mentor, placement C
>
> *I use patients as a kind of litmus paper to see how students are doing. Because if a patient has a good rapport with a student you can develop that, you can develop the student's learning through that. And because they get on so well they can gain feedback as well so they can use their own experience and the testimonies* [from patients] *and patient care studies as well as evidence of their learning.* Mentor, placement G

This apparent interdependency between students and older patients was also reflected by the staff on the placement, and in the most enriched environments care staff also clearly appreciated and gained from the students' presence:

> *I learn off them and they learn off me; so really it is good vibes on both sides. Sometimes they will say 'I never thought of that', and then another time they will say 'don't do that, do this'. So really we are learning all the time with all the students so I think it's a good thing for us. At the end of the day I'm not qualified in anything, students are going to be qualified nurses so they are going to know more than me*

> *about some things. I'm only going by experience on my side. ... The ones I have worked with have been absolutely brilliant; they have not just stood there watching us, they have mucked in. This week is the week that D and A leave, it has gone so quick, I do miss them when they go because they really get into the teamwork with us.* Care assistant, placement G

Perhaps a more tangible recognition of how students have contributed to care and developed their knowledge and skills lies with the placement documentation. All the case study placements endeavoured to give students ongoing feedback about their performance throughout the placement, but students become anxious to discover if their perception of their performance matched that of the staff:

> *I know how important its is for them* [students] *to have their booklets filled in and I think it important that we do it while our memories of them are still fresh. So I insist that mentors make time to fill in the booklets and time to sit down with the student and talk them through the marks and comments before they leave. I have worked in places where students are coming back and phoning weeks after they have left trying to chase up signatures and the like.* Leader, placement B

This once again reinforces the importance of the mentor role. Even at this late stage a sense of belonging and achievement was created for some students when they were invited to return to the placement in a different capacity:

> *I'm really pleased with my report and they have asked if I would like to come and work on the bank, so I can't have been that bad, can I?* Student, placement G

Placements too saw the fact that students wished to return as an endorsement of the care environment that they had created:

> *I have had students come back three or four times, they like it so much here. They like what we do and the way we do it.* Leader, placement A

Appreciating individual older patients allowed students to begin to recognise the importance of older people as a client group. Indeed, in the most enriched environments, students were encouraged to take that a stage further and consider nursing in its wider societal context:

There are some things which you don't know if they are right or wrong because things are not cut and dried. But there are things that we as human beings and citizens ought to be discussing. Health care is more than just within the confines of the hospital. It's a personal thing, they need to consider their actions as citizens. I think we should be challenging things as citizens and the students should try that. Leader, placement A

Although there was evidence that some students had developed a wider view of health, there was also a keen reminder of the vulnerability that students feel. This can understandably constrain them from developing a more overtly 'political' stance:

She [an older patient] *was actually going to feed back to the ward. And I said that was a marvellous thing because they do act on feedback because the Trusts want to achieve and improve. So I encouraged her to do that, but I spoke about this with my university tutor because you walk a very thin line really when you are encouraging patients to write to their MP and say how things are. I don't think you can help but be political as a nurse, I don't mean be associated with parties, but it is a political issue if they are the ones making the decisions allocating the resources to elderly patients.* Student, placement E

Although an enriched environment was mainly about the attitudes and actions of staff, it was also clear that maintaining standards required not only commitment, but also sufficient resources. On my first visit to placement F, students spoke of team working, skilful staff, and the way they valued patients and their carers. Returning some weeks latter I was surprised to hear students describe a very different experience:

I came here to learn about strokes as well and the rehabilitation, which I found quite interesting. The first six weeks were fine we learnt a lot but this last six weeks, because it has just been hell here we have just been used as auxiliaries so we haven't really learnt much. Student, placement F

In the interim the ward had undergone some considerable staffing and organisational changes:

I think the main thing that has happened since you were here is that I have lost four E grades. Just coincidence: one was pregnant, one got promotion, another took a sideways move and the other went to work

> *in Australia for a year. You just can't replace senior staff nurses like that. Although we advertised we only got two applicants, neither of which has had any E grade stroke or rehab* [rehabilitation] *experience. I have also lost my F grade because she has got a G* [grade] *downstairs. She didn't want to go, but you can't stand in their way can you? We have been forced to close six beds and take on newly qualified staff nurses, which is far from ideal. But we can't even get enough of them. I'm having to use agency staff all the time, it's a nightmare. On top of that the therapy departments are having to rationalise because they can't recruit either and for the time being we don't have dedicated therapy staff ... they come now on a rota basis. It took us ages to get that system and in reality now they have managed to take our dedicated staff away I doubt that we will ever get them back.* Placement leader, placement F

Staff found it difficult to sustain their earlier person-centred approach, and as many new junior or inexperienced staff were still operating in self as focus mode themselves, they were less able to support patients or students:

> *There are lots of newly qualified* [nurses] *which makes it very difficult when we are trying to get information because they are not 100% sure of the answer. The patients are very heavy and demanding and they need specialised care, rehabilitation and they are just not getting it anymore...Some of them* [newly qualified nurses] *are a bit insecure, I think, and they are not as confident in teaching us you know.* Student, placement F

This once again demonstrates the importance of continuity in creating a person-centred environment for patients, students and staff.

Summary

Students in phase II recognised that some of the clinical placements had an overall philosophy of person as focus, and others that of patient as focus. However, even in the most short-stay acute care environments, seeing older people in relation to the context of their lives outside the health care arena can enhance the experience for both patients and students. Exposure to more enriched environments helped students see the person behind the patient and consequently better appreciate the needs of older people as a client group. However, person-centred environments do not occur by chance and require leadership and a shared philosophy that values the contributions of all staff, students and patients. The difficulty in establishing a

person-centred environment was highlighted by the contrasting experiences of the two students on placement D. It is clear that all the staff in a clinical placement need to embrace a person-centred focus for their work and that the Senses (security, belonging, continuity, purpose, achievement and significance) have to be created for patients, staff and students if a truly person-centred culture is to emerge. It is also clear that a person-focused environment for older patients, students and staff requires commitment and resources. Table 4.2 summarises the various foci and the factors that serve to create the Senses in an enriched environment.

Now that the empirical elements of the study have been described, the focus in the final chapter is on the extent to which the study addressed its initial aims, and the contribution it makes to a better understanding of what factors influence students' desire (or not) to work with older people using the Senses and foci as an analysis framework. First, however, consideration is given to the manner in which the study has been reported.

Table 4.2: Factors that create the Senses in each foci of an enriched environment

Senses	Self as focus	Course as focus	Professional care as focus
Security	Letters of welcome, invitations to visit prior to the placement reduces pre placement anxiety Giving the students information specific to the placement helps them feel less isolated Having a mentor from the start gives students confidence Preparation in school prior to placement can allay some anxieties	Allowing space for students to address course requirements on placement helps them to feel more secure	Giving students flexible boundaries within which to operate. Welcoming challenge from students Appreciating that students who challenge are still vulnerable and need continued support Supporting students in taking on responsibility
Belonging	Time to settle and get to know the environment and staff promotes a Sense of belonging Being expected on the placement helps students to feel they belong.	Staff taking an interest in the academic demands placed upon the student	Feeling your views are important and impact on care deepens a students sense of belonging
Continuity	Specific preparation for the placement in school prior to the experience Mentorship established and maintained	Developing a relationship with the mentor which lasts throughout the placement Working in with the same team of nurses throughout Working with the same group of patients throughout Helping students link theory to practice	Need for continued support A culture of challenge is maintained by placement leaders leading by example A positive learning culture, attitudes and philosophy shared by staff and students
Purpose	Does not figure prominently at this stage Measures to help the student pass through self as focus (eg early assignment of mentor, allowing time to settle) allow them to focus more quickly on purpose and achievement	Full assessment of students' learning needs by the mentor ie getting to know the student; understanding set objectives; identifying students' personal objectives helps both mentor and student to define learning objectives and consider how they can be met Staff encouraging students to take responsibility for their own learning Shared learning between students at different stages of the course	Students allowed to question clinical care. Observing a range of practitioners giving care helps students develop their own philosophy of nursing Staff also challenge preconceptions of students regarding older people and their health care needs
Achievement	Does not figure prominently at this stage	Encouraging students to arrange their own visits to other health professionals Acknowledging learning from students and allowing learning on placement to impact on patient care	Students see their views being taken on board by the placement As staff communicate their passion and enthusiasm for working with older people to students, students return to the placement for further experience or to work when qualified.
Significance	Being expected on the placement by the staff Senior staff taking time to show students around Being able to establish key relationships early Being provided with speciality specific information by placement staff	Staff acknowledging the importance of students academic work	Students feeling their opinions are valued and respected by staff

Table 4.2 continued

Senses	Patient as Focus	Person as focus	Self as focus once again
Security	If a student's need to feel competent and acquire clinical skills are met, they will feel more secure	Seeing the individual complex requirements of older people with challenging needs being met in a creative way by staff makes students feel secure	Need to pass the placement re-emerges strongly and prompt completion of placement documentation is important Senior students have anxieties about being competent when qualified and the responsibilities involved in being a qualified nurse
Belonging	Students who experience placements where the care of older people is therapeutic and dynamic and where they perceive that staff makes a difference are more likely to want to belong to such a team	Being able to build a relationship with individual older people and experiencing reciprocity	Students wish to be able to feel they belong to the profession
Continuity	Students still need continued support from mentors. Students with this focus are attempting to establish the trajectory of disease conditions as they come into contact with health care	Students begin to appreciate the health care needs of older people within a wider political context. While working within this focus students continue to need support from mentors and school.	Mentor helps the students disengage with the placement and make positive preparations for the next by their assessment in the placement documentation and giving constructive feedback
Purpose	Students wish to learn how to put the different elements of nursing they have learnt together so they can develop a blueprint of the typical care of patients with given conditions Therapeutic purpose: In some acute care settings students appreciated that staff found it difficult to meet the complex needs of older people with multiple pathology and that other settings were better able to meet such needs	Students begin to see what older patients are looking for and appreciate that some environments are more able to meet the complex needs of older people with multiple pathology Seeing the passion and commitment of staff who work with older people helps students to appreciate the satisfactions of working with the client group	Students need to manage a successful disengagement from the placement by getting feedback on their performance, recognition for their participation and achievement and an opportunity to say goodbye. Having had an enjoyable and productive placement helps students to look forward with anticipation to the challenges of joining a new team and gaining new insights into nursing.
Achievement	Achievement for students with this focus was seen in terms of being able to relate signs, symptoms, investigations, diagnosis and treatment for particular conditions in a holistic fashion.	Working closely with older patients allows students to appreciate older people as individuals Students who have been exposed to enriched environments and for whom person is focus are more likely to choose to work with older people	Acknowledgement of achievements and contributions of the students by staff seen especially in terms of the placement documentation
Significance	Although some students remain with patient as focus others began to appreciate the significance of older people and that nursing older people requires a wider view which incorporates contextual knowledge of the ways in which older people live their lives outside the healthcare setting.	Students begin to see beyond the disease to view older people as important Seeing staff who work with older people being given respect for their skills by other member of the multidisciplinary team Students begin to appreciate the wider political context of health care needs of older people	Mentors finding time to sit down and de- brief students and complete assessment documentation before the students leave the placement Students who are asked back as staff nurses or to work on the bank feel they their contributions have been valuable to the placement. Placements where students wish to return see this as an achievement

CHAPTER 5
DISCUSSION OF THE FINDINGS

As noted in the introduction, the genesis of the study upon which this thesis is based is complex, with the work it reports being a major part of a larger funded study, the AGEIN project. The project was commissioned by the ENB as a consequence of the concerns that the Board had about the effectiveness of the educational preparation of nurses in the context of an increasingly complex multi-disciplinary and multi-agency health care environment. The AGEIN project focused primarily on the preparation of practitioners, at both pre and post-registration levels, to work with older people. The original project specification was driven by a desire to address two key issues:

- to identify what the Board termed an 'epistemology of practice' to provide an overall framework giving direction for nurses working with older people;

- to identify the type of educational experiences that might promote positive attitudes towards work with older people.

In responding to the tender the project team, of which I was part, argued, just as Barker et al (1997) had done of psychiatric nursing, that gerontological nursing had yet to identify its 'proper focus'. We believed that this was particularly true in respect of frail older people where cure, and in many cases rehabilitation, are not appropriate goals. Although there has been some recognition of this, other studies commissioned by the Board concluded that the education of practitioners still focused primarily on 'hi-tech' areas of care and paid scant attention to chronic illness and disability (Davies et al 1997, Nolan et al 1997). Therefore, notwithstanding the fact that at the start of AGEIN new 'cultures' of care were emerging in work with older people with dementia (Kitwood 1997), and in long-term care settings (Henderson and Vesperi 1995), it was evident that a biomedical model still predominated. The ultimate goal of the AGEIN project was to see if it were possible to identify a framework for practice and education that would not replace, but rather complement, existing models and provide a rationale for care when cure was no longer an appropriate goal. In interpreting the project

specification from the ENB the AGEIN project set out to address four key questions, namely:

- How do nurses acquire and sustain their perceptions of, and predispositions to work with, older people?

- How, over time, do nurses develop their theoretical and practical frameworks for work with older people?

- What is the nature of the students' educational experience, and how does this impact on their perceptions, predispositions and theoretical and practical frameworks in relation to older people?

- What other factors may influence students' perceptions, predispositions and theoretical/practical frameworks?

In order to address these aims the study adopted a multi-stage, multi-method approach comprising a conceptual phase that involved a comprehensive synthesis of the available literature (see Chapter 1), together with two empirical elements, an extensive phase comprising large-scale postal surveys of both student nurses and qualified staff, and an intensive phase involving both student nurses undertaking their basic training and qualified staff undertaking a range of post-registration programmes. Some of these phases were consecutive, others concurrent, but consistent with the constructivist methodology adopted, the design of the study was emergent and there was iteration between the above phases with each informing the other (see Chapter 2).

Within the overall project I was involved in all phases and participated in the review of the literature, as well as the postal surveys. Indeed, the design of the 'perceptions quiz' in the surveys (see Chapter 1 and Appendix IV) was explicitly informed by the early focus groups with student nurses. Inevitably, therefore, both the conceptual phase and the surveys influenced the work on which this thesis is primarily based, that is the intensive phase that involved longitudinal focus groups over 18 months

with student nurses from four schools of nursing in England and thirty-three one-day visits to clinical environments in preparation for 7 in-depth case studies of practice placements, recommended by students as providing good care to older people.

As the early stages of the project unfolded the emerging results influenced the later stages, and the goals of the study evolved in light of previous work. Therefore, based on the insights gained from the conceptual phase, and another study contemporaneous with AGEIN that I was also involved in (Dignity on the Ward, Davies et al 1999), it was argued that the Senses Framework had much to offer in understanding the relationships between the experiences of staff, older people and families in those environments providing good, or even excellent care. The Senses were mapped onto the existing empirical and theoretical literature (see Table 1.3), and further supported by the extensive data from the Dignity project (Davies et al 1999), which demonstrated how the Senses could be achieved in an acute care environment for older people (see Table 1.2 and Figure 1.1). Data from some of the early focus groups with students clearly indicated that the Senses resonated with their own experiences and therefore they were used as 'sensitising concepts' and explored in greater detail in future focus groups.

As these focus groups were progressing the survey element of the AGEIN project was being completed, and the results that were relevant to this thesis were outlined in Chapter 1. These gave a clear indication that most students in the study entered their training with a generally positive disposition towards work with older people and saw such work as potentially interesting and challenging. However, the majority also had prior experience of work with older people and those for whom this experience was positive were far more likely to view working with older people in a favourable light, and were also far more likely to consider working with older people when they qualified. Prior experience was therefore a key factor, but current experiences emerged as an even more significant influence. Students not only had experience of work with older people during their training placements, but most also worked as care assistants to supplement their bursary, and were frequently exposed to poor standards of care. On the basis of the data from the surveys, therefore, the notion of an impoverished environment emerged, exposure to which was likely to reinforce negative images of work with older people.

Based on the above the main aims of this thesis were therefore to explore the relevance of the Senses Framework to an understanding of the students' experiences, both positive and negative, and to determine if, when present, the Senses might result in an enriched as opposed to an impoverished environment of care. The detailed results reported in Chapters 3 and 4 indicate that the Senses were highly relevant to the students' experiences of working with older people, and help to create enriched care environments.

In exploring these issues further it emerged that both the course as a whole, and each placement, comprised a number of 'foci' that followed a temporal sequence that was also related to, and could be understood in terms of, the Senses. It was clear that the ways in which students progressed through the foci, and the speed with which such progress was made, also varied. The initial focus was on the students' own need to feel safe and that they belonged, both within their own group and on each placement (self as focus). Once a sense of security and belonging had been attained, students tended to shift their focus to the course or placement, and the need to achieve their learning outcomes provided the main sense of purpose and achievement that motivated their efforts. Students who were unable to meet the needs of the course or the placement found it hard to progress further. However, in the more enriched environments of care, students' needs were recognised and efforts made to help them to feel safe and to belong as quickly as possible, often before the placements began. Furthermore, attention was given to their learning needs so that students could progress beyond these and grasp the wider learning opportunities that the best placements offered. These included the chance for students to develop and refine their own professional standards (professional care as focus), to learn about the range of circumstances that bring older people into hospital (patient as focus), and to gain a fuller understanding of what it means to be an older person (person as focus).

The primary aim of this chapter is to discuss the above findings further in light of the current literature, and subsequently to identify the main implications of the study for policy, practice and education in gerontological nursing. However, before doing so, attention is turned to the strengths and limitations of the work that comprises this thesis. Consideration was given to the 'trustworthiness' criteria in Chapter 2, and

these will not be addressed again here; rather, attention now turns to the separate 'authenticity' criteria (Guba and Lincoln 1989, Rodwell 1998).

Strengths and Limitations of the Study

Establishing the quality of a study is important but, particularly in qualitative working, challenging. Emden et al (1987) with the assistance of 11 post-doctoral qualitative researchers, explored the concept of quality in qualitative research, and highlighted an evolution in thinking and associated practices, charting the move from a reliance on 'scientific certitude' in the form of validity and reliability to recognition of post-modern arguments about the uncertainty of knowledge. While asserting that there is no list of universal best quality criteria, they concluded that qualitative research needs to:

- pay attention to detail with honesty and trustworthiness (process);
- be written with impact, meaning and believability (writing);
- relate usefully to practice and other/ongoing research (outcome);
- show that quality is important, consensual and achievable (excellence).

With these assertions in mind it seems essential that this study be considered in the first instance in light of its strengths and limitations.

The reasons for selecting a constructivist approach were described in Chapter 2, and at that point the strengths and limitations of the study were considered in the light of the so-called 'parallel' trustworthiness criteria which mirror the traditional quality criteria of positivist science. At the time these criteria were developed, Guba and Lincoln (1989) were concerned that their emerging naturalistic (constructivist) model would not find acceptance amongst more quantitative researchers and would struggle to be seen as robust, with potentially serious implications for funding and ethics committees. Therefore, the trustworthiness criteria were designed to address largely pragmatic goals. Even at this early stage, however, Guba and Lincoln (1989) had concerns that these criteria were not consistent with the principles upon which constructivism is based. They therefore proposed another set of criteria that they called the authenticity criteria (Guba and Lincoln 1989, 1994).

Guba and Lincoln's (1994) authenticity criteria identify five areas that should be explored when taking into account the quality of a study: fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity. Rodwell (1998: 107) suggests that 'authenticity speaks to the integrity and quality of the interactive process in constructivism that is attentive to multiple constructions shaped by the context'. Although the authenticity criteria are being increasingly used, Nolan et al (2003) have criticised them, not for the principles upon which they are based, but rather for the way in which these principles are articulated. They argue that in using terms such as 'ontological authenticity' Guba and Lincoln render the authenticity criteria exclusive and limit their use and value in enabling full participation in debate, particularly for a non-academic audience. In order to make the authenticity criteria more accessible and understandable Nolan et al (2003) have suggested that they be relabelled. They maintain that re-labelling the criteria 'helps to ensure that they **speak to** older people, family carers and practitioners' (Nolan et al 2003 emphasis added). These relabelled criteria are summarised in Table 5.1.

Table 5.1: The original authenticity criteria and proposed new headings

Original Criteria	**Renamed**
Fairness	**E**qual **A**ccess
Ontological authenticity	**E**nhanced **A**wareness of the position/views of self/own group
Educative authenticity	**E**nhanced **A**wareness of the position/views of others
Catalytic authenticity	**E**ncouraging **A**ction by providing a rationale or impetus for change
Tactical authenticity	**E**nabling **A**ction by providing the means to achieve, or at least begin to achieve, change

The stakeholders represented within this study are student nurses, practice placement staff and older people: other interested parties include nurse teachers

and academics. It seems appropriate to explore the quality of the study using the authenticity criteria, as renamed by Nolan et al (2003), as these provide a more accessible lens through which to consider the authenticity of this research. Each of the relabelled authenticity criteria will now be considered in turn as they are represented in the literature and relate to this study.

Equal Access

Equal access involves ensuring that the differing 'constructions' of stakeholders are sought and represented in the research process (Rodwell 1998), thereby ensuring that all stakeholders have a voice. For Rodwell (1998: 107), having a voice is not just having one's story heard and acknowledged, it also includes participation in the analysis and interpretation stages of the inquiry. Participation from a position of equal power and with complete information is essential for equal access. Finally, achieving equal access calls for serious attention to minority views. Rodwell (1998: 108) reminds us that consensus building in constructivist research is not a democratic process where the most popular viewpoint is used to represent the whole. Instead, it is a process of mutuality in which all those with a stake 'involve themselves in educating themselves and each other about alternatives in order to determine the viable construction of the phenomena under construction'.

Equal Access in this study

Rodwell (1998) reiterates the importance of ensuring that the different constructions of stakeholders are sought. Within this study, purposive sampling was used as a means of ensuring that as wide a range of voices and constructions as possible were heard. Students from a variety of ethnic backgrounds from four institutes of higher education, situated in a range of geographical locations, both urban and rural, and studying three branches of nursing (adult, mental health and learning disability) from both the common foundation and branch programmes, with and without prior experience of older people, were included in the study.

However, as students in the focus groups volunteered themselves to take part in the study it could be argued that the sample was potentially open to bias, comprising

individuals who may have had particular reasons for wanting to take part such as previous experiences or the promotion of extreme views. On the other hand, as a wide range of both positive and negative views and experiences were expressed, this concern may be unfounded. It must be recognised, however, that no data were collected outside England and therefore the findings may not reflect education in the other countries and provinces in the United Kingdom.

Furthermore, while students were encouraged to maintain their input throughout the data collection period, the composition of the groups varied from one occasion to the next. Some 'core' participants attended all the focus groups, while others dipped in and out. This may be considered to have jeopardised the hermeneutic cycle, and participation in the analysis and interpretation as impressions and analysis were not fed back to all the original focus group members. However, the focus groups were cohort specific; that is, everyone who took part in any one set of focus groups was from the same cohort (and in the branch programme, from the same branch). Although consistency within the focus groups may have intensified the joint constructions, having more perspectives and fresh ideas on the topic added breadth to the discussions. Moreover, while this study is undoubtedly data rich, by the end of the data collection period few new perspectives were emerging. I would therefore argue that, within the constraints of the study and the ability of students to be present at all the focus groups, due attention was given to the principle of equal access.

In the case study element the time spent at each site was limited and the impressions I gained of the placements were necessarily snapshot views. Due to the constraints of time and resources contextual information was gathered by observation of between 1 and 4 days in each placement over a period of 4 to 6 weeks. The majority of the observation took place between 9am and 4pm and although this is a limited time frame it represents the busiest parts of the day in many clinical areas. The detrimental effects of spending only limited time in observation was alleviated to some extent as the aims of the visits were specific and observations focused on caregiving, mentoring and other related activities. The undertaking of over 30 one-day visits assisted in focusing the aims and techniques used during the case studies as well as giving an unrivalled breadth of rich impressions and a deeper

understanding of the learning context in placements. I was able to take this with me into the case study sites.

The principle data collection method within the in-depth case study placements was interview. One-to-one interviews were undertaken with students in each clinical area at the beginning and the end of their placements, and single interviews with individual placement staff. Interviews with students about a placement while they are still present and learning in that environment may be less likely to produce honest opinions on sensitive issues. However, in order to allow participants more freedom to express their views, wherever possible, interviews were undertaken away from the placement area – for example, in cafés, common rooms and libraries. Participants were also given reassurances that the researcher had no formal position within either the clinical trust or the school of nursing and that opinions expressed would be kept confidential. Initial interviews focused in general terms on the students' beliefs and expectations of learning to care in that environment. The second interviews were, wherever possible, carried out after the completion of the student's final clinical assessment, in the hope that participants would feel able to express their views in a more open and uninhibited way.

Rodwell (1998) asserts that fairness or equal access should also involve including participants in the analysis. The participants in longitudinal focus groups were involved in considering and commenting on the findings from previous focus groups, both their own and those held in other data collection sites in the hermeneutic cycle. However, due to time constraints, I was unable to ensure this degree of equal access to the participants in the case studies. Nevertheless, constructions and impressions gained in this phase were fed back to the participants in the focus groups who had initially recommended the practice placements. Charmaz (2000: 527) reminds investigators that experience is not necessarily linear, nor is it always readily drawn with clear boundaries. However, it has to be acknowledged that equal access was not granted to all participants in the analysis phase of the study.

Enhanced awareness of the position/views of self and ones own group and enhanced awareness of the position/views of others

Enhanced awareness of the position/views of self relates to the extent to which individual respondents' own emic constructions are improved, matured, expanded and elaborated as a result of taking part in the study. That is, do participants have new insights into their own situation? It should also mean greater appreciation by all stakeholders of the complexities of the situation. Enhanced awareness of the position/views of others, on the other hand, considers whether participants now better understand and appreciate the views and values of other stakeholders. Total agreement with an alternative perspective may never develop, but sympathy for it should be enhanced (Rodwell 1998: 109).

Enhanced awareness of the position/views of self and ones own group and enhanced awareness of the position/views of others in this study

Student nurses participating in the study from the four institutions of higher education gained an enhanced awareness of their own and each other's perspectives in the focus groups, by relating and considering their own experiences and listening to those of others. Furthermore, an understanding of the perspectives of other stakeholders (students, mentors, placement leaders, older patients and staff) was gained through consideration of data from focus groups held in other institutions and case study data, through the hermeneutic cycle. This facilitated an increased awareness and understanding of the complexities of learning for all participants, including the researcher.

Participants in the focus groups certainly indicated that they benefited from having the opportunity to stand back and think about placement experiences, with discussions sometimes giving participants a sense of a shared experience, as demonstrated by comments such as *'I thought it was only me that felt like that'*. Some students wanted similar sessions to be facilitated by teachers as a regular part of their course development. The value that students placed on the meetings was demonstrated by the way in which they continued to contribute to the research throughout an extended period of data collection and in the way that word spread in

the student body, and others asked if they could join the groups. Sometimes, our meetings would begin with the students wishing to debrief by discussing issues of immediate concern, and it is possible that by sharing my own views and experiences of the constraints that professionals were operating under I was able to enhance the awareness of participants to some degree. Participants from phase II also appeared to gain from taking time out to think about their roles and experiences. But as contact with them was limited, they were less able to benefit from an appreciation of the position/views of others taking part in the project. However, feedback from the presentation of one of the products of this study, a CD-ROM and video package (see below for details), to a wide range of stakeholder groups, has suggested that the findings of the study resonate with other groups of students and practitioners.

Encouraging and enabling action by providing a rationale or impetus for change

Shared understanding and creating new knowledge alone is not always sufficient for constructivist inquiry. Rather, constructivist research should also *'facilitate, stimulate, or otherwise evoke action'* (Rodwell 1998: 09). Rodwell contends that some degree of rethinking or reshaping should occur in a process of empowerment; creating a sense of enhanced possibilities by those involved in the study. However, Rodwell also acknowledges that these aspects of authenticity will frequently not have occurred by the end of a given project, but rather may emerge later.

Encouraging action by providing a rationale or impetus for change in this study

The rationale or impetus for change in this study has come through the use of the Senses Framework, a useful heuristic in helping students and mentors to better appreciate how the conditions for a positive learning experience can be created, without massively increased resources. Therefore, practice placements can become more enriched environments by attention to the 'little things' in the detail of the student experience, and by exploring ways in which the Senses may be created for all those involved in practice placements. Indeed, facilitating such an aim is one of the main purposes of the CD-ROM and video package emerging from the study.

In an attempt to ensure that the results of the study were as widely available as possible, I was successful in applying for funding from the Learning Media Unit of the University of Sheffield to produce a CD-ROM and video package of the main study findings. This has been written and produced by the AGEIN research team in conjunction with the Learning Media Unit. Early evaluation of a prototype version of the product presented to groups of student nurses and in conferences has been positive. We hope that this product will be of value to mentors, students and other placement staff, and provide a sense of vicarious experience (Rodwell 1998) for those not involved in the study.

A commitment to making the results of a study as widely available as possible is therefore also important to ensuring equal access, and further enhances the potential of the work to enhance awareness and encourage/enable action. This provides an illustration of the interactive and dynamic ways in which the authenticity criteria interact in determining the quality of a particular study.

Any study has limitations, and the present one is no exception. However, it is hoped that the efforts that were made to ensure that the study was as 'authentic' as possible, have been successful. Having discussed the quality of the study, attention is now turned to the interpretation and discussion of the results.

Interpreting the Results: The Senses as a Potential Framework for Education and Practice

The ENB's main motivation in commissioning the AGEIN project was to see it if was possible to identify an appropriate epistemology of practice that might guide work with older people, and the educational preparation of practitioners for such work by exploring the type of educational experiences that promote positive attitudes towards gerontological nursing as a career choice. The results of the AGEIN project in general, and those contained in this thesis in particular, suggest that the Senses Framework addresses both of the above issues.

The original tender to the ENB noted that, at the time, new cultures of care were emerging but that there was little detail as to how they could be applied, and very

limited empirical support for them. However, the notion of person-centred care now emerged as being particularly influential (Kitwood and Bredin 1992, Kitwood 1997), extending its influence far beyond the field of dementia. So, for example, person-centred care now lies at the heart of the National Service Framework (NSF) for Older People (DoH 2001a), and is seen by many to provide a way forward for gerontological nursing (see, for example, McCormack 2004). However, person-centred care remains rather ill defined (Dewing 2004), making its application difficult.

One of the goals of the initial conceptual phase of the AGEIN project was to consider the then extant literature and to attempt a synthesis of key themes, person-centred care amongst them. On the basis of the review it was suggested that one of the most complete definitions of person-centred care was that provided by Mulrooney (Nolan et al 2001c), who sees person-centred care as comprising three linked elements. These are:

- Respect for personhood
- Valuing interdependence
- Investing in caregiving as a choice

Mulrooney's conceptualisation still has much to offer as it extends beyond the notion of personhood, with its focus on the individual (see NSF for Older People, DoH 2001a), to recognise that both interdependence and choice are key dimensions of care (Davies 1995, Brechin 1998). Indeed in respect of the questions that AGEIN sought to address, Mulrooney's third criterion has particular resonance, as it was the general failure of practitioners to actively choose gerontological nursing that was the main motivation behind the ENB's decision to commission the study at the outset. The findings described in this thesis shed considerable light on the factors that might predispose nurses to choose to work with older people (or not). Furthermore, with regard to respect for personhood, the results indicate that this generally tends to develop over time, as exemplified by the foci. Both choosing to work with older people, and developing a vision of care with person as focus, are significantly influenced by the experiences that students have and the extent to which they

encounter enriched as opposed to impoverished environments of care. Such environments can be understood in terms of the Senses, with the suggestion being that in an enriched environment all the main stakeholders experience the Senses, reinforcing Mulrooney's second point – valuing interdependence. As a heuristic device, therefore, Mulrooney's work seems particularly appropriate and will be used here to shape the discussion of the results, beginning with 'investing in caregiving' as a choice'.

Investing in caregiving as a choice

Difficulties in the recruitment and retention of nursing staff working with older people was one of the prime concerns of the ENB when commissioning the AGEIN project (see Introduction and Chapter 1) and, as a subsequent major review of gerontological nursing noted, the persistence of negative attitudes towards work with older people remains a 'great concern' (Standing Nursing Midwifery Advisory Committee, 2001). Insights into why this negative perception of gerontological nursing persists are needed if the situation is to be improved.

Mulrooney's third prerequisite for good person-centred care is based upon the premise that individuals providing care to older people, whether family members or paid carers, are unlikely to deliver care of the highest quality unless they have a positive predisposition towards such care. It is apparent from the literature that many nurses, both qualified and students, find gerontological nursing unchallenging, untechnical and unrewarding (Gunter 1971, Kyser and Minnigerode 1975, Hooper 1979, Happell 2002) and are not drawn to work in this field (Campbell 1971, Hooper 1979, Robb 1979, Tagliareni and Boring 1988, Söderhamn et al 2001). Reinforcing such conclusions, some student nurses responding to the questionnaire in the AGEIN study were not attracted to working with older people because they could see no obvious source of job satisfaction or reward, and because they thought that the work would be onerous. Respondents used words such as '*heavy demanding work*', '*depressing*', '*degrading*', '*bored*', '*frustrating*', '*un-stimulating*', '*not challenging*', which convey a very negative perception of working with older people. However, it transpired that the majority of students did not start their training with such a perception, but rather that it resulted from their experiences,

primarily during their training. This was not universally the case though as some students had already determined that work with older people was 'not for me', either because they wanted to work with other client groups, – children, for example – or because they had extensive experience of work with older people before starting their training and wanted a change. Furthermore, it emerged that most students had some prior experience of care work with older people before starting their training, and those who viewed this experience as positive were far more likely to see work with older people as challenging and stimulating and were more likely to choose to work in gerontological nursing upon qualification. Clearly, therefore, past experience is one of the factors influencing perceptions of and predispositions to work with older people, unrelated to the educational experience of students during their training.

However, far more significant was students' experience during their programme, whether as part of their training, or because of extracurricular work as care assistants to support their bursary. The questionnaire survey data indicated that students recognised ageism at three levels: the wider societal attitudes towards older people; the standards of care that older people received in the health care system; and the negative view that many practitioners had of gerontological nursing. All these potentially eroded an initially positive perception of work with older people. But it was students' exposure to what we termed impoverished environments that left the most lasting impression. Moreover, data indicated that it was not the educational experience in the classroom, or the theoretical content of the programme that exerted the greatest impact; indeed, these rarely figured in the students' accounts. Rather it was the practice placements that were to the fore, together with extracurricular work.

Combating ageism in health care is key to the success of the NSF (DoH 2001a), and this is an issue that will be returned to later. However, a major theoretical contribution of this thesis is the identification of enriched and impoverished environments of care, and an understanding of how they are created for students in terms of the Senses Framework.

Enriched and impoverished environments

Although it is impossible to militate for learning experiences prior to the pre-registration nursing programme, and very difficult to prevent negative extracurricular experiences, it is reasonable to assume a greater degree of potential control exists within the training itself. At the time of the study the nursing programme comprised two components, each of which constituted 50% of course content; that undertaken in the university, relating primarily to the theory of nursing, and that undertaken in the clinical area, concerned primarily, though not exclusively, with practice. Clinical placements have been shown to be the most popular elements of a nursing course (Kinsella et al 1999), and early in the life of this project it became overwhelmingly clear that students considered learning to care for older people to occur overwhelmingly during their clinical placements, which are seen by many as the 'heart' of professional practice (McCabe 1985).

Findings from the AGEIN survey provided compelling evidence that students, whether as a result of placements during their course or because of working in care settings to supplement their bursary, were often exposed to impoverished environments: that is, clinical areas where standards of care and the practice milieu were so poor that they had potentially profound detrimental effects. However, the data also suggested that placements in enriched environments could do much to reverse such effects. Therefore, if nurses are to qualify with a positive view of older people, prepared to give more than passing consideration to gerontological nursing as a career option, they need to have experience of nursing older people in a range of enriched environments. For this to happen it is essential to be able to differentiate between impoverished and enriched environments so that the latter can be promoted and valued. As this study has demonstrated, the Senses provide a way of differentiating the two, and Tables 5.2 to 5.7 compare and contrast an impoverished and an enriched environment using the Senses (Nolan 1997, Nolan et al 2001a, c). As the study upon which this thesis is based progressed, one of the main goals was to determine if the Senses were relevant to the student experience, and if they could help to differentiate the type of experience that would have a positive impact on students' perceptions and predispositions to work with older people. These tables provide convincing evidence of the value of the Senses in this regard, and show a wide range of concrete ways in which the Senses can be created for students.

Table 5.2: The characteristics and facilitators of a Sense of security in enriched and impoverished environments for students and mentors

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Students	**Feeling well prepared**	Having clear ,discrete and appropriate theoretical content relating to older people Feeling that you are sufficiently prepared in clinical skills to contribute to practice (Greenwood and Winifreyda 1995)	**Feeling Unprepared**	Theoretical content relating to older people hidden or absent from the curriculum (Recchia-Jeffers and Campbell 2005) Feeling you lack the clinical skills for practice
	Feeling supported	Having a mentor who works with you and/or is available to support you throughout the placement, makes you feel safe to learn and practice (Gray and Smith 2000) Having a named mentor who is interested in teaching and student learning and understands the requirements of your course and placement documentation (Price 2005, Rawcliffe 2005) Positive leadership from the mentor, with boundaries clearly defined	**Feeling Unsupported**	Having no mentor or lack of support from mentor due to holidays or sickness for example, makes students feel scared and alone Mentor not showing any interest in teaching or student learning or not knowing about the requirements of the course especially in relation to placement documentation (Gray and Smith 2000) Having little direction or guidance from the mentor – being unclear about your role
	Help to 'talk things through'	Being able to raise concerns without fear Staff being approachable (Rawcliffe 2005)	**Isolated with no one to turn to**	Concerns being cast aside or disparaged (Edwards 1991) Staff being unapproachable
	Feeling secure	Feeling able to contribute (Price 2005) Staff have a passion for working with older people (Gray and Smith 2000)	**Feeling insecure**	Feel you are in the way (Davies et al 1994) Staff clearly do not enjoy working with older people
	Feeling staff are highly skilled and knowledgeable	Staff consistently deliver a high standard of individualised care to older people, explain what they are doing to the student and the older person (Orton et al 1993, Davies et al 1994)	**Feeling staff lack the requisite skills and knowledge**	Staff demonstrating poor care leaving students feeling shocked and frightened

Table 5.2 continued

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Mentors	**Feeling supported by colleagues, management and education**	Mentors discuss situations and problems with colleagues Colleagues take over and work with the student on occasions (Atkins and Williams 1995, Sharp 2000) Lecturer practitioners/link tutors consulted by mentors with particular problems (Atkins and Williams 1995) Placement leaders are interested in students and approachable for advice on mentorship issues Regular contact with the link tutor	**Feeling unsupported by colleagues, management and education**	Mentors feels isolated and has to 'go it alone' in mentoring the students Mentor works with the student without a break No access to lecturer practitioners or link tutor Placement leader sees students as an extra pair of hands and has no interest in student learning Link tutor rarely seen on the placement and hard to contact
	Feeling supported by students	Students are sensitive to the needs of mentors eg if they are very busy or have difficult patient issues (Atkins and Williams 1995) Students are keen and interested in learning	**Feeling unsupported by students**	Students demand attention even when the mentor is very busy Students have preconceived ideas about working with older people and are not open to new ideas
	Mentorship as choice	Mentorship role should be freely chosen (Pearcey and Elliot 2004)	**Mentorship thrust upon you**	Nurses allocated students without consultation
	Being allowed time to mentor	That mentors need to give students time is recognised and seen as a valid activity by the nursing team	**Mentoring students seen as a way of avoiding work**	Having insufficient time for undertaking the mentor role (Omerod and Murphy 1994, Earnshaw 1995, Wilson–Barnett et al 1995) Learning is not valued on the placement and spending time with students is seen as a way of avoiding work

Table 5.3: The Characteristics and Facilitators of a Sense of belonging in enriched and impoverished environments for students and mentors

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Students	**Being made to feel welcome**	Being expected on the placement – having a welcome letter Having a mentor to 'broker' their relationships with other members of the team – being welcomed by older people and their carers (Gray and Smith 2000) Mentors waiting to go on duty with students Going on break with your 'team'	**Not feeling welcome on the ward**	Not being expected eg no one is expecting you when you ring for your first shifts Having to introduce and explain yourself to staff and patients Being sent out of 'hand-over' because the room is too small (Davies et al 1994)
	Feeling like part of the team	Being asked to return to work on the ward again	**Feeling like a stranger**	Students feel they do not fit into the team they become isolated, and staff seem distant and aloof (Davies et al 1994)
	Accessing the team spirit	Joining a placement with a good team spirit – staff appear to be happy and work well together Taking some responsibility for sustaining the positive atmosphere by showing a willingness to learn and being flexible to the needs of the clinical setting (Gray and Smith 2000)	**Lack of team spirit**	Back biting and gossip between placement staff Avoiding a negative atmosphere by 'keeping your head down'
	Staff appreciate the importance of learning opportunities for students	Being brought away from the 'work' to take advantage of a learning opportunity	**Being treated like a pair of hands**	Students feel accepted only when 'filling in the gaps' in staff provision or when they contributed to ward routine and helped to ensure that things got done on time (Gray and Smith 2000)
	Being able to identify with older people	Students recognising the 'person' in older people and acknowledging their biography	**Being unable to identify with older people**	Staff fail to identify with older people and treat them as 'other' so students find it difficult to relate older people to themselves or their own situation
	Feeling you belong to your cohort and the wider student body	Students identify strongly with their cohort and especially with their branch. The university accords student nurses equal status to other students when planning Timetabling takes into account the needs of nursing students to participate in university activities	**Not feeling part of the wider student body**	Reduced library and canteen facilities during 'university' vacations when student nurses were still attending university Being denied the opportunity to participate in normal student activities such as 'Freshers' week

Table 5.3 continued

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Mentors	**Feeling part of a wider community of mentors**	Having the opportunity to meet with mentors form other areas to discuss issues – especially important to mentors working in the community or independent sector (Atkins and Williams 1995) Being able to undertake effective mentor preparation courses	**Feeling isolated as a mentor**	Having little opportunity to meet with mentors from there own or other areas No/poor mentorship preparation programmes available. Quality of mentorship preparation varies, the value of some is questionable (Rogers and Lawton 1995)
	Feeling part of a wider community of learners	Continuing to undertake courses and professional development helps mentors to empathise with students		Professional development for staff not a priority
	Being part of the team	Feeling part of the wider multidisciplinary team (Davies et al 1999)	**Feeling isolated as a nurse**	Professional jealousy between members of the multidisciplinary team

Table 5.4: The Characteristics and Facilitators of a Sense of continuity in enriched and impoverished environments for students and mentors

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Students	**A clear and effective relationship between placement and the University**	Practitioners come into school to teach Staff frequently have recent experience of education and value learning Mentors have a clear understanding of course requirements and documentation (Darling 1984) Link tutors are known and evident on the placement Theory relating to the placement is delivered directly prior to the placement (Corlett 2000) Rationale given for practice helps to relate it to theory (Burkitt et al 2000) Theory about older people discrete, well defined and delivered close to an appropriate placement High quality communication between school and placement makes students feel they are in accord	**A poor relationship between school and ward**	Programme of training being disjointed Staff do not value theory or education (Andrews et al 2005) Mentors do not understand course requirements and rely on students to understand the documentation Placements are unsure who the link tutor is or how to contact them. The students does not see the link tutor during their placement Theory and practice not timed to coincide leaving students feeling disconnected (Corlett 2000) Little connection between nursing as taught and nursing as witnessed (Andrews et al 2005) Theory about older people too well hidden in the course to be relevant to students (Earthy 1993, Andrews et al 2005) Lack of communication between placements and school leave students acting as go between (Burkitt et al 2000)
	Exposure to a clear philosophy of care	Students see and are aware of a living working philosophy of care which is enacted and discussed rather than looking good on paper	**Little evidence of a philosophy of care**	Students and staff are unable to articulate a coherent philosophy of care and placements lack vision beyond day to day tasks
	Consistent relationships	Mentor is key in making the links and connections Directional leadership (Gray and Smith 2000)	**Lack of consistent relationships**	Mentors changing due to holidays and sickness Students left o their own devises

Table 5.4 continued

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Mentors	**A clear and effective relationship between placement and the university**	Help and support given by lecturer practitioner (Atkins and Williams 1995) and link tutor Mentorship preparation programmes run jointly between Trusts and universities	**Unclear and uncertain relationship between placement and University**	Lecturer practitioner and link tutor hardly known by the mentor in the clinical area Quality of mentorship preparation varies, the value of some is questionable (Rogers and Lawton 1995)
	Getting feedback about the progress of a student you have failed	Mentors are informed of outcome of failing a student on placement (Duffy 2004)	**No feedback on student progress**	Mentors hear nothing of students (good or poor) once they leave the placement
	Feeling the value of uninterrupted mentorship is understood	Off duty time for mentor and student is synchronised Mentors are not allocated a student when they are going on holiday		Staff given opposite shifts to student No consideration of holidays or study leave in the allocation of students
	Feeling ownership of a clear philosophy of care	Mentors take part in devising and creating a living philosophy of care which they use daily to guide their practice and teaching		The placement philosophy is not evident or explicit in practice
	Consistent relationships	There is a core of stable staff in the clinical area (Davies et al 1999)		Heavy reliance on bank, agency, and junior staff on the placement (HAS 2000 1998)

Table 5.5: The Characteristics and Facilitators of a Sense of purpose in enriched and impoverished environments for students and mentors

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Students	**Having something to aim for**	Having an agreed set of goals for older people and students Understanding their role on placement Having an effective mentor to assist in identifying and maintaining their sense of purpose by facilitating learning opportunities and having a 'feel' for the amount of input needed by individual students (Gray and Smith 2000) Placement outcomes set by school that clearly relate to the placement (Burkitt et al 2000) Feeling able to challenge practice without censure	**Feeling unclear about the purpose of a placement**	Having no clear goals -feeling frustrated, annoyed, and exploited –that they are wasting their time (Mackay 1989) Finding it difficult to maintain motivation where the student role is unclear Having limited/no mentor contact leaves students 'in the wilderness' Not being able to see the relevance of placement outcomes set by school Becoming socialised into the culture which made them assume there was not point in questioning things as they were impossible to change (Pursey and Luke 1995)
	Managing the placement	Trying to fit in to a good team Getting to know how to approach staff to achieve their goals (Gray and Smith 2000) Using humour to challenge practice	**Confused and frustrated by the placement**	Refusing to return to a placement/going off sick Feeling alienated form staff and isolated (Davies et al 1994) Fitting in with practice they do not agree with in order to pass the placement

Table 5.5 continued

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Mentors	**Mentoring an integral part of the role of the staff nurse**	Mentorship taken as an integral and enhancing part of the nurse's role (Atkins and Williams1995) Mentor's workload reflects the extra time commitments required	**Mentoring an additional responsibility for the staff nurse**	Perception that mentoring generates extra work and pressure (Collins 1983, Darling 1984, Atkins and Williams 1995) Mentoring puts extra time pressures on an already stretched professional (Collins 1983, Darling 1984, Atkins and Williams 1995)
	Mentor given control to organise own workload	Planning ahead to take account of commitments to students Planning care to make the most of the opportunities for students and older people	**Mentor lacks control over their own workload**	Responsibilities towards student conflict with those towards patients and colleagues (Wilson 1989, Wright 1990, Atkins and Williams 1995) Mentor allocates tasks to student
	Preparation for mentorship	Having formal mentorship preparation programme including the principals of adult learning, facilitation and reflective practice (Atkins and Williams 1995)	**Lack of sufficient/appropriate mentorship preparation**	Little or no preparation for mentorship (Pearcey and Elliot 2004)
	Students are willing to learn	Students show interest in the field, ask questions and challenge practice; stimulate the mentor Students make themselves known to staff before they begin the placement	**Student lacks motivation and commitment**	Students who come to a placement with preconceived ideas and who are unwilling to be open makes mentors frustrated (Atkins and Williams 1995) Students who turn up late
	Preparing for students	Mentors and clinical staff have the opportunity to produce specific information for students about their speciality	**Lack of preparation for students**	No learning resources available to mentors or students
	Getting help to spread the 'load' of mentorship	Getting students at different stages in the course to work together Having an associate mentor, usually a junior nurse, who is learning to mentor	**Taking the full weight of mentorship**	Placements have few staff trained to be mentors Junior nurses are not encouraged to learn the skills of mentorship
	Staff have ownership and responsibility for standards of practice on the placement	Nurses take a special area in a specific area of practice, such as diabetes or wound care Staff feel free to challenge practice without censure	**Practice development not a priority on the placement**	Ad hoc approach to practice development Routinised, task orientated care

Table 5.6: **The Characteristics and Facilitators of a Sense of achievement in enriched and impoverished environments for students and mentors**

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Students	**Inspiring placements**	Staff delivering high standards of care Older patients are a priority Person-centred care is the practiced philosophy Staff involved in learning themselves Staff fully aware of the learning opportunities available to students and ensure they get the opportunity to take advantage of these Staff are skilled and knowledgeable Staff gain a sense of achievement from their work which they communicate to students Senior nurses are approachable High quality mentoring facilitating learning (Darling 1984)	**Uninspiring placements**	Observation of poor standards of care (Pursey and Luke 1995) Older people not seen as important Systems that operate for the benefit of the institutions rather than the patient (Pursey and Luke 1995) No culture of learning for qualified staff or others on the placement Staff unaware of what students learned or how they could help Staff lack essential skills and knowledge to care for older people Staff unhappy and dissatisfied with their work and advise students to work elsewhere (Pursey and Luke 1995) Senior staff not evident on the placement – seem aloof Mentoring is not valued by senior nurses – lack of investment in mentor training
	Seamless links between university and placements	Course work relates closely to placements focus (Burkitt et al 2000, Corlett 2000) Theory about older people, well defined and delivered close to an appropriate placement helps to focus students on what is possible to achieve (Earthy 1993) Placement staff aware of what is required of the student in course work and able to offer support and suggestions Mentor and placement leader having a good working relationship with link tutor (Corlett 2000)	**Disconnected University Experience**	Endless demands of academic work seem to be unrelated to the placement making students feel stressed (Burkitt et al 2000) Poor balance in the curriculum which eroded students sense of being able to make a difference Placement staff unaware and interested in students course work Mentor and placement leader have little time for the link tutor

Table 5.6 continued

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Students	**Personal achievement**	Passing the course, the placement or an assignment Making a difference to older people (Pursey and Luke 1995, Ironside et al 2005) Students begin to develop their own standards of care (Pursey and Luke 1995) Students' challenge to poor practice is welcomed by senior nurses The presence of students helps to maintain standards Able to bring new insights to the ward Students have their contribution to care recognised by staff, patients and carers	**Lack of personal achievement**	Struggling to get placement documentation completed by mentor Feeling unable to change things or make a difference to an individual older person (Pursey and Luke 1995) Students adopt poor standards they see around them (Gray and Smith 2000) Students wanting to distance themselves from poor leads to them disengaging from the placement (Pursey and Luke 1995) Demonstrating good practice can make you a threat to staff on the placement Feeling you have little to learn on the ward Students feel that no matter how hard they work no one notices

Table 5.6 continued

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Mentors	**Learning through students**	Mentor's own professional role enhanced as a result of mentoring (Talarczyk and Milbrandt 1988, Wilson 1989, Wright 1990, Atkins and Williams 1995)		Feeling mentorship as an additional burden
		Students' questioning 'refreshing and helpful' in clarifying aspects of work (Talarczyk and Milbrandt 1988, Wilson 1989, Wright 1990, Atkins and Williams 1995)		Feeling anxious about students probing questions
		Learning one's own limitations, help one to reflect (Talarczyk and Milbrandt 1988, Wilson 1989, Wright 1990, Atkins and Williams 1995)		Feeling that you have to seem to know all the answers
		Learning the importance of life experience, eg in mature students (Talarczyk and Milbrandt 1988, Wilson 1989, Wright 1990, Atkins and Williams 1995)		Feeling intimidated by mature students
		Reading more literature and keeping up to date (Talarczyk and Milbrandt 1988, Wilson 1989, Wright 1990, Atkins and Williams 1995)		Feeling pressured if students probe too closely (Pearcey and Elliot 2004)
	Working in Partnership	Reciprocity learning through students (Atkins and Williams 1995)	**Working in Isolation**	Feeling that teaching students is a one way street (Atkins and Williams 1995)
		Mentor and student making expectations of each other explicit (Atkins and Williams 1995)		Being unclear about what is expected of you as a mentor and unclear about what students need from a placement
		Student and mentor have a relationship based on mutual respect (Spouse 2000)		Mentors and students have a relationship based on mistrust and suspicion
		Mentor and student sharing something of themselves and building trust (Atkins and Williams 1995)		Mentor and students reluctant to give of themselves
	Getting feedback	Feedback from lecturer practitioners/link tutors and placement leaders on their performance (Atkins and Williams 1995)	**Working in the dark**	No feedback from peers and colleagues
		Getting feedback from the students		No feedback from students

Table 5.7: The Characteristics and Facilitators of a Sense of significance in enriched and impoverished environments for students and mentors

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Students	**Feeling that you matter**	Not being just a pair of hands (Davies et al 1994, Gray and Smith 2000) Feeling you have a valued contribution to make to patient care and to the ward What you do makes a difference (Gray and Smith 2000) Feeling staff are interested in you (Gray and Smith 2000) Feeling cared for (Gray and Smith 2000) Feeling noticed by relatives	**Feeling that you don't matter**	Being made to feel you are a drain on ward resources Being used to undertake tasks with little rationale Your efforts are not appreciated and make no difference to patients (Hirvonen et al 2004) People showing no interest in you accept as another pair of hands Being told that your training is not valued Relatives unsure of your purpose or role
	Feeling that working with older people matters	Older people being given prominence in university teaching in University and placement staff showing passion for their work with older people Older people given equal access to resources as other patients	**Feeling that working with older people does not matter**	The study of older people 'tagged on' to other sessions (Earthy 1993) University and placement staff demonstrating ageist attitudes and discriminatory language Lack of resources for caring for older people

Table 5.7 continued

	Enriched environments		Impoverished environments	
	Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Mentors	**Having support from peers**	Everyday support from colleagues (Hyde 1988, Armitage and Burnard 1991), understanding when mentor needs time away with the student Understanding that working with a student does not mean that the staff nurse can take care of more patients (Atkins and Williams 1995)	**Peers do not value mentorship**	Being interrupted when taking time out with a student Being given extra patients to care for because you have a student working with you
	Feeling that mentorship is valued within the Trust	Having the opportunity to meet with mentors form other areas to discuss issues – especially important to mentors working in the community or independent sector (Atkins and Williams 1995)	**Mentorship is seen as a minor role**	Mentorship has little or no kudos on the placement
	Feeling that learning is valued in the clinical area	Mentors are encouraged to undertake mentor preparation courses and others Off duty times for mentor and student are synchronised Mentors are not allocated a student when they are going on holiday A colleague will take over as mentor if you are away	**Learning is not valued**	Mentors find it hard to get onto or get released to go on mentorship preparation programmes Having opposite off duty to the student Being given a student to mentor during a holiday period Being unsure that students will be supported if you are away
	Student learning is the responsibility of each and every member of the ward team	Staff other than the mentor teach the students and offer them learning opportunities Placement leaders act as student mentors from time to time Staff give the mentor feedback on student performance	**Student learning the prerogative of the mentor**	Other members of the team do not consider student learning Placement leaders never mentor students Mentor takes sole responsibility for assessing student performance
	Staff are given a break from mentorship	Chance to recharge their batteries, staff feel motivated for the next student, gives time for learning from the mentoring experience and a chance to develop teaching materials	**Staff constantly have a student to mentor**	Mentors burn out, begin to forget what they have taught to each student, lack motivation and energy for the task

Table 5.7 continued

Enriched environments		Impoverished environments	
Characteristics	**Facilitators**	**Characteristics**	**Facilitators**
Mentor going above and beyond the call of duty recognised by placement leader	Completing documentation, or discussions in your 'own time' is not routine or expected and there is an opportunity to get some 'time back'	**Mentors expected to**	Additional input to student learning not recognised
Mentors confident in their knowledge and skills	Mentors have confidence in answering student questions Mentors are not afraid to being challenged by students Mentors have a repertoire of skills to pass on to students	**Mentors not confident in their knowledge and skills**	Mentors dread probing student questions Staff lack skills in gerontological nursing (Brymer et al 1996, Moyle 1996) Mentors stifle students challenge Mentors feel they lack the technical skills students want
Feeling that working with older people matters	Placement leader's role model , working closely with patients		
Mentor are proud of being gerontological nurses	Mentors feel able to challenge students misconceptions about working with older people Staff have a passion for working with older people (Davies et al 1999) Mentors highlight therapeutic potential of working with older people to students		Practice demonstrated by staff strengthens misconceptions held by students Staff express and demonstrate their dissatisfaction in working in the field

However, it was evident in this study, as in others, (Aggleton et al 1987, Kirkpatrick et al 1991, Smith and Russell 1991, Jowett et al 1992, Faugier 1993, White et al 1993, Neary et al 1996) that the overarching influence mediating many of these factors for students was the quality of their mentor. While the primary focus of this study has been student nurses' experiences of learning to care for older people, it became abundantly clear that these experiences are inextricably linked with those of staff, and particularly the mentor, with the quality of mentorship being one of the main criteria by which students evaluate a placement (Cahill 1996).

The literature clearly indicates that it is the personal qualities of the mentor, and the nature of the relationship between mentors and students, that is central to the success of mentorship (Andrews and Wallis 1999). The roles and characteristics of the best mentors in this study reflect those described in the three mentoring roles identified by Darling (1984):

- an **inspirer**, someone who pushes the student to achieve high standards (Darling 1984) and is a good role model (Li 1997);
- an **investor**, who gives constructive criticism (Fretwell 1985, Cahill 1996, Fowler 1996, Li 1997) and is interested in the student as a person (Fretwell 1985, Cahill 1996);
- a **supporter**, someone who is approachable (Darling 1984, Fretwell 1985, Cahill 1996).

To fulfil these roles requires mutual respect between mentors and students, and the investment of time and energy (Darling 1984).

While there is much talk in the literature of the attributes of a good mentor, little mention is made of what support mentors need to in order to 'inspire', 'support' and 'invest' in student learning, other than more time and quality mentorship preparation courses (Andrews and Wallis 1999). However, it is evident from this study that, in order to give the best quality support to students, mentors have personal and professional needs which can also be articulated using the Senses Framework. This study has shown that where environments are impoverished for staff it is virtually

impossible for mentors to create an enriched environment for students. Therefore the creation of the Senses for mentors is also key to a positive learning experience for students. The ways in which the Senses are created for mentors based on the findings from this study and the relevant literature, especially that emerging from the Dignity on the Ward Study (Davies et al 1999), therefore are also summarised alongside the student data in Tables 5.2 to 5.7.

Although it can be seen from these tables that the Senses are created for mentors in differing ways than for students, it is apparent that the four key principles identified by Davies et al (1999) as underpinning good practice with older people also support the creation of the Senses for both students and mentors. The principles are:

- Valuing fundamental practice
- Fostering a stable environment of care while embracing challenge
- Establishing clear, equitable and therapeutic goals
- Having a shared set of values and an agreed philosophy of care for both patients and staff

These are discussed below.

Valuing fundamental practice

This requires a commitment to ensuring that the basic but essential care needs of older people are not only met but seen as important. The literature often portrays work with older people and their families as consisting mostly of 'basic nursing care' such as washing and feeding, skills that have been found lacking among nurses (HAS 2000 1998). However, consistent with the findings of Dignity on the Ward study (Davies et al 1999), the more enriched clinical areas in the present study placed a high priority on such needs. The value accorded to this essential care was reinforced by senior nursing staff working closely with patients during each shift, allowing them both to role model and to monitor care delivery in a supportive way, giving an appreciation to both students and staff of the importance of working with older people, and helping to create a sense of the 'significance' of this work for both groups. Furthermore, staff developed personal but professional relationships with

patients, ensuring they knew the older person based on an understanding of their biographical life (Liaschenko 1997). Working in this way helps to reinforce students' and mentors' sense of belonging, security and purpose.

Fostering a stable environment of care while embracing challenge

The importance of creating an effective team that works well together was universally evident in AGEIN and the Dignity project. This helps nurture and sustain a sense of belonging and continuity for staff, as well as a sense of security for students. However, while stability is important, change is inevitable in today's health service, and throughout the more enriched practice placements in this study senior staff sought to improve their practice and welcomed new challenges from staff and students, further enhancing the Senses of purpose, achievement and significance for both groups. Promoting challenge was, in the best environments, a reciprocal affair, and mentors also gained a sense of achievement by challenging the misconceptions some students held about older people.

Again reinforcing the conclusion of the Dignity project, this study highlighted the importance of staff development. For participants in this study, being able to undertake mentorship preparation programmes and other courses helped to create a sense of purpose, and provided a better understanding of the significance of student learning, while also promoting a sense of security, as mentors felt well prepared for the role. For students, having a well-prepared mentor made them feel significant.

The clinical case studies in this study were notable for their commitment to supporting and encouraging staff at all levels in their own professional development. Structured appraisal systems complemented by widespread availability of clinical supervision, mentorship and extensive programmes of in-house education were in place in most placements. These formal structures were supplemented by the development of individual roles and responsibilities within the placement team; for example, assuming responsibility for updating the team in relation to a specific area of practice. Mentors who worked in these environments had regular structured support (creating a sense of security, and continuity), knew what was expected of them (a sense of purpose), took some responsibility for practice in the placement

(significance) and could clearly see that they were contributing to team goals (achievement), all of which helped to promote high staff morale. Other studies have noted a correlation between morale in the clinical area and the quality of mentorship, indicating that where staff work together and are motivated and satisfied, students feel more supported (Wilson-Barnett et al 1995). Conversely, as in this study, where there is low morale and dissatisfaction, students are seen as an imposition (Wilson Barnett et al 1995).

Key to creating an enriched environment for mentors and students was the quality of the placement leader. Placement leaders are crucial in ensuring that units **establish clear and equitable therapeutic goals** and have **a shared set of values that underpin an agreed philosophy of care**, two other characteristics of the 'excellent care' environments described by Davies et al (1999) and the enriched environments identified in this study. In this study the best placement leaders were reflective, self aware and attuned to the complexities of learning in the clinical environment. They demonstrated the characteristics of patient-centred clinical leaders described by Cunningham and Kitson (2000): *learning to manage self* – becoming more self aware, less defensive and open to criticism; *effective relationships within teams; developing a consistent patient focus on care* – observing practice and listening to patient stories and networking; and *developing political awareness* – becoming more aware of stakeholders and policy outside their own clinical area. Furthermore, they also utilised many of the strategies adopted by exceptional leaders, as described in case studies of over 1100 managers from all walks of life, by Posner and Kouzes (1993, 1998), namely:

- challenging the process – searching for opportunities, experimenting and taking risks;
- inspiring the vision – envisioning the future, enlisting the support of others;
- enabling other to act – fostering collaboration, strengthening others;
- modelling the way – set the example, plan small wins;
- encouraging the heart – recognising contributions, celebrating accomplishments.

The above characteristics and practices seem to exemplify the type of leadership necessary to creating enriched environments of care for both students and mentors. What this study has not demonstrated is the type of support and encouragement that such leaders need, and whether or not these can be understood in terms of the Senses. This is perhaps an area for further research.

While the learning stage may be set by the placement leader, individual mentors still need to buy into the philosophy, and although it was evident that the vast majority of staff in the more enriched placements in this study did just that, there were exceptions. This was most notable in a mental health assessment unit where two mature male students had widely contrasting experiences of mentorship and working with older people in the same placement at the same time (see Chapter 4 for a detailed account). It was evident that for one student the Senses had been fulfilled and the experience of working with his mentor in this environment had markedly changed his perceptions of gerontological mental health nursing. Conversely, experience on the same unit served only to reinforce the negative preconceptions of the other student, and he was unable to complete the placement. This demonstrates that even in enriched environments, good and bad practice can coexist, based in this case on the actions of individual mentors. Good mentors feel genuine concern for students as individuals, and want to be mentors (Gray and Smith 2000). A positive mentor–student relationship is one based on partnership, consistency and mutual respect (Cahill 1996, Andrews and Wallis 1999). Poor mentors, on the other hand, break promises, lack knowledge, and expertise and have poor teaching skills; they tend to either over-protect their students or throw them in at the deep end and delegate unwanted jobs to them.

The reasons for the difference in attitude to, and implementation of, the mentorship role by these two nurses is not clear, but they serve to highlight two points. First, they provide a dramatic illustration of the importance of the creation of the Senses for staff and students to the quality of student learning. Furthermore, they eloquently make the point that it is highly unlikely that any one clinical area is either a completely enriched or an entirely impoverished environment. In reality the majority of placements will be enriched in some areas and impoverished in others. However, it is the overall balance of these factors that largely determines a student's

attitude towards working with older people, particularly the balance between enriched or impoverished experiences over the course of a nursing programme. Although it is suggested here that students who enjoy a range of enriched environments with older people will be subsequently more likely to choose to work in gerontological nursing, this may not always be the case.

Respect for personhood

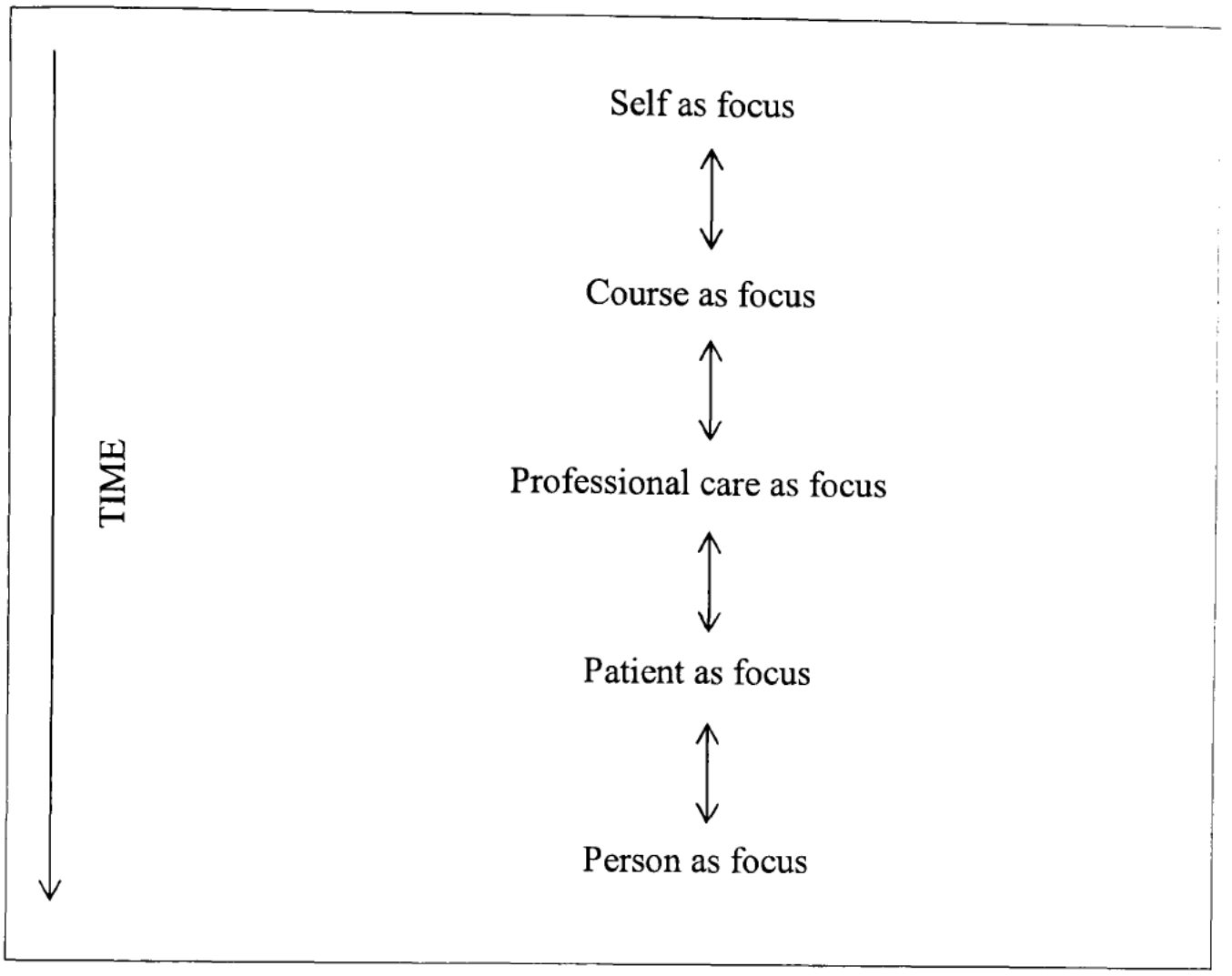
One of the other key questions that the AGEIN project sought to address was how, over time, nurses develop their theoretical and practical frameworks for work with older people. This study suggested that the students received very little in the way of theoretical input, and that they often did not have a well articulated theoretical rationale for the work that they undertook. Rather, as elaborated upon above, it was their practice experiences that shaped their perceptions of, and predispositions to work with, older people. What emerged clearly, however, was that both for the course as a whole, and to a lesser extent for each of the placements, the focus of students' attention changed over time, again in large part influenced by the degree to which the Senses were experienced.

The temporal sequencing indicated that, whist not being entirely discrete, there was an iterative relationship between the foci (Figure 5.1).

The data suggested that, if the students were to achieve 'person as focus', they had first to move beyond the other foci; this was far more likely to happen in enriched environments, but was also influenced in part by the student's stage of training.

This notion of a temporal sequencing, where progression is not simply a facet of the passage of time but is dependent in part on students experiencing the Senses, is important, especially given the emphasis now placed on person-centred care.

Figure 5.1: Temporal relationship between the foci



As noted earlier, person-centred care is now one of the main policy drivers in health care, and this is reflected not only in the general philosophy for the 'New NHS', as outlined in the NHS plan (DoH 2000), but explicitly underpins the NSF for Older People (DoH 2001a). Indeed, two inextricably linked principles lie at the heart of the NSF: the promotion of person-centred care, and the rooting out of age discrimination in the NHS. The links between the two were highlighted in the present study, with the data suggesting, as discussed earlier, that students experienced ageism at several levels: societal, organisational and professional. Experiencing ageism undermined students' initially positive views of older people, and in ageist placements students were unlikely to achieve 'person as focus'. Indeed, in such impoverished placements, students rarely moved beyond 'course as focus', and many remained concerned primarily with their own Senses of safety and self.

Although I do not wish to dwell unduly on the negative aspects of care reported by the study participants, several examples serve to show the sensitivity of students to deficits in older peoples' care. While many of the participants in this study did not explicitly relate these issues to politics or government policy, they appreciated that the root of the problems often lay outside the control of front line staff, citing, in common with the HAS report (HAS 2000 1998), lack of resources, pressure of work, and lack of skills as the main reasons for the poor care afforded older people. However, in other instances, the care students witnessed was such an affront to their own maturing vision of what they considered good care (professional care as focus) that they voiced their concerns, irrespective of any potentially negative personal consequences.

However, many more felt overwhelmed by the extent of the problems they encountered and powerless to begin to address such issues, a problem identified by Burkitt et al (2000) who suggested that a fundamental source of stress amongst nurses is the mismatch between the shared image of the 'good nurse' and the inability to deliver the quality of care they would wish. At the core of nursing's commitment and professional self-regard there is both a strong shared identity, and a specialist identity within areas of practice based on a vision of what it means to be a 'good nurse'.

Many students who experienced difficulties in providing 'good' care to older people within institutionally ageist and impoverished environments had their initially positive predisposition to work with older people severely shaken. Some took active steps to disassociate themselves from such practices by choosing to work in other specialities on qualification.

Although there are no easy solutions to the above challenges, data from the present study indicate that if students are to move towards a position where their main focus is on the person, then most have to achieve the other foci first. Although there will always be exceptional individuals who can deliver 'person-centred care' in any environment, most need a supportive culture, as defined in enriched environments, to do so effectively.

An understanding of how students may come to hold a person-centred focus has been described in this thesis. From this work it is clear that for most students gaining a person-centred focus has a temporal dimension, with the creation of the relevant Senses at the appropriate point being key. Therefore, although each Sense remains pertinent throughout, it is evident that some assume greater importance than others at various times.

The data suggest that both for the course as a whole, and for each separate placement, students' initial focus is on themselves as they feel the need to fit in and establish relationships before they can begin to learn in earnest. At this point a Sense of security and belonging are to the fore. The ways in which these can be created as rapidly as possible were described in some detail in the preceding chapter. Once students feel that they belong they can shift their focus to addressing their placement outcomes, which for some, particularly if they lack confidence, can be an overriding concern. Here their Senses of purpose and achievement are defined largely in terms of meeting such objectives. Once again, the data attest to how such concerns are addressed in enriched environments.

The results of this study also illustrate that the majority of students come into nursing with some 'caring' experience and therefore have an emerging set of standards, however loosely defined, by which to begin to judge the appropriateness and quality of the care they see delivered. However, as they progress through their training they develop an increasingly sophisticated, partly personal, partly professional, vision of care. This is professional care as focus. Here they are looking for continuity and linkages between their maturing vision and the care they witness. However, if their experience is such that they are exposed to what they perceive as inappropriate standards of care then, unless they are exceptional, they learn to survive that placement but may take with them an enduringly negative perception of work in a similar context. However, where students are allowed to develop and test their vision of what constitutes good professional care by questioning and challenging the practice they witness, they are far more likely to have their positive perceptions of such work sustained and augmented.

When they are at a particular point in their training, and especially when their placements are in hi-tech, rapid-throughput environments, a key focus for the student is on the patient, not so much as an individual with distinct needs, but rather as a set of signs and symptoms to understand and address. Here a largely biomedical view is predominant and the Senses of purpose and achievement are defined largely in terms of learning and mastering increasingly complex clinical skills. To do so students need to feel safe and supported in an environment that promotes a degree of personal responsibility and autonomy, but within a secure and nurturing relationship.

In order to achieve person-centred care, however, students need to move beyond the patient as focus and see the unique individual and understand their situation in a biographical context (Liaschenko 1997). This is particularly important for frail older people, and much of the data in the preceding chapters has provided eloquent testimony as to how the 'right' placement can have a transformative effect on students, resulting in them learning, not only about older people, but also about themselves. Person as focus is therefore an expanded vision of what gerontological nursing is, or at least could be, about, and might be on the road to identifying the 'proper focus' that Barker et al (1997) asserted was required for psychiatric nursing and, as we argued when constructing the proposal for the AGEIN project, is still required in gerontological nursing.

In charting the students' progress through their training, this study has indicated that, as they near completion and face the prospect of becoming a staff nurse, they once again turn their attention to 'self as focus' and feel the need to be secure and to belong. This also occurs to a lesser extent at the end of each placement as there is a need to disengage and move on.

The above conclusions have received strong empirical support from the data collected during the study. However, the foci and the Senses are also supported by the recent literature, as demonstrated in Table 5.8, which maps relevant studies against the foci and the Senses.

Table 5.8 The foci and Senses as they relate to the results of the study and the recent literature

	Security	Belonging	Purpose	Achievement	Continuity	Significance
Self as focus	Letters of welcome, invitations to visit in advance of the placement reduces pre-placement anxiety Being expected by staff on placement (Field 1998) Giving the students information specific to the placement helps them feel less isolated (Öhrling and Rahm Hallberg 2000) Having a mentor from the start gives students confidence (Cuddie 2002, Thomas and Thompson 2003) Preparation in school prior to placement can allay some anxieties (Glover 2000)	Time to settle (Cuddie 2002) and get to know the environment and staff promotes a sense of belonging (Thomas and Thompson 2003) Wearing uniform helps some students to fit in.	Students see their purpose in terms of addressing school set outcomes (Glover 2000) Measures to help the student pass through self as focus (eg early assignment of mentor, allowing time to settle) allow them to focus more quickly on purpose and achievement (Darling 1984, Andrews and Wallis 1999, Öhrling and Rahm Hallberg 2000, Thomas and Thompson 2003)	Seen by the student in terms of passing/surviving the placement (Glover 2000)	Specific preparation for the placement in school before the experience Mentorship established (Glover 2000, Öhrling and Rahm Hallberg 2000)	Being expected on the placement by the staff (Cuddie 2002) Being welcomed by a senior nurse and introduced to placement and staff (Freilburger 1996) Being able to establish key relationships early (Glover 2000, Thomas and Thompson 2003) Being provided with speciality-specific information by placement staff (Glover 2000)
Course as focus	Allowing space for students to address course requirements on placement helps them to feel more secure (Freilburger 1996, Öhrling and Rahm Hallberg 2000)	Staff taking an interest in the academic requirements placed upon the student (Cuddie 2002, Thomas and Thompson 2003)	Full assessment of student's learning needs by the mentor ie (1) getting to know the student, (2) understanding set objectives, (3) identifying student's personal objectives helps both mentor and student to define learning objectives and consider how they are to be met (Gallo 1999, Glover 2000, Cuddie 2002, Martin and Riley 2002) Staff encourage students to take responsibility for their own learning (Glover 2000) Shared learning between students at different stages of the course (Öhrling and Rahm Hallberg 2000)	Encouraging students to arrange their own visits to other health professionals (Glover 2000) Acknowledging learning from students and allowing learning on placement to impact on patient care (Öhrling and Rahm Hallberg 2000, Thomas and Thompson 2003,)	Developing a relationship with the mentor, which lasts throughout the placement, creates a sense of continuity (Hutton 2001, Thomas and Thompson 2003) Working in with the same team of nurses throughout (Andrews and Wallis 1999, Öhrling and Rahm Hallberg 2000) Working with the same group of patients throughout (Wilson-Barnett et al 1995) Helping students link theory to practice (Freilburger 1996, Hutton 2001)	Staff acknowledge the importance of students' academic work (Andrews and Wallis 1999, Thomas and Thompson 2003)

Table 5.8 continued

Profession as focus	Students' professional socialisation is progressed by observing nurses and participating in nursing functions (Windsor 1987) Welcoming challenge from students (Glover 2000) Appreciating that students who challenge are still vulnerable and need continued support (Wilson-Barnett et al 1995, Glover 2000) Supporting students in taking on responsibility (Öhrling and Rahm Hallberg 2000, Thomas and Thompson 2003)	Feeling your views re important and impact on care deepens a student's sense of belonging (Öhrling and Rahm Hallberg 2000, Cuddie 2002)	Students allowed to question clinical care (Glover 2000) Observing a range of practitioners giving care helps students develop their own philosophy of nursing (Öhrling and Rahm Hallberg 2000, Thomas and Thompson 2003) Staff also challenge preconceptions of students regarding older people and their health care needs (Glover 2000)	Students see their views being taken on board by the placement (Glover 2000) As staff communicate to students their passion and enthusiasm for working with older people, students return to the placement for further experience or to work when qualified. (Gallo 1999, Langston 2001, Cuddie 2002)	Need for continued support A culture of challenge is maintained by placement leaders leading by example (Freilburger 1996, Glover 2000) A positive learning culture, attitudes and philosophy shared by staff and students (Glover 2000, Langston 2001)	Students feeling their opinions are valued by staff (Cuddie 2002)
Patient as focus	If a students need to feel competent and acquire clinical skills are met then they will feel more secure (Glover 2000, Öhrling and Rahm Hallberg 2000, Cuddie 2002, Thomas and Thompson 2003)	Feeling able to 'make the links' helps students feel they belong to the profession (Glover 2000)	Students wish to learn how to put the different elements of nursing they have learnt together so they can develop a blueprint of the typical care of patients with given conditions Therapeutic purpose: In some acute care settings students appreciated that staff found it difficult to meet he complex needs of older people with multiple pathology and that other settings were more able to meet their needs (Hutton 2001) – reflection on observed action (Öhrling and Rahm Hallberg 2000)	Achievement for students with this focus was seen in terms of being able to relate signs, symptoms, investigations, diagnosis and treatment particular condition (Öhrling and Rahm Hallberg 2000)	Students still need continued support from mentors (Öhrling and Rahm Hallberg 2000, Langston 2001) Students with this focus are attempting to establish the life history of disease conditions as they come into contact with health care	Students feel significant when their understanding of disease processes and their competence in the associated clinical skills is recognised by placement staff

Table 5.8 continued

Person as focus	Security of the student is challenged when they appreciate that the needs of individual older patients are not being met in particular clinical environments. Their inability to fully meet the needs of older people causes them stress	Students who have been exposed to enriched environments and for whom person is focus are more likely to choose to work with older people	Students begin to 'see what older patients are looking for' and appreciate that some environments are more able to meet the complex needs of older people with multiple pathology (Freilburger 1996) Seeing the passion and commitment of staff who work with older people helps students to appreciate the satisfactions of working with the client group (Cuddie 2002)	Working closely with older patients allows students to appreciate older people as individuals Students feel they can make a difference to older people	Students begin to appreciate the health care needs of older people within a wider political context (Howkins and Ewens 1999) While working within this focus students continue to need support from mentors and school (Freilburger 1996)	Students begin to see beyond the disease to view older people as important Seeing staff who work with older people given respect for their skills by other member of the multi-disciplinary team (Freilburger 1996, Thomas and Thompson 2003) Students begin to appreciate the wider political context of health care needs of older people
Self as focus once again	Need to pass the placement re-emerges strongly, and prompt completion of placement documentation is important (Glover 2000) Senior students have anxieties about being competent when qualified and the responsibilities involved in being a qualified nurse (Glover 2000, Öhrling and Rahm Hallberg 2000)	Students wish to be able to feel they belong to the profession (Langston 2001)	Students need to manage a successful disengagement from the placement (Hunt and Michael 1983, Glover 2000)	Acknowledgement of achievements and contributions of the students by staff seen especially in terms of the placement documentation (Glover 2000, Öhrling and Rahm Hallberg 2000)	Mentor helps the students disengage with the placement and make positive preparations for the next by their assessment in the placement documentation and giving constructive feedback (Glover 2000)	Mentors finding time to sit down and debrief students and complete assessment documentation before the students leave the placement (Glover 2000) Students who are asked back as staff nurses or to work on the bank feel they their contributions have been valuable to the placement Placements where students wish to return see this as an achievement

In considering how Mulrooney's (1997) second prerequisite for person-centred care, that is 'respect for personhood', can be achieved, the study has illustrated how the focus of students' attention varies over time, both for the course as a whole, and for individual placements. However, there is still a need to address Mulrooney's third criterion: valuing interdependence.

Valuing interdependence: the 'proper' focus of gerontological nursing?

As noted above, the promotion of person-centred care is the second of the eight standards in the NSF for Older People (DoH 2001a) which states:

> *NHS and social care services treat older people as individuals and enable them to make choices about their own care.*
>
> (DoH 2001a: 23)

Person-centred care is a frequently quoted but ill-defined concept (Dewing 2004) that has nevertheless exerted a considerable influence on the policy, practice and academic literatures, particularly in nursing (see McCormack 2004). The focus on the individual in person-centred care reflects wider trends within health and social care that emphasise the promotion of independence and autonomy of older people (Audit Commission 2004) which, together with notions of greater user involvement, have become major policy drivers (Hanford et al 1999).

However, what is interesting in Mulrooney's (1997) definition of person-centred care is that he identifies 'interdependence' rather than independence as a key attribute. This seems entirely consistent with the position of Kitwood (1997), who defined personhood as 'the standing or status bestowed upon one human being in the context of a **relationship**' [emphasis added]. More recently McCormack (2001) has argued that autonomy cannot be understood primarily in terms of individuality and that such a definition is 'untenable', especially for older people in care environments. Rather, he suggests that we need to talk of 'interconnectedness and partnerships'. However, McCormack's (2001) emphasis is primarily on the nurse–patient relationship, and the data presented here suggest that a far wider set of 'interconnections' need to be considered. Nolan's (1997) initial conceptualisation of

the Senses Framework was concerned primarily with the interconnections between care of older people that created a sense of security, belonging, continuity, purpose, fulfilment (later changed to achievement) and significance for them, and the need for staff too to experience a work environment that ensured that they felt secure, that they belonged and so on.

Later, the Dignity on the Ward project (Davies et al 1999) provided empirical support for the Senses in respect of an acute care setting for older people, and also highlighted their relevance to family carers. The conceptual phase of AGEIN (Nolan et al 2001a, c) provided further empirical and theoretical support for the Senses, and data from other sources in AGEIN showed how they could also be relevant to family carers in community contexts.

The unique contribution of this thesis has been to illustrate how the Senses can be applied to the experience of student nurses, and how the presence of the Senses helps to shape an enriched care environment, exposure to which not only exerts a significant influence on the way that students acquire and sustain their predisposition to work with older people, but also how, over time, helps them to develop a more mature vision of care – 'person as focus'.

The notion of interdependency is highly relevant in this context and, using the Senses as a heuristic, it is possible to demonstrate a range of interdependencies that characterise an enriched care environment, as illustrated in the matrix below (Table 5.9).

Table 5.9: Interdependencies in an enriched care environment

Sense	Older people	Staff	Students	Family carers
Security				
Belonging				
Continuity				
Purpose				
Achievement				
Significance				

On the basis of previous work it was possible to identify what creates the Senses for each group in many care settings. Now, as a result of this study, it is possible to add the factors necessary to create the Senses for students, and for a particular group of staff – mentors. However, the study also raises fundamental questions about the value of person-centred care or person as focus that are based on notions of individual independence and autonomy. As Nolan et al (2004) suggest, interdependency might rather create a different vision of gerontological nursing, based around the notion of **relationship-centred care**.

The concept of relationship-centred care was developed in the 1990s by the Pew Fetzer Task Force in the USA (Tresolini and the Pew Fetzer Task Force 1994). Concerned that the health care system in North America was not geared towards the needs of an increasingly multi-cultural society in which the main demands for health care come from chronic illness, the Task Force was convened to try and identify a more appropriate model that recognised the interaction of a range of psychological, social and biological factors. As a result the Task Force proposed a new model for health care delivery that they termed 'relationship-centred care', capturing the *'importance of interactions amongst people as the foundation for any therapeutic or healing activity'* (Tresolini and the Pew Fetzer Task Force 1994: 22).

Such interactions or relationships exist at several levels, including those between patients, their families, staff from all disciplines, and the wider community (Nolan et al 2004). As Tresolini and the Pew Fetzer Task Force (1994) noted, every participant in a health care encounter 'interprets and constructs a subjective world, and these worlds are modified by the dialogue between them. Both are changed in the process ... [and] form an inseparable unit of interdependent subjects'. Nolan et al (2004) suggest that such a vision of health care is likely to prove far more useful for gerontological nursing than one based on notions of person-centred care underpinned by independence and autonomy. If personhood is best understood in the context of relationships, it is important to recognise that the best relationships, as in this study, are reciprocal and interdependent (McDonald 2002, Rønning 2002). Such relationships are created and sustained in situations where all parties appreciate the need to achieve an appropriate balance between independence, dependence, and interdependence (Nolan et al 2004), as in such circumstances a relationship can

develop in which all parties grow as a result. Perhaps 'relationship as focus' provides the sense of direction for which gerontological nursing is searching, one that might promote and sustain the Senses of purpose, achievement and significance that the discipline currently lacks, thereby acting, at least in part, as a framework or epistemology for practice and education.

Where to From Here? Implications for Policy, Practice and Education

As noted earlier in this chapter the original AGEIN project specification was driven by a desire to address two key issues. Firstly to identify an epistemology of practice, an overall framework giving direction for nurses working with older people and secondly, to identify the type of educational experiences that might promote positive attitudes towards work with older people. It was anticipated that any framework for education and practice emerging would not replace, but rather complement, existing models and provide a rationale for the care of older people where cure was no longer appropriate.

Together with AGEIN the work presented in this thesis has endeavoured to provide such a direction and to identify a framework for gerontological nursing, primarily in relation to student nurses. It has illustrated how the experiences of student nurses can be understood in terms of the Senses, and how the presence of the Senses helps to shape an enriched environment that exerts not only a significant influence on how students acquire and sustain their predisposition to work with older people, but also, over time, assists them to develop a more mature vision of care. As the study progressed, however, it became clear that the experiences of student nurses could not be considered in isolation but were inextricably linked to those of older people, family carers, staff, and qualified nurses, (especially those engaged in the mentorship role). On this basis it has been argued that relationship-centred care, together with the Senses offers one way of valuing older people, family carers and health care staff at a number of levels in terms of policy, education and practice. The following section will briefly consider the implications of the research reported in this thesis and make recommendations in relation to these three areas.

The study upon which the thesis is based was completed during a period of significant change in the delivery of health care, with far greater attention being given to the voices of users and carers. In relation to older people, this has resulted in a major policy initiative that has focused attention on the need to root out age discrimination and preserve the autonomy and independence of older people by putting them and their needs at the centre of any health care encounter (DoH 2001a). As has been argued here and in other places, (Nolan et al 2001c). Such an emphasis on autonomy and independence may be misplaced, especially for the frailest members of society, as it fails fully to recognise the importance of the relationship networks that support older people in their everyday lives. For example, a study undertaken by the Joseph Rowntree Foundation (Godfrey et al 2004) mapped the experience of ageing in two localities in England and found that even the frailest older people invested significant time and energy in taking responsibility for and looking after themselves, but that they also had substantial help from family, friends, and neighbours on a day-to-day basis (Godfrey et al 2004: 208). However, older people considered this help as reciprocal, a two-way flow of care and support across the generations and between family members. Success in managing the changes that accompany ageing was found in large part to be determined by the extent to which people were able to maintain interdependent lives, which they define as being able to view themselves as both givers and receivers of emotional, social and practical support. (Godfrey et al 2004: 212). Furthermore, very high value was placed on interactions with staff in health, social care and other community organisations where a personal relationship was developed.

Notwithstanding the findings from the Godfrey et al (2004) study and the opinion of other commentators (Fagermoen 1997, Mulroony 1997, Davies et al 1999, Brown et at 2001, Nolan et al 2004) a report looking at the progress of the National Service Framework for older people over the last three years (Philp 2004) suggested that person-centred care should remain as the focus of health and social care. However, there is evidence of some shift in emphasis among policy makers. While maintaining that autonomy and independence are central to frameworks for local approaches to the care of older people, there is emerging evidence of a change in emphasis. In a series of reports designed to help public bodies to work with older

people, the Audit Commission (2004) has gone some way to define independence in a way that acknowledges the importance of 'interdependence' for older people:

> *Independence is subjective and relative, varying according to the person and situation. At the heart of older people's sense of independence and well-being lies their capacity to make choices and to exercise control over their lives. This is not the same as being able to do everything without help. Indeed, accepting help in some areas of their lives allows many older people to remain independent in others.*
>
> (Audit Commission 2004: 7)

This statement adds weight to the suggestion that person-centred care is a concept that needs fuller elaboration (Dewing 2004), and Godfrey et al (2004: 224) offer some suggestions of the form that might take.

> *The conception of 'person-centred planning' must be broadened and deepened to encompass an understanding of the person in terms of their whole life – past experiences, current relationships, values, aspirations and goals – towards sustaining or reorienting those things that are valued and substituting for those that can no longer be accomplished.*
>
> (Godfrey et al 2004: 224)

Any framework for work with older people needs to be able to take account of individual subjective interpretations of experience but also to provide a shared set of concepts which are seen as relevant and meaningful by disparate groups of people both giving and receiving care (Nolan et al 2001c). Relationship-centred care together with the Senses offers such as framework; one that might more accurately characterise the reality of what inter-dependence, in-dependence and autonomy mean for older people. The Senses have already been explored with several key groups (including older people, family carers, and qualified staff) and now the voices of student nurses have been added. The relevance and usefulness of the Senses to each group has been demonstrated. Although there is need for further research to determine more fully what the Senses mean and how they interact for different groups in differing caring contexts, this thesis adds weight to the argument that this framework offers a more complete understanding of the experiences of older people, family carers, staff and student nurses than person-centred care alone.

Findings suggest that adoption of relationship-centred care, together with the Senses as a guiding framework, would help health staff to provide more sensitive care by considering and including other individuals, important in the lives of older people when planning and carrying out care giving activities. Acknowledgement of these other contributions can only add to the quality of the care experience for older people themselves and those they consider significant in their lives, but also potentially improves the job satisfaction and morale of staff. Fundamentally, by providing a 'proper focus', relationship-centred care might help to raise the status of gerontological nursing – a prerequisite to improved recruitment and retention of staff.

The rooting out of ageism was the second standard in the National Service Framework (NSF 2001). Participants in this study recognised societal ageism and identified examples of organisational ageism, in lack of resources, and personal ageism demonstrated by staff (see below for recommendations in relation to education and practice). Findings suggest that there is a need for widespread public education about ageing, and our ageing population using a variety of media and formats. For example, education in schools highlighting life-course issues might incorporate a consideration of what it means for an individual to age in our society, thus helping younger people to appreciate that life planning goes beyond ambitions of going to university or getting married. Furthermore, courses on retirement planning in the workplace could be more widespread and contain sections on planning for later old age.

Recently there has been greater interest and discussion around issues of ageing such as those which have been prompted by recent high profile campaigns and fictional representations of life in later years such as the Comic Relief 2005 focus on Elder abuse which was launched by a BBC 1 Drama, 'Dad', (by Lucy Gannon, broadcast on BBC television on 02/02/2005) and these should be encouraged. Furthermore, recent debates around pension provision and funding an ageing society should be broadened to incorporate discussion of future care provision. Actions such as these might begin to address some of the societal manifestations of ageism.

Many argue that one of the most effective ways to combat ageism in nursing is through the educational curriculum and practice experience (Philipose et al 1991, King 1995, Sheffler 1995, Wade 1999), and this thesis has demonstrated that the nature of that experience for student nurses is a key factor in the development of attitudes towards working with older people. Doreen Norton, a researcher and early pioneer of gerontological practice development, identified two factors essential to changing the approach to nursing older people; firstly, the need to educate people to believe that older patients needed more than toilet attention and feeding, and secondly, to show new nurses the scope and interests of the work (Norton et al 1962).

Norton believed that a positive approach to the health and welfare problems of older people could be considered 'true nursing' (Norton 1977: 1622). While this was an encouraging start, the history of gerontological nursing can be seen as one of missed opportunities. The nursing profession has been unable to construct an operational nursing framework for working with older people around the principles identified by Norton and others and the AGEIN project team contended, in submission to the English National Board, that gerontological nursing had yet to establish its 'proper focus'

This is also true of gerontological nurse education as it continues to prioritise hi-tech areas of care, perpetuating negative beliefs and attitudes about older people (Davies et al 1997, Nolan et al 1997). Scant attention is paid to the needs of older people and the espoused commitment to the 'relational' aspects of nursing (Fagermoen 1997, Mulroony 1997) has received little coverage in curricula, which instead demonstrate a continued biomedical dominance (Davies et al 1997, Nolan et al 1997). The emphasis on technical aspects of care within nurse education has been further heightened by external pressures, such as criticism of the Project 2000 curriculum for producing nurses who were not competent to act as independent practitioners upon qualification and reports such as Not Because they Are Old (HAS 2000 1998), which raised the importance of professional competence and accountability in the public consciousness as never before. These events, and others like them, have led to the technical competence of nurses both within education and practice being addressed with renewed vigour as demonstrated by the Department of

Health's development of competencies for health staff working with older people (Working together, Learning together, DoH 2001b). It would appear that as Halldorsdottir (1997) suggests there has been a separation of competence from caring, with the skills of caring reduced to the status of optional extra. It could be argued that in nurse education it is evident that a focus on competence (patient as focus) has been at the expense of more holistic and personalised caring skills (person as focus). The government has recognised chronic illness as the greatest future health challenge faced by modern society (Hutt et al 2004) and this, in conjunction with the emergence of a person-centred care agenda, indicates a clear need for nurse education to strike a better balance between competence and care.

However, while it is true that to provide good care the recipient has in some way to 'matter' (Adams et al 1998) (person-centred care), in an NHS care environment in which recruitment and retention of nurses continues to be a major challenge (O'Dowd 2005), particularly in less popular areas of practice such as gerontological nursing, it is equally important that both the care given and the caregiver are also valued and matter (Adams et al 1998, Davies 1998). Findings from this study have demonstrated that in an enriched environment consideration is given to all stakeholders (older people, family carers, staff and student nurses).

This thesis has suggested some of the steps that can be taken to redress that balance within gerontological nursing. Education could begin by taking a lead from the National Service Framework by 'rooting out' ageism. Clearly ageism is complex and has many faces but is in part undoubtedly created and sustained by misconceptions about the nature of older age and the demography of ageing. Schools of nursing should invest in anti- discrimination seminars for teaching staff and students to raise awareness of the subtle ways in which ageism is proliferated within organisations.

The students participating in this study had a wide range of previous and current experience of working with older people (often working as care assistants to supplement the bursary). While student experiences of extra-curricula working with older people are not necessarily always detrimental, exposure to impoverished environments was much more frequent in such circumstances. Therefore

consideration should be given to raising the level of bursary payments so that extra-curricular work is no longer essential for some students' economic survival.

The survey phase of the AGEIN project provided some interesting insights into students' and qualified nurses' understanding of ageing. Both groups demonstrated a very limited appreciation of the 'facts' relating to ageing and the older population. Staff and students nurses need to be provided with a sound knowledge of current and future trends relating to older people in the UK. The potential for using an updated version of the Ageing quiz (see Appendix IV) or a similar format as an interesting way of exploring the demography of ageing could be considered. Moreover, student predispositions towards work with older people should be identified at an early stage of nursing programmes and open and informed debate about student's current beliefs and future intentions promoted.

Theoretical education about the needs of older people was largely dismissed by participants in this study as insignificant and unmemorable when compared to practice placement experiences. There was evidence that gerontological nursing theory, threaded through the course, was largely lost and subsumed within the wider curriculum. To compound difficulties the timing of theory was, in some instances, unrelated to clinical experience. Gerontological theory should be more closely linked to placement experience, and delivered in a more discrete and identifiable format, such as a distinct module for example. The Senses Framework, as discussed earlier, been used to develop teaching materials in a CD ROM and workbook format. Further material of this nature could also be developed.

The recent trend for secondment of specialist practitioners to teach within schools of nursing may go some way toward helping students to make the links between nursing as taught and nursing as witnessed. Even where long term secondments are not feasible, schools should encourage managers to see practitioners teaching within schools as a positive form of professional development and as a way of promoting gerontological nursing among the student body. Teachers should explore creative ways of including older people and their family carers in curriculum development and delivery.

The Senses Framework offers a way of understanding and exploring the key relational aspects of nursing and could be developed further as a tool for encouraging reflection. Students could be asked to consider for example, how a sense of security was created for themselves, older people, family carers and staff within a practice setting, giving a greater understanding of relationship-centred care. These reflections could then be used in the classroom as a vehicle to explore the type of complex care situations frequently found in caring for older people. Measures such as these would increase the profile of gerontological nursing and provide the structure, coherence and continuity that is currently lacking.

Students in this study saw few links between university learning and practice placements and findings suggested that communication between schools of nursing and clinical placements need to be strengthened. Careful preparation for placement is an essential part of establishing those links and should include timely theoretical input in the university, together with an opportunity to learn and practice appropriate clinical skills. The concentration of placements relating to older people at the beginning of courses, which was noted by some study participants, should be discouraged as this gives students the impression that the client group, and the lessons to be learnt, are less complex than those to be gained from later placements. Irrespective of where placements are located within the programme, students should have the opportunity to experience a range of enriched learning environments. Monitoring of placements is generally undertaken by audit and, with development, the Senses could underpin a relevant and effective audit tool that could be used to identify attributes that contribute to an enriched environment. Placements that lack the attributes of an enriched environment should, if remedial action is ineffective, be removed from the placement circuit. Given the current paucity of placements this is likely to prove difficult, but it is essential if students are to develop a positive view of work with older people. Moreover, it became apparent in this study that environments which are impoverished for students are more likely to be impoverished for older people and therefore it becomes a professional responsibility to institute change.

Although the student assessment strategy is often highlighted in mentor preparation courses it was evident in this study that some staff lacked even a basic understanding

of the academic requirements for students and further work is needed to ensure that practitioners are aware of, and comfortable with, student assessment documentation. Practitioners should be included in helping to design student placement documentation to ensure that it fully reflects the opportunities available to students and that it is seen as relevant and achievable by practice assessors. This may reduce the instances of students being presented with learning outcomes that are too generic or unrelated to individual placement areas, thereby presenting an obstacle to student learning in the clinical environment. Learning outcomes should be more specifically tailored to the experiences available in placements and schools of nursing should ensure that academic requirements are not so onerous that they constrain students from being open to other learning opportunities in practice.

Students also wanted staff in schools of nursing to have an understanding of the opportunities and constraints of clinical learning. University staff should establish better and more regular links with clinical areas so that they gain a fuller appreciation of the pressures on students and mentors. Those who wish should be able to spend time practicing in the clinical area as part of their personal development.

There is no doubt of the value that students placed on enriched practice placements and this study has demonstrated numerous ways in which enriched learning environments can be created (see Tables 5.1 to 5.8). In common with many other studies the role of the mentor emerged as the single most important influence on student learning in practice. Good mentors can only flourish in an environment that: values learning and mentorship within the placement; understands the time and commitment that mentorship requires; provides peer support for mentors; facilitates access to high quality mentor preparation programmes that provide training in key interpersonal skills required for the roles; ensures that there are opportunities to keep up-to-date with developments in clinical practice, and to share experiences with mentors from other areas. The importance of the mentor role has been recognised by the English National Board and the Department of Health in their publication Preparation of Mentors and Teachers (ENB/DoH 2001), in which they suggest implementation of many of the above recommendations.

Many of the prerequisites needed by mentors to maximise their role are dependent upon support from the placement leader. The role of the placement leader and the maintenance of a high clinical presence are essential elements in creating an enriched environment. Management style in the best environments in this study was found to be participative and inclusive rather than dogmatic or dictatorial, this enabled students to develop a more sophisticated and mature set of professional standards as they explored their own developing skills by embracing and challenging practice.

Placement leaders in such settings had a clear and focused philosophy of care that valued older people, family carers, staff and students. However, good nurses do not automatically make envisioned managers and placement leaders should be enabled to access leadership courses that allow them to consider ways in which the Senses can be created in their clinical area. Leadership support groups within the gerontological field should be developed to allow leaders to reflect on issues and share experiences with others. This can only help to establish the 'proper focus' for Gerontological nursing.

The importance of competent technical care is undeniable and as this study has clearly demonstrated knowledgeable and skilful staff are essential ingredients of an enriched environment. However, treatment without care is poor and often ineffective treatment (Fitzgerald 1999) and the importance of combining both proficient technical care and considerate fundamental care together with good interpersonal care cannot be over stated (Nolan et al 2001c). While relationship-centred care and the Senses should not be viewed as a global panacea for gerontological nursing there is a pressing need to bring competence and caring into a new alliance (Davies 1998) and relationship-centred care and the Senses offer, for the first time since Norton proclaimed gerontological nursing to be true nursing, an integrated operational framework for gerontological education and practice.

There is now considerable empirical evidence supporting the Senses Framework and its relevance to older people, family carers and staff in a range of settings. However, there is a need for further research. For example, although this study has shown that placement leaders are crucial to the creation of an enriched environment, little is

known about the relevance or ways of creating the Senses for them. Similarly the meaning of the Senses for care assistants needs further exploration. Student nurses in enriched environments experienced differing foci from self as focus through to person as focus, as they passed through their educational programme returning to self as focus as they neared qualification. Further research is needed to explore which of the Senses comes to the fore on qualification and how they manifest themselves for newly qualified nurses and other new members of the team.

This study has identified the ways in which enriched environments are created and has mapped out many of their features. Establishing an enriched environment is complex and takes time, however it was apparent that these environments are vulnerable to changes in circumstances (such as changes in staff for example). Longitudinal research of enriched environments is needed in order to explore the natural history of these settings and explore ways of maintaining and sustaining enriched environments during periods of change.

Some Final Thoughts

The usefulness of the concept of 'person-centred care' as a basis for practice with older people has been questioned and it is suggested that 'relationship-centred care' offers a more appropriate framework. The Senses represent a useful, relevant and user friendly set of concepts, and this and other studies have indicated that they have intuitive appeal to several quite different groups of people. This study has added to the growing evidence in support of such a framework by helping to define some important dimensions of relationship-centred care as it relates to student nurses. This work has demonstrated that by establishing a high quality experience for student nurses learning to care for older people it is possible to nurture positive perceptions of such work, thus making it a more attractive career option. The enriched environments in this study and the people in them were inspiring. However, it is clear that creating an enriched environment is not serendipitous, it requires sufficient resources, solid leadership, continuity of staff, self awareness and passion for gerontological nursing to create a care environment for older people that engenders excitement and enthusiasm in student nurses. It seems that the words of

William Butler Yeats (1865-1935) still ring true *'education is not the filling of a pail but the lighting of a fire'*.

STUDENT NURSES' EXPERIENCE OF LEARNING TO CARE FOR OLDER PEOPLE IN ENRICHED ENVIRONMENTS: A CONSTRUCTIVIST INQUIRY

A thesis submitted for the degree of Doctor of Philosophy

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Description of the schools of nursing from which focus group respondents were drawn

The four schools of nursing used for the case study have some elements of their pre-registration nursing course provision in common:

- All four case study sites offered the Diploma of Higher Education (DipHE) in nursing in the branches of interest to the study (adult, mental health, learning disabilities and mental health nursing), with intakes twice a year in the spring and autumn.

- All sites offered some opportunity to top up diploma qualification at level 2 with level 3 credits to degree level.

- All courses provided a 50/50 split between theoretical input and practice placements.

- All courses had a common foundation programme (CFP) of approximately 18 months duration when the research began.

- Courses used a wide variety of teaching and assessment methods for both theory and practice but all contained some element of reflection, in the form of a reflective log or journal for practice placement experiences.

- All sites utilised a range of placement opportunities in primary, secondary and continuing health care settings, including both statutory and voluntary providers.

- All sites offered students academic, pastoral and placement support.

- All sites offered clinical mentorship using practising clinical staff to assess practice. Mentors were offered preparation for this role.

- All sites audited practice placements in relation to their suitability as an educational placement.

However, all four schools of nursing had different characteristics and atmosphere, as discussed below.

School of Nursing 1

Site 1 was a large urban school of nursing in the Midlands offering a full-time modular diploma in higher education in all the branches of interest. When the study began the school admitted approximately 260 pre-registration students per year to nursing courses. Typically the percentage of the student cohorts in each branch was 60% adult, 18% mental health and 5% learning disabilities. Twenty-one lecturers and clinical teachers facilitated the course in the CFP. Branch programmes had dedicated lecturing teams of 39 lecturers for the adult branch, 13 in mental health, and 2 in learning disabilities.

Within the CFP, 2 ten-day periods of branch-specific practice took place. Only students who were intending to undertake the adult branch of the course were allocated to a 'care of the elderly' placement for one of these experiences. This placement focused on health and aspects of health promotion, and preparation for the placement was provided by community health, population studies, and nursing theory modules. The additional 75 hours practice experience required to meet the European Nursing Directives for adult nursing was included within the adult branch using an integrated approach. Because of the adoption of this model the branch programmes did not include a specific allocation to elderly care. However, it was anticipated by the school that some students would be allocated to elderly wards during a module focusing on chronic illness and that others might choose an elderly care setting for their final, elective, placement. Within the curriculum there was no explicit theoretical input in CFP relating to the care for older people for students who were undertaking branches other than adult. Within the outline branch programmes the needs of older people were covered in a module called 'care of the chronically ill adult' for adult students, and reference was made to all age groups for learning disabilities students in a module entitled 'life span approaches to disability'.

Site 1 also offered a full-time modular BSc Hons Nursing (RN), again in all branches of interest, taking 50 students per intake with approximately equal numbers studying each branch. The care of older people was not specifically itemised in the placement hours for the CFP or branch programmes, but the curriculum indicated that students would have experience of health care issues relating to older people during the Community Health Nursing, Well People and the Adult and Mental Health placement experiences.

School of Nursing 2

Site 2 was a large school of nursing in the south-west of England that served both urban and rural communities. The pre-registration nursing course was delivered on five geographically dispersed sites, and the rural nature of much of the school's catchment area meant that both staff and students travelled considerable distances to meet. The school offered courses for a range of health professionals, including radiographers, physiotherapists, occupational therapists, and social workers, although there was little evidence of any interdisciplinary learning as data collection commenced.

Undergraduate nursing was offered in DipHE and degree courses in the full range of professional disciplines (adult, mental health, learning disabilities, child and midwifery). There were 1,586 full time nursing students at the beginning of data collection, 90% of who were women, which was congruent with the profile of the profession; however, recruitment from ethnic minorities was low (4%). Forty-eight per cent of entrants were aged between 18 and 21, 16% aged between 22 and 25, 36% aged 26 and over. Entrants to all nursing programmes were drawn mainly from the surrounding region, with a smaller number recruited nationally and internationally.

Students were supported by 119 staff (whole-time equivalent). Clinical staff contributed to teaching and assessment, and visiting lecturers were used as subject specialists. The DipHE Nursing Studies introduces students to subjects such as health, social and biological sciences, interpersonal skills and research.

Nursing older people was integrated into the curriculum for the DipHE and most often considered in a six-week 'Nursing Skills' module of s held at the transition from CFP to branch programmes. However this covers a number of subject areas. The BSc Nursing programme had a more specific block of theoretical input relating to the care of older people at the end of the second year. Typically, over 90% of students passed each year of the BSc Nursing, and the figures for the other programmes were comparable. The attrition rate for cohorts entering the nursing programme in 1998, when data collection began, was 8% overall. Students were supported by a personal tutor who would normally stay with them throughout the period of study. Student views were sought through module evaluations, award route, management committees and Dean's meetings.

School of Nursing 3

School 3 was a school based in two locations in a large conurbation in the south of England. It offers a dual programme with outcomes at degree and diploma levels leading to BSc (Hons) Nursing within the academic and practice framework of the DipHE nursing in all branches of interest to the study. The BSc was awarded for success at level 3 in modules of applied academic work and level 2 outcomes in nursing practice modules. Students on the DipHE programme who had successfully completed the CFP at the appropriate level were eligible to proceed to the branch programme at level 3. On successful completion of the course students who had followed the BSc programme were given the opportunity to undertake a research project submitted within a year of completion of the course leading to the award of BSc Hons Nursing. The proportion of students commissioned in each branch was 150 adult, 50 mental health and 20 learning disabilities, with intakes twice a year. Practice placements were provided across 13 Trusts and, in common with other case study sites, a range of other voluntary charitable and social service organisations. Placements in CFP were shorter than seen elsewhere, with students having one two-week observation placement in semester 1 followed by four one-week placements in semester 2 and with one four-week placement in semester 3. One notable feature of this school was the development of 'pre-semester skills workshops' in which new students had the opportunity to develop knowledge and skills in, for example,

communications skills and first aid. Senior students used the workshops to develop skills identified by managers as key to qualified staff, such as intravenous drug administration, venepuncture, and caseload management. Caring for older people was not identified as a discrete theme or module within the curriculum but integrated within modules such as 'Nursing Profession and Practice'.

School of Nursing 4

School 4 was a school of nursing based in the north of England encompassing both industrial and rural communities in a university. It attracts 250 pre-registration students of nursing each year, supported by 38 lecturers. A diploma in higher education (DipHE) in nursing was validated in all branches of interest to the study; however, the learning disability courses did not run throughout the period of the study because of a lack of demand from the commissioning consortia. The DipHE ran alongside a BSc Hons Nursing (Pre-registration) which offered students the opportunity for transfer between the two courses at the completion of the level one modules. Some modules at levels 1 and 2 were common to both courses, thereby facilitating shared learning experiences. Students who left the diploma course on successful completion of the CFP were eligible for the award of Certificate in Foundation Studies in Caring. Students completing the DipHE had the opportunity to 'top up' this qualification to degree level with one year full-time or two years part-time study.

This school grades practice placement assessments as well as theory elements of the course, thus allowing the option of awarding distinction to those students who meet the requirements. Students had the opportunity to gain further qualifications within the course, as modules in information technology and management carried national vocational qualifications (NVQ).

Clinical placements lasted a minimum of four weeks in CFP and eight weeks in the branch programme. One placement focusing on the needs of older people was undertaken by all students during CFP; however, as with School 1, further theoretical input was integrated into the branch modules such as 'illness dependence

and nursing practice'. Experience with an older client group, although not specified within the curriculum, was described by students as extensive.

As commented on above, the schools of nursing from which student nurse respondents were drawn for this study had much in common with each other and other institutions providing nurse training. Most notably, in relation to this study, it was clear that learning to care for older people was seldom, if ever, a specific focus of teaching in school. Moreover, working with older people as a planned clinical experience was patchy within and between the schools of nursing but because of the widespread distribution of older people throughout the health care system most students had some experience of caring for older people and for many the experience was extensive.

Details of search methods used for 'Working With Older People and their Families: Key Issues in Policy and Practice' (Nolan et al 2001)

The book by Nolan et al (2001), *Working With Older People and their Families: Key Issues in Policy and Practice*, formed the interim product of Phase I of the AGEIN project. This book was based on extensive reviews of the available literature in six key areas of practice with older people, augmented by new data collected in a number of these areas:

- Acute/rehabilitative care
- Primary care
- Continuing care
- Older people with mental health problems
- Older people with learning disabilities
- Palliative care and older people

The intention of the review was to identify areas of commonality and contrast in the above areas that might begin to form the basis of a framework of practice with older people. The identification of literature sources was rigorous, and the guiding principle behind the mechanics of the review was that it should be systematic, explicit and reproducible (Nolan et al 1997). In order to produce a synthesis of knowledge across six distinct areas of practice with older people it was important that the review was carried out in a consistent manner across these boundaries. This would also allow the review to be regularly updated. A wide range of bibliographic sources were consulted (Table A).

Table A: Bibliographic sources consulted for the review of the literature which formed the basis of 'Working With Older People and their Families: Key Issues in Policy and Practice' (Nolan et al 2001)

Cinahl	-	The Cumulative Index to Nursing and Allied Health Literature provides coverage of the literature related to nursing and allied health
Medline	-	Encompasses information from Index Medicus, Index to Dental Literature and International Nursing as well as other sources of coverage
Psychlit	-	Covers international literature on psychology and related fields
Bids	-	ISI service provides access to four bibliographic databases supplied by the Institute for Scientific Information, covering scientific and technical information, social science, arts and humanities; we searched the social science database
AgeInfo	-	the database from the Centre for Policy on Ageing
HMIC	-	The Health Management Information Consortium brings together three complete bibliographic databases covering UK and overseas health management and related topics; the three data bases included are the Department of Health Library, the Nuffield Institute for Health database and the King's Fund database

Work produced during the period 1988–1998 provided the initial focus for the search. Key references identified from the retrieved sources which were published before this period were also included and the review was regularly updated as new items became available.

Search terms were identified by chapter authors for each of the discrete areas. When theses were collated, it became apparent that many of the themes and concepts were common to all six areas and these became core terms which were relevant across the entire review. Search terms specific to each field of practice were also subsequently identified (Table B).

Table B: Core and specific search terms

	Mike Nolan	Liz Hanson	Gordon Grant	Sue Davies	Janet Nolan	John Keady
Field of study	Acute and rehabilitative care	Palliative care	Learning disabilities	Continuing care	Primary care	Mental health
Core terms	Ethnic group and ethnicity Quality of life Communication Needs and needs assessment Nursing care Carers Models Discharge Services					
Specific terms	Rehabilitation Rehabilitation nursing Acute care	End of life care and decision making Long term care Quality of life Palliative care Terminal care Hospice care Death Bereavement	Learning disorders Learning difficulty Learning disability Developmental disabilities Intellectual disability Mental retardation Rational processes disorder Mental health services	Continuing care Nursing homes Retirement centres Residential homes Residential care	Primary health care Community health services Community health nursing District nursing Health visiting Practice nursing	Mental health Community mental health services Dementia Mental processes Schizophrenia Late-onset paraphrenia Anxiety disorders Depression Alcohol misuse HIV

This approach initially identified more than 22,000 references. The majority of these items were academic papers in peer-reviewed journals, with books and reports contributing approximately 5% of the total. The abstract for each item was scrutinised and key themes and concepts identified. Material that was obviously not relevant to the focus of the review was eliminated at this stage. Following this initial classification, each abstract was examined a second time and an attempt was made to prioritise references in order to produce a more manageable volume of literature for retrieval and closer scrutiny. For example, those that appeared to represent service user views and professional views and those representing rigorous reviews of the literature, or which claimed to provide new theoretical insights, were given a higher priority. This process resulted in the identification of approximately 200–300 items for each field. These items were then retrieved, reviewed and grouped thematically to provide a structure for each chapter.

In reviewing each reference a broad three-stage iterative process was followed. Initially, each reference was read independently and a set of notes made identifying and summarising key themes. Subsequently, the notes from this first order of analysis were scrutinised in detail so to distil the core attributes of the key themes. Finally, comparisons were made within and between themes to explore the conceptual links and achieve an element of synthesis. For detailed account of the principles understanding both the relevance of the literature and the subsequent analyses see Nolan et al (1997).

(Adapted from the appendix 'Study Methodology' in *Working With Older People and their Families: Key Issues in Policy and Practice* Nolan et al 2001).

The 'Knowledge Quiz' taken from the AGEIN Report (Nolan et al 2002)

(Correct answers indicated by a X, correct percentages etc are in brackets)

Below are some statements about older people in the UK today: Please indicate whether you think each of the following statistics is either toohigh, about right, or too low by placing a tick on the appropriate box:

	I think this figure is:		
	Too High	**About Right**	**Too Low**
The percentage of people currently over the age of 65 in the UK is about 17%	☐	☒	☐
The percentage of people in ethnic minority groups who are currently over the age of 65 years in the UK is about 10% (3.2%)	☒	☐	☐
Between now and 2034 the percentage of people over the age of 85 is expected to increase by about 60% (89%)	☐	☐	☒
By 2016 the number of people aged over 100 will treble (quadruple)	☐	☐	☒
Of women over the age of 75 about 60% live alone	☐	☒	☐
The percentage of people between the ages of 60-74 living in residential or nursing homes is about 5% (1%)	☒	☐	☐
People aged 75 years and over are 3 times more likely to die an accidental death than the general population (6 times)	☐	☐	☒
Of people aged 75 years and over about 50% report long-term illness or disability (66%)	☐	☐	☒
The percentage of people over the age of 65 who need help with the following activities is about:			
Washing all over (12%)	20%	☒	☐	☐
Dressing	12%	☐	☒	☐
Using the toilet (4%)	10%	☒	☐	☐
Climbing steps/stairs	30%	☐	☒	☐
Hearing someone talk	20%	☐	☒	☐
Reading a newspaper even with glasses (10%)	15%	☒	☐	☐
The percentage of people between the ages of 65-74 in some form of paid employment is about 5% (9%)		☐	☐	☒
In any one year the percentage of people aged 75+ who have an in-patient stay in hospital is about 30% (20%)		☒	☐	☐
On average people aged over 75 spend about 15% of their income on heating and lighting (8%)		☒	☐	☐

The 'Perceptions Quiz' taken from the AGEIN Report (Nolan et al 2002)

Please read the statements below and indicate how much you agree with each by circling the number that best reflects your opinion

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Nursing older people is mainly about basic care – it does not require much skill	5	4	3	2	1
I would definitely consider working with older people when I qualify	5	4	3	2	1
Work with older people is a dead-end job	5	4	3	2	1
I am really looking forward/I really looked forward to my first placement with older people	5	4	3	2	1
Nursing older people is challenging and stimulating	5	4	3	2	1
Nurses work with older people because they cannot cope with hi-tech care	5	4	3	2	1
Working with older people has a high status	5	4	3	2	1
Once you work with older people it is difficult to get a job elsewhere	5	4	3	2	1
The older you are the easier it is to have a good rapport with older people	5	4	3	2	1
I am/ I was really anxious about my first placement with older people	5	4	3	2	1
Working with older people does not appeal to me at all	5	4	3	2	1
Nursing older people is a highly skilled job	5	4	3	2	1
Nursing older people provides little satisfaction as they rarely get better	5	4	3	2	1
Working with older people is not a good career move	5	4	3	2	1
I think older people are really interesting to nurse	5	4	3	2	1

THE UNIVERSITY
OF SHEFFIELD

The AGEIN Project

The AGEIN Project

The AGEIN Project

Prifysgol Cymru · University of Wales
BANGOR

WHAT ARE WE INTERESTED IN AND WHY?

We are asking you to help us with one phase of an important national research study. We are interested in the opinions and experiences of students as they learn to care for older adults. This will help us to understand the ways in which knowledge; beliefs and attitudes develop in relation to older people and their care. We think that it is important for us to understand these things so that we can suggest ways of improving students' experiences and the way we teach in this area.

WHAT WOULD I HAVE TO DO?

We are asking you to join us in a group of about 10-12 of your fellow students in a focus group, to reflect on your experiences of learning to care for older people. We would like to tape record our meeting so we don't miss any of your contributions. These experiences could stem from classroom teaching or clinical experiences, wherever you come into contact with older people, care of the elderly, surgery, gynaecology, nursing homes or accident & emergency for example.

WHAT WILL YOU DO WITH THE TAPE?

We will be listening to all the tapes and your comments will be typed into a computer, almost word for word. We will be thinking about the themes and issues that you raise, and we may reflect this back to our other volunteers to explore these issues further.

WHEN AND WHERE WILL THIS HAPPEN?

To make it as easy as possible for you to join in we have arranged for us to meet in your school of nursing whilst you are in school but if after the first meeting the group would prefer to meet elsewhere that can be arranged.

HOW MANY OTHER PEOPLE WILL BE TAKING PART IN THIS?

Altogether there will be between 90 and 120 students in this part of the study, based throughout England. They could be studying either adult; mental health or learning disabilities nursing and they will be at different stages of their courses

IS THERE ANY WAY THAT THE PEOPLE IN SCHOOL OR WHERE I WORK WILL KNOW WHAT I HAVE SAID?

All your views and opinions are important to us, and we are interested in making it as easy as possible for you to think about your experiences and discuss them candidly with us. Therefore we will not be allowing people in either the school of nursing or the clinical areas to have access to your responses. However, like you, they will be able to see a copy of the final report. This will include the responses of over 180 pre- and post - registration students and a number of teachers and clinicians from between 4 - 12 sites. We will at times use direct quotes to illustrate a point, but we will maintain confidentiality throughout by not identifying you by name or organisation and we will endeavour to ensure your anonymity, although we are sure you may recognise yourself quoted in the report.

WHAT WILL YOU DO WITH ALL THIS INFORMATION?

We will write a report for the English National Board on our findings, and one member of our team is hoping to base her PhD studies on this research project. But we are very keen to ensure that our work has real impact on the shop floor i.e. in schools of nursing, so we intend to produce some books based on our work that will help teachers and students in preparing to look after older people. In addition we are aiming to produce teaching and study materials that can be used directly in the classroom or by students.

WHAT'S IN IT FOR ME?

Reflective practice is an integral part of nursing today and helping us with the research could help you to develop your skills of reflection. Experience has told us that having someone to share experiences with can help people to sort out their thoughts and feelings and help to clarify their thinking. Although we cannot guarantee this will happen it may be a useful tool to you during your course.

We all have the opportunity to participate in this major research project; this work gives us the chance to make a real contribution to:

- Examining the experience's of students as they develop their knowledge beliefs attitudes and caring behaviours with older people, so that we can better understand the important influences on them, and the most effective way of preparing practitioners to work in this field.

- Clearly articulating the knowledge, skills and attitudes essential to the care of older people, which can provide a sound basis for practice.

We hope you will feel able to join us in our efforts to improve the care of older people and would like to thank you for showing an interest in this work.

Jayne Brown

Examples of 'member checking' and respondent participation in data analysis

Example of unitised data from focus groups		Researcher Coding	Participant Coding	Respondent examples from further experience of the codes
(2) SIGNIFICANCE	**(2 1) Positive attributes significance**			
They said 'What have you been doing?', like the research, 'What information have you got to bring to us?', they were interested and that was elderly as well.	(2 1 4)	Feeling you have something to offer staff	Feeling you count	*It's good if they are interested in what you are learning without feeling threatened. One placement, in community, sent me on a wound healing day, because everyone else was busy, and asked me to get them all the information.*
Patients' families as well, when they come up and thank you for what you have done, because it shows that you have been noticed not just by the ward.	(2 1 8)	Feeling noticed by relatives	Feeling you count	*I know how good that feels. On my last placement a relative always came to find me out when they visited.*
	(2 2) Negative attributes significance			
'You're a mental health student, you don't need to be doing this, you don't need to know this', she said. There were like 9 students on that ward to one qualified member of staff.	(2 2 6)	Feeling your branch is not valued	Not being important	*Midwives expect mental health students to be able to do blood pressures.*

It's not changed, we reported it [incident of poor care]. *I was talking to someone who started there in March and it's still the same.*	(2 2 11)	Feeling I cant make a difference	Not being valued	*I was asked to feed patients on the ward ... that there were four people who needed feeding but I found that I was the only one left ... it was like a conveyer belt.*
They asked if I wanted to go back [to a nursing home] *and do bank and the pay they were offering was £4:00 per hour; and I said 'what about weekends?' and she said 'oh, it's still £4:00 per hour'.* (NB This quotation dates from 1999)	(2 2 12)	Feeling that people working in care homes are not valued	Not being important	*I try not to tell people that I worked in a nursing home because they always make some clever comment like they bet I don't want to go back.*

(2 3) Factors that help create significance

Investing in the Student

When one of the consultants was actually quite happy to interact with students	(2 3 15)	Senior people taking an interest in you	Feeling important	*I had this fantastic sister in my first year who let me shadow her for two days, it really gave me chance to see how things worked.*
They were great they'd show me everything you could think of. The patients were treated brilliantly.	(2 3 12)	Staff going the extra mile to give student experience	Feeling important	*If you get a mentor who fills in your* [assessment] *booklet as you are going along, that's such a help.*

		Client group is important		
It doesn't make any difference whether you are working on elderly care, you're nursing elderly patients on every ward anyway.	(2 3 27)	Nursing adults is nursing older people	We all get older	*If you walk on to a ward you expect at least 70% of those patient to be elderly.*
		(2 4) Factors that militate against significance		
		Lack of Respect		
Most ward managers don't even know your name at the end of your post – we are just students.	(2 4 36)	Ward manager not knowing your name	Insulting	*I worked in a place where the sister used to refer to all students as 'the little students'. She'd say to the staff nurse, while I was stood there, 'Has the little student been for her break yet?' – How insulting.*
		Work low status		
I think there is a massive stigma attached to nursing the elderly. I think that is really wrong.	(2 4 10)	Nursing older people perceived as low status	Care under valued	*I think that we have all been on placements working with the elderly where it was not dynamic or exciting.*

Broad interview schedule used in the first and second interviews with students in practice placement case study sites

INTERVIEW ONE

Can you describe the experiences have you had in looking after older people up to this point?

Prompt 1 Re: experience in their personal life, work experience in and out of the course.

Prompt 2 Have you enjoyed your experiences with older people?
Why do you think that is?

What are the ideal characteristics of a mentor for you?

Prompt 1 Can you think of any more?
Why are these particular characteristics important to you?

Prompt 2 Have you ever had a mentor like that?

If yes: What was special about them?
What do you think made them so good?

If no: Why do you think that is?
What prevents mentors from demonstrating those characteristics?
Has anyone come close?

What are your expectations of this placement?

Prompt 1 Expectations of nurses, mentors, placement leaders, patients, family carers, link tutors, other students.

What do you think people expect of you on this placement?

Prompt 1 Mentor, patients, school, other members of staff other students, self.

Prompt 2 Is that reasonable do you think?

INTERVIEW TWO

How have you enjoyed this placement?

What has made it so good/bad for you?

Prompt 1 Staff, organisation, therapeutic care, treatment of students, treatment of older people, resources.

Would you say that the placement has lived up to your expectations?

Prompt 1 Why is that?

Prompt 2 Prompt student to give details and examples.

How have you found your mentorship on the ward?

Prompt 1 How has it compared to your ideal mentorship experience?

Prompt 2 Go through the specific characteristics mentioned in the first interview.

If yes: What was special about them?
What do you think made them so good?

If no: Why do you think that is?
What prevents mentors from demonstrating those characteristics?

Review the expectations that the student highlighted in the last interview and ask:

Now the placement is coming to an end do you think that people did expect those things of you?

If yes: Do you think that they were reasonable?
Where you able to meet them?
If yes how?
If no why not?
How did that make you feel?

If no: What did they expect of you?
Would you say that their expectations were harder or easier to live up to than you expected?
In what way?
How did that make you feel?

What do you think about the care of older people on this ward?

Prompt 1 By mentor, patients, placement leader, other members of staff other students, self.

Prompt 2 What do you think helps/constrains the staff in giving good care?

How do you recognise good care of older people when you see it?

Key features of the case study practice placements

Practice Placement A

This practice placement, an assessment ward, was based within community services working with older people with mental health problems. The mental health team served a somewhat geographically isolated post-industrial coastal area in the north-east of England. The housing was a mixture of terraces and large Victorian villas, many of which were converted into flats, and the nearby streets and amenities had a run-down feel. . The mental health services for the elderly were housed in one section of an old Victorian hospital located directly on the coast that has been internally modernised with magnolia walls with floral borders, armchairs covered in easy-clean materials and Formica-topped tables.

Students were allocated to one of the clinical areas. There were two wards, the first specialising in assessment of older people with mental health problems and the other a continuing care ward for older people who have mental health problems that lead them to display challenging behaviours. The ground floor housed a day hospital for patients with functional and organic illnesses. Community psychiatric nurses, social workers, and occupational therapists formed the therapeutic team housed within the building.

Although all members of the team contributed to data collection through interviews, most of the observation took place on the assessment ward. This ward took up to three students on practice placements at any one time. The majority of the students were in the first year of their nursing course; others were in their third year, and had almost completed the course and were undertaking their management placements in which they gained experience of planning and coordinating care. Mentors were allocated to students before their arrival and each student was sent a letter of welcome inviting them to visit the area before the placement began.

The assessment ward

The 25-bedd assessment ward was situated on the second floor of the building approached from a rather stark, uncarpeted staircase which seemed to be a funnel for the wind blowing from the sea. Entrance was gained by means of an intercom system and two sets of locked doors. Once inside the ward the layout was not immediately evident: there was no plan of the ward, no evidence of client names or indication of where their bed space was to be found, although a notice-board on the wall of the corridor had photographs of staff members. However, the intercom admission system ensured that someone was aware of a visitor's presence and available to answer questions. Turning left from the entrance, a short corridor led to two small offices which were somewhat isolated from the main ward area. The larger of the two was the ward managers' office, a cluttered area that was mostly used for private discussion and staff handover; the smaller office was the consultant/ interview room.

Turning right at the entrance to the ward brought you to a nurses' station, a fitted desk area from which the door intercom was operated. This central area of the ward, a square of approximately 20 feet square, had a stark appearance with strip lighting, magnolia-painted walls and vinyl flooring. Some armchairs were arranged on a rug around a table to one side of the space: this did little to soften its appearance, but these chairs were popular with residents.

To the right of the entrance was a small kitchen and next to that a dual-purpose room used for dining and as a second sitting area with tables and chairs and a settee. Once again, the harsh lighting and vinyl floor covering made this room seem uninviting. At the opposite side of the central area were a few single bedrooms. Most patients slept in what were very recognisably six-bedded hospital bay areas situated down a second corridor running to the right off the central area. These bed bays had been adapted to sleep four people in order to give more room and privacy, and the curtains and bedding were of an attractive floral design. There was no television in the bedrooms and the only place for patients to sit was in the chairs placed next to each bed. The bedrooms were very tidy and there were a few personal touches – photographs etc. – but storage space was obviously very limited. It was rare to see patients in the bedrooms during the day, except the occasional person taking a nap following lunch.

Opposite these bed areas there was a large comfortable lounge with windows looking out over the front of the building from which it was possible to see the sea. The furniture was arranged round a television and a table. There was a sideboard with a floral arrangement, magazines, jigsaw puzzles and games readily available. The walls had floral wallpaper, pictures and mirrors, and although it is difficult to give a homely feel to a room one wall of which is a half-glass partition onto a corridor, this was the most popular room on the ward. Next to it was another smaller carpeted room completely furnished with domestic furniture. Armchairs were arranged round a mock fireplace and there was an old dining room suite to one end of the room. This room was less popular with the patients, primarily because it had no television, although it was used a quiet place to read this was mostly at the suggestion of staff.

The client group

The purpose of this ward was to assess the mental health care needs of patients over the age of 75 who were referred to them. The majority of the patients were suffering from depression and spent between 8 and 12 weeks on the ward. The ward worked closely with the other services for older people with mental health problems situated in the same building. This meant that some patients could attend the day hospital from the ward, in preparation for attending from home on discharge. Although it was an assessment ward, some patients participated in therapy before being discharge into the community. Other patients were transferred for longer-term care to the other ward in the unit.

The daily ward routine

Care was undertaken using a primary nursing system. Senior staff nurses undertook this role and were responsible for undertaking client assessment and care planning. These primary nurses were supported by associate nurses, more junior staff who undertook the plan of care for a patient during the absence of the primary nurse.

Staff arrived on the ward at 7.15 am and a tray of tea and coffee was brought into the ward office where night staff gave report. The report given included a brief description of the patients' condition and discussion of any changes during the previous shift. The care of a small number of patients would be presented by the primary or associate nurse and discussed in detail by the ward team. Suggestions were made for the resolution of care problems. The manager also used report to discuss management and organisational issues and make points of policy. For example, during data collection the placement leader was promoting the importance of non-verbal communication in therapy. This was presented during report over a number of days and staff brought examples from practice to the meeting for discussion. Following report staff dispersed to assist patients to prepare for breakfast, which was served for most patients in the dining room. Those patients who wished had their breakfast in their rooms. Therapists began to arrive on the ward and some patients participated in groups run by staff, such as an anxiety management or relaxation group. Some staff worked on a one-to-one basis with patients. Consultant ward rounds were combined with multidisciplinary team meetings; older people and their family carers were frequently invited to attend. Visitors were officially welcome on the ward from 10am to 8pm, but in reality there appeared to be little restriction.

Groups came to a conclusion at about 12 noon and lunch followed shortly. A relaxation hour for patients followed while afternoon staff took report. Some further therapy continued in the afternoon but was generally finished by 3.30 p.m. Patients then tended to watch television until the evening meal was served at 5.30 p.m. Some patients had visitors in the evening, other just relaxed. Patients chose when they wished to go to bed.

It was a challenge for staff to make an old Victorian building suitable for the requirements of older clients with mental health problems, and initial impressions were not positive. However, within a short time it became apparent that this was a friendly, warm environment in which skilled staff demonstrated care and undertook therapeutic care of older people with mental health problems.

Practice Placement B

This placement centred round the experience offered to students by a group of district nurses working in a city in the south-west of England. The district nurses were based at a health centre and were 'GP attached'; which meant that their work involved the care of the patients registered with the doctors at the health centre. The health centre also housed practice nurses, health visitors and midwives. The nurses' 'patch' was divided into two areas with distinctly different housing. The first included large numbers of older terrace properties, largely populated by older people many of whom had lived there for many years. The demise of traditional industry had forced younger people to move away in search of employment. However, they were slowly returning to the second, newer, housing sector within the area. The health centre was built at the same time as this newer housing, which was reflected in its design; it was a grey, low-level building, built during the early 1970s, that sat at the heart of a poor inner city estate of monotonous grey, flat-roofed houses and high-rise flats. These newer developments lay on either side of a dual carriageway, surrounding a very large roundabout, a major artery to the city centre. Most the patients under the care of the district nurse were older people, many of whom were housebound. The four nurses shared one rather crowded office in the health centre, with a number of desks, hot drink facilities and filing cabinets that made negotiation of the room difficult.

The nursing team

A very experienced district nurse led the team of three other community nurses. In addition to her other duties, this nurse contributed to student learning within the university, undertaking some guest lecturing on the nursing diploma and community nursing courses, and organised in-service training for other community nurses. She was also active in a group of practitioners acting as consultants in the design of the 'new' pre-registration curriculum at the local university. She had been in post for two years. The rest of the team consisted of two nurses who had worked from the health centre in excess of five years and a third nurse who had been qualified for eighteen months and who had just joined the team some five weeks before our meeting.

The nurses' day

The nurses 'workload varied widely, depending upon the number of clients they had 'on the books'. There was some seasonal variation, with the winter months being particularly busy. The nurses made some regular early-morning visits on their way into the office, such as administration of insulin to diabetic clients. The team then met at their office to discuss care and allocate existing patient visits and new referrals. Visits to patients were organised to take into account clinical need, geographical proximity and the numbers of nurses required to undertake the patient's care. Arrangements to meet at the homes of patients who needed more than one nurse were made, and the nurses then went on their separate ways undertake their allocated patient visits. Twice a week one of the nurses ran a clinic at the health centre for more able patients who could attend. The daily work of the team varied widely but included wound, catheter and stoma care, visiting patients recently discharged from hospital, caring for terminally ill patients, health promotion and information giving.

Staff frequently took lunch between visits, but at busy times lunch was delayed this until they returned to the office in the middle of the afternoon. The afternoons were used for full assessments of new patients, and attendance of and feedback from meetings, teaching and completing student assessment documentation.

Patient referrals received in the office by telephone or fax while nurses were making their morning visits were again prioritised: some would require a nurse to visit before the end of the day and others were allocated to the next day's work.

Organisation of student learning

Students were always allocated to a mentor and an assessor. However, in order that they could *'compare the style of the different nurses in the team'*, students worked with every member of the team at some point during their placement.

Early in the placement the students met the team at their base in the health centre and accompanied their mentor on their visits to observe the care given. They then progressed, under the supervision of a qualified nurse, to giving care to patients in

their homes. If considered competent and safe in their practice by the mentor, students went on to give patient care and make visits independently to two or three patients.

The nurses seemed to have close and supportive working relationships that they enjoyed. The nurse leader was dynamic and eager to develop her staff, and students benefited from a range of experience and learning opportunities

Practice Placement C

This placement was a 27-bedded orthopaedic rehabilitation ward based within a purpose-built orthopaedic unit. The unit was sited in the grounds of a large hospital, on the outskirts of city in the south-west of England. Half of the beds on the ward were intended for patients admitted to the hospital for elective orthopaedic surgery. Most of these patients were older and required a variety of surgical procedures such as hip and knee replacements. The other half of the beds were intended for second-stage trauma patients who came from another large hospital some miles across the city. These patients were mainly older people who had incurred injuries that required orthopaedic surgery and subsequently came to the ward for rehabilitation. Although the intention was for patients to return to their own homes, this was often complex and in some cases infeasible because of their deterioration in both general health and mobility. The ward frequently had less than its quota of second-stage trauma patients and because of increasing pressure for beds from within hospital the spare capacity was frequently taken up by people with medical problems termed on the ward as 'medical outliers'. These patients were under the care of the medical consultants based in the main building of the hospital.

Design and layout of the practice placement

The orthopaedic centre was a low-rise building sympathetically built in soft-coloured brick with attractive landscaping to all sides. The entrance to the building opened onto a central space which was a hive of activity, with an attractive seating area, shop and café.

The ward itself was situated on the ground floor. Access to the ward led directly to a windowless central work area housing the nurses' station, sister's office, store room and occupational health kitchen. This kitchen was used by the occupational therapists who were based on the ward and by others from neighbouring wards. The area was also used as a quiet area for patients and staff to meet and for patients to make private phone calls. Physiotherapists visited the ward but had their main therapy department elsewhere in the building. The central area and nurses' station were the busiest areas of the ward and it was possible to stand there for some time waiting for the obviously busy staff to give you attention. The patients' six-bedded bays leading off this central area all enjoyed views of the grounds and most of them had glass partitions for easy viewing of the central work area. The décor was plain and functional, with painted walls, the bed and public areas were spacious, allowing for ease of movement, and the walls had conveniently placed handrails. There was no sitting room for the patients, and with the central area being such a hub of activity patients in the surrounding beds may have found it difficult to relax at times.

Organisation of ward work

The ward had two leaders, one G and one F grade, when data collection began. The F grade left during this period and another senior staff nurse was 'acting up' as the junior ward leader. The ward staff worked in two teams and members from each team were present on each shift. When staffing is a problem, members of nursing staff have to change teams in order that all patient had their care needs met. The aim of the two-team system was to give patients and staff some element of continuity.

Organisation of the ward day

This was a very busy ward, with very few quiet times in the day. Day staff came on duty at 7.30 a.m. and immediately took report in the office, from the night staff for about 30 minutes, leaving one member of the staff out on the ward. The handover then continued at the bedside, where patients contributed and were introduced to the member of staff who was to care for them for the shift. Patients were then assisted to get ready for breakfast. The period immediately after breakfast was generally used by patients and staff in meeting personal hygiene needs. This phase of the day seemed to

merge with the arrival of therapy staff. Some patients were assisted to wash and dress by the occupational therapist and others began treatment with the physiotherapist. Drug rounds, undertaken by a senior nurse from each team, took place at 8.00 am and 2pm. In addition to patient care, staff answered telephone enquiries, received admissions and organised patient discharges.

Patients were under the care of a number of consultants, who came to the ward on different days and at different times. The nurse responsible for the care of the patient usually accompanied the doctors on their rounds. These frequent ward rounds generated a large amount of work for nurses as treatments and prescriptions changed, tests were ordered and patients transferred or discharged. The ward became even busier as junior doctors, pharmacists and social workers among others swarmed into the ward to do their work for the patients. On theatre days nurses were particularly busy, preparing some patients for theatre and receiving others back.

Lunches were served between 12 and 12.30 pm and the afternoon staff came on duty at 1.15pm. The round of reports in the office and at the bedside was repeated. After this, patients had a 'rest hour' when curtains were drawn and patients were encouraged to rest on their beds. The day staff had a short break and then completed their duties by writing up the care they had given in the nursing notes. If staffing levels were good there was a short time for staff to spend on such things as student assessments, writing ward protocols and rewriting the 'introduction to the ward' student booklet, as was happening while I was visiting. Ward staffing levels declined, however, during the period of data collection. Although the nursing team tried to make up the shortfall 'in-house', it was evident that this extra working and overtime had began to take its toll with sickness levels increasing and a growing reliance on bank and agency staff to staff the ward. Nurses frequently undertook administrative tasks, such as completing student assessment documentation, at home in their own time.

There was open visiting on the ward between 11am and 8pm, with a break for the rest hour. As explained previously, this unit was part of a large hospital based on the outskirts of the city. Some visitors told me that this long journey made it difficult for some older relatives and carers to get to the ward, and they suggested that having got

there they liked to 'make the most of it'. I noticed that many visitors stayed on the ward visiting for long periods of the day. The shop and café facilities close to hand made their stay more pleasant and served as 'somewhere to go' with patients who were fit enough.

Night staff came on duty at 9pm, at which time the ward would begin to quieten a little as visitors and day staff went home leaving the night staff to settle undertake a last drug round and to settle the patients for the night.

Practice Placement D

The fourth placement was an 18-bedded psychiatric assessment ward for older people, part of a large Victorian psychiatric hospital in the Midlands. The placement was housed in a modern low-rise purpose-built building away from the main hospital, which gave a feeling of being softer and more approachable than some of the nearby Victorian institutional-type buildings. The main entrance to the unit had a manned reception and seating area. Close by there was a shop with a small but popular café attached and a dining room that was open to all. The ward specialised in the assessment of functional mental health problems and the average patient stay was three months. Although it was not unknown for patients to return to the ward for a second visit the team aimed to assess client need, begin therapy, and ensure that services were in place within the community to support the client before they were discharged home. The placement had *'good'* links with the university and the placement leader had been asked to be a guest lecturer. However, he declined: he felt that:

> *I would be doing their job for them. If I go in and teach, what will they be doing? My job? I don't think so.*
>
> (Placement leader)

Design and layout

The ground floor ward was in the course of refurbishment during data collection. The manager explained that he ensured that he was aware of any local and national

funding opportunities and regularly applied to charities for specific funding to improve the environment or provide equipment. The ward was accessed via a short corridor into a central living area with dining room, kitchen, office, sitting room and open-plan seating/lounge area.

The first room to the right of the corridor was a sitting room. This room was small but comfortably furnished with domestic furniture, wallpaper, paintings and bookcase. To complete the effect, there was no television in this room. A little further up the corridor was the kitchen. The ward office, a glass-partitioned structure in the middle of the central space, was very small, cluttered and well used; it was unusual to see this room empty. It overlooked the open-plan seating/lounge area where many patients chose to spend most of their day. This area was carpeted and decorated in a homely style with wallpaper, pictures and furniture creating that indefinable and incongruous mixture of home comforts within an institutional environment. French windows in this area made it seem light and airy and led into a small enclosed garden that was widely used and tended by staff and patients. The dining area, which was situated at the rear of the office, was also light with windows out onto the landscaped grounds. Bedrooms, most of which were single occupancy, were situated together in a corridor off the main area.

The client group

The ward served to meet the needs of older people with mental health problems from a designated geographical area within the city. Patients were predominately experiencing functional illnesses and approximately 60% of the intake were suffering from depression. The main treatments used in the treatment of depression were antidepressant and antipsychotic medication and electroconvulsive therapy. Of the remaining 40% of patients, approximately 10% were described as suffering from 'mania', 10% schizophrenia, and 10% with physical health problems that manifested themselves in mental health symptoms. The remaining 10% had predominantly social problems of loneliness, isolation, alcohol misuse, or personality problems. The average patient stay was three months, which might consist of four weeks patient assessment, four weeks treatment and four weeks preparing the patient for home by daily, overnight and weekend leave. For those patients who did not return to

independent living this period on the ward could be extended by a number of weeks as re-homing arrangements were made.

The placement day

Day staff arrived at 7.15 am to take report from the night staff. Staff took coffee as the report was given. Patients were allocated 'key workers' and 'associate nurses' on admission. If the key worker or associate nurse was on duty, they would assume responsibility for their allocated patients. Some patients required physical care and assistance to mobilise while others where very independent. The morning began with nurses giving assistance to the less independent patients and encouraging and supervising those who were more able. Breakfast was normally served in the dining room, but patients who felt unable to do that were given breakfast in their room. Nursing staff administered medications to patients, and after this the morning was spent in a variety of ways.

Some patients went off the ward for therapy – the unit had occupational, speech and art therapists. Some patients were assessed by professionals on the ward, for example the dietician or social worker would attend the ward on a regular basis. Staff encouraged patients to continue their therapies on the ward: for example, some staff and patients went out into the garden to work, others to enjoy sitting in the fresh air. The television was on constantly, although the sound was usually at a reasonable level. Some staff spent many hours talking with patients and gaining insights into their conditions. Others seemed less engaged with the patients and seemed more focused on tasks such as serving meals.

Visitors were welcome on the ward for much of the day. The ward kitchen was open to any patient or visitor. This enabled patients to maintain some of their independence and also meant that visiting could become a very social event, with both parties enjoying a cup of tea or some toast together. The more regular visitors often made drinks for patients other than the person they were visiting, and this contributed to the relaxed atmosphere on the ward. Some patients and their visitors went out to the garden area, some went to the patient's room for privacy, and others walked to the front of the building to visit the shop or café. Those patients who required more

assistance to mobilise and meet their personal needs were assisted throughout the day by the staff.

Doctors' rounds and multidisciplinary team meetings took place on a weekly basis. These were often very time-consuming, with in-depth discussions of each patient. Patients were not always present at these meetings, but they and their family carers were frequently invited in to discuss progress, treatment and discharge arrangements. Students were also involved in all these meetings and some mentors encouraged them to participate by giving their views on patients they had cared for.

Most patients took lunch in the dining room and while I was there a number of patients eagerly awaited meal times, asking staff if the food had arrived or walking to the door to look for the arrival of the food trolley. Some patients had lunch off the ward either at therapy, following a cookery class or at the café.

After lunch the patients had a quiet period. Nursing staff took the opportunity to change shift and the afternoon staff took report. Other staff used this time to catch up on paper work and phone calls. The paper work related both to patients and students assessments. There were more visitors in the afternoons, although some patients had very few, if any, visitors. Formal therapy sessions were finished in the afternoon by 4 p.m. and patients then tended to congregate around the television. Evening meals were served around 5:30pm and some clients retired to bed quite early, while others appeared to be content not to. Night staff came on at about 8.45pm.

Practice Placement E

This very busy medical assessment unit was situated on the second floor of a district general hospital in the south of England, serving the local adult population. Most of the patients were older people. The area had a mixture of housing, much of it in the Victorian villa style of terrace housing with other larger detached properties. The area had long been popular with commuters for its 'county town' feel, and this had led to property prices being inhibiting for many people. The hospital itself was a building of three or four stories, built in a busy part of the area in the 1970s.

Design and layout

This practice placement is a 30-bedded medical admissions unit. The unit had a 'racetrack' design, with the six-bedded and single rooms on the outer edge and offices, storerooms and other facilities on the inner. There was no communal sitting area. All interviews had to be held in a small claustrophobic room, which acted as a waiting room for relatives and carers. Although the ward had the staffing establishment for 28 beds, because of 'winter pressures' an office and a storeroom had been converted in single rooms. These rooms continued to hold patients although data collection took place in the height of summer. At the time of data collection major building work was taking place close by and the atmosphere was noisy, dusty and uncomfortable. The environment was utilitarian and showed little in the way of personality except for the reception/office area, which was the hub of the unit where the very cheerful receptionist greeted at visitors. This utilitarian feel seemed appropriate for a transitional area where most patients stayed for less than 48 hours. All the patient bays were self-contained and could not be seen from any central point, which meant that the corridor outside these areas was extremely busy with ward staff. Many of the older patients were transferred from the unit to the three medical wards on the floor below.

Organisation of the work

There were five qualified nurses and five health care workers on duty for the morning and afternoon shift. Each team of one staff nurse and one health care worker is responsible for one six-bedded bay and one side room. This unit introduced a management system they termed 'patient-focused care' in 1993. Each unit had its own budget and bought the staff they deem appropriate to meet patient need. So, for example, if the unit felt it need more occupational therapists and fewer nurses then they had the power to alter their establishment figures to reflect that need. The unit therefore employed and was the base for its own physiotherapists, occupational therapist and social workers as well as nurses, porters and cleaners. The placement leader found that this way of working had several advantages:

- encouraging team working across professional boundaries

- making the unit the focus of staff loyalty
- encouraging flexibility in roles
- reducing bureaucracy
- reducing the number of people dealing with patients during their stay in hospital
- increasing continuity.

Many of the staff where multi-skilled. Occupational and physiotherapists were trained in 'core skills' that included moving and handling of patients, basic life support, feeding and mobilising patients.

The unit manager, who was also responsible for two other wards specialising in the care of older people, worked clinically on the unit for one or two days a week. A senior nurse supported the unit on every shift and also acted as bed manager within the medical directorate. There were two G grades and six F grade nurses and a 'clinical nurse specialist for the elderly' whose role it was to attend the accident and emergency department to assess the needs of people over 65 years of age who where still awaiting admission; also to liaise with local colleagues with respect to the referral of appropriate patients for admission to local community hospitals. She also worked with older people in the medical assessment unit with regard to assessment. Unfortunately, during data collection the nurse specialist was on long-term sick leave and her post had not been filled in her absence.

Recruitment and retention of experienced staff was one of the main issues for the placement manager. Newly qualified staff were offered accommodation, but experienced staff found it difficult to obtain affordable housing and frequently left the area. In order to meet that shortfall and to encourage junior nurses to stay, the unit ran a staff development programme. Originally intended for newly appointed E grade nurses, the programme was now being offered to D grade staff in order to prepare them for applying for more senior posts. Topics covered included 'managing your team', evidence-based practice' and 'reviewing performance'.

The client group

The majority of patients who were admitted to the medical assessment unit were older people who came via the accident and emergency department. Others were referred directly by their general practitioner, or from local community hospitals when their condition deteriorated. Patients spent between 30 minutes and 48 hours on the unit. The length of their stay was determined by their condition, the investigations required and the availability of a bed elsewhere in the hospital.

The student experience

This placement only took students in the latter part of the third year of their training. The placement on the unit lasted ten weeks, with one 'reading' week midway through. Although offered the opportunity to work the normal hospital eight-hour shift pattern, students tended to work three 'long day' shifts a week of twelve hours in order to spend time with their mentors.

This was, as may be expected, a very busy area for staff and patients. Much work was undertaken in relation to investigations and diagnosis, but because of the short-term nature of patient stay little attempt was made to form relationships with patients or begin any major therapeutic interventions

Practice Placement F

This placement was a situated in a hospital serving a major Midlands conurbation in England. The hospital itself was very large and stood in sizeable grounds: it took over half an hour to walk from one side of the grounds to the other. The original buildings were over 100 years old, with many subsequent additions. As with many NHS hospitals, the old and the new were merged by connecting corridors which were colour coded. Many of the corridors had notice boards, some containing health promotional material and patient information, but many notices were aimed at staff, covering topics such as audit and research. The practice placement was a 24- bedded medical ward with twelve beds allocated for care of the elderly and twelve for stroke patients. There were two consultants with patients on the ward, one of whom was a

neurologist and the other a professorial consultant specialising in the care of older people.

Design and layout

The practice placement was situated in a relatively new building. Each floor had a central lift/lobby area with two projecting arms each housing a ward. Each ward had rooms coming off either side of a central corridor. As you entered on the left were offices, kitchen and sluice, toilets and bathrooms, a physiotherapy gymnasium and occupational therapy kitchen. Two single-bedded side rooms were also on the left, some distance from the nurse's station. To the right of the corridor was the ward sitting room, which doubled as a storage area for therapy equipment. Although this room was attractively decorated and had a three-piece suite set out traditionally around a television, the use of the room as storage for equipment made it feel less than relaxing. Because many of the patients on the ward were in the acute phase of their illness, or had newly acquired mobility problems, few patients or visitors used the sitting room.

The main six-bedded patient bays were on the right of the corridor and had windows looking out onto a leafy area with trees. The bedding and window curtains were attractive and in good repair, but the bays always looked untidy and overcrowded. This was due in the main to the amount of equipment such as hoists, specialist chairs, footstools and specialised feeding equipment required for the care of the patients on this unit. Bays were gender delineated, with the most ill patients being situated opposite the nurses' station for ease of observation. The nurse's station or desk area stood in front of a number of rooms on the corridor and acted as a barrier to clinical store rooms, ward office and doctor's office, etc. The ward clerk was to be found at her desk at the station for most of the day during the week but not at weekends. This area was always busy with health care staff of all professions, queries and questions and was undoubtedly the hub of the ward. There was a small resource room for staff.

The patients

Although the ward's bed allocation was split between medicine and stroke, most of the patients were older people who had suffered profound strokes. A minority of beds held people with other medical conditions including cancer, heart failure, and respiratory problems. There appeared to be few patients on the ward able to care for themselves.

The placement day

Staff came on duty at 7 am and took report from night staff. The ward undertook team nursing to aid continuity for patients and staff. Teams worked almost independently of each other until the middle of the morning 'clearing up', when teams helped each other to ensure that all patients were out of bed, dressed, toileted and given their medications. Therapy staff began arriving on the ward around 9 am and undertook dressing practice and other therapeutic interventions throughout the morning. In the afternoon further therapy occurred between 2 and 4pm and junior doctors and consultants reviewed individual patients' care and undertook ward rounds. Visiting times were 2pm – 8pm.

Ward organisation and students

The nursing staff on the ward were split into four teams. Each team contained an E grade and a D grade nurse, as well as other support staff. Up to five student nurses were on placement on the ward at any one time. These students were allocated two mentors. This system was adopted to allow for student supervision by a familiar nurse during periods of staff sickness, holidays and rotation to night duty. The students were not required to do night duty while on the ward, although there was the opportunity for them to experience this with their mentors if they wished. All the seniors nurses (E, F, and G grades) had undertaken a recognised teaching course. Students were given the same duty roster as their mentor in order to promote continuity, but they were allowed to change it if they wished. The ward ran a monthly rolling multidisciplinary teaching programme that was well attended.

This was a frenetic ward, a constantly busy and moving environment with little respite for patients or staff.

Practice Placement G

This nursing /residential home was situated on the outskirts of a small attractive village which housed people who worked mainly in the two nearby medium-sized towns in the north-east of England. It was a 20-bedded nursing home including three palliative care beds, with a 20-bedded residential home attached. A home-care service and respite care was also provided and the levels of service for all the residents were tailored to individual need. Most residents moved into the home from the local community and many of the staff also lived locally, so many residents had known staff before moving into the home and vice versa. The fees that the home charged were 'towards the top end of the scale'. The residential home was managed separately from the nursing home and each had designated staff. The nursing home sometimes admitted people who were waiting for a bed in the residential side of the home. The local community nurses provided any nursing care that was required by people who lived in the residential home.

Design and layout

The nursing home occupied a purpose-built addition to a large converted house that provided the residential accommodation. The office, which usually had its door open. was situated near the entrance to the home. Information about how to make complaints and access the nursing homes inspection unit was displayed on the wall outside the nursing office. The entrance had a few chairs, where residents were frequently found. A coat stand in the corridor seemed to hold the coats of both staff and residents, and created a domestic feel.

The resident's rooms, mostly single, all en-suite, were pleasant; the bathrooms were well stocked with toiletries, wipes, pads, etc. Some of the rooms had been individualised; residents had brought some of their own furnishings and belongings to decorate their rooms. As the rooms became due for refurbishment the residents were consulted and offered some choice of decoration. One lady showed me her collection

of plates displayed on a shelf that went around her room; the homeowner had installed this specifically for the purpose.

There was a communal lounge and dining area where some residents choose to sit during the day, but many remained in their rooms. There was only a minimal staff presence in the lounge but it was visible from the office. The television was invariably on throughout the day, although the manager did put some music on at lunchtime. Wheelchairs and Zimmer frames were placed in a large alcove in the wall next to the lounge when not being used, which prevented them from becoming an obstruction. Many of the wheelchairs were missing foot-plates. A second large lounge upstairs seemed to be rarely used.

Learning resources for students and staff were kept in the staff room. Files included content on nutrition, dementia and continence, and a notice-board in the staff room had details of local courses.

The placement day

Breakfast was taken to residents' rooms on a tray. The daughter of one resident came in every morning to help her mother get up and stayed with her while she had her breakfast. Most residents had lunch and tea in the dining room, with carers serving from trays plated in the kitchen. However, carers then stood chatting to one side of the room and there was little social communication between residents as they ate. The menu changed weekly, but the food was bland and unattractive with no choice being offered. Biscuits were served with morning coffee, and appetising home-made cakes with afternoon tea. During visits to the placement the whole activities programme included bingo, dominoes, skittles and gardening was delegated to the carers, who seemed a little unprepared for their role. People from both the nursing and residential sides of the home mingled and participated in the activities. The home also organised seasonal events that were open to relatives, visitors and the village.

Student learning

The home tended to have students who were at the end of the first year of the three-year nursing course, and for some students it was their first clinical experience. One of the senior staff nurses took the lead with the assessment documentation, but the students worked with all the care staff. The placement tended to be divided into two sections. The first few weeks students spent working with care assistants caring for residents' needs. In the second part of the placement they worked primarily with the qualified staff looking at their role and the management issues involved in running the home. Students were studying two modules during this placement, communication and ethics. The placement leader had qualifications in palliative care but while students and staff could see clear links between the placement and the communication module, they found the ethics module more problematic.

Overall this home had a comfortable and welcoming feel: staff and residents were welcoming and seemed to enjoy being there.

Birmingham NHS
Health Authority

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Chairman: Professor C Clifford
Administrator: Mrs A P McCullough

Committee 2

Our ref: CC/APM/DD/C2/0130
Please quote: 0638

Professor Mike Nolan
Professor of Gerontological Nursing
University of Sheffield
School of Nursing & Midwifery
301 Glossop Road
Sheffield S10 2HQ

Dear Professor Nolan

LREC reference number 0638
The AGEIN Project (Advancing Gerontological Education in Nursing). A longitudinal study of the effectiveness of educational preparation to meet the needs of older people and carers

South Birmingham Local Research Ethics Committee are happy to Approve your Study subject to the following:

- Satisfactory indemnity arrangements being in place.
- Clearance from your Trust or relevant employer.
- Subject to submission of an annual report in line with Good Clinical Practice Guidelines.
- Active approval is required until the Study has been completed.
- The Committee would wish to be kept informed of Serious Adverse Events, Amendments and any modifications to Patient Information Leaflets and Consent Forms.

Approval is given for three years, however, if it is intended to continue the Study after THREE YEARS from the date of this letter South Birmingham Local Research Ethics Committee would wish to re-examine it.

Would you please communicate this approval immediately to all members of the investigating team and where appropriate the sponsoring commercial company. Please also advise your Research and Development Office of this approval.

Yours sincerely

[redacted]

Professor C Clifford
Chairman
Local Research Ethics Committee

cc: Appropriate Trust

Research Ethics Committee
APPROVED

North Bristol NHS
NHS Trust

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Our ref: jbjan.01

1 February 2001

Ms J Brown
Research Fellow/Lecturer in Nursing
The University of Sheffield
301 Glossop Road
Sheffield
S10 2HL

Dear Ms Brown

The AGEIN project (Advanced gerontological eduction in nursing). A longitudinal study of the effectiveness of educational preparation to meet the needs of older people and carers (Short title: The AGEIN project)

I am writing to confirm, as advised to you be telephone a few days ago, that Dr L Dow, Joint Chair of the Avon Health Authority, North Bristol NHS Trust (Frenchay) Research Ethics Committee feels that there is very little aspect of ethical concern in the above project and there would be nothing to be gained by full ethical review.

However, I would just draw your attention to the following paragraphs which are in respect of standard requirements.

The Trust's Chief Executive has requested that the Trust's Directors for Clinical Services/Operations Directors be advised of all research being undertaken within their Directorate to ensure that there are no operational implications affecting their departments and for their interest and information. Therefore, may I ask you as a matter of courtesy to advise Mrs J Lane, Operations Director Family Health Care of your study. ✓ Done

It would be appreciated if you would notify the Committee when your study is completed. Should the results be published, the Committee would like to receive a copy for information and for the benefit of any future studies that may be undertaken in this field.

In order to assist the Trust with its obligations in respect of reporting procedures, we ask that you complete and return the enclosed research project registration form to Dr A MacGowan as information may need to be included for the Trust's R&D Support Costs Funding and the submission to the National Research Registry. Unless we hear within two weeks of this letter, we will assume that you have no objections.

/ 2

Please contact the Trust's Medical Manpower Department regarding contracts if there are any medical staff involved in your study who are not already members of the Trust's staff but may need honorary contracts for this study, and Mr K Spencer, Employment Services Officer, Frenchay Hospital, Frenchay Park Road, Bristol, BS16 1LE for consideration of the need for an honorary contract for yourself.

Data Protection Act 1998 : If your study involves any data which relates to a living individual, please contact Ms C Adams, Data Protection Officer, Information Department, Portacabin, Frenchay Hospital, Beckspool Road, Frenchay, Bristol, BS16 1JE telephone No. (0117) 9701212 on extension 2029.

Yours sincerely

[redacted]

Mrs K M Matthews
Research Ethics Administrator
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