

**Factors That Influence Nurses'  
Attitudes Towards Working With  
Older Adults: A Qualitative  
Descriptive Study**

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A Thesis in Partial Fulfilment of the Degree in

Master of Health Science at

Auckland University of Technology

September 2018

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## **Abstract**

In line with global trends, the population in New Zealand is ageing. It is projected that the total population of New Zealand will be around 5 million people by the mid-2020s and by the late 2020s approximately 20% of those will be aged 65 years and older (Stats NZ Tatauranga Aotearoa, 2016). It has been suggested that an ageing population may mean an increase in chronic and long term health issues that require a disproportionate level of input from the healthcare sector. To meet these needs there will need to be an increased number of nurses who specialise in the care of the older adult. The concern is that not enough nursing graduates are choosing to specialise in gerontology, leaving a workforce that is ill equipped to cope with the increased future demands our populations will place on the healthcare system.

An extensive literature review highlighted a number of reasons that new graduate nurses are not choosing the older adult setting. The purpose of this study was to ascertain the factors that influence new graduate nurses in New Zealand when making choices to work with older adults and to establish where the similarities and differences may be with regard to what is currently understood.

Using a qualitative descriptive methodology, eight participants were interviewed, four student nurses from Auckland nursing schools and four experienced RNs from a regional Auckland DHB. Two main themes emerged from the data, the first being pre-existing factors and the second is specific factors related to nursing education. Each theme is then broken down into a further three subthemes. The findings of this research have implications for how specialist knowledge around nursing older adults is delivered at undergraduate level. It is hoped that by offering recommendations on how changes could be incorporated there will be a beneficial impact on how student nurses understand and perceive the complexity of nursing older adults which will increase the numbers choosing this area of nursing to practice in.

## Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgments) nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Waller

Dated:

31 August 2018

## Acknowledgements

There are a number of people who I would like to acknowledge as having contributed to this work in various different, but equally important ways.

Firstly I would like to thank the participants who all happily and easily gave up their time, stories and experiences to me, without you, there would be no study.

Secondly my supervisor, Shayne Rasmussen, who continuously found the positive in whatever writing I presented to him, never nagged me more than necessary and convinced me, sometimes on a daily basis, that I could do it. Your guidance and expertise was always appreciated.

Thirdly, my long suffering colleagues (you know who you are), who must feel like they have walked every tortuous step with me but never once told me to harden up.

Finally, thank you to my family who have kept the home fires burning and allowed me this time to be immersed in my research, and to my mum and dad for feeding me literally and figuratively whenever I needed it.

# **Chapter One: Introduction and Overview**

## **1.1 Introduction**

With this thesis I explore the factors that influence New Zealand nurses when making their choices whether to practice in an older adult setting, through interviews with participants at the beginning of the registered nurse (RN) journey, as well as a group of experienced RNs currently working within the older adult setting.

## **1.2 Aims of the Research**

The primary aim of this research is to identify what factors influence nurses' choices whether to practice in an older adult environment specifically in a New Zealand setting and to establish where this is supported by existing research, or where it may differ.

## **1.3 Background**

There is a worldwide issue around the increasing gap between an ageing population and a healthcare workforce that is prepared to care for older adults. This is reflected in New Zealand where the older adult population group doubled between 1998 and 2016 to a total of 700,000 and is anticipated to double again by 2048 (Stats NZ Tatauranga Aotearoa, 2016). This is in part due to the large group of baby boomers who are moving through the age groups, but is also related to the decrease in birth rates and conversely death rates (Stats NZ Tatauranga Aotearoa, 2016). By 2050 approximately 25% of the New Zealand population, or 1 in 4, will be aged 65 years or over compared to only 15% in 2016; of these about 280,000 will be aged over 85 years (Stats NZ Tatauranga Aotearoa, 2016).

While not all older adults will develop a disease or disability, it is an inevitable part of the physiological ageing process that, with growing numbers of older adults, there will be greater demand on the healthcare system, including the nursing workforce (Nana, Stokes, Molano, & Dixon, 2013). One challenge facing nursing in NZ is that the average age of nurses is also increasing with over half the nursing workforce in 2010 aged over 45 years (Nana et al., 2013). The implications of this are that by 2035, it is expected that up to 23,000 currently practicing nurses will be retired. Newly graduated RNs



need to be considered as an important part of the solution to this issue and can be used to fill the gaps that will inevitably be left, particularly around nursing older adults.

The reality is that nursing in older adult settings is generally regarded as one of the least attractive options for newly graduated nurses to choose when applying for positions. Working with population groups such as babies and children, or within speciality areas including emergency, surgical and ICU were seen as having longer term benefits for new graduate nurses over older adult settings including aged residential care (ARC) (Wilkinson, Neville, Huntington, & Watson, 2016).

Gerontology, healthcare of older adults, in this sense is not confined to aged residential care (ARC) or assessment, treatment and rehabilitation (AT&R) wards as older adults are to be found in any general medical or surgical ward, or speciality area, in virtually every hospital or community setting in New Zealand (Coleman, 2015; de la Rue, 2003). A nurse who chooses to work in a surgical ward, will naturally be caring for older adults, the point of difference being that this is an accepted reality of working in that ward, as opposed to a conscious decision to work with an older adult population.

There have been studies carried around the theme of new graduate or novice practitioners within the field of gerontology (Brown, Nolan, Davies, Nolan, & Keady, 2008; Carlson, 2015; Coleman, 2015; Sarabia-Cobo & Castanedo Pfeiffer, 2015). Studies deal with the necessity of attracting new nurses to the speciality area of aged care and also identify reasons why this is not happening. These include the impact of undergraduate clinical placements in aged care facilities; ageism and negative stereotypes of the older adult; the role of the placement preceptor in influencing student decision-making; and the perception that aged care does not offer the same level of technical ability as other healthcare fields (Algozo, Peters, Ramjan, & East, 2015; Brown et al., 2008; Sarabia-Cobo & Castanedo Pfeiffer, 2015).

## **1.4 Overview of the Study**

Using a qualitative descriptive methodology, this research explored the topic drawing on final year student nurses and experienced RNs currently working in the older adult setting. The research methodology will be explained in the next chapter.

## **1.5 Overview of the Thesis**

This thesis is presented in five chapters. Chapter one introduces the background for the study and the relevance to the current situation is also discussed. Chapter two discusses the research design, qualitative descriptive methodology is defined, and justification for using this methodology to answer the research question is argued. In chapter three, the current literature is reviewed to understand what is already known about the factors that influence nurses' attitudes towards working with older adults. In chapter four the findings from the participant data is discussed in two sections: theme one – pre-existing factors and theme two – factors related to nursing education.

Finally in chapter five, the findings are discussed with particular emphasis on how they are similar or relate to what is already known. Recommendations are made for how the findings can be utilised to make future changes in practice in order to encourage more nurses to take up positions in older adult settings.

## **Chapter Two: Research Methodology and Method**

In this chapter, I identify the key features of the qualitative research perspective and how this is relevant to the research question posed.

### **2.1 Qualitative Descriptive Research**

This study asked what factors influence decision making when choosing to work with older adults or not. It was identified during the literature review that a number of studies have used a quantitative research method to answer a similar question. As such, there is some statistical, numerically measureable data related to students' attitudes to older adults, and how this relates to the probability of these students choosing to work with that population group. To me, this analysis did not seem to fully address the reasons underpinning these attitudes; while it may be useful to measure an attitude, measurement alone does not tell us why the attitude exists in the first place. More nuanced understanding of the 'whys' and 'wherefores' of decision making may be evident in hearing the stories from those immersed in the situation. In this study, this includes those individuals on the cusp of starting their professional nursing careers, and those nurses who are already working with older adults and have identified it as their area of expertise.

Qualitative descriptive research is a way of gaining understanding of a concept or phenomenon from the direct perspective of the people who are experiencing that phenomena (Sandelowski, 2000). According to Sullivan-Bolyai et al. (2005) one of the main benefits of qualitative descriptive research is that it enables interventions or solutions to a particular health issue to be specific and tailored to those who are in the middle of the experience. It does this by hearing from them what the issues are that they believe are important, rather than what the researcher decides on their behalf has meaning (Cresswell, 2009; Sullivan-Bolyai, Bova, & Harper, 2005).

The aim of qualitative descriptive research is to gather first-hand knowledge of a topic or problem from the perspective of the participants in order to understand how it is for the affected population group. Other qualitative research methods such as

phenomenology, grounded theory and ethnographic studies are underpinned by specific theoretical paradigms however qualitative descriptive research is the least theoretical of the qualitative methodologies (Lambert & Lambert, 2012; Sandelowski, 2000). This is not to say that this research method is without underpinning theory but just that it uses a naturalistic approach where a phenomenon is studied in the most natural setting possible (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2010). For this reason, it was an appropriate choice to answer the research question as the most valid source of information around decision making clearly comes from those who are in the process of doing it or have already made the decision and are working with older adults.

Low inference analysis is a core component of qualitative descriptive research and means that although some interpretation is unavoidable, unlike other qualitative research methodology, results will be presented in the language used by the participants (Neergaard et al., 2009). This is without the underpinning bias that may occur when other methodology is used that has theoretical elements that must be incorporated (Sandelowski, 2000). Low inference ensures that meanings extracted from the data remain as closely aligned to the experiences described by participants as possible (Sandelowski, 2000). The end result of qualitative descriptive research is to have a clear description of an experience, with as little interpretation by the researcher as is possible (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005).

There is always some requirement for interpretation of data as it is necessary to cluster similar ideas together from multiple individual experiences in order to identify common themes (Bradshaw, Atkinson, & Doody, 2017; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). The researcher must ensure however that they remain as close as possible to the data so it conveys the meaning and intention given to it by the participant, in order to accurately reflect their viewpoint on the research question.

The challenge with qualitative descriptive research is how to minimise researcher interpretation in order to remain true to the meaning implied by the participants, while managing to ensure that common ideas across multiple sources are identified and connected appropriately. Sandelowski (2000) believes this can be achieved, as although two researchers may describe one scene from individual viewpoints,

ultimately they should be able to agree on the truths of a scenario even if they do not report from the same perspective. Although each researcher may choose what they describe in summary and this could be different from the other, they could still agree that the other's description is accurate as the data is presented with minimal inference applied.

The sampling used in qualitative descriptive research is often purposeful as the basis of data collection is to gather as much information from the perspective of those affected by a situation or phenomenon, rather than generate data for interpretation as with other qualitative research (Kim, Sefcik, & Bradway, 2017; Neergaard et al., 2009). Data collection can be undertaken in a variety of ways, but often interviews or focus groups are used to gain a broad understanding of a topic (Neergaard et al., 2009). As discussed below, the original research method included focus group interviews for data collection, but this was altered to individual interviews as the reality of the difficulty of recruiting enough participants became apparent.

Neergaard et al. (2009) maintain that one of the limitations of qualitative descriptive data is that the analysis process can be subjective as it is impossible to separate the researcher's own biases or perceptions when analysis is undertaken. They suggest that one means of minimising the impact of the potential limitation, is to have more than one researcher involved in at least the analytic phase of the study. This is not always possible and a self-awareness on the part of the lone researcher, may lessen the issue identified by Neergaard et al.

In this study, regular discussions between the researcher and supervisor ensured that themes and ideas were routinely verbalised and discussed as a way of exploring and justifying the emerging data. This act of brainstorming ensured that ideas or concepts that were worth exploring became apparent by the depth of data supporting them, and conversely, where this depth was not apparent, views were discarded. This ensured that analysis remained based in the data and ensured a level of triangulation which contributed to the trustworthiness of the findings. Additionally, in the study, thick description through quotes from the participants has been provided, to allow their voices to come through and give credibility to the research findings (Tracy, 2010).

Further critique of the methodology is that justification or explanation for the use of qualitative descriptive research, over and above other methodologies is often not clearly articulated by researchers (Kim et al., 2017). Sandelowski (2010) argues quite strongly that some researchers use qualitative descriptive methodology as a “default or salvage method” (p. 80) when their research is poorly planned or conducted and it should not be. There is some support for Sandelowski from Willis et al. (2016) who contends that qualitative descriptive research actually requires a detailed level of planning to implement, particularly around the initial interview questions. This is in contrast to Kim et al. (2016) who believe that it is the lack of strict rules and boundaries in qualitative descriptive research that enhances the depth and richness of data that can be gained from the methodology.

My feeling is that the ideal approach for using qualitative descriptive research is somewhere between the two styles described by Willis et al. and Kim et al. Undoubtedly a level of planning is required to avoid the “salvage” moniker that Sandelowski (2010) highlights, but equally, an ability to adapt the approach to a number of factors within the design of the study is essential to stay true to the methodology. As I discuss in the following sections, there was most definitely a need to develop the method used in the study as several unforeseen difficulties manifested during the early part of the research.

## **2.2 Method**

### **Population**

The initial population group was identified as student nurses in their final year of an undergraduate nursing degree, either fifth or sixth semester. This group of potential participants was identified as appropriate given the original research question was related directly to factors affecting student nurses and their decision making around working with older adults. In line with the qualitative descriptive research approach, it was clear that in order to understand what was influencing student nurses in decision making, the right people to ask were student nurses.

As the project continued however, it became clear that recruiting student nurses at that stage of their study was more difficult than I had anticipated for reasons outlined

below. After only two interviews, I also felt that the data I was collecting had an idealism that, while interesting, did not feel like it was going to be particularly useful in making practical, reality based changes to practice. The idealism displayed by the students was possibility related to the fact that as they were yet to experience real world nursing, they were discussing a largely abstract theory of what they perceived practice will be.

At that stage, I decided to extend my population group and recruit experienced RNs who have chosen to work with older adults. At this point, I went back to AUTECH to get the change of population group approved. My hope was that the contrast between brand new nurses with idealistic worldviews, and the reality based understanding from more experienced practitioners, would provide a depth of understanding of the topic that did not seem possible with my initial population group of student nurses only. This approach was still closely aligned with my original research question as I was able to determine what factors had an influence on decision making. With an average length of practice of over 20 years in the RN group, the breadth of material gained from the two disparate groups at either end of the practice continuum, led to a more in-depth understanding of the phenomenon.

As the purpose of qualitative descriptive research is to explore a particular situation from the perspective of those experiencing it, it is not unusual for participants to be chosen, or recruited purposefully and on the basis of the depth of relevant knowledge they can bring to the research (Bradshaw et al., 2017; Bristowe, Selman, & Murtagh, 2015; Milne & Oberle, 2005; Thorne, 2008). Milne et al. (2005) further assert that sampling and recruiting of participants should be an evolving process as concurrent data collection and analysis begins to show emerging themes. The researcher may identify areas that warrant further, in-depth exploration on the basis of emerging themes, or, as happened with this study, the realisation that the original participant group may not be sufficient to answer the research question. Approaches to population groups and recruitment should remain flexible throughout the process of data collection to allow for emerging themes to be further explored with appropriate participants (Milne & Oberle, 2005).

## **Recruitment**

For the student nurse participants, I approached identified teaching leaders at the five Auckland based nursing schools – Auckland University of Technology (AUT), Manukau Institute of Technology, Massey University, Unitec and University of Auckland – to enlist their help in recruiting students. I sent an e-mail to the Head of each nursing school, introducing myself and my study. I included a recruitment poster (appendix 2) and asked for this to be disseminated to final year students via the usual method of communication used within each school. I had responses from all but one School. In one case I was redirected to a more appropriate contact within the school, and in two cases I had reassurances from the Head of School that the e-mail would be sent on to the right person to be distributed to students. Despite repeated e-mails and phone calls over a number of months, to the remaining school, I was unable to be sure that the students from this school were ever aware of my research request. One other school requested that I seek ethics approval from their own board, which I successfully achieved, and information was then disseminated to their students. Interested students were asked to contact me directly via e-mail.

As well as contacting the schools in the role of researcher, as part of my job, I visit the Auckland nursing schools to give presentations to students twice a year. During two of these visits, I was able to speak face-to-face with third year co-ordinators and explain my research and enlist their help in recruiting more student participants. Meanwhile my supervisor was also working towards getting participants by speaking with his colleagues to promote the research.

Following this recruitment drive I had three students contact me, from two different nursing schools. I sent all three respondents further participant information and a consent form (Appendices 2 and 3). In supplying further participant information to interested students I ensured that the research design was transparent and there was no attempt to deceive or coerce students into participating. Throughout the recruitment process and then into the data collection period, participants were given the option to withdraw their consent to participate with no disadvantageous consequences for them. I ensured that all participants had several methods of contacting me (telephone and e-mail) and were aware that I was happy to answer any



questions they may have before or after the interview. Two of the three initial respondents returned the signed consent form to me. I attempted several more times to engage with the third student but I was unable to get any further response. As I had initially felt that the benefit of focus groups was to give participants a level of ease that would contribute to open discussion, I wanted the groups to comprise students from the same school. As such, I advised the two participants who returned the consent forms that I would be in touch once I had enough students from that school to proceed with the focus group.

Approximately four weeks after my initial e-mail to the Nursing Schools, I followed up with a phone call to the School. I was able to speak to contacts within two of the schools and explain the context of my research and again request assistance in identifying interested students. As a result of this follow-up phone call, I had three more enquiries from students from two schools. As outlined above, my plan had been to have focus groups of between 3 and 5 students, but in reality I was unable to recruit enough participants to form even one group.

At this point, following discussions with my supervisor, a decision was made to modify the focus of the research, to include experienced RNs working in gerontology areas, as well as alter the mode of data collection from focus groups to 1:1 semi-structured interviews, as explained below. Due to time constraints and the need to move the research forward, I used my professional networks to identify and recruit experienced RNs, on the basis that they had chosen to work within an older adult environment as well as being available to take part. It is not unusual for participants to be chosen, or recruited on the basis of the depth of relevant knowledge and information they can bring to the research (Milne & Oberle, 2005). This change in recruitment and interviewing remained consistent with the qualitative approach; participants' needs can change and approaches to recruitment and population groups should remain flexible throughout the process of data collection to allow for emerging themes to be further explored with appropriate participants (Milne & Oberle, 2005). During data analysis, the researcher may identify areas that warrant further, in-depth exploration on the basis of emerging themes, or, as happened with this study, the realisation that

the original participant group may not be sufficient to fully answer the research question.

## Participants

In the end, four student nurses were recruited from two nursing schools within the metropolitan region. Three of these participants were at the beginning of their final semester and were about to start their pre-registration placements. The other participant had not completed her final semester for personal reasons and was currently taking a semester away from studying with the intention of returning to complete her degree later in the year.

Four experienced RN participants were recruited from within an Auckland region District Health Board. All four held senior nurse roles within a gerontology space. RN participants were chosen on the basis of their clinical expertise in working with older adults, their availability and also willingness to participate.

All participants across both groups were women.

**Table 1: Participant Demographics**

Participant*	Student/RN	Workplace	Age	Year of study or practice
Amanda	3 <sup>rd</sup> yr student	NA	25 – 30	Final semester
Joanne	3 <sup>rd</sup> yr student	NA	20 – 25	Final semester
Kirsty	3 <sup>rd</sup> yr student	NA	20 – 25	Final semester
Tania	3 <sup>rd</sup> yr student	NA	25 – 30	Finished 5 <sup>th</sup> semester
Alice	RN	AT&R	50 – 55	30yrs+
Ellen	RN	GNS	50 – 55	25yrs
Lisa	RN	AT&R	30 – 35	10yrs+
Shelley	RN	AT&R	55 – 59	30yrs+

\* Pseudonyms have been used

## Data Collection

As previously discussed, data collection was initially proposed to be by way of focus groups, comprising between three and five student nurse participants per group. The rationale for focus groups was to promote discussion and the sharing of ideas and thoughts in a supportive environment, to gain a depth and richness of data. Focus

groups are often seen as a way to ensure that different personalities are able to find a place within a group, as the discussion progresses. Often those more confident speakers will encourage less assured participants to open up and tell their own stories as the group develops a more cohesive and supportive feel (Milne & Oberle, 2005).

Limitations of the focus group as a method of data collection are that they can be challenging to arrange as well as to facilitate (Bristowe et al., 2015). This was certainly the reality of my experience as it became obvious, within a relatively short timeframe that I was going to have difficulty in recruiting enough participants from each nursing school to form a focus group. Added to that, was the challenge of retaining those few that I did recruit long enough to identify further participants from the same school. As outlined in the Recruitment section above, by the time I had a second volunteer from the same School of Nursing, I had lost contact with the initial participant. The emphasis on using participants from the same School of Nursing, rather than mixing up the Schools, came from a belief that there would be a level of security from being in a group with students from the same School, that would contribute to the depth of conversation and therefore data.

As this challenge of recruitment became clear, a decision was made to approach the Ethics Committee to get approval to change the data collection method to interviews with individual participants. At the same time, further approval to recruit from experienced RNs, for reasons discussed above, was also sought. Both amendments were agreed by the Ethics Committee (Appendix 1).

While the impetus to change methods was around the unanticipated difficulty in recruiting participants, I also felt that the motivation for using focus groups in the beginning was actually misinformed by a belief that participants would need encouragement to speak up about their experiences. What I found in actuality, from the e-mail communications I had with interested students and a few follow up phone calls, was that those that had made contact, were actually eager to share their thoughts and it did not appear they would not need the support of other students to articulate their experiences.

Interviews are often the preferred method of data collection when dealing with small sample sizes (Doody & Noonan, 2013; Kim et al., 2017). They can include structured, semi-structured and unstructured formats depending on the research design and objectives (Doody & Noonan, 2013). In this case a semi-structured format was chosen to best answer the research question as it meant the interviewer had the capacity to potentially identify areas that seemed important and warranted further attention. There were a set of guideline questions developed but there was the ability to be flexible on the questions and to deviate and explore in more depth, depending on the answers given by participants (Appendix 5).

Interviews were conducted at a mutually agreed time. All student interviews were held within the university campus and RN interviews were at the DHB. Interview times varied between 15 and 50 minutes, with the RN interviews generally lasting longer than the student nurse interviews. This was in part because of the content of the RN interviews, and the nature of their experience, but another contributory factor was the development of interview skills by the researcher from the early, student nurse interviews to the RN interviews which occurred towards the end of the data collection period. At first some of the interviews felt slightly awkward and I found it difficult in the beginning to feel confident in the role of interviewer. This will be discussed more fully in a later section.

All interviews were electronically recorded and then transcribed after the event. Recording interviews is a more efficient way of accurately capturing the participants' intention rather than note taking by the interviewer (Doody & Noonan, 2013). It also allows the interviewer to remain present at all times rather than dividing attention as may happen if trying to simultaneously listen to, develop ongoing questions and write down the information being given.

The number of participants was determined by two factors: the number of responses from potential participants to the recruitment drives; and time constraints. Similar themes and stories were clearly identified within each group of participants, within the four interviews undertaken with each group, and it was determined that adequate saturation had been reached at this point. It is also noted that time and resource

constraints are not an unreasonable factor to be considered when defining a sample size (Thorne, 2008).

## **Data Analysis**

As discussed in the choice of methodology, the aim of qualitative descriptive research is to remain as close to the participant's voice as possible. For this reason a mixed process of content analysis and directed content analysis was used to collate and organise the data into themes focussing very much on keeping the intention and integrity of the data intact. In the initial read through of transcripts, I made comments using post-it notes on anything that seemed interesting. I then grouped these according to common words, phrases or concepts using large pieces of butcher's paper. The process involved a lot of back and forth as I decided what piece of information fitted in to which grouping.

Content analysis is a process where data is analysed and then grouped according to categories where it is assumed that all information included in that category shares a similar meaning (Elo & Kyngäs, 2008). Directed content analysis is a subgroup of content analysis (Hsieh & Shannon, 2005). It is often used where there is already a substantial body of research around a topic, and clear themes have been identified across multiples studies. This approach uses evidence gained from previous research to begin the process of analysis in new research. In this way, directed content analysis seeks to validate or extend existing knowledge. Using themes from previous studies ensured that I was able to group data appropriately based on what was already known from the existing data. There were a number of similarities to current knowledge but I also found that some of the data had a perspective I had not seen previously. This will be further considered in the Findings and Discussion chapters.

## **2.3 Limitations**

Interviewing and drawing stories from participants is a learned skill and one that can be developed and honed over time (Doody & Noonan, 2013). As a novice researcher, I was mindful of the lack of skill and proficiency I had in this area. Listening to my earliest interviews, I became very aware of the tendency I had for filling silences with more questions, often interrupting the flow of the interview, and nearly always

diverting the interview away from the participants intended point. Equally, I realised while listening back to recorded interviews, that I would again often pick up on something the interviewee said and immediately move the interview off topic to explore what I believed was an interesting concept. In effect, this was about me deciding what I considered important, rather than allowing the participant to be the one to decide what was relevant and significant to their experience. This concept is vital to the core of qualitative descriptive research as the main tenet of the methodology is to hear the lived experiences of the participants in their own words.

As the interviews proceeded I did learn to allow for conversational lapses and become comfortable with these silences and see them as indicative of thought gathering, as opposed to running out of words. Listening to, and reading transcriptions of the later interviews, I can see that my interviewing skills had developed from the first few experiences. The general lack of experience on behalf of the researcher undoubtedly contributed to the limitations of the research. For example, while the method of data analysis was certainly the appropriate choice for the study, it must be acknowledged that the process can be challenging for a novice researcher as it is not a prescriptive or straightforward “right” way to do it (Elo & Kyngäs, 2008). Therefore it is inherent on the researcher to continuously reflect on the approach and whether it is remaining faithful to the original research question.

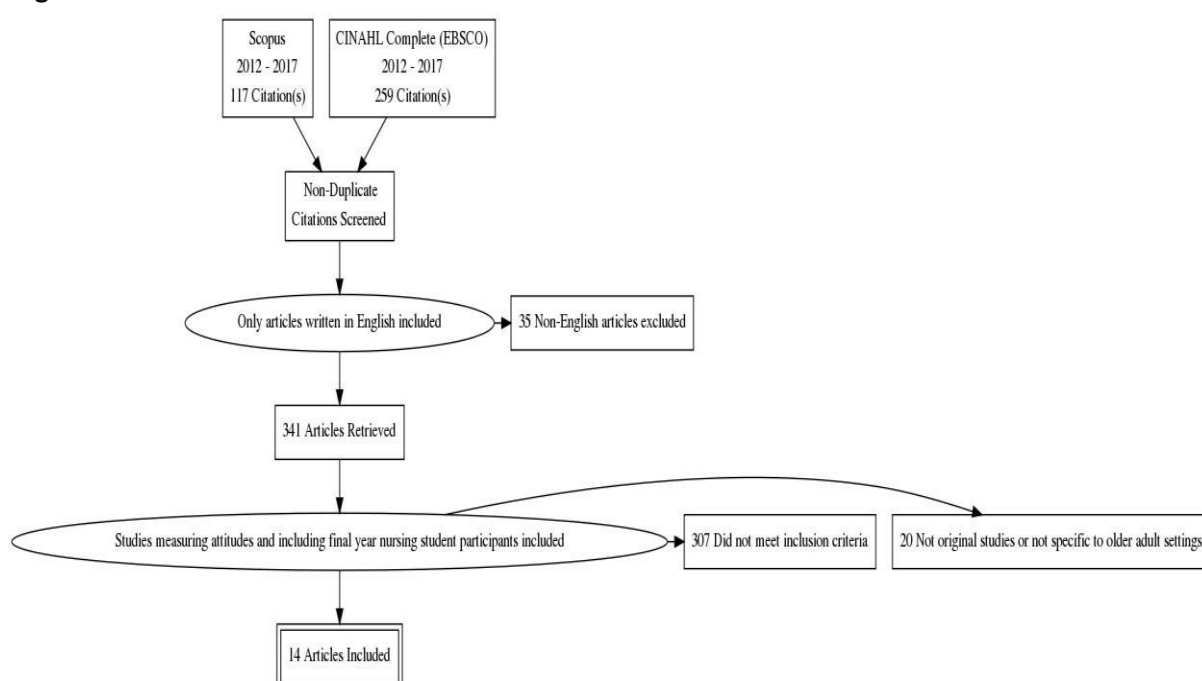
This chapter has described the qualitative descriptive methodology and how the research was undertaken. The following chapter reviews the current literature about nurses’ intentions to work with older adults.

## Chapter Three: Literature Review

There has been a significant amount of research, conducted internationally, that identifies the necessity for specialised gerontology nurses to meet the future population needs, and what factors may influence student nurses when considering their career pathways. This literature review is a summary of the most current research around the topic.

Literature searches were conducted between April 2016 and June 2018. Inclusion criteria included articles published between 2012 and 2018, available in English, participants were final year student nurses (3<sup>rd</sup> or 4<sup>th</sup> year depending on the length of degree course), or were included as participants, original studies only and measuring attitudes not interventions. Journal articles were accessed using the health databases CINAHL Complete (EBSCO) and Scopus. Search terms with Boolean operators used included nurs\*, student\*, geront\*, older adult, attitudes. Article titles and abstracts were initially scanned to ascertain probable inclusion in the review. Further possible articles that were identified as citations in acceptable articles were accessed via the databases and inclusion criteria were applied to assess suitability for inclusion. A total of 14 studies were identified as appropriate to review (See Figure 1 and Table 2).

**Figure 1: Literature Review**



**Table 2: Literature Review Inclusions**

<b>Authors</b>	<b>Country</b>	<b>Methodology</b>	<b>Participants</b>
Carlson, E.	Sweden	Part of a larger quantitative study	224 from one university. 42 final year students
Cheng, M., Cheng, C., Tian, Y. and Fan, X.	China	Cross-sectional survey	916 final year nursing students from seven universities
Chi, M., Shyu, M., Wang, S., Chuang, H. and Chuang, Y.	Taiwan	Cross-sectional research	612 from seven nursing schools. 222 final year students
Gould, O., Dupuis-Blanchard, S. and MacLennan, A.	Canada	Qualitative descriptive	20 third year students from an urban nursing school
Haron, Y., Levy, S., Albagli, M., Rotstein, R. and Riba, S.	Israel	Two stage, first stage focus groups, second stage cross-sectional quantitative	40 in stage one, 20 RNs and 20 final year nursing students 486 in stage two, final year nursing students
Kydd, A.	Scotland, Sweden and USA	Quantitative	1,587 registered nurse and nursing student participants from three countries, recruited from acute hospitals, healthcare setting for older adults, long-term care facilities and five universities.
Neville, C.	Australia	Cross-sectional study	886 student nurses from eight universities 239 final year students
Ozdemir, O. and Bilgili, N.	Turkey	Cross-sectional survey	495 from four university nursing schools 239 final year students
Potter, G., Clarke, T., Hackett, S. and Little, M.	Canada	Qualitative, exploratory descriptive	19 from one school of nursing 13 final year students
Prentice, D.*	Canada	Descriptive exploratory	8 RNs graduated < 3yrs
Rathnayake, S., Athukorala, Y. and Siop, S.	Sri Lanka	Cross-sectional study	98 students from one university 30 final year students
Shen, J. and Dongxia Xiao, L.	China	Cross-sectional survey	622 nursing students from one university 77 final year students
Swanlund, S. and Kujath, A.	USA	Mixed methods	50 students from one university 8 final year students



Turgay, A., Sahin, S, Senuzun, F., Sari, D., Badir, A. and Canli Ozer, Z.	Turkey	Cross-sectional and descriptive	931 from four schools of nursing. 168 final year students.
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\*All participants were newly graduated RNs. Study questions related to experiences as final year students so included in literature review.

All of the research identified as appropriate for this literature review has highlighted that there is a very real, worldwide need to attract nurses to the gerontology speciality due to the increasing ageing population. Additionally, five main themes were identified from the literature, as having significant impact on career choices in student nurses. These themes are: clinical placements; perception of the workforce in older adults; basic skills versus technical skills; impact of education and educators at undergraduate level; and any prior relationships with older adults.

**Table 3: Themes in literature**

	Carlson	Cheng et al.	Chi et al.	Gould et al.	Haron et al.	Kydd	Neville et al.	Ozdemir et al.	Potter et al.	Prentice	Rathnayake et al.	Shen et al.	Swanlund et al.	Turgay et al.
Clinical placements	●						●	●		●	●	●	●	
Perception of workforce in older adult settings	●			●		●	●							
Basic skills versus technical skills				●		●	●							
Impact of education and educators at undergraduate level								●	●		●		●	
Prior relationships with older adults		●	●		●		●	●		●	●		●	●

### **3.1 Clinical Placements**

The importance given to clinical placements, in the development of a positive attitude towards working with older adults is highlighted in several studies (Carlson, 2015; Neville, Dickie, & Goetz, 2014; Ozdemir & Bilgili, 2016; Prentice, 2012). Ozdemir et al. (2016) suggest that the length of clinical placement is the main indicator for a positive attitude towards working with older adults. They proposed that the increased opportunity to observe older adults and develop communication styles that benefit therapeutic relationships, directly relates to the sense of job satisfaction that increases likelihood of working with that population group (Ozdemir & Bilgili, 2016).

The physical work environment is clearly identified as having an impact on the probability of a student wanting to work in that area. Students placed in workplaces that were described as boring, stressful and depressing were less likely to have a positive attitude to working in that environment (Carlson, 2015). Shen et al (2012), Carlson (2015) and Neville (2015) have all identified that following a clinical placement, participants were discouraged from older adult settings, by what they saw as below standard care given to patients, understaffing and low morale from staff that were present, as well as low pay and little chance of career advancement (Carlson, 2015; Neville, 2016; Neville et al., 2014). Prentice (2012) and Neville (2016) further highlighted that students found that the work with older adults was physically demanding after their exposure on clinical placement (Neville, 2016; Prentice, 2012).

A number of participants also note that their older adult clinical placements were in areas that were unprepared for, or did not want, students. This presented as limited ability to influence care of patients, poor preceptorship and role modelling from disengaged staff, and often feeling unwelcome and being excluded from the team (Carlson, 2015; Neville, 2016). Conversely, when students felt valued and witnessed exemplary care from RN colleagues and had support from expert colleagues with specific gerontology knowledge, this increased their belief that there was high worth in the work environment (Neville, 2016; Prentice, 2012). Unsurprisingly, on the other hand, working with enthusiastic, passionate RNs in the older adult setting could definitely make a positive difference to students in identifying the area as an exciting place to work (Prentice, 2012).

Another aspect of the clinical placement theme is the timing of the placement within the undergraduate programme (Prentice, 2012). For several participants, this placement occurred in the first year of the degree programme. At this point in their education, a number of students commented that they had yet to fully comprehend the exact role of the RN. By placing them in a situation where they were often utilised in a health care assistant capacity, this lessened their understanding of what the RN does in this setting and the level of speciality required. Others commented that as the first external placement, the focus was often on learning skills such as assessment of the well adult, or tasks including taking a blood pressure, and less on the population group of older adults (Prentice, 2012).

Other students noted that it often felt like the only reason they were placed in older adult settings was that there was an availability of clinical placements in those areas of practice. Clinical placements in older adult settings often seemed opportunistic rather than deliberate (Potter, Clarke, Hackett, & Little, 2013). This reinforced to some students that nursing schools did not necessarily place any value on older adult clinical placements nor did the schools recognise the importance of developing gerontology specialist nurses.

### **3.2 Perception of Workforce in Older Adult Environments**

The other concept that is regularly linked to the physical working environment in an older adult setting, is the perception that the nursing workforce in these areas is seen as having a lower professional standing compared to other, more acute or technical, areas of nursing (Kydd, Touhy, Newman, Fagerberg, & Engstrom, 2014). Nursing students further reported that they had been advised by tutors and other nurses not to start in an older adult setting but rather “go higher then come down” (A19T, cited in Gould et al., 2013, p. 805), thereby reinforcing the idea that nursing older adults is somehow inferior to other areas of nursing (Gould, Dupuis-Blanchard, & MacLennan, 2013).

The characteristics of nurses working in older adult settings are variously described in the reviewed literature as lazy, unlikely to possess the high technical knowledge required for any other type of nursing, slowing down and at the end of their careers

(Gould et al., 2013; Neville, 2016). This impression, while not always overt, is identified by students during clinical placement and can have a significant impact on how they feel about working in this environment as a registered professional (Gould et al., 2013; Kydd et al., 2014). In one study, participants clearly highlighted the fact that other nurses routinely discouraged them from pursuing a career with older adults as there would not be sufficient challenges or career advancements in the setting (Gould et al., 2013).

There is an impression that, even beyond students, some nurses do not understand that caring for older adults can be a highly skilled speciality, but the skills are not often related to what is perceived as the kind of high tech nursing seen in areas such as ICU or cardiology areas (Kydd et al., 2014).

### **3.3 Basic Skills versus Technical Skills**

Study participants often highlighted the understanding that caring for older adults utilised a more basic set of skills, rather than the highly technical skills used in other, more acute areas of nursing (Gould et al., 2013; Kydd et al., 2014; Neville, 2016). For some participants this difference in skill requirements can be seen as a negative and contributes to their understanding of the area of older adults as boring and dead end as far as career trajectory is measured. There is often a fear that by working in an older adult setting, transferable skills will be lost and the nurse will no longer be employable in any other area (Gould et al., 2013; Kydd et al., 2014; Neville, 2016)

While *basic* was the term regularly applied by most participants when describing those skills needed to work in older adults, it was not always seen in a negative light. Nursing student participants reported that the act of washing or bathing a patient, often presented as an ideal opportunity to establish a trusting connection which in turn increased the likelihood of a beneficial therapeutic relationship being developed (Gould et al., 2013). Additionally, there was the realisation that important assessments around skin and mobility could be done while bathing a patient. It was also highlighted that sometimes even basic cares, identified in the study as communicating with patients, can become complicated by hearing and visual impairments as well as cognitive issues (Gould et al., 2013).

There was also acknowledgement by some of the participants in Gould et al.'s (2013) study that care of the older adult can be complex and does involve technical skills, such as when trying to diagnosis often atypical symptoms and establish medication regimes to manage interacting and incompatible co-morbidities. Also, participants in Potter's (2013) study recognise that one of the challenges of working with older adults can be "...to find a balance of trying to assist them to live a happier life or have a greater sense of wellness, but also supporting them in their desire to move on beyond this life" (p. 451). The students in both these studies, have clearly identified that there is a complexity to nursing older adults but it does not relate to the type of tasks that others perceive to be so important in nursing. This could suggest that those who understand nursing older adults is predominately around utilising basic skills, do not see beyond the science of nursing to consider the art of nursing.

There are often contradictory or conflicting statements identified in the research. For example in Neville's study (2015) while 58% of participants agreed or strongly agreed that nursing older adults is challenging and stimulating, 74% agreed or strongly agreed that working with older people is a dead end job and 71% agreed or strongly agreed that it would be difficult to move from older adults to another nursing job. This is supported by Kydd (2014) where almost equal numbers agreed or strongly agreed to both the following statements: working in older adults could be described as both challenging and stimulating; and working with older people can be very depressing. This clearly illustrates an interesting contradiction in attitudes from nursing students whereby both affirmative and condescending views exist and may be held simultaneously.

In other studies, while students did not necessarily feel negatively towards working with older adults, they just had a stronger interest in working in a faster paced, acute environment (Swanlund & Kujath, 2012). Another factor noted in some studies was the desire to work in an area with better, or more positive outcomes as there was a feeling that there is a lot of compromise with care that comes from working with older adults. There was also acknowledgment that working with older adults can be frustrating as there is often not a full return to base line functionality, either physically or cognitively,

following an acute episode of illness and this can limit job satisfaction for some people (Carlson, 2015).

### **3.4 Impact of Education and Educators at Undergraduate Level**

The reality that students are highly influenced by the practice they witness in registered colleagues during clinical placements is highlighted in a number of studies (Potter et al., 2013; Prentice, 2012). Prentice (2012) found that alongside the importance of clinical placements, was the influence of nursing school clinical educators who support students on placement. More specifically this was the negative impact that educators have on students, and their understanding of the area as a speciality, when these educators were not from gerontology backgrounds. It reinforced to students that there was not necessarily a requirement to have any expert knowledge to work in gerontology, further undermining the idea of it being a speciality area of nursing (Prentice, 2012).

The importance of involving speciality gerontology nurses within the education component of any undergraduate course is seen as a vital part of developing an interest in working with older adults as a registered nurse (Potter et al., 2013). Alongside that, is the potential impact of speciality gerontology modules within the degree course itself (Ozdemir & Bilgili, 2016; Potter et al., 2013; Rathnayake, Athukorala, & Siop, 2016; Swanlund & Kujath, 2012). A number of nursing students highlight the stigma around ageing that is predominant in society. These participants acknowledge that if education on a healthy ageing process was part of the curriculum from early on, these stereotypes could be challenged and potentially debunked (Swanlund & Kujath, 2012).

Potter et al. (2013) report that there is no mandated directive in Canadian nursing schools for the inclusion of specific gerontology content and individual schools are able to decide independently how they will deliver speciality content, if at all. Participants in Potter's study, highlight the gaps they feel exist as a result of the perceived limitations in their education, and report that any education around older adults focusses on chronic disease, cognitive issues and pharmacology rather than emphasising healthy ageing.

Similarly, also in a Canadian setting, Prentice (2012) reports that there was little homogeneity with her participants when it came to whether they had had speciality gerontology modules offered as part of the nursing curriculum. Of her eight participants, two had gerontology components as mandatory in their undergraduate programme, one further student had a module as an elective and the remaining five did not have specific gerontology education. Prentice reports in her findings that a positive educational experience with older adults, during undergraduate education, is one factor that can affect students' attitudes to working with the population group after graduating. In addition, she highlights the importance of a knowledgeable clinical tutor who can work with students on placement, and integrate theory and practice, as well as role modelling expert behaviour, as being equally important in developing positive attitudes.

Other studies support the potential importance of specific gerontology modules being offered at undergraduate level, either as part of the curriculum, or as elective modules (Swanlund & Kujath, 2012). Rathnayake et al. (2016) found no significant difference in attitudes to older adults across academic years, which they attribute to a lack of specific gerontology education. They surmise that if nursing schools were to develop and incorporate modules around older adults, and link these with well supported clinical placements, that this would have a hugely positive impact on how attitudes amongst student nurses, towards older adults, could be improved (Rathnayake et al., 2016).

### **3.5 Prior Relationships with Older Adults**

A number of studies found that any kind of relationship with older adults, prior to starting nursing training, led to a more positive attitude to older adults which in turn increased the likelihood of those participants indicating they may work with older adults once qualified. There were two predominant types of relationships highlighted in the studies: the first one being a familial relationship, often with grandparents, and secondly, previous work experience with older adults, often in aged residential care (Cheng, Cheng, Tian, & Fan, 2015; Chi, Shyu, Wang, Chuang, & Chuang, 2016; Haron, Levy, Albagli, Rotstein, & Riba, 2013; Neville, 2016; Neville et al., 2014; Ozdemir &

Bilgili, 2016; Prentice, 2012; Rathnayake et al., 2016; Swanlund & Kujath, 2012; Türgay et al., 2015).

A number of these studies suggest that there is a cultural component to young student nurse participants feeling an increased positive attitude towards older adults. The concepts of a collective based society with associated filial expectations are explicitly named in one study but supported by several other authors (Chi et al., 2016; Neville et al., 2014; Ozdemir & Bilgili, 2016). Given that all of the studies that included participants who lived with or cared for an elderly relative (parents or grandparents) or had an ongoing close relationship with an older person, noted an increased value placed on older adults by that participant this cultural component may not be the only factor that has an impact (Cheng et al., 2015; Chi et al., 2016; Neville et al., 2014; Rathnayake et al., 2016; Türgay et al., 2015).

In Shen et al.'s (2012) study they found that the first year (which generally correlated with younger) student participants had a stronger positive attitude to working with older adults than any other year included in the study. They hypothesised that this was related to the predominant experience of first year students with older adults was caring for elderly grandparents in the home. In comparison, the participants further on in their degree had actual work experience with older adults in various settings as a result of clinical placements. The reality of working in these settings, caring for strangers versus caring for relatives, may have impacted on their decreased interest in working with older adults as a professional nurse (Neville et al., 2014).

This is in direct contrast to Neville (2016), who found that first year students had less positive perceptions towards working with older adults, than those in their second, third or final years. One suggestion was that more mature students have had more experience and opportunity with older adults, leading them to a more realistic view of what ageing entails (Neville, 2016).

Neville (2016) found that students who had previous experience with older adults were generally more receptive to the idea of working with the population group once they had completed their degree. Previous experience incorporates several components. In Neville's study, only 7% of participants had no experience with older



adults at all. With the remainder of the group, their experience was either related to grandparents or other older family members, in some cases where they lived with the relative or otherwise visited regularly, or voluntary or paid work experience in older adult settings.

Nearly a third of the respondents in Neville's study (2016) indicated that they had had paid work experience with older adults prior to beginning their nursing degree. Of those, the majority had worked in aged residential care facilities (ARC), with the remainder spread across hospital settings, private homes, day care centres and community support providers. Most of these students had had a very positive or quite positive experience in their previous work and this correlated with a more positive perception of working with older adults (Neville, 2016).

The link between constructive work experience with older adults and a positive attitude towards working with them, has a connection with the findings in some research. Namely, that study participants suggested developing relationships with healthy older adults, outside of the healthcare setting, could be a factor in increasing willingness to work in that environment (Swanlund & Kujath, 2012). Although it could be argued that while ARC facilities are not explicitly outside of the healthcare setting, it is still separate to the acute setting. Experiences like volunteering in the community, had a positive correlation to future career choices around working with older adults (Chi et al., 2016). While there was an acknowledgment that negative stereotypes of ageing could often influence the interest in working with older adults, these participants felt that actual experience with healthy older adults, before seeing chronically, unwell older adults on clinical placements in hospitals or other long term settings, would counteract this effect (Swanlund & Kujath, 2012).

This chapter has reviewed recent research in relation to nurses choosing to work with older adults, demonstrating a number of factors influencing that decision. The findings chapter describes and analyses the data gathered with nursing students and RNs in New Zealand.

## Chapter Four: Findings

The previous chapter discussed what the current understanding is from existing literature around student nurses and the factors influencing their choice of practicing in an older adult setting. This chapter presents the themes of by this study, using participant narratives to uncover what has contributed to their own decisions regarding work place options. The analysis uses the student participants' own words to understand what influences have shaped the choices they may make around workplace settings on completion of their degree. This chapter will also include stories from the experienced nurses, already working with older adults, and demonstrate common themes apparent in both groups.

There are two overarching themes identified from the data, they are pre-existing factors and specific factors related to nursing education. Each of these main themes can be further broken down into three subthemes. The first central theme is around the factors that are developed through experiences that occur before beginning any kind of nursing education and the other main theme are the factors that influence decision making, related specifically to experiences had as part of the nursing programme. The first theme is evident in the subthemes of: the impact of experiences as a child/adolescent with older adults; the influence of ageism in society; and the idea of older adults as others. The second theme is apparent in the subthemes of: clinical placements; older adults are everywhere; and the perception that nursing older adults requires less skills than other areas of nursing.

## **4.1 Theme One – Pre-existing Factors**

In the context of this research, pre-existing factors are the conscious or unconscious influences that have been identified by study participants as impacting on their decision to work with older adults. They are the beliefs and values that have been developed over a lifetime, from a variety of life experiences and societal influences that combine with outside or external aspects. These factors are generally entrenched prior to the commencement of any kind of formal nursing training.

The subthemes in this category focus on the impact of having older adults in your life as a child or young person, how societal values and beliefs are inherent in shaping individual views and how this can translate into an understanding of older adults as being different from other population groups. All of these subthemes have very clearly impacted across both participant groups when it comes to deciding whether to work with older adults or not.

### **The impact of experiences as child/adolescent with older adults**

All study participants commented on relationships they had with older adults as they grew up; in all but one case, these were positive experiences. The experiences with older adults were predominately familial relationships (e.g. grandparents), but also in some cases, via professional relationships had by parents, for example Ellen states:

*My mum was a nurse, and she'd worked in older adults, with older adults and we kind of spent a little bit of time with them.*

Another participant Alice, reports that her father's physiotherapy practice was situated in a suburb where *the population was quite mature compared to other areas*. As well as the private practice, her father also visited patients in local rest homes and was often accompanied by his young daughter. Through this experience, Alice had positively reinforced experiences, as a child or adolescent, that continue to inform her attitude towards older adults, through adulthood:

*....the whole time it was the elderly people in the hospitals that gave me the most pleasure.*

Several participants highlighted strong relationships with older family members, including, in one case an older father, as well as grandparents. In the case of the older father, it was this relationship, and his health issues that drew Lisa to the healthcare profession:

*Part of it was with my dad being older and his health needs sort of led me into it.*

Tania, a student nurse participant had had a similar experience with her grandmother being hospitalised when Tania was a child. She remembers helping her grandmother and the pleasure it gave her to be able to care for her during this time:

*Um my nana! Utterly! Um she was in hospital for a bit. Quite a serious condition and I just looked after her, just nothing medically just like those little bits like putting her socks on and just little things that she can't do that would matter to some, like matter to someone like that.*

Only one study participant, Kirsty, reported having no older adults in her life as a child or adolescent. This was secondary to a peripatetic lifestyle (related to her father's employment and then emigration from her country of birth to a new home with no extended family involvement). Kirsty had no interest in working with an older adult population, or geriatrics as she labelled them. She described her feelings towards older adults as being:

*I haven't had a lot of older influence in my life. And then like going to church, there's a lot of old people but I'm too scared to talk to them.*

She then goes on to say:

*....it (they) freaks me out a little bit I guess. They make me nervous...*

This lack of interaction with older adults has clearly lead Kirsty to feel uncomfortable and a little anxious around older adults, which has in turn contributed to her lack of interest in, or intention to, work with older adults. Part of the distress and unease this participant feels around older adults is a belief that they would have higher

expectations of her, particularly around conversations, which she doesn't think would be present with children.

*.....kids, I don't know, you don't.....like I wouldn't sit there and have philosophical, ah good conversation with them, but an old person they just kind of expect that you would.*

It seems an unrealistic understanding that Kirsty has around conversation or discussions as there is no particular reason that the general older adult population would be any more interested in having philosophical discussions than any other population group, including children. Kirsty compares what she thinks older adults would want (good or philosophical conversation) with what she sees is required by children:

*With a kid I'm not going to talk about my life I mean you can talk about their toys and I don't know it's just simple conversation.*

For Kirsty this clear difference in communication needs, between older adults and children, also translates into nursing cares, with her belief being that older adults have different requirements with regards to care versus medical, than children:

*I would say the more caring side is, is more complex with the adults.  
Whereas the more medical side is more complex with children.*

Kirsty was not the only participant who generalised when it came to seeing a difference in communicating or interacting with older adults, although she was the only one who saw this difference from a negative perspective. The remainder of the participants, all of whom had older adults in their lives to some extent, as children or young adults, recognised there were some differences in communication styles. These identified differences seemed to relate more to giving older adults more time to express themselves, or to understand what is being asked of them by the healthcare professional. For example, Lisa identified what she felt were the specific skills required when communicating with this population group:

*Ah listening um yeah and I think just, communicating with them um at, at their level, at their pace type thing.*

Joanne supported the belief that older adults may need more time to effectively communicate their needs:

*...as people with a past with the life that they had and connecting the experiences and, and giving them that time to tell you what's actually bothering them.*

Joanne went on to describe a situation where a patient was not drinking enough fluid, and was showing signs of being clinically dehydrated. She was able to spend time with him, and establish that he was actively choosing not to drink after an earlier incident where he had been unable to get to the toilet in time and had been incontinent. Once this had been recognised, and strategies put in place, the patient was happy to increase his fluid intake and this made a big difference to his health outcomes.

*He started drinking. And he started meeting his hydration quota um, and that was so amazing to see just how such a little thing made such a difference to his health.*

Interestingly, Kirsty differentiated between what she saw as caring needs and medical needs and was then able to apportion different levels of each to the older adult and the child population groups .

She also used what she was been taught at undergraduate level, to support children as having more complex medical needs:

*.....all kids are different whereas most adults their cares are generally similar in terms of medications and that.....we're always taught medications especially with kids is different because of the way they absorb it, it's all of that.*

This understanding of the differences between the two population groups, at either end of the developmental scale is somewhat skewed and is possibly related to her lack of inter-generational contact growing up. There are undoubtedly physiological differences around how medications are metabolised along the age spectrum, there are any number of other factors that influence how medications affect an individual including gender, patient size and amount of muscle, and any other drugs taken. Kirsty

had not, for example, taken into account any of the complexities of drug administration caused by co-morbidities that are more often present in older adults.

Kirsty stated that she had made a conscious decision to work with children for some of the reasons outlined previously, and before deciding on nursing, had considered a career in teaching as a way of working with children:

*I've always said paediatrics um that's pretty much why I wanted to start nursing was to work with kids. I wanted to be a teacher beforehand so that kind of led me on to being a nurse. So yeah kids is definitely my passion.*

Shelley believed that the resilience and problem solving skills that older adults sometimes have, simply from more life experience, are not always clearly understood by younger people. Shelley thought this was especially true for younger people who have had few or no relationships with older adults in their early lives:

*...when you talk to them [older adults] and when you use their resources you think about their ability to problem solve, um, they're better than us. Because they've been doing it for longer but younger people don't view older people like that. And I think particularly young people who haven't had a lot to do with older people ..... might even have stronger views.*

Shelley's own experience with older adults includes a childhood with an unusually high number of grandparents as a result of separations and remarriage. She clearly remembered her grandparents with a huge amount of love and warmth:

*We did lots of things with my grandparents. We used to go and garden at my grandfather's with my father. Um, I can remember my grandmother with the three of us in her bed, a single bed, you know those kind of very loving relationships with my grandparents.*

Shelley has worked with older adults for over three decades and acknowledges that her interest in older adults stems from her positive childhood experiences:

*...[grandparents] were a very important part and I know about older people from that.*

The lack of familiarity with older adults, as seen in Kirsty, is not seen in any of the other participants who, to varying degrees, have all had positive experiences with older adults in their younger years. It may be that with little exposure to older adults during her formative years, Kirsty's understanding of what it is to be an older adult is largely informed by images and stereotypes seen in mainstream media which I will explore in the next section. While this has not necessarily translated into a definite idea of working within an older setting for all of them, it has also not seen any of the other participants being quite as strong in their rejection of this population group as Kirsty was.

### **Ageism in Society**

As shown in the previous section, attitudes towards working with older adults can be formed by personal exposure, or lack of, to older adults. Another factor that appears from the data to be as meaningful in influencing decision making is the impact that society has on defining what we understand an older adult to be. The idea that perceptions of what it means to be an older person are developed as a result of what is seen in the media, or commonly held populace opinions are threaded through the data. Ageism and stereotyping of older adults is often acknowledged, in some cases overtly, as with Lisa's comment:

*I think that society is really ageist and I think that really influences um yeah how people view and value older people.*

In other cases, for example Kirsty, her observations are often inadvertently ageist, for example when she dismisses an entire population group without acknowledging that there are any number of differences in older adults as there are with any other population group:

*I didn't like old people.*

Kirsty also routinely described the older adult population group as *geriatrics*, a term that is rarely used in modern healthcare settings. It could be that this was her way of



depersonalising a population group that she already had preconceived (negative) views of. By rejecting the use of the more individual term of older adult, it feels like Kirsty has covertly emphasised her dismissal of the group as a whole.

This sense of grouping individuals based on their common age, was commented on by Alice, an experienced RN, who saw this on her ward when some staff attributed a set of characteristics based on an assumption that all 80 year olds are the same:

*I think they see 80 and that's, yeah that's..... that resounds with, with all medical personnel. You know it's pretty much oh you know they're 80, that's it.*

Alice believed these assumptions were ageist and not complicit with an understanding of individuality that extends throughout a lifetime, and was based on life experience and world views that do not end at a particular age or stage. Alice articulates the view that:

*.....you can't just put an 80 year old man in one box and every, everybody else fits that bill.*

Amanda agreed that there is often an assumption that all older adults are going to be a certain way as they age:

*I think that they get a little bit um, depersonalised as they get older, they get written off as confused or they don't know what they're talking about, they're past it.*

Both Alice and Amanda's points counteract the idea of older adults being objectified as can be seen from comments in the previous section around older adults as others. Both Alice and Amanda made positive comments regarding older adults and it may be that their ability to see older adults as individuals relates to more positive attitudes:

*.....but the whole time it was the elderly people in the hospitals that gave me the most pleasure. [Alice]*

*Their lived experience is you know worth something. [Amanda]*

Joanne clearly expressed the belief that society values the working ability of the individual and therefore devalued the older adult at the end of their working life. Although not explicitly said, it feels like Joanne saw this devaluing of older adults by society, as transferring to a devaluing of the nurses who may choose to work with the older adult population:

*Because at the moment as a society we put price on people in terms of their working abilities and how much they can contribute through full time work. And so we often disregard older adults because they are no longer in the work force.*

Further to how older adults are seen by society is a perception of how they present as inpatients in secondary institutes, or as residents in aged residential care. It is that perception that is often seen as a barrier to inspiring new RNs into the gerontology speciality.

Lisa sums it up as:

*.... it's the connotations associated with older adults you know like confusion, cognitive impairment, challenging behaviours and I think that puts a lot of people off.*

Shelley went further by suggesting that the first impression of many older adult wards reinforces the undesirability of working in this environment:

*I walk on to the [rehab] wards I think just think oh god what does this look like? Do you kind of, do you know what I mean? That you, there's lots of older people in beds with, and it's hard to sell that as anything other than it is, you need to get in there and talk to the people before it looks anything other than wrinklies lying in bed.*

Shelley highlighted the importance of not taking the environment at face value. She believed that taking the time to look beyond the superficial, and talking with the patients, is the key to overcoming the negative impressions:

*I think that um yeah showing people the kinds of interactions that you can have, showing other nurses, with older people is really important. Makes them kind of realise that oh, I can [do it]*

Lisa also felt that the perception of older adults is often based on ignorance or a general lack of understanding of them, and is a reason that new nurses do not actively choose to work in older adult settings:

*I think it's um lack of awareness or lack of understanding of older adults and I think that's why people choose not to.....[work in older adult wards]*

There was a clear message from participants that they felt that the media often contributes to the idea that older adults are less than their younger counterparts. As one participant, Ellen, stated

*You don't have television programmes that show you how cool it is to look after old people.*

Another comment made was:

*I think that there's lots and lots of ageism not um on purpose but I think that you know the media, the socially we think of older people as being different from what they are. [Shelley]*

Shelley went on to comment on how older adults can be perceived based on how they are portrayed in the media or other societal influences.

*So I think that society is really ageist and I think that really influences um yeah how people view and value older people yeah. Yeah.*

To overcome this barrier, Shelley highlighted that in her work with new nurses she emphasises that older adults are not different from younger patients, when it comes to their emotional needs or unique personalities. In other words, that older adults are as diverse in their differences as any other population group.

*.....it's like the new grads that, that come through AT&R and I say to them, in a jokey way um, don't you ever forget what you learned here!*

*And the relationships and I guess trying to show them that you can have the same kind, kinds of conversations with older people that you have with younger people. You know it isn't.....you know they laugh, they do the same things as everybody else does.*

There is a strong perception from the participants that despite their individual experiences with older adults, society as a whole does not portray older adults in a meaningful or positive way. This suggested that even before considering the older adults setting as a worthwhile or desirable place to work, student nurses somehow needed to understand how their views of the population group are already formed and influenced by the meaning imposed on older adults by society.

### **Older Adults as “Others”**

Strongly linked to the theme of ageism in society is the idea that older adults are somehow a separate species of human, be that more special or just different, rather than adults who have lived a longer time than others. This is apparent (and perhaps not unexpected) when looking at the data collected from student nurses. More surprising was that the sense was also equally clear when evaluating the information from the RN participant group.

A concept that was repeated throughout the data was that all older adults always had life experience and interesting stories to tell. Many participants talked about how older adults had stories to share of that life:

*It's their life experience and the fact that they're willing to share. They're willing to teach. ....that there's just a myriad of experience they have. They impart knowledge to you [Alice]*

*I like elderly people, they've got really interesting stories. [Amanda]*

*I like older people, they've got a story to tell. [Ellen]*

*....because they have so much experience, so much life knowledge. [Joanne]*

Other comments were around how special older adults were, simply as a result of having been alive for a longer time:

*For an old person you know it's a privilege to get to 90 and they've done it and you kind of should celebrate it. I guess there's a certain amount of they're at the end of their life, and they've obviously lived really good rich lives. [Ellen]*

*I actually really enjoy older population I think they're fantastic. [Joanne]*

While these quotes may appear they have a positive viewpoint, this kind of objectification does reduce older adults to a stereotype. Like any population group, some older adults will have led interesting, rich lives (by their own standards if no-one else's), but equally many may judge their own lives as unfulfilled or unsatisfying. To attribute all these generalised qualities, such as a full life, and interesting stories, to all older adults, negates the realities of older adults being another population group with as many, if not more, variances and differences as any other group. An assumption that all older adults are a particular way, could obscure a real need for emotional and/or psychological support that could otherwise be part of nursing care.

This sense of otherness is echoed by Kirsty who has already identified that she wants to work with children once she has qualified. Kirsty clearly divided older adults into a separate, almost alien group, particularly when relating them to children:

*With a kid I'm not going to talk about my life I mean you can talk about their toys and I don't know it's just simple conversation. Yeah compared to I think the more adult conversation with ah, with the adults.*

Kirsty is not clear by what she thought adult conversation entails, only that it was not as simple as conversation with a child would be. When she related conversation with a child being as easy as talking about their toys, Kirsty seems unable to see that toys could be a metaphor for any material object that all age groups acquire. For example a conversation with a toy for a child could easily be transferred to an ornament or a family photo on display, for an adult. Kirsty's sense of adult conversations is based on

an assumption that an adult is other and as such, she will have no way to initiate an interaction because of the perceived differentness.

Older adults as others is clearly linked to both the previous subthemes. It seems that the subversive message given by society, via media including television, films and print media, can be balanced out or negated by positive personal experiences of older adults. Conversely, it appears that in the absence of any involvement with older adults, such as with Kirsty, the concept of older adults as others is not only present, but in fact is reinforced.

## 4.2 Theme Two – Specific Factors Related to Nursing Education

In the context of this study, specific factors related to nursing education are identified as those factors that have been influential on decision making, as a direct result of starting an undergraduate nursing degree. In this case, the subthemes have been identified as the clinical placements undertaken as part of the curriculum, the acknowledgment that older adults are a population group common to all adult areas of nursing, and finally the perceptions held by other nurses of those who choose to work in older adult settings.

### Clinical Placements

Clinical placements are seen as both a highlight and lowlight by the student nurse participants. The impact and influence of undergraduate clinical placements was highlighted throughout the interviews by both the student group and experienced nurses. When the placement went well, there was clear link with a positive attitude for that area of nursing. The physical ward or area that students were placed in, and whether they had much say or choice in this, seems to have an influence on whether the placement was a positive experience or not. Amanda requested a hospice placement twice during her undergraduate course, and was successful the second time. She had expected it to be a great experience and it was.

*I had requested it twice and it's like if I haven't already been picked for Hospice pick me.....I'm probably going to put my name down for hospice again because I've really just, blossomed in that placement.*

On the other hand, a bad experience on clinical placement has the ability to negatively impact the decision to work in that area once graduated. Joanne had a particularly damaging experience during a placement on an older adult rehabilitation ward. This ward uses an Early Warning Score (EWS) which is a numerical system used to indicate a deteriorating patient on the basis of abnormal parameters for vital signs. Following an assessment on a patient, including a complete set of observations (heart rate, temperature, respiration rate and blood pressure), Joanne recorded the EWS as a 0, i.e. a stable patient. The patient's actual EWS was 5, which indicated an unwell patient,

with the potential to further decline. Joanne acknowledged several factors that led to her mistake, including tiredness, recovering from illness and it being a busy morning shift but she also states that she attempted to alert her RN preceptor on the ward, to the possibility of the patient being unwell on the basis of how he looked and sounded, despite the (incorrect) EWS score of 0. Her concerns were dismissed by the RN but the patient was later found to be seriously unwell and Joanne's practice was called into question.

*And so in the end I got called into the charge's nurse's office and pretty much got told that I could have killed a man which elicited a very strong emotional response..... I did communicate my concerns with my preceptor and I was very concerned for, for the gentleman..... I'm really concerned can you please go check him. But he just brushed me off.....*

This episode highlights both the potential undervaluing of student nurses by RNs and the over reliance of an EWS as the sole indicator of a deteriorating patient. Had the RN respected Joanne's opinion that the patient sounded and looked unwell, he may have reviewed the patient as requested, despite the EWS being 0, realised a mistake had been made and appropriately escalated the situation. As none of this was done, Joanne was left feeling overwhelmed by the situation and totally unsupported by her preceptor.

Kirsty felt similarly undervalued while on placement in a rest home when she was unable to speak up about patient cares she witnessed, as she perceived staff did not respect her knowledge or skills as a student nurse:

*As a student nurse they looked down on you even more because they think you're too big for your boots so you can't say anything.*

Kirsty also commented that her position as a student nurse made it very difficult to know how to speak up to make any kind of impact on patient care, within a ward or unit:

*As student nurses how we feel we don't, we don't know what to do or say to make a difference.*



This is supported by Joanne who found that other issues she experienced on her rehabilitation placement, made her to decide it was futile to even try to raise any of her concerns with staff. Joanne felt she had the confidence to raise her concerns but she was rarely listened to and very few changes were ever made to nursing care as a result of her input. She found it became increasingly frustrating and ultimately counterproductive to even try to instigate change so she eventually gave up:

*....trying to make some sort of change because I've always been that sort of trail blazer in terms of change it just, I felt like it, kept hitting, hitting the ceiling.*

A further aspect of Joanne's experience on her clinical placement was a sense of being let down by her RN preceptor. She had a palpable sense of injustice related to the event described above and in particular, by having the blame shifted on to her by the RN. She was left feeling frustrated and angry about a situation that she felt powerless to change or control. The experience continues to distress her and in her mind, is still very much unresolved:

*I was quite, quite um, frustrated that the, the nurse, the preceptor that I was with, shifted the blame onto me because he met me after the conversation I had with the charge nurse and the resus team and told me that, oh you know you should have ah, you should have come to me and told me the score you know, you made the mistake of not um, checking the score or something like that...*

Joanne further describes the incident as:

*.....leaving a bad taste in my mouth.*

She cites a lack of support from the Charge Nurse Manager as being a further contributing factor in feeling let down and disappointed in the placement:

*I felt so unsupported um, that I just, yeah I just didn't want to come anywhere near it afterwards.....tried to communicate with them and I tried to tell the Charge Nurse that you know that wasn't good enough.....*

.

Added to that, was the reaction of her clinical tutor from the nursing school:

*My own clinical educator also focussed so much on what I've done wrong and the fact that I haven't contact, contacted her immediately on that day, um I was just so lost and just I didn't know what to do and where to go. And so she sort of suggested that it was all my fault and I need to look at my practice.*

Joanne clearly felt that there was no-one on her side in this situation and although she goes on to say that she enjoyed the experience of working with older adults and developing ongoing relationships with the patients, that this incident and feeling so unsupported in the aftermath meant she was no longer considering older adults as a career option. Conversely, a hugely enjoyable placement at an acute mental health inpatient unit had led her to a probable decision to go into mental health nursing once registered as well as reinforcing the unlikely option of working with older adults:

*My final one was at the [name of unit] inpatient unit at [larger city] Hospital which I immensely enjoyed.*

Joanne's experience on clinical placement was at the extreme end of experiences described by the student nurse participant group and as such has dominated this section. It is however, a very strong example of how an experience in the real world of nursing can have such a significant impact on decision making, with Joanne clearly disregarding older adults as a potential area to work in as a result of what happened to her.

The RNs, HCAs and other staff working in older adult areas have a huge impact on how student nurses perceive the benefits or disadvantages to working in these areas. Kirsty felt that the nursing workforce in older adults was on average older than their counterparts working in medical areas:

*I found that people who work in geriatrics [sic] are usually older like maybe in their 40s, maybe 30s upwards, whereas people who work in medical are younger.*

As a younger nurse herself, she had a preference for working with her own age group. Beyond this perception of the aged workforce, student nurses often saw collective issues with ward staff including lack of care and compassion, as well as what they perceived as below standards of nursing cares.

*....actually witnessed a lot of bad practice um and I'm all for dignity of patients and seeing how they were treated like, practically cattle in the morning, trying to get them to shower and so forth, it just broke my heart. [Joanne]*

This could be attributed to the mismatch between perception of practice and the realities of life on a busy ward. It may be that the student nurses have an idea of what they believe excellent care should look like and how it should be delivered that is at odds with what is seen in reality. There is a clear sense of disappointment from the students when care is not delivered as you understood it could be, should be and would be.

Other observations included the fact that it looked like staff no longer wanted to be working in the area and were just going through the motions. A comment made by Kirsty was around the standard of care being delivered and how she felt it did not align with her values or was good enough:

*I couldn't be a part of a team like that and I felt like I couldn't make a difference. So I just felt the care that older people, is not what I would like it to be.*

Kirsty did consider the notion that she should be thinking about being part of a change of practice if that is the reality but without much enthusiasm:

*.....and you would probably say, well you should be there and make a difference.*

Alongside the less successful experiences of some participants with RN preceptors, there were individual RNs who role modelled the positive aspects of practice that was held in high esteem by the students. Joanne commented on one nurse:

*I think I had one nurse that I was with and she was quite lovely she was a Filipino girl [sic] and she was literally the only nurse in the four weeks that took my concerns about the [EWS] score seriously.*

Her use of the terminology “lovely” is interesting as it is not clear as to what made her lovely and whether this is related to her practice or the fact that she took her student nurses’ concerns seriously. Joanne also made the following comment:

*We had two wings and I was on the more unfortunate wing with all the sort of unpleasant nurses.*

Again with the use of a term like “unpleasant”, it is not clear what this means to the student. It could be related to the nursing practice of the RNs in the wing or how they treat their colleagues or patients.

Tania is clearer in her description of an RN she admired, that it was her practice in advocating for patients, and her treatment of them that earned her respect:

*.....she was yeah one of the best RNs there, and all of the patients just loved her and she was just really good with all of them and advocated for all of them.*

Compassion was frequently highlighted as a fundamental concept relating to nursing and it was mentioned several times as being lacking in some of the staff in the older adult placements. For example, Kirsty found a rest home placement particularly difficult due to how some of the staff treated the residents, which Kirsty believed showed a lack of compassion for patients with cognitive impairments such as dementia:

*....they were very hard towards the old people and I always found that because of um illnesses like dementia where people forget things, they treat them like second class citizens.*

Tania agreed that sometimes care was less than ideal, especially around cognitive impairments:

*A lot of them [patients] had dementia or Alzheimer's or just a lot of cognitive um problems and they [nurses] just sort of, rushed them.*

Kirsty also commented that in one of her older adult clinical placements:

*....I just found the nurses had lost empathy*

This concept is often labelled compassion fatigue or burnout and is echoed by Ellen and Shelley, both experienced gerontology nurses. They both commented that at times in their careers, they have needed to leave the older adult environment to experience other areas of nursing. Neither of them specify that the break from older adults was directly related to losing compassion for the patients, although Shelley talks about decreased enthusiasm and Ellen felt over it, which could be ways of describing the phenomenon of compassion fatigue.

*I had felt that I needed to have a break. That it's quite physically and emotionally demanding looking after older people. And when I found that I wasn't really enthusiastic, I would go away and have a break.*

*[Shelley]*

*Kind of got over that [older adults] a little bit and I went back into acute care so I went to acute orthopaedics. [Ellen]*

The fact that these expert nurses recognised the need to take a break from a physically and emotionally challenging area of nursing yet consistently return once recharged could mitigate the burnout witnessed by the student.

Another core concept consistently reiterated by participants was the importance of connecting with older adults, to move nursing care beyond tasking and into a holistic realm. Many of the participants felt that being able to form relationships, or make connections was a strong positive component that they saw during their older adult clinical placements. Tania felt that during her older adult placement she worked in an environment where the concept of holistic nursing was practiced very well:

*....their whole wellbeing together not just like here's your medicines to keep you alive for a couple whatever, it's actually what can we do to sort*

*of keep you mentally going, physically going and all of that which I really loved about that place.*

The time and space to form therapeutic relationships in older adult settings is reiterated by experienced RN Shelley. She compared the nature of relationships in older adult setting to those in a surgical ward:

*It's really meaningful for me to have those relationships and help them make those changes rather than just um, the quick surgical interventions.*

She also discusses that it is these relationships that enable her to feel she is making a real difference to a patients' outcome, and that working in the older adult setting was the first time that she had seen this:

*....that the relationships that you developed with patients often made a real difference to their outcome and that happened more in the area of [rehab] nursing than I'd experienced in others.*

Alice, a senior nurse participant felt that some of the overseas trained nursing staff in older adult rehabilitation were only there to get a foot in the door and were not overly interested in working with older adults nor forming the kind of meaningful relationships that others have identified as being core to their own nursing philosophy. She commented:

*Some are quite task [focussed] they get the job done quickly and they look to be efficient and good, um but actually they're missing out because they're not having that connection.*

Clearly, the kind of experience that student nurses have on clinical placements can have a huge impact on how they view that area as a place to practice once registered. For some, it is the physical aspects of the workplace, including the environment and heavy workload that impacts on the likelihood of choosing an older adult context. Seemingly more important though, is the effect of the existing workforce, mainly RNs, that will have the biggest influence on deciding to work with older adults or not. Feeling valued and seeing a workforce that respects the older adult population are significant to developing a positive impression of the setting.

## Older Adults are Everywhere

The importance of nurses with expertise in caring for older adults is highlighted numerous times by the RN participants, across all areas of nursing, not just older adult specific areas such as assessment, treatment and rehabilitation wards. Older adults are identified by the RNs as an already a significant population group across most health areas, secondary, primary and community. Lisa made the following points:

*The population is getting older so no matter where we go in nursing there's always going to be older adults.*

Lisa goes on to reiterate that regardless of where an RN is working, the reality is, that they will need to have the kind of speciality skills required for looking after older adults:

*I think you need to be able to have the skills to care for older adults no matter what career path in nursing you choose.*

Ellen and Alice, both experienced RNs working with older adults, also agree that the need for skills in nursing older adults is relevant whatever area you are nursing in:

*When you look at our population and our demographics, everybody needs to be a gerontology nurse. [Ellen]*

*Older adults is for me is.....we're going to nurse them at everything. [Alice]*

Ellen goes further when she talks to student or new nurses and tells them:

*Our health system's full of old people, it comes with this demographic, everybody is and I teach this and they all look at me and I stand in front of a class and I say so who in here is a gerontology nurse and they all look at me. And I say, and who works in a hospital? And I get a few hands up. Who works in the community? Few more hands up. Who works in what and they all put their hands up and I say you're all gerontology nurses,*

*people live in the community, they come into hospital, they're in primary care, every single one of you needs to be a gerontology nurse.*

This observation is clear across the experienced RN group, but only one of the student nurses, Amanda, acknowledges the reality that older adults are across all areas in the health system. Amanda talks about her clinical placement experience in the community and remarks:

*....um I guess it's just the nature of health, that you will see mostly elderly people.*

Tania, a student nurse, talks about gaining some general knowledge and experience in an inpatient setting before eventually working with older adults at a later stage in her career. Tania does not acknowledge or recognise that working in an adult inpatient setting, she is very likely to find that a majority of her patients are older adults anyway:

*Yeah I think just, I think just sort of, get my foot in the door, get that sort of broad knowledge of caring for a whole lot of different um, problems and patients.....I would like to go into elderly one day.*

It is clear that the experienced RN group, understand the reality of nursing and acknowledge that there is a need to have nursing skills for older adults regardless of the setting that you are nursing in. What is less clear, is whether the student nurse group have a similar understanding and if so, how prepared they are for the actuality of working with a population group with speciality needs.

### **Lesser Skills or Different Skills?**

The concept of different skills was raised by several participants, and in Ellen's case, she felt this was around not just different skills, but actually was seen by other nurses as skills of less value. For her, nursing older adults was often seen by colleagues as the easy option if you were unable to nurse in more acute areas.

*....yeah that's always kind of been my perception is that people think it's, that's where nurses go to because they can't cope everywhere else.*



She further commented that to her evident surprise, she is often asked if her ward (an older adult rehabilitation ward) was able to undertake some types of reasonably common nursing interventions:

*.....those perceptions still pervade today you know I still get asked um, can Ward [older adult rehabilitation ward] do IV antibiotics? Those kind of things. I'm like really? Um really?*

Kirsty talks about spending time on a stroke rehabilitation ward and the repetitive nature of the nursing, with seemingly no understanding of the differences conferred by nursing unique individuals. Her perception seems to be that the nature of looking after a patient following a stroke will always be the same, regardless of any other factors that may have any affect:

*.....just so repetitive and it was the same thing over and over again.*

Kirsty follows this up with a comment around the repetitive nature of looking after other older adult patients, and again concludes that all patient presentations of a similar type, will be nursed the same way:

*...it's mostly the same thing I found like it's mostly dementia or Parkinson's, stroke definitely. So things like that that I just found was a little bit repetitive.*

Lisa, one of the experienced RN participants acknowledged that there can be a perception amongst other nurses, that nursing older adults could potentially have an impact on decreasing nurse skills. She believes that there is no deskilling when nursing older adults and in fact other skills need to be more strongly developed to be effective:

*You still get those skills and the skills are still in hand so I don't think you become deskilled. If anything you become more aware of it and it's not just um about those skills it's about communication, understanding, I think you get a real good understanding of, of those skills as well that are needed for working with older adults.*

Contradicting this, and outlined in the section on clinical placements above, is the fact that two of the experienced RNs acknowledged the need to leave the older adult environment at times during their careers. Both Ellen and Shelley recognised that they were feeling emotionally and physically drained after working with older adults for some time, and the solution was to leave the ward or unit and work in another area until such time as they felt ready to return to their preferred area of nursing. This would seem to challenge the perception that working with older adults is not complex. The fact that both Ellen and Shelley are drawn back into nursing older adults, after periods away, should be seen as a positive by student nurses.

It is obvious from some of the comments made, that nursing older adults is often underrated by other nursing colleagues who see it as less technically challenging than other areas. However, the experienced nurses who were part of this study, who work in the older adult settings, clearly recognise that different skills are often employed when working with older adults, but that the nursing itself is no less complex. The influence exerted by substandard clinical placements, combined with the opinions of nurses outside of the older adult setting must contribute somehow to the inability to attract new nurses to the area.

This chapter has outlined the findings from the research data and categorised them as: *pre-existing factors*; and *specific factors related to the nursing education*. Each of these themes has been further defined by a set of subthemes. Having defined what factors influence nurses' attitudes towards working with older adults, in the next chapter I discuss the implications of the findings and compare them with what is already known and suggest some recommendations for practical application to improve the interest of new graduate nurses in working in the older adult setting.

## Chapter Five: Discussion

As described in the previous section, there were two main themes that came through in the data that were clearly important to the participants. The first was the *pre-existing factors* that participants develop over the course of their lifetime through experience and exposure. This theme was made up of how and why older adults are perceived in a certain way; what impact ageism in society has on student nurses; and then how this can present as viewing older adults as being “others”. The third subtheme is around the impact of having older adults in your life as a child or young person and what influence this can have on your decision to work with them in a professional sense.

The second distinct theme looks at how *specific factors arising from nursing education* can impact on the decision to work with older adults. This includes the subtheme of how and why clinical placements can affect decision making in student nurses. The theme continues to develop with the observation that older adults are everywhere in the health system so what this means for all nurses about understanding specific concepts around ageing. The final aspect of this theme is concerned with the idea that the skills needed to effectively nurse older adults may be lesser than for other population groups.

In this chapter, I will look at how these themes, and the related subthemes in each category, share similarities and differences from existing knowledge and the implications and recommendations for nursing education.

### 5.1 Pre-Existing Factors

The subthemes in this category, the impact of experiences as a child/adolescent with older adults, ageism in society and older adults as “others”, are all represented in the literature.

Ageism, like any of the “isms” refers to the act of discriminating against a group on the basis of the characteristics of that group, i.e. in this case, treating people differently because they are aged over 65 years (Organisation, 2014). The concept of ageism

overlaps both the subthemes of ageism in society and the perception of older adults as “*others*” as both are ways of viewing people as a homogeneous group, rather than as individuals with age as the only definitive commonality.

The treatment of older adults as different has a long history in Western (and other) cultures (Kagan & Melendez-Torres, 2015). For instance, there is some evidence of Neolithic populations abandoning their elderly members once they were no longer physically able to keep up with the majority of the tribe (Butler, 2009). The origins of modern ageism may be traced back to the demise of agricultural based productivity, in favour of an industrial based economy, where for the first time the majority of employment was now conducted outside of the home. Until then older men, who often owned the land that produced a living for families and communities, were valued as the holder of knowledge and experience that had previously contributed to the ability of the group to adapt to changes and ensured the survival of dependents. As the emphasis moved away from working on the land, older adults lost their elevated status as their ability to work decreased and their wisdom was no longer required for survival. Older adults came to be seen as a burden and ageing was now associated with an inability to contribute in meaningful ways to society (Butler, 2009; North & Fiske, 2015).

The viewpoint that ageing is associated with illness, loneliness, loss of physical and cognitive function, seems to be a predominately Western concept of a problem that cannot be fixed (Hanson, 2014). In a number of studies undertaken within other cultural groups, including China, Taiwan, Turkey and Sri Lanka, the cultural value of collectivism seems to result in a lesser level of ageism seen in participants in those studies (Cheng et al., 2015; Chi et al., 2016; Ozdemir & Bilgili, 2016; Rathnayake et al., 2016; Türgay et al., 2015). This is further supported by Usta et al. (2012) who found there was a strong correlation between decreased levels of ageism and those who lived with older family members as is normal in some cultures including Turkish culture (Usta, Demir, Yönder, & Yildiz, 2012).

Usta et al. (2012) suggested that one reason for the decreased level of ageism seen in their study, was that by living with older adults they were not seen as “*others*” but as a diverse and varied population group like any other age group. This is certainly seen in

the findings of this research where the affection and respect for older family members can be seen clearly in the stories of several participants. Shelley, an experienced RN participant, was particularly close to her grandparents and talks about them with a genuine warmth and love which has contributed to her enduring and ongoing desire to work with an older adult population.

Within a Western cultural context, a number of studies support the finding that personal experience with older adults had more influence than theoretical knowledge when it came to interacting positively with the population group (Hirst & Lane, 2016; Neville, 2016; Prentice, 2012). This aligns with the findings of this research wherein participants who had experiences with older adults as a child or adolescent had a more positive overall view of older adults in general. In some cases this manifested as a desire to work with older adults, particularly with the experienced RN group.

According to Sarabia-Cobo et al. (2015) the stage of old age is frequently defined in one of two ways: either from a positive paradigm of wisdom, influence and worthy of respect; or from a perspective of ageing as a deficit with significant physical and mental deterioration that is irreversible and undesirable. In my findings, the sense of “other” of older adults was almost exclusively positive with older adults being variously described by the participants as “*grandfatherly*”, “*kind and helpful*”, “*fantastic*” and “*so much life knowledge*”. This sense of older adults as “*others*” as identified in the study findings is essentially another facet of ageism whereby the group is regarded as homogeneous and represented on a whole as interesting with rich life stories to share. Whether the stereotyping is presented in a positive or negative context, the net effect is the same: discrimination based on a single characteristic, in this case age, which can lead to behaviours by caregivers, that are not helpful or holistically therapeutic (Sarabia-Cobo & Castanedo Pfeiffer, 2015).

Beyond the inherent unfairness of judging an entire population group on the basis of one shared characteristic there is a concern that unrecognised ageist attitudes can impact on the quality of care given to older adults in the acute setting (Moyle, 2003; Phelan, 2011; Sarabia-Cobo & Castanedo Pfeiffer, 2015). Moyle (2003) suggests that if some nurses see ageing in terms of a natural decline in function and ability, both physical and cognitive, they are likely to see little benefit in encouraging health

promotion as the perception is that decline is normal, inevitable and irreversible. This is seen by Alice, an experienced RN participant in this study, in her personal observation that other healthcare professionals often see an 80 year old and base their medical decision making on the age of the patient, without consideration for any other factors. It is argued that when people are grouped together by one common feature, then an assumption is made that that their experience of everything will be the same. This perception removes the individual and holistic approach to nursing (Hanson, 2014).

There are a number of unhelpful behaviours seen when ageist attitudes manifest in nursing cares. This includes nomenclatures that infantilise individuals such as “love” or “dear” used by healthcare professionals when addressing older adult patients (Potter et al., 2013). Another example is the inappropriate and unnecessary use of patronising, childlike speech, to communicate with a patient with a level of hearing loss. Other nursing behaviours that are influenced by ageist attitudes include assuming older adults will need assistance with cares, without asking or discussing it with the patient (Hanson, 2014; Kagan & Melendez-Torres, 2015; Potter et al., 2013). Hanson (2014) goes further to say that when older adults are automatically treated as fragile and requiring increased support for cares, whether that is accurate or not, this compromises independence and autonomy for older adult patients.

Ageist attitudes develop over time and are affected by life experiences, cultural background, values and beliefs, some of which we absorb from the world around us (REF). There is an assumption that as individuals we all possess the freedom of thought and ability to interpret and understand the world around us based on our own perceptions and values. It is impossible however to separate the impact that external factors have on the early formation of our attitudes and beliefs, including how the media choose to portray older adults (Moyle, 2003; Phelan, 2011; Whitfield, 2001).

In Moyle’s (2002) study into how older adults are portrayed in film, participants were equally split as to whether a movie featuring an older adult couple as the central romantic characters would be a hit across all audiences. Although 50% felt it could be popular, this was on the proviso that the intended audience was also older adults, as it would be unappealing to a younger audience. The main reason given for this was the

belief that older adults are considered either asexual or sexually unappealing in a society that measures sexual attraction in relation to physical attributes more often seen with younger bodies (Moyle, 2003). One participant in the study goes so far as to say that the general populous would be disgusted to see “old people” in sexual roles in movies or TV.

As discussed above, ageism and stereotyping of older adults as “*others*” has consequences beyond an abstract wrongness, in that it has implications for nursing practice. There is a potential for stereotyping to lead to discrimination and an impact on nursing care delivery when assumptions are made based on a perception of what it is to be an older adult (Hanson, 2014; Kagan & Melendez-Torres, 2015). Furthermore for the purposes of this research, the understanding of what it is to nurse older adults, as a result of media images and societal presentation of ageing, seems to be impacting on student nurses and their decisions to work with older adults. While there doesn’t appear to be a quick fix for this issue, some of the research suggests that by addressing the concept of ageism in a more overt way at undergraduate level, there are increased positive attitudes towards older adults, which has a beneficial impact on the effects of ageism (Heise, Johnsen, Himes, & Wing, 2012; Sarabia-Cobo & Castanedo Pfeiffer, 2015). I will discuss this idea further in the recommendations section.

## **5.2 Specific Factors Related to Nursing Education**

As identified in the findings, clinical placements for nursing students have a significant impact on whether the student will consider that environment as a setting to work once registered or not. This is clearly supported by a number of studies, some of which were included in the literature review, but even more so when inclusion criteria is expanded to cover a multitude of research (Arreciado Marañón & Isla Pera, 2015; King, Roberts, & Bowers, 2013). The reasons for the importance of clinical placements are multi-factorial and include the physical aspect of working with older adults, as well as the environment, and the attitudes of staff working with older adults as well as the attitude of other RNs towards nursing older adults. It also includes a misunderstanding of the level of skill needed to work in older adult settings and how educational institutions perpetuate this myth in a variety of ways.

For many undergraduate programmes, the first clinical placement for students is frequently undertaken in an older adult setting such as ARC facilities or retirement villages within the first year of the degree programme (Abbey et al., 2006; King et al., 2013; Kydd et al., 2014; Neville et al., 2014; Prentice, 2012). Students and clinical educators often see this first placement as an opportunity to practice basic nursing skills with a relatively well population group, in a setting that is not as fast paced as an acute ward (Prentice, 2012). Basic skills are seen as the task orientated skills such as learning to take accurate vital signs or learning to safely mobilise or wash patients. These skills may be practiced in an older adult setting, but are often without the added depth of understanding what they may mean for a patient. For example knowing that vital signs in an older adult do not necessarily correlate to the textbook adult norms, does not necessarily lead to an understanding of what the implications of this could be for the patient.

Abbey et al. (2006) found that students in this environment were often paired with a health care assistant (HCA) rather than a qualified RN, for periods of time. This subsequently removed the student from seeing or being involved in the clinical decision making and care planning from a nursing perspective (Abbey et al., 2006). This aligns with the experience Tania had in her first clinical placement in an ARC facility, where she spent the first 2 weeks working with the ward assistant learning how to wash patients and make beds. Tania reports this was a positive experience for her as she felt that as part of caring for somebody (which underpinned her nursing philosophy) making a bed was within her role. Tania acknowledged however, that her placement was mainly around learning some basic cares and working with the MDT team rather than learning the complexity of nursing older adults.

Moyle (2003) believes the effect of older adults being an early placement reinforces to students that nursing older adults does not require any particular speciality knowledge, and therefore adds to the impression that nursing in this area is not complex or challenging. Although the skills being learned in this environment may include a top to toe assessment as well as measuring vital signs, with little to no clinical experience to draw on, students may not recognise the cues that indicate there are social or physical issues that need to be followed up on. This further supports the idea



that anyone can nurse older adults and it not an area that requires any specific specialist skills (Abbey et al., 2006). Moyle (2003) argues that in fact nursing older adults requires highly accomplished practitioners who are skilled in a number of areas including assessment, pharmacology, palliation and rehabilitation (Moyle, 2003). Moyle (2003) suggests that there are more appropriate areas for the first clinical placement such as orthopaedics, day surgery or maternity, all areas where there is less likelihood of patients presenting with multiple co-morbidities.

Heise et al. (2012) report however, that clinical placements based in community settings such as ARC facilities or retirement villages can have a positive impact on students' attitudes to working with older adults. They argue that these placements should continue to be an early part of undergraduate study as they are an appropriate time in the degree programme to begin to develop an understanding of healthy older adults. They do add the warning though that an initial placement with well, independent adults can actually increase the negative perception later on, of working with older adults in more acute settings, who are by the nature of being in an acute setting, more frail and unwell (Heise et al., 2012).

There is a strong indication that the quality of the clinical placement setting is important to the development of a positive attitude to older adults (Heise et al., 2012). The term "*quality*" is not well defined in the literature, but various sources suggest it is related to a number of components such as the physical environment as well as the staff working in the area. Other research discussed the perception that older adult settings are underfunded which leads to dated and unattractive work environments, and not well resourced in terms of the equipment or supplies required for effective nursing cares (Stevens, 2011). Older adult settings were variously described as boring, stressful and depressing with unqualified and unengaged staff (Carlson, 2015).

As highlighted in the findings chapter, the idea of disengaged staff causing a negative reaction certainly resonated with several of the current study participants. In particular the experience had by Joanne while on clinical placement in an assessment, treatment and rehabilitation ward (AT&R) in a hospital was formative in her decision to discount working with older adults on graduation. Joanne stated that while she enjoyed working with the patient population group, her interactions with RN colleagues was the main

determinant in deciding to look elsewhere for her area of practice once registered. Unsurprisingly, the lack of support that Joanne felt she had from colleagues, including senior staff, is often a reason given for a lack of interest in a specific area of nursing, and sometimes in nursing as a profession (Clements, Kinman, Leggetter, Teoh, & Guppy, 2016).

Other participants commented on the standard of care they saw being delivered by staff, including nurses and ward assistants, and how this was less than what they considered exemplary levels. This is supported throughout the literature where students comment on seeing below par care being delivered in older adult settings and how this disappoints and frustrates them (Arreciado Marañón & Isla Pera, 2015; Traynor & Buus, 2016). This in turn leads to a lack of interest in working with colleagues who are not delivering what they perceive to be at the very least, adequate care.

It is interesting to consider how much of this perception is related to an idealism based on theoretical understanding of the workplace, as compared to the reality on the ward. There is possibly a mismatch between what students expect to see and what is actually happening that could lead to the disillusionment that some participants describe. This discrepancy between what new nurses, or student nurses, believe is the ideal level of care, and what they witness in reality is well documented as causing anxiety related to professional identity (Arreciado Marañón & Isla Pera, 2015; Clements et al., 2016; Traynor & Buus, 2016).

Developing a professional identity is seen as part of the education process around becoming a nurse and is a key element in any profession. It is about learning the cultural norms, values, behaviours and attitudes that are inherent to the profession that one aspires to be part of (Arreciado Marañón & Isla Pera, 2015). Arreciado Marañón et al. (2015) found that while both theoretical and practical learning in nursing education are vital to developing the necessary skills and knowledge, it is in the practical application, during clinical placements, that the professional identity is most specifically developed. Clements et al. (2016) agree that the importance of clinical placements lies not only in the growth of nursing knowledge skills, but it is essential to the development of a professional identity and attitudes, as well as an

initial introduction to cultural norms within an area. This is seen in the findings with the experienced RNs who all understand that the skill in working with older adults is around communication and advocacy. Shelley in particular attempts to convey a positive professional identity to student nurses who have placements in her ward, by encouraging them to see beyond the superficial impression of the area, and to begin to understand the complexity of nursing older adults.

The importance of clinical placements should not be underestimated and a vital component of the overall experience is the clinical preceptor working with the student within that placement. Preceptorship should provide a strong role model for student nurses and where this does not happen, it can lead to the development of a negative feeling towards a whole practice setting (Arreciado Marañón & Isla Pera, 2015).

Where the current study participants perceived disengaged or indifferent staff during clinical placements, there was naturally a level of disappointment that the reality of care did not match their ideals. This was also recognised by the experienced RN participants in the current study whereby both Ellen and Shelley chose to leave the older adult environment for a time when they accepted that the emotional and physical toll of nursing in that setting could impact on their delivery of care. That both RNs returned to the older adult setting after recharging their emotional bank accounts, should be seen by student nurses as a positive strategy to maintain excellent care.

Student nurses may have already developed an unconscious bias against older adult settings for some of the reasons described above – inherent ageism, misunderstanding of the complexity of the setting, a perception that the work is boring and repetitive and/or physically demanding (Prentice, 2012). Duggan et al. (2012) suggests that this is as a result of the emphasis that undergraduate nursing education providers place on acute care and that older adult placements are predominately about basic skill acquisition. Prentice (2012) asserts that university staff, tasked with supporting student nurses on clinical placements with older adults, are often not necessarily experienced with older adults. This differs from other areas of nursing, such as paediatrics or mental health nursing, where university clinical educators would be more likely to have a background in either of those areas, in order to support students practising there.

Where an educator has no specific experience in older adults, it may imply to student nurses that nursing of older adults is not a speciality where expert knowledge is required and so reinforces the belief that it is a less valued area of practice (Duggan, Mitchell, & Moore, 2013). According to findings from Ben Natan et al. (2015) nursing school educators are an important influence when students are considering working with older adults or not. In their study, they found that only 19.5% of participants agreed that their nursing school educators would encourage them to work with older adults (Ben Natan, Danino, Freundlich, Barda, & Yosef, 2015).

This idea that nursing older adults is somehow less valued or respected than other areas, is a common thread seen in both the findings from the current study, and woven throughout the literature (de la Rue, 2003; Henderson, Xiao, Siegloff, Kelton, & Paterson, 2008). Several participants in our study reported that they had had conversations with colleagues who overtly referred to the older adult setting as being more basic when it came to skill requirements than when compared to what they perceived as higher tech nursing. The literature supports this finding and suggests that nurses from other settings may question the calibre of nurses who choose an older adult area of nursing; that is, nurses working with older adults are perceived as less capable by some colleagues in other areas (Gould et al., 2013; Kydd et al., 2014; Neville, 2016).

Nursing older adults is described by student nurses in a range of studies in terms of boring, utilising basic skills, less technical than other areas, slow, routine and mundane (Adibelli & Kılıç, 2013; de la Rue, 2003; Neville, 2016; Stevens, 2011). The concept of basic care or basic skills required for nursing older adults is highlighted by Neville (2014) where participants felt that nurses choose older adult settings as they are unable to manage the technological demands of other areas, namely ICU or cardiology wards. They further describe that participants reported working with older adults was a dead end job with limited career advancement and little job satisfaction as patients rarely get better. This is supported by de la Rue (2003) who reports that areas such as ICU are perceived as high-status in the nursing world, while aged care and mental health nursing are seen as low-status. She argues that this is as a result of the priorities

of most health care facilities, where cure is seen as a measure of success (de la Rue, 2003).

The idea that there are limited career opportunities in older adult settings is repeated in the literature as a reason for not choosing older adults (Stevens, 2011). Stevens (2011) argues an interesting point that in actual fact, there are likely more opportunities for nurses working in older adults to develop professional skills, as the area is equally unpopular with medical staff (Stevens, 2011). This means that it is an area that will need to rely heavily on the professional development of nurse specialists in gerontology, unlike the so-called “high tech” areas, which are highly medicalised and focus on treatment over care (Stevens, 2011).

The idea that there is more prestige in working in a “*high tech*” area of nursing highlights the differences between the art of nursing, where caring and compassion generally sit, with the science of nursing which incorporates the technical and scientific knowledge required for modern nursing (K. Brown & Bright, 2017; Gould, Dupuis-Blanchard, & MacLennan, 2015; Palos, 2014). This definition of the two sides of nursing is of course simplistic and in reality, neither aspect exists in isolation without incorporating parts of each of the other in practice. Gould et al. (2015) found that while some participants understood that there are negative elements to the highly technical areas of nursing, namely around the difficulty in developing meaningful interactions with patients, the majority of participants viewed the perceived loss of technical skills as inevitable and undesirable if they went into an older adult setting. Gould et al. (2015) argue that the resolution of the dichotomy between the art and science of nursing is when nurses develop a strong integral professional identity. This certainly seems to be the case with our findings where the experienced RN group demonstrated a continued desire to remain working with older adults. All of them cited the ability to build meaningful relationships that made a difference to their patients, as a reason for continuing to work with the population group.

The third finding in my study, within this theme of specific factors related to nursing education, is that of older adults being everywhere in the health system, not just in particular older adult settings. Stevens (2011) states that unless nurses are working in speciality areas such as paediatrics or maternity, the majority of patients they will be

working with will be older than 65 years. Even within paediatrics and maternity, it must be considered that nurses will still be dealing with family members over 65 years old so it could be argued that older adults will be encountered in all settings (Heise et al., 2012)

### **5.3 Recommendations**

While it is acknowledged that there is no quick fix for the problem of not enough new nurses wanting to work with older adults, there are some recommendations that come from the existing literature, and are supported by the findings. Firstly, given the importance placed on clinical placements, by students, educators and other stakeholders, it seems more consideration on when the older adult placement occurs during nursing education should be a priority. If the focus during the first introduction to real life health consumers is to develop the so-called basic (or fundamental) nursing skills, then it may be more valuable for students to be practicing on less complex patients. As suggested by Moyle (2003) there are more appropriate settings to find less unwell people including day-stay surgical procedures, orthopaedics and maternity units. Although there is no guarantee that these areas will always be populated by less complicated patients, with fewer medical needs, there is still more potential to find these kinds of patients in those settings, than in the older adult setting. This also negates the suggestion that older adults do not require speciality knowledge and skills in order to effectively care for them. Although ageing is not in itself an indicator of ill health, there is undoubtedly an impact of ageing on those who are unwell, around different responses to medications, physiological reactions and mental health presentations (Hirst & Lane, 2016).

Secondly, as the impact of ageism on delivery of nursing care has been thoroughly discussed in this section, a further recommendation is that in order to minimise the impact, it is necessary to raise awareness in students of any ageist attitudes they may have and ensuring they understand the potential impact of these attitudes. One way to do this is to deliver education at undergraduate level, specifically aimed at introducing the concepts of ageism and stereotyping (de la Rue, 2003). This may be a stand-alone session or may be part of a wider gerontology specific module as discussed below. De la Rue (2003) however, argues that challenging ageist stereotypes

should be part of all ongoing education and not confined to specific gerontology teaching as older adults are present throughout all health care areas.

Finally, there is currently no provision for specific teaching around gerontology as dictated by the Nursing Council of New Zealand, although there is a requirement for “clinical experiences [to] occur in a range of settings with health consumers across the lifespan (p. 62)”. Numerous studies have shown increases in positive attitudes towards older adults following education specifically around the complexity of caring for the population group (Kydd et al., 2014; Potter et al., 2013). In Kydd et al. (2014) student participants from Scotland, Sweden and the USA, all agreed that the care of older adults should be taught as a specialist subject and further, should be taught by specialists.

Hirst et al. (2015) suggest that at the very least, there should be specific teaching woven through all semesters and topics, around how older adults will respond differently to a number of factors, including medications, wound healing, developing infections, as a result of the pathophysiological differences caused by ageing. This would serve for those already interested in nursing older adults, but would also address the fact that older adults already make up the majority of patients throughout most healthcare areas, so by default, all nurses should have a level of knowledge to nurse older adults more effectively.

In conclusion, the findings from this research are that pre-existing factors and specific factors related to nursing education are influences on decision making for nurses to work with older adults. The findings support the results seen in existing international research and strengthen the argument that there are issues that need further exploration in order to make working with older adults a more attractive proposition to student nurses. The research further identifies a number of areas that could be changed to increase appeal for older adult settings and gives recommendations of how changes may be implemented. As highlighted here, there is undoubtedly an opportunity to develop resolutions to the problem of a nursing workforce underprepared to meet the demands of an ageing population.





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## Appendix 1: Ethics Approval

### AUTEC Secretariat

Auckland University of Technology  
D-88, WU406 Level 4 WU Building City Campus  
T: +64 9 921 9999 ext. 8316  
E: [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz)

19 October 2016

The logo for Auckland University of Technology (AUT) is displayed in white text on a black rectangular background.

Shayne Rasmussen  
Faculty of Health and Environmental Sciences  
Dear Shayne

Re: Ethics Application: **16/226 Factors influencing student nurses' choices whether to practice in an older adult environment: A qualitative descriptive study**

Thank you for your request for approval of an amendment to your ethics application.

I have approved the minor amendment to your ethics application allowing changes to the data collection protocols – focus groups to interviews.

I remind you that as part of the ethics approval process, you are required to submit the following to the Auckland University of Technology Ethics Committee (AUTEC):

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 28 June 2019;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 28 June 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz).

All the very best with your research,

A handwritten signature in black ink, appearing to read 'K O'Connor', is placed above the printed name.

Kate O'Connor, Executive Secretary, **Auckland University of Technology Ethics Committee**

Cc: Sharon Fisher, [shafis81@aut.ac.nz](mailto:shafis81@aut.ac.nz)



***Are you...***

***...a third year undergraduate nursing student?***

***...thinking about applying for your first  
job in the next 6 -12 months?***

We invite you to take part in a study on the factors influencing student nurses' and the decision whether to work in an older adult environment or not after registration.

***Who can participate?***

- Nursing students in their final year of study at an Auckland Nursing School who are able to participate in an interview in English

***How?***

- One to one interviews will be held in a location convenient to each of the five Auckland Nursing Schools. Each participant will be asked some general questions on the topic. It is anticipated each interview will take approximately 20 - 30 minutes.

**Your participation is voluntary.**

This study is part of my MHS at AUT. If you are interested in participating or would like more details please contact:

*Primary Researcher*

Sharon Fisher

[shafis81@aut.ac.nz](mailto:shafis81@aut.ac.nz)

021 705 147

*Supervisor*

Shayne Rasmussen

[shayne.rasmussen@aut.ac.nz](mailto:shayne.rasmussen@aut.ac.nz)

921 9999, ext 7118

## Appendix 3: Participant Information Sheet



### Participant Information Sheet

September 2017

**Project Title** Factors that influence nurses' attitudes towards working with older adults: A qualitative descriptive study

#### An Invitation

Hello, my name is Sharon Fisher and I am a Registered Nurse (RN). I have worked in a number of areas, both in primary and secondary health, including ED and District Nursing. My current role is Nurse Educator for the Nurse Entry to Practice (NETP) programme at Waitemata DHB where I work with New Graduate nurses in their first year of practice.

As part of my MHS research at AUT, I am looking at the factors that influence nurses' attitudes towards working with older adults. I would like to invite you to participate in an interview to discuss your career choices and what reasons you can identify that have got you to that point.

Participation is voluntary and you can change your mind and withdraw from the study at any stage before data collection is complete, probably around December 2017. If you decide not to continue as part of the study there will be no negative repercussions for you.

#### What is the purpose of this research?

There are not enough nurses choosing to work in the older adult sector, either in aged care or within public hospitals. As the average age of the NZ population increases, the health sector needs to attract more nurses to this speciality area. While worldwide studies have identified several themes that highlight why new graduate nurses are not choosing to work with older adults, there is limited data around the topic that is specific to a New Zealand context. I hope this study will identify what factors are present in nurses currently working in the older adult setting and how these attitudes could be transferred to new graduate nurses. The overall purpose is to contribute to finding ways of increasing the number of new graduate nurses who actively choose to take up the opportunity to work with an older adult population.

At the conclusion of the study I will achieve my MHS and have the results published in a reputable peer-reviewed academic journal. I will also look at presenting the findings at appropriate nursing forums.

#### How was I identified and why am I being invited to participate in this research?

You have been identified as a possible participant as you are currently working as an RN in an older adult setting.

#### What will happen in this research?

Participation will be in the form of one to one interviews. Interviews will take place at a mutually agreed time. It is anticipated that each interview will take between 30 - 45 minutes. While there will be some standard questions I ask to facilitate dialogue, some questions will be generated specifically as a result of the discussion itself. You do not have to answer any question/s you feel uncomfortable with at any point in the interview.

You will be asked to complete a written consent form prior to the interview. Information will be collected by digital recording and note taking by me, and transcribed by a third party who has signed a confidentiality form. Data will only be used for the purpose of this study, notes and transcriptions will be kept in a secure environment the digital recorder will be password protected. *What are the discomforts and risks and how will these be alleviated?*

I anticipate minimal risks associated with this study.

### **What are the benefits?**

#### Benefits to Participants

- The opportunity to analyse and critically assess career choices
- The opportunity to be involved and contribute to an area of research that may inform the way undergraduate education could be delivered in the future

#### Benefits to Researcher

- Completion of MHSc
- An increased understanding, , of the employment choices and factors that may influence decision making of new graduate nurses
- The opportunity to contribute to workforce development that will meet the increasing demands of an ageing population.
- Gaining skills in researching and presenting research findings at an academic level

#### Benefits to Wider Community

- Potential to inform and improve healthcare service delivery to older adults
- Possibility of informing the way nursing schools teach at undergraduate level

### **How will my privacy be protected?**

Each participant will sign a consent form, prior to the interview taking place. The identity of all fellow participants and discussions in other interviews are confidential.. Pseudonyms will be used in all writings pertaining to the study and I will not identify you in the final report.

### **What are the costs of participating in this research?**

Beyond the initial contact you make with me, the physical time you will need to set aside for the focus group session is approximately 30 - 45 minutes.

### **What opportunity do I have to consider this invitation?**

Until I have reached the number of participants I require.

### **How do I agree to participate in this research?**

Once you have decided you would like to take part in this research, you just need to agree to come to an interview. Please contact me via e-mail or text (as below) to arrange this.

### **Will I receive feedback on the results of this research?**

I will send each participant a summary of the results of the study unless you choose to opt out.

### **What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Shayne Rasmussen, *shayne.rasmussen@aut.ac.nz*, (09) 921 9999, ext 7118.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

**Whom do I contact for further information about this research?**

Please keep this Information Sheet and a copy of the Consent Form for your future reference.  
You are also able to contact the research team as follows:

***Researcher Contact Details:***

Sharon Fisher

E: [shafis81@aut.ac.nz](mailto:shafis81@aut.ac.nz)

T: 021 705 147

***Project Supervisor Contact Details:***

Shayne Rasmussen

E: shayne.rasmussen@aut.ac.nz

T: (09) 921 9999, ext 7118

**Approved by the Auckland University of Technology Ethics Committee on *19 October 2016*, AUTEC  
Reference number *16/266*.**

## Appendix 4: Participant Consent Form

**AUT**

TE WĀNANGA ARONUI  
O TĀMAKI MAKĀU RAU

### Consent Form

*Project title:* **Factors that influence nurses' attitudes towards working with older adults: A qualitative descriptive study**

*Project Supervisor:* **Shayne Rasmussen**

*Researcher:* **Sharon Fisher**

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated September 2017.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interview and that it will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature: .....

Participant's Name: .....

Participant's Contact Details (if appropriate):

.....  
.....  
.....

Date: .....

**Approved by the Auckland University of Technology Ethics Committee on 19 October 2016 AUTEK Reference number 16/266**

*Note: The Participant should retain a copy of this form.*

## Appendix 5: Indicative Interview Questions

**AUT**

TE WĀNANGA ARONUI  
O TĀMAKI MAKĀU RAU

### Indicative Questions for Interviews

*Project title:* **Factors that influence nurses' attitudes towards working with older adults: A qualitative descriptive study**

*Project Supervisor:* **Shayne Rasmussen**

*Researcher:* **Sharon Fisher**

Can you outline your career history to date?

How long have you worked with older adults/in this setting?

What is it you enjoy about working with older adults?

Can you identify how that (attitude/perception) developed?

What was it about (personal experience) that led you to decide/choose .....?

What has fostered/encouraged your (passion/love/enjoyment) for working with the older adult population?

Tell me more ....."

The purpose of this discussion was to talk about.....is there anything else anyone would like to add?