What do RNs working in hospital aged care units identify as the positive and negative aspects of aged care nursing?

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Dedication

I dedicate this work to my family who have supported me every step of the way. To my parents, Martin and Theresa who dedicated their lives to me as a child and young man, instilling in me a work ethic and encouraging me to continually improve myself. Finally to my wife Carol and sons Sèan and Christopher who have made many sacrifices over the years so that I could dedicate time to the completion of this research, to whom I am most indebted and love dearly.

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I am indebted to the hospitals which allowed me access and permitted the registered nurses to engage in this study.

Finally, I would like to thank my work colleagues who supported, listened and encouraged me throughout.

Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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(Signature)

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Table of Contents

List of Tables

Abstract

This study reports the positive and negative aspects identified by registered nurses (RNs) working with older people in public hospital aged care units and was conducted in 4 public hospitals in Sydney, Australia.

Qualitative data using questionnaires and telephone interviews was collected from 26 female and 4 male RNs of which 46% (n 14) had worked in an aged care unit for 10 years or more. The participants identified positive perceptions within three major themes: a genuine liking of older people; the stories older people tell and the complexity of the older patient's illnesses. Positive responses were a focus as it was identified that this was a gap in the literature which required addressing at the time. These findings are significant and have implications for nursing practice for several reasons:

Data was collected exclusively from RNs and focused on their positive perceptions about aged care nursing in public hospitals. Participants reported a genuine liking for older people. Patients' telling their stories was reported by 60% (n 18) of participants as being interesting in their work and meaningful to the patient and should be considered more as a therapeutic process during hospitalisation to assist support and enhance patient outcomes and therapy. The participants reported that aged care nursing is complex, rewarding and requires mature nurses, with current nursing knowledge and skilled in the art of caring for older people. These findings can be used to improve recruitment and retention of RNs within aged care nursing.

1. CHAPTER 1 – INTRODUCTION

1.1. PURPOSE OF THE STUDY

At the time the study commenced I was a Director of Nursing of a public hospital specialising in the acute and subacute care of older people. ('Acute' refers to acute care hospitals, 'subacute' refers to rehabilitation hospitals and people aged over 65 years are referred to in this study as 'older people'). With the national and international recognition of the general nursing workforce shortage (Burke 2003; Carpenter, Conway-Morana, Petersen, Dooley, Walters & Wilder 2004; Hill & Walker 2004; Knowles 2000; Numerof & Abrams 2004; Poduska 2003, all articles from refereed journals) there was a need to consider recruitment and retention strategies relating to registered nurses (RNs) in all areas of nursing. I was particularly concerned about the difficulty in attracting experienced RNs to specialised units for older people in public hospitals, and had personal experience in the hospital where I worked. There was also a lack of interest from newly graduated nurses in aged care, and the general shortage of nurses in the hospital system meant that nurses had an opportunity to work in many different areas.

In reviewing literature about aged care nursing, (which in this study refers directly to aged care services within public hospitals unless stated otherwise) there were many studies undertaken which reported negative attitudes towards older people, aged care nursing and the system of care. Lefrancois (1980) in his psychology text book defines an attitude as "a prevailing and consistent tendency to react in a given way, describable as being positive or negative and having important motivational consequences" (p. 561). These expressed reactions have implications, for example,

on the manner in which people relate to others. These attitudes may also have an influence on future motives, for example, the decision to work in a particular place. Therefore, RNs' attitudes have relevance to the current study, as it is a motivating factor that has the potential to affect the recruitment and retention of RNs.

Also, there was a view that nurses and nursing in hospital aged care units and aged care services had a lower status than other nurses and nursing. The principal focus of this study was on positive aspects in order o address an identifiable gap in the literature, however, participants were also asked to identify what they liked least about nursing older people, which reduced the possibility of a biased evaluation.

The positive and negative aspects describe the attitudes; feelings and beliefs nurses have towards older people and to this nursing specialty. The two main areas of interest focus on the attraction RNs have for aged care nursing and the concerns they have in applying for work in this specialty. As previously stated aged care nursing is low on the list of preferences for newly graduated nurses and recruitment into the specialty has been managerially difficult. Anecdotally I have experienced concerns from RNs in aged care who believe that they are considered at a lower status than other RNs in different specialties. From these two areas flow subsequent interesting factors that include the reasons why RNs were initially attracted to aged care nursing, and specifically what are the interesting issues about older people that can be classified as being both clinical and non clinical that provide continued job satisfaction and maintain their interest in the specialty. The data received from RNs working in the specialty will assist in developing a range of strategies that can be used to improve the recruitment and retention of RNs in the future.

I therefore decided to ask the RNs to identify both positive and negative aspects of aged care nursing in the units in which they worked. The questions I posed were:

- *What are the interesting factors identified by RNs nursing older people in public hospital aged care units?*
- *What did RNs identify in nursing practices which need change to attract RNs back into areas specialising in nursing older people?*
- *What makes nursing older people less attractive to RNs compared with other areas of nursing?*

To assist in clarifying the current situation and to justify the purpose of this study, further information is provided below.

1.2. BACKGROUND

The study should be considered in the context of current trends of an ageing population, the implications this may have on the health industry, ageism in contemporary Australian society, and the current and future issues relating to workforce and aged care nursing practices for hospitalised aged care patients.

1.2.1. Australia's ageing population

The Australian Bureau of Statistics (ABS) in a non-refereed publication by the Commonwealth Government of Australia reported a rapid increase in the elderly population, which has grown 164% over the last 20 years (ABS, 2006). This phenomenon has also been reported in other western countries. Australia's ageing population, already evident in the current age structure, will continue. This is the result of sustained low levels of fertility combined with increasing life expectancy at birth.

With the expected changes in the demographic composition of the Australian population, by the year 2051 almost 1 in 2 Australians will be older than 50 years; in contrast to the ratio of 1 in 3 Australians over 50 years in 2004. The number of people aged 65 years and over will increase rapidly over the next 50 years, from 2.6 million in 2004 to between 7 and 9 million people in 2051. By then, slightly more than 1 in 4 Australians will be aged 65 years and over as opposed to 1 in 8 in 2004. The Australian Institute of Health & Welfare (AIHW, 2006), in a non-refereed publication of the Commonwealth Government of Australia stated that the number of people aged 85 years and over will increase even faster, from fewer than 300,000 in

2004 to between 1.6 million and 2.7 million in 2051. By then, people aged 85 years and over will make up 6% to 8% of Australia's population, compared to only 1.5% in 2004. Sax (1993) in his book about ageing and public policy in Australia identified that the ageing population had the potential to cause a major impact upon the workforce, the economy and other social aspects of life. In the future there will be more older people hospitalised who will be older than the current group of patients, and, in general there will be more older people to care for, and fewer younger people, as nurses, to care for them.

1.2.2. Implications of an ageing population on healthcare in Australia

An important implication of Australia's population is the number of older people who currently occupy beds in Australian public hospitals. The AIHW (2006) found that people over the age of 65 years have a higher rate of admissions to hospital than the general population and tend to stay longer. This will require nurses to regularly care for more older people in the future.

Hospital Utilisation

The Australian Health Ministers' Advisory Council stated in a non-refereed document published by the Victorian Government Department of Human Services that "People aged 65 years and older are significant users of public hospitals" (2004, p. 3). In the same report it was identified that 34% of all public hospital separations (separation is when a patient leaves the hospital following discharge or death) and 48% of all public hospital beds days in 2002-2003 were attributed to people aged 65 years and older. The Australian Institute of Health & Welfare (2004) reports the average length of stay in hospital increased with age in 2001–02. For 65–74 year olds the average stay was

3.75 days, 5.5 days for those 75–84 and 9 days for those 85 years and over. Females tend to stay slightly longer than males. This data shows there is a correlation between age and length of stay, the older the person is the longer he or she is likely to stay in hospital. With increasing life expectancy, there will be a higher number and proportion of people reaching advanced old age of 85 years and over resulting in more older people requiring healthcare and subsequently, hospitalisation.

This will encourage the health industry, and especially nursing services to consider if current models of care for older hospitalised patients are satisfactory, efficient and produce effective outcomes. This information can be made clearer with statistical information collected for the industry to determine health and political strategy.
As people become older they have an increased incidence of acquiring a disability and requiring health care interventions.

Disability

As people grow older they become susceptible to other ailments. Steinman (1997), in a refereed article stated “Aging is not inevitably associated with disability, but the prevalence of functional limitations increases dramatically with age” (p. 91).

In a non-refereed document published by NSW Department of Health the incidence of older people living with disabilities was stated as “Older people are frequently ageing in place with multiple disabilities” (NSW Department of Health, 2004, p. 15). Eventually, older people would be admitted to hospital, for many different reasons presenting with comorbid disabilities

Sarkisian, Hays and Mangione (2002) identified that “chronic disease and disability continue to serve as significant challenges for most older adults”. (p.1). In this refereed article the authors performed a mail survey on 588 community residing older people aged between 65 to 100 years of age. The aim of the survey was to measure older people’s expectations regarding aging, identify characteristics associated with having low expectations regarding aging, and to examine whether expectations regarding aging are associated with healthcare-seeking beliefs for age-associated conditions in the Greater Los Angeles area of the United States. The data was collected on a specially designed survey tool called The Expectations Regarding Aging Survey. The authors found that “More than 50% of participants felt it was an expected part of aging to become depressed, to become more dependent, to have more aches and pains, to have less ability to have sex, and to have less energy” (2002, p. 1). The authors acknowledge that the findings of the survey cannot be generalized as the surveys were filtered through general practitioners who were asked to exclude patients for various reasons, one being if the patient was from a non-English speaking background. Also it was acknowledged that the residents reported higher incomes on average than those in population - based studies. The survey findings confirm that older people require more physical assistance and become less independent as age increases and with the onset of long-term medical conditions which may result in various levels of disability.

Ina reporting the health of Australians The AIHW (2006) identified that among people aged 65 years or more, the main conditions associated with a disability were hearing loss (30% in males, 21% in females), arthritis (22% in males, 29% in females), stroke and other cardiovascular diseases (21% in males, 19% in females) and other

musculoskeletal problems (17% in males, 19% in females). The report also noted the sharp rise for most health conditions in the prevalence of associated disability in the 85 years and over age group. The presence of these health conditions gives rise to other complications, in particular, the risk
of a fall.

Sydney West Area Health Service (2005) in a non-refereed published action plan developed to implement The NSW Department of Health Management Policy to Reduce Fall Injury Among Older People stated the following:

> In Australia, as in other developed countries, fall injury is a major cause of injury-related preventable hospitalisation and loss of independence among people aged 65 years and over. Between one and three percent of older people are hospitalised for falls each year (p. i).

Older people are less able to survive and recover from an injury than younger age groups and falls account for about one-fifth of fatal injuries in Australia (AIHW, 2006).

The increasing population of people 65 years and over and the possible proportionate increase in health service utilisation and disability within this group, requires health services to prepare to manage the challenging health and ageing needs of older people.

1.2.3. Ageism in contemporary Australian society

Butler (1980) reported in his book that older people have for many years suffered the stigma of ageism, which he likened to bigotry and its systematic stereotyping, and

discrimination of a person due to age. Nurses and the nursing profession have also demonstrated ageist attitudes and have been described as significant agents in contributing to and perpetuating ageism is society (Stevens & Herbert, 1997; Wade, 1999). Ageism and stereotyping will both be explored further in Chapter 2.

1.2.4. Current issues relating to RN workforce in hospital aged care

At the time of the study there were three important factors affecting nursing, which were recognised internationally and locally and in particular, with nursing services for older people, they were:

- Shortage of RNs in the general workforce.
- Newly qualified RNs not choosing to work in aged care as a specialty.
- Negative image of aged care nurses and nursing.

These issues are explained further below.

1.2.5. The shortage of RNs in the general workforce

The shortage of RNs has been described as a phenomenon in developed nations throughout the world (Nelson, 2004) and has the potential to threaten the quality and safety of patients if the trend continues. Hospitals, over a period of time, have developed a model of care that has nursing services supporting medical treatment, with RNs being responsible for managing patient care in the absence of the doctor. If, in the future, there were insufficient RNs to assume responsibility, the same level of patient care could not be guaranteed. To produce the same level of care previously acclaimed may take some time, and yet, the same level of care may not be achieved regardless of any new models.

Workforce shortages are a concern for the health sector and nursing in particular. The NSW Ministerial Standing Committee on the Nursing Workforce (2003) published by the NSW Health Department stated, "The ageing of the nursing workforce has critical implications for future replacement needs" (p. 1). The average age of a registered nurse in NSW, Australia was 44 years in 2003 and has been consistently rising since 1999 (NSW Health, 2003). Nursing requires physical activity and effort; and therefore, with an ageing workforce the physical activity required for the job may become a problem for nurses and the nursing workforce if the average age of nurses continues to rise. Health Services are attempting to attract nurses back to nursing after they have taken many years off to attend to other interests or priorities. One such program is The Re-Connect Program (Iemma, 2004) developed by the NSW Department of Health in Australia. The program was described in a ministerial release as being "a clinically focused, supported employment re-entry plan tailored to individual needs" (Iemma, 2004) by the NSW Minister for Health in 2004. The program exclusively recruits nurses who have had an absence from nursing for a period of time, most can be described as mature, and that is, they have spent a period of time since first graduating as an RN in other life activities which could be considered personally and professionally developmental.

1.2.6. Newly graduated RNs not choosing aged care as a specialty

I have experienced this problem as a Director of Nursing through the lack of interest shown from newly registered nurses in accepting post registration placements in hospitals specialising in aged care, accepting that acute hospitals have experienced a down turn in postgraduate applications for transitional programs. These concerns could be the result of identified issues previously studied with students and nurses

caring for older people, such as, the routine geriatric care described as the impersonal and rigid way of organising care in the wards (Baker, 1978; Koch & Webb, 1996), similarly the structural context of work (Pursey & Luker, 1995) the perceptions of the work being basic rather than technical (Stevens & Herbert, 1997), teacher influence (McLafferty & Morrison, 2004) and professional socialisation (McLafferty & Morrison, 2004; Slevin, 1991; Stevens & Crouch, 1995) described as "the process by which individuals acquire the values, attitudes, morals, knowledge and skills espoused by the group"(Goldenberg & Iwasiw, 1993, p. 4).

These studies highlight the problems newly registered nurses may have when considering an RN transitional program designed to support new graduates into the workplace and workforce. Newly graduated nurses appear to prefer programs within the larger teaching hospitals, which provide acute child and adult services, where the graduates receive a broader range of experience.

The fact remains that older people aged 65 years and over have been reported as the majority hospitalised group in general adult units within public hospitals, regardless of the medical specialty, i.e., medical unit or surgical unit, accounting for 48% of all recorded inpatient days during 2001–2002 (ABS, 2006).

With an estimated increase in the population of older hospitalised patients it was reasonable to gain a better understanding of what interests nurses most about their work with older people which might assistance in the recruitment and retention of nurses into aged care. Whilst investigating the interesting factors it seemed reasonable

to consider, from the viewpoint of other people the image of aged care nurses and nursing.

1.2.7. Negative images of aged care nurses and nursing

Nurses' working with hospitalised aged care patients and in aged care services have reported to feel a sense of lower status than other nurses, for reasons such as technical nursing being more valued than basic nursing care (Bowling & Formby, 1991; Stevens & Crouch, 1997); the expertise required being seen as inferior to other types of nursing (Lawler, 1991; Wade, 1999) and the work being considered routinised and not valued by others (Baker, 1978; Pursey & Luker, 1995; Reed, 1994).

Negative images can relate to the difference in the workforce profile between hospital aged care and residential aged care. The Commonwealth Department of Health and Ageing in Australia commissioned The National Institute of Labour Studies to conduct a survey of to provide an accurate picture of direct care employment in Australian aged care residential facilities. This un-refereed report showed that personal care assistants were the predominant occupational work group comprising 57% of direct care staff with registered nurses providing 22% and enrolled nurses 13% respectively (National Institute of Labour Studies, 2004). This high ratio of personal care assistants to registered and enrolled nurses can imply the work involved in caring for older people does not require the skills of a trained nurse. The use of person care assistants in hospital aged care units is much less than that in residential facilities. The hospital system predominantly uses registered and enrolled nurses in aged care units and the nursing profile and nurse patient ratios are determined by nursing dependency systems to provide a safe and competent nurse skill mix. The

sites used in this research study did use assistants in nursing (with similar training to the personal care assistants in the aged care residential facilities) but on a limited basis. In the sub-acute units assistants in nursing were the minority occupational group comprising, on average only 5% of direct care staff (much less than the 57% in the Australian aged care residential facilities) and this was less in the acute units.

Both settings require nurses with current knowledge, experience and professional skills in caring for older people (Routasalo, Wagner & Virtanen, 2004) and "who can be focused on the restorative, supportive, life-enhancing and educative functions set within the context of multidisciplinary teamwork" (Ford & McCormack, 1999, p. 739). The RN in the residential and nursing home environment usually works independently, without the availability of medical staff. The RN in the hospital requires current knowledge and skills in acute and subacute care specific to the needs of the older patient, for example, old age psychiatry and rehabilitation nursing. Wade (1999) noted that the historical image of caring for older people, particularly in specialised settings, did little to promote the expertise of caring for older people. Long term care, as sometimes referred to when caring for older people has been associated with the asylum where recipients of care occupied a marginalised and stigmatised position in society.

The care of older people is more often associated with residential and nursing home care. The perception of care given to older people was central to a study undertaken by Nay (1998) in 5 Australian nursing homes involving interviews with residents and nursing staff. Nay wrote "Nursing is equated with caring and yet reports of nursing home care frequently cite such uncaring practices as neglect, fostered dependency,

infantalisation and depersonalisation" (p. 401). This refereed article described the contradictions that occur between perceptions and practices of caring for older people in long-term facilities. Nay concluded that this was due to the lack of nursing education and training of those employed to care for older people and that those who did have nursing education were schooled in the medical model and had not recognised the inappropriateness of this model to the care of older people. Nay referred to a participatory model of care as being more appropriate but recognized that the introduction of such a model "is challenged by the devalued status of care of older people, insufficient numbers of appropriately qualified nurses and the pervasive influence of inappropriate models of care" (p. 406).

In later years, these concerns still appear as negative accounts reported in national newspapers which do not improve the image of the nurse, reflect upon the practice of nurses in all aged care areas and, more concerning report the continued presence of poor patient care**,** for example:

> **'<u>Nursing homes still getting it wrong</u>'**
> Nearly half the NSW nursing homes inspected by the federal watchdog have failed basic standards of patient care and management, official audits show. Sydney Morning Herald 12/08/2004

These issues have received the attention of federal politicians who met specifically to discuss the best ways of reducing abuse of the elderly in Australian Government funded aged care services and agreed on measures to monitor a plan for improvement (Department of Health and Ageing, 2006). The outcomes of the meeting have also been discussed at other National Health Services Organisations, such as Catholic Health Australia (Catholic Health Australia, 2006).

1.2.8. Older people in specialised units

The treatment of older people has been classified as a medical specialty for many years. In the acute services, older people are treated on general wards and units with adult patients when they require medical and surgical treatment or other specialty treatment, such as intensive care. However, there are wards and units in the acute and sub-acute hospitals that are dedicated to the treatment and care of certain medical specialties, such as aged care assessment, rehabilitation and psychiatry. The study participants were drawn from a sample group of RNs working in aged care units which will be described later in section 3.5.

This chapter provided the purpose, aims and research question for the study. Chang, Hancock, Chenoweth, Jeon, Glasson, Gradidge and Graham (2003), stated that "Nursing older people has been referred to as 'Cinderella service' because of its unpopularity with nurses and its lack of status and resources" (p. 191). Background information gave context to my study and literature will be further investigated to show that aged care nursing is an area which offers professional challenges and personal job satisfaction.

The following paragraphs provide a brief overview of the subsequent chapters in the thesis.

Chapter 2 identifies literature and pertinent concepts relevant to the research for further investigation. The literature enabled me to conclude that there had been little written about the positive aspects of nursing older people in public hospitals from the

viewpoint of practicing RNs. On the contrary, a majority of the studies had reported on the negative aspects with many studies referring to the viewpoint of undergraduate nursing students.

The literature review is presented within six aspects, and they are ageism; stereotyping of aged care; low status in aged care nursing; nurses' attitudes towards older people; important factors identified by the patient and issues relating to recruitment and retention of nursing staff. These aspects contributed to the development of questions contained in the questionnaires and telephone interviews for the participants of the study.

Chapter 3 considers the methodology and method of this study. It continues with a comprehensive description of the participating hospitals, sample group of RNs and the tools used during the data collection and analysis phase of the study. Ethical considerations relating to data collection and the rigor underpinning the methodology are discussed. Methodological limitations of the study are presented.

Chapter 4 describes the findings of the study which emerged through responses given in the questionnaires and telephone interviews. The findings are described under the different aspects identified from the literature review with supporting quotes from the participants.

Chapter 5 discusses the relevance of the study themes with the intention of highlighting the interesting aspects of the role of the RN with the purpose of challenging managers to explore new ways of improving the recruitment and retention

of RNs in aged care. Recommendations emanating from the study findings are provided with suggestions about further consideration to other research possibilities.

2. CHAPTER 2 - LITERATURE REVIEW

This chapter reviews literature sourced from searches made through university and public library holdings, electronic search engines such as the Clinical Information Access Program (CIAP), and newspaper articles. Specifically I sought literature relating to registered nurses nursing older people in public hospitals, key words encompassed within the title of the research. The literature helped me understand current knowledge, identify knowledge gaps on the subject, and clarify what was required for further investigation. The majority of references provided are from articles in refereed health journals. All references acknowledge their source on the first reference only. The majority of references provided are from articles in refereed health journals. References that are not from a refereed journal state their source or that they are from a non-refereed journal.

I commenced by searching for literature specifically about the positive and negative aspects of nursing older people from the viewpoint of RN's. In so doing, it led me to many different factors that may impact RN's and influence their views, opinion and behaviours. The plethora of literature considered many different aspects to nursing older people for example, the perceptions and attitudes of student nurses, enrolled nurses and untrained workers. However, there was a notable gap in the literature of research specifically investigating what RN's find interesting in nursing older people. The literature search continued throughout the life of the research study as is evidenced in the contemporary citations.

From the literature review the following different aspects emerged:

- Ageism
- Stereotyping of aged care
- Low status of aged care nursing
- Attitude of nurse's towards older people
- Important factors identified by the patient
- Recruitment and retention issues

I found these different aspects important as they can create the environment in which nurses' views and opinions are formed, nurtured and expressed. As this study asks RNs to identify the positive and negative aspects of working in aged care, an understanding of how older people are perceived in the general community was important. In my opinion the identified aspects relate to each other and have purposely been listed to start with ageism and finish with recruitment and retention. RNs can be influenced by societal views on ageism and the stereotyping of old age and older people, this can effect the status of RNs working in aged care, the attitudes RNs have towards older people and the eventual recruitment and retention of RNs in aged care. A section of the literature review considers the viewpoint of the patient in aged care, and now it is with ageism the literature review begins.

2.1. AGEISM

Ageism is a modern term accredited to Butler (1980) when he was describing the deep and profound prejudice in American society against older adults. Butler went as far as comparing ageism to bigotry. Butler's words paved the way for researchers, theorists and social commentators to write about the circumstances of older people in society.

An Australian perspective on how ageist myths developed was provided by Powell (1992). In her refereed paper which focused on the attitudes of society which hindered successful, Powell identified how ageing ageist myths were generated. In her opinion ageist myths were generated through factors, such as one's own experiences with older people; media images and political messages warning us of the "geriatric tidal wave unfolding in our society, the ballooning the cost of dependency, the growing burden of an ageing population" (p.38). Though these messages painted a negative and gloomy picture about older people, ageing and prospective future problems, Powell believed there would be a change of public opinion for the better and suggested that the way to combat the ageist myths was to change the myth generators.

Later, Sax (1993) wrote in his book on ageing and public policy in Australia, that discrimination and attitudes were the main features of Australian ageism, manifested by poor re-employment opportunities, public transport difficulties and restricted access to information for the frail aged. Sax commented that the literature available at the time emphasised old people's health decline; illness; the associated high cost of continued care, and the way medicine was practised, which he believed, "medicalised" (p.1) old age to an extent that many older people became convinced that illness and frailty were inevitable features of becoming old. These comments were useful in that they provided a challenge to government, health and aged care agencies to address and deal with issues facing older people in general.

Some years later Stevens and Herbert (1997) in a refereed discussion paper on behalf of the Australian Royal College of Nursing confirmed that ageism was still present in the Australian health care system and identified that "nurses and the nursing

profession have also been significant agents involved in the production and reproduction of ageism in society" (p. 2). Stevens and Herbert based their findings on previous research they had undertaken. They noted that ageism could be demonstrated in many different ways, for example, "derogatory remarks, harmless jokes, patronising gestures, and through the physical handling of older people" (p. 11), such negative attitudes could influence the care nurses give to patients.

As academic papers were produced, it was evident that ageism was a problem facing many countries. Wade (1999) in a referred article outlined the context in which health services for older people emerged in England. Wade identified that a key factor influencing the quality of aged care was the persistence of ageist attitudes held by society and those working within health and social care settings at all levels, importantly, nurses were identified as demonstrating ageist attitudes towards older people. Wade also noted that in general, older people had been portrayed through drama, advertising and literature in a way that perpetuated ageism, and that in the past, later life tended to be portrayed "in a negative stance, being perceived as a time of physical and mental decline, with social withdrawal and increasing self preoccupation" (p. 340). These findings by Wade confirmed that there were some in society with preconceived attitudes and ideas about older people in general which could be an influencing factor upon others. These observations were similar to the concept of Disengagement Theory proposed by Cumming and Henry and defined in their book on growing old as "an inevitable process in which many of the relationships between a person and other members of society are severed, and those remaining are altered in quality" (Cummings & Henry, 1961, p. 210). Cummings & Henry suggested older people changed from being centered on society and interacting

in the community to being self-centered people withdrawing from society by virtue of becoming older. This theory was not widely accepted and over simplified the notion that some people retire from the workforce to perform other tasks rather and retreat from others, however, Cumming and Henry's theory would have supported those wishing to perpetuate ageism.

As the different views on ageism were argued, the general public received negative views about the concerns of an ageing population and the burden this may bring on society, for example:

> **'Caring for elderly a new burden facing workforce'**
>
> Working men and women were still dealing with the problems of child care and were not prepared for the looming burden of caring for their aged, infirm parents.
>
> Sydney Morning Herald 11/06/1997

This newspaper description may explain how ideas can be created to perpetuate ageism.

Not all reports on have been negative. Sax (1993) noted in his book the traditional and historical customs in which older people in other times and in other forms of social structure held a different status, and their positive contributions to social life were acknowledged. More recently, Perlstein (2006) commenting on the development of new programs which highlighted the special qualities of older people said "For decades the American culture neglected to recognise the innate creativity in elders, who were too often viewed as debilitated and in need of medical attention" (p. 5).

Through the ages people have overcome ageist attitudes by caring for and managing people in their old age in different ways. Some people use the term “extended family” to include older members living with them in their homes. Traditional methods of caring for older family members and relatives have been assimilated into Australian life and culture through the many migrants since colonisation. Stevens (2003), in a refereed report on the history of nursing in Australia indicated that the Nightingale nurses gave society the skills and language for the elderly to emerge as a category of society with unique and special needs. It was here that nurses became prominent in the care and advocacy of older people receiving hospital care (Sinfield, 2001). It took a century of care before the specialty of geriatric medicine developed in response to the particular health needs of frail older people in the United Kingdom (Young and Philp, 2000).

Overtime, Australian aged care services improved through the introduction and development of hostels, nursing homes, residential services and care in the home made available through government legislation and private enterprise. Resources were made available, and businesses emerged, ranging from the family-owned and managed to large corporate enterprises. However, even with these changes many older people still find they become isolated, not out of choice but for other reasons, such as losing contact with people, for example family and friends dying and being unable to regain contact with others. In some ways this could be considered an insidious form of ageism. Isolation can bring about psychological and physical damage such as loneliness, predisposing a person to feelings of misery, self neglect, hopelessness, depression and suicide (Encel, Kaye, & Zdenkowski, 1996). Self neglect in older people was identified by Rathbone-McCuan and Fabian (1992) in their book, not as a

new phenomenon but an increasing problem which "usually resulted from physical and or mental impairment that reduced the elder's ability to perform life tasks" (p.3), so rendering them to be incapacitated and in need of help. This can manifest itself as poor nutrition, malnutrition and may lead to further physical complications and illness eventuating in hospitalisation. These problems can also arise through other people neglecting the older person, for example, when family members move away from home leaving behind an elderly parent or relative, or when older people find they are left alone with no known relatives nearby to show concern, and they become isolated.

Encel et al. (1996) writing in a non-refereed discussion paper for the NSW Consultative Commission on Ageing believed isolation and other associated problems could be overcome using an intergenerational approach, which proposed that simply keeping in touch provided a feeling of well being and safety for most older people, and that there were no additional services required to make this occur. Using an intergenerational approach may bring about a change in people's negative behaviour and attitude towards older people.

In undertaking this literature review I believe that ageism can be identified as a mechanism that can influence the views and opinions of nurses who work with older people which in turn may affect their work and decisions about their future career. With the expected increase in the population of older people (ABS, 2006) more social commentary on the potential impact of older people on health and social services may occur, such as the following, "Population represents one of the most profound social, health and economic challenges facing us" (Bowling and Ebrahim, 2001, p. 223). The professional challenge in nursing is to view every person as an individual and afford

them the required care to meet their health and ageing needs through a holistic nursing approach. Wade (1999) suggested that to combat ageism and to improve the care of older people, close attention to the educational needs of all nurses is required. Also, that the care settings are as appropriate as possible, enabling nurses to fulfil their relevant roles satisfactorily which may construct learning environments helping staff to promote positive staff attitudes towards their older patients.

A study by Lookinland and Anson (1995) in a refereed article measured the attitudes of RNs working in acute hospitals, and high school students enrolled in a community occupational program in California. Data were collected by survey using Kogan's Attitude to Older People Scale (Kogan, 1961) in a comparative-descriptive-correlational study. There were two target groups in the study, one group of RNs who worked with elderly patients in acute care facilities and a group of high school students who were enrolled in health career work study programs. Although the results showed that the school students had significantly more unfavourable attitudes than the nurses, stereotypical perceptions and ageist attitudes towards older people were held by the RNs. The authors acknowledged that a limitation of the study design was to use a single survey instrument to measure the multidimensional construct of attitude toward elderly people. They suggested that further research on students' attitudes toward elderly people could use triangulation as a method to "capture the essence of the construct and individual heterogeneity" (p. 54). The findings of the study confirmed that there was a continued need for nurses to receive education to combat stereotypical attitudes about older people. Unfortunately, older people and the care provided to them are stereotyped and this is considered below.

2.2. STEREOTYPING OF AGED CARE

Stereotype is defined by Lefrancois in his psychology textbook as “widely held attitudes and opinions concerning identifiable groups” (1980, p. 562). The ageist attitudes and opinions of health professionals and society in general have previously been acknowledged may cause the stereotyping of aged care and older people either as a group or an individual (Palmore, 1992).

Stereotyping of older people and aged care may produce a standardisation of care, which describes tasks and activities delivered to patients performed in the same way without acknowledging the differences that exist between the individuals receiving the care.

Stevens and Herbert (1997) in a refereed discussion paper claimed that indicators of ageism existed in the broader community through “negative stereotypes of older people as frail, dependent and unproductive” (p. 9). This has been reported by other researchers (Baker, 1978; Pursey and Luker, 1995) and their findings will now be considered.

Baker (1978) in an unpublished Ph.D. thesis in Manchester, England coined the term Routine Geriatric Care to describe the impersonal and rigid way of organising care in the wards she studied. Everything was geared to getting the work done with the maximum economy of human resources. Patients felt dominated and unable to express their individual needs. Though this study was undertaken in the 1970’s, it still has relevance to today’s issues. Unlike nursing routines occurring with general hospitalised adult patients, routines in geriatric care have described practices, which

could be determined by the patient as a matter of need or choice. Baker described examples of routine geriatric care involving all patients being taken to the toilet regardless of need and with no choice available to the individual patient.

This was later confirmed by Pursey and Luker (1995) in their refereed article. The intent of the study was to examine the retrospective experiences of the nurses and to describe differences between nurses' attitudes towards work with older people in the collective sense and their attitudes towards the individual patients with whom they worked. Their study was conducted at four institutions in the north west of England which provided health visiting and practice nursing courses. The nurses were selected using a convenience sample (n = 136) consisting of experienced health visitors, student health visitors and practice nurses. Data was collected using a two phased multi-method approach. Participants were asked to complete a questionnaire, write an account of two incidents in which they had been effective and ineffective as a nurse with older people and an in-depth conversation style interview. Their findings identified several important issues for nurses and nursing practice. Firstly, nurses had positive feelings for older people and secondly nurses had negative feelings about the structural context of the work. The results showed that ward routine was a dominant category in the data. This related to the type of care respondents were able to deliver on the ward which appeared to undermine the standard of care respondents felt they should be able to give patients, causing much frustration to the respondents. The authors described routine methods of organising patient care as an approach which "commonly involve treating all patients the same, and are underpinned by the assumption that all patients have the same needs" (p. 551). They gave examples of patients routinely being toileted every three hours, but when requesting assistance to the toilet, outside the routine time, would be denied inevitably leading to the patient

being incontinent on the next toilet round. This type of practice was not only frustrating and concerning but described as by the nurses as **"**depressing and very ineffective" (p. 551), and memories of geriatric wards prompted vivid descriptions of "bias, intolerance and, on occasions, abuse" (p. 550**).** Pursey and Luker acknowledged that the retrospective nature of nurses' experiences may not be valued by some readers due to changes in the care practices with older people. The authors suggested that the inherent tension in the difference between nurses' feelings makes work with older people an unpopular choice once qualified and suggested changing work routines from being task focused to patient focused. This is similar to Koch and Webb's (1996) findings that patients' individual needs were not being met.

Koch and Webb (1996) performed a study in a 1000-bed National Health Service Hospital in the United Kingdom that involved interviewing fourteen elderly patients and collecting data from journals and observations they made. The aim of the study was to listen to the voices of older people and "Through all the patients' stories, the 'geriatric routine' was one of the most abhorred yet tolerated aspects of care" (p. 955). In this refereed article they asserted that negative images stereotyping aged care was reinforced through the biomedical construction of old age which has been concerned with the degenerative as opposed to the adaptive and developmental progress of ageing. This has had important implications for the way in which nurses view older people and the way ageism is perpetuated in the wider community. Koch and Webb (1996) stated that the medical model influenced nurses giving way to the negative stereotyping of old age by associating it with decay and degeneration. This study importantly recognised differences in the resource distribution between the wards for older people and wards for children "both in material and human terms"

(p. 958), which indicated the value placed on the services to older people. The authors went as far as stating "In devaluing patients by using stereotypes, nurses at the same time devalue themselves" (p. 958).

Segregating patients to units or separate facilities or hospitals because of their age may be considered another form of stereotyping. Koch, Webb and Williams (1995) described in a refereed article their study aimed at gaining the experiences of older people receiving care in hospital and found that older patients viewed age segregation in hospital negatively. The study was performed in a public hospital in the United Kingdom with traditional "Nightingale wards" (p. 186). Two wards, one female and one male both with 22 beds for the care and treatment of acutely ill older people were used. The study used an eexistential-phenomenological approach and data was collected from patient interviews and field journals**.** The patients believed that because they were not "mentally incapacitated" (p. 190) they did not view themselves as being old and yet they wished to distinguish themselves from those who were "really old" (p. 190). The authors acknowledged that limitations posed by past management deficiencies, which included under-staffing and poor physical environment contributed to the situation reported. Importantly trained nurses felt they worked hard but were hindered due to constraints relating to a high ratio of untrained staff and lack of continuing education which meant that their levels of achievement were far from ideal.

Later, Koch and Webb (1996) recommended a review of segregation based on age and linked it to the problems associated with routine geriatric style of care which. In their opinion this style limited nurses who resorted to "a reductionist approach to care,

where only the most basic needs were considered, and even these were sometimes not met" (p. 958). They argued that older people required nursing skills that are needed by patients of all ages. Similarly, Ford & McCormack (1998) believe that "all nurses need to be able to relate such knowledge and expertise specifically to older people" (p. 16), recognising that older people are cared for in integrated units within healthcare facilities. They assert that problems relating to hydration, nutrition and continence, for example, are far form being basic and require a range of knowledge, skills and competence.

The identification of skills for the aged care nurse will be dealt with in the next section, establishing what nurses know about aged care needs is a useful start.

Wilkes, LeMiere and Walker (1998) performed a study with 261 RNs in acute units in a large metropolitan hospital in Australia to determine what RN's thought of older people and to identify RN's knowledge base about older people and ageing. In a refereed article they described how they used the Rosencrantz and McNevin Semantic Differential Scale to measure attitude and a modified Palmore's Facts on Ageing Quiz to measure knowledge The researchers found that the RN's had reasonable knowledge about aspects of ageing, but were negative in their attitude and stereotype older people rather than treating them as individuals. Though the RN's knowledge overall was reasonable, researchers stated that upon examination of erroneous answers, there were significant gaps in knowledge which posed implications for the nurses' clinical practice. In particular, "The high error rates may affect how nurses teach older patients in that they may become impatient when explaining procedures to older people" (p. 11) and ultimately "they might not be able to provide the best possible

care to older people" (p. 15). The researchers determined that the participating RN's had deficiencies in attributes that relate to knowledge about aspects of older people's characteristics taking into consideration the age and individuality of a person. The authors acknowledged that the low response rate of the nurses in the study was a limitation to generalising the findings. Also, that the Rosencranz and McNevin tool used was dated and that male and female nurse responded but the tool was only verified with male subjects.

Stereotypical views expressed by the nurse towards older people may compromise the quality of care provided. Courtney, Tong and Walsh (2000) recognised that "with increases in life expectancy and increasing numbers of older patients utilising the acute setting, attitudes of registered nurses caring for older people may affect the quality of care provided". (p.62). In a refereed article of the literature review they performed they identified that nurses with positive attitudes towards older people may also hold negative stereotypical, ageist attitudes. These may interfere in the delivery of care, especially if patients are considered by the nurses to be "cantankerous and complaining" (p. 66), then their requests to nurses may not be taken seriously, which may result in adverse events.

Research studies have considered the effect nursing education programs have on nurses' attitudes. In a refereed article McLafferty and Morrison (2004) described a study they performed to examine whether negative attitudes towards older people persisted. A qualitative approach using purposive sampling was used with participants involved in focus groups, which were video-recorded to collect data. Several sites were used including specialised areas for the care of older people, acute

medical/surgical settings and a school of nursing and midwifery in Scotland. There were 36 participants who included RN's, nurse teachers and nursing students. The authors found that education programs may cause negative influences upon student nurses and pre-registration programs were perceived to "over-rely the teaching of negative aspects of ageing" (p.446). The authors did acknowledge limitations due to using a small sample, but noted that it was congruent with qualitative research. This supports earlier research by Stevens and Crouch (1995) who conducted a three year long longitudinal into undergraduate student nurses' attitudes to a career in aged care. The study was conducted in five schools of nursing in Australia. The participants were asked to complete a specially designed questionnaire on entry to the course, at the midway point and just prior to the completion of the nursing course. A total of 156 matching responses were obtained. The researchers found that "negative attitudes towards the elderly are consolidated rather than dissolved in the course of their training" (p 233). They reported that the processes within nursing education helped discourage students from considering aged care as an option. Stevens and Crouch suggested the reason may lie more in the professional socialisation process embedded within the nursing course which, in some way devalued personal care duties as opposed to activities related to medical technology which some considered to have a higher status.

Proposing an alternative view to Stevens and Crouch (1995), a research study by Haight, Christ and Dias (1994) found that nursing education promoted more positive feelings towards older people and "early exposure to well elderly people as clients has a lasting effect on nursing students' attitudes to older people" (p. 389). The research was conducted at a university in the USA and involved one hundred and eighteen

baccalaureate nursing students in a longitudinal study. The study design was test-retest with one experimental group. The Kogan's Attitude Toward Old People Scale and the Rosencranz and McNevin instruments were used to measure students attitude. Important outcomes of this research include the findings that older nurses have improved attitudes towards older people; grandparents created positive role models for ageing to the students, exposure to well older people had a positive effect on students' attitude and nursing education promoted positive feelings towards older people.

Stereotyping older people and aged care can be considered a by-product of ageism, which has occurred in the health system and with RN's working with older people. Though many researchers, clinicians and managers identify and write about aged care stereotyping, there will be many more that do not recognise or fail to see the importance of this insidious form of discrimination.

Ageist attitudes and stereotyping of aged care can influence other people's views about the status of aged care nurses and nursing and will be considered in the following section.

2.3. LOW STATUS OF AGED CARE NURSING

The low status of aged care nurses and nursing has been reported by nurse researchers over the years (Baker, 1978; Jones, 1993; Koch & Webb, 1996; Lawler 1991; Nay, 1998; Pursey & Luker, 1995; Reed, 1994; Stevens & Crouch, 1995; Wade, 1999). The reasons for this are many and interrelate with other factors. Jones (1993) writing a commentary about the care of older people in a refereed journal states "Within the

health caring professions, work with older people is still generally accorded a low status and seen as unrewarding, despite the fact that many professionals hold the opposite view"(214). I believe that ageism and stereotyping are two related factors that can influence others people's views to consider aged care nursing as being a lower status than other clinical specialties.

Aged care nursing has been practised by qualified nurses since early days of colonisation in Australia. The history of nursing in Australia commenced with the arrival of a group of religious nuns of the Sisters of Charity in 1838, on behalf of the Catholic Church. These religious sisters were occupationally trained nurses and commenced their ministry "visiting the sick in their homes, the sick inmates in gaols and to the destitute patients in the Sydney Infirmary" (Stevens, 2003, p. 21). The arrival of Lucy Osborne and 5 trained Nightingale nurses for the Sydney Infirmary can be considered the commencement of a formal nursing service which prior to this was drawn from the convict mass under the control of the medical officer. Many of the patients receiving care in those early days were older infirm people.

As nursing developed, nurses became more engaged in activities closely aligned to the doctor's work (Lawler, 1991). Nursing practice has been described by the activities nurses performed, and two terms commonly used are basic and technical care. Melia (1978) described basic care as being "nursing which provides the patient with all the needs in terms of physical comfort, which he would have provided for himself if he were fit to do so" (p. 61), and technical as being "the care given as a result of the disease from which the patient is suffering" (p. 61). Melia suggested activities such as dressings, injections, catheterisations and oral administration of drugs as examples

of technical care and said that “basic care has fallen into disrepute because it can be seen to imply lack of skill or importance” (p. 62).

The effect of views and opinions about the status of aged care nursing has been reported by nursing researchers and in government reports. The Marles Report (Marles, 1988) was a study commissioned by the Victorian Government in Australia to review the status of the profession of nursing in the state. The study considered concerns of nurses in aged care both in the hospital and nursing home sector. Nurses reported that the low status assigned to them was due to the area in which they worked and that they considered their work to be highly skilled. The non-refereed report identified aged care rehabilitation as an example of nurses working in increasingly specialised areas and highlighted this comment from a nurse, “Nurses in this unit feel they are perceived by other health professionals as lower status” (p. 104). Marles noted that particular to aged care “dramatic changes in the complexity of nursing work and in nursing workloads have emerged as the dominant source of job dissatisfaction” (p. 100). In support of the nurses role King (1995) asserted The nurse’s role is critical because older patients are sicker, their treatments more intense and chronic conditions often underlie their acute illnesses” (p. 28). To improve the system, specific recommendations were given for certain hospitals, but in general the focus of providing educational programs was made.

Stevens and Crouch (1995) found in their longitudinal study with nursing students that personal care duties were devalued and the activities related to medical technology given greater status. The personal care duties referred to as basic were given low ratings each year for 3 years, while other specialties characterised as more

technical consistently received higher ratings. Negative comments included "I do not enjoy working with the old people primarily because you work at a slow pace and you tend to concentrate your skills around basic body care and diversional therapy" (p. 238). Similarly, Happell (1999) wrote:

> data (from her research) would suggest that pre-registration education programs produce registered nurses who are socialised during their student years to perceive 'real' nursing as a role associated with acute general hospitals and the manipulation of technology and "machines that go beep" (p. 504).

Happel (1999) reported in a refereed article a study conducted on 1st year undergraduate nursing students in nine universities in Victoria, Australia. Students received a questionnaire within their first 3 months of commencing the course in order to minimise the influence of nursing education on their attitudes. There were 847 questionnaires distributed with a 93% return rate. The results clearly indicated that students had firm preconceived ideas as to the areas in which they wish to practice following training. Midwifery, paediatrics, operating theatre and critical/intensive were highly favoured, while working with the elderly, psychiatric nursing and community health nursing significantly less popular.

In a discussion paper for the Royal College of Nursing Australia, Stevens and Herbert (1997) wrote that students and newly graduated nurses perceived technical nursing to be the "stock and trade of a professional nurse" (p. 16) and "technical, medically informed, curative work is regarded as the pinnacle of professional practice" (p. 17).

Clearly, the basic and technical aspects of the nurse's role can be distinguished and certain specialties will perform more technical work than others. The operating theatres and critical care require nurses to employ technical work regularly within the nursing tasks performed. The nurses in these areas usually work side by side with their medical colleagues providing care and treatment to the patients. Lawler (1991), in her book suggests nurses may be socialised into believing that there is a hierarchy of nursing tasks and that a nurse performing such technical skills has higher status than a nurse performing more basic care which Lawler refers to as "body care" (p. 119), yet with no less skills required.

Due to factors associated with disability and frailty, older patients in acute units often require more assistance with activities such as washing, attending the toilet and having a meal than younger patients who may perform these tasks independently on a more regular basis. When the older patient moves to a less acute area for post acute care and/or rehabilitation, this type of work continues and becomes more prominent in their continued care. As nurses have made changes to work practices, this work may have been allocated to nursing assistants, and some may call this type of worker less trained or unskilled. King (1995), writing in a refereed article about specialised courses for nurses in gerontological nursing comments that there is a common perception that "it is acceptable for an extremely dependent older person to be cared for by an untrained worker" (p. 28). Instead King argues this area of care is "complex, demanding and sophisticated" (p. 30). This has been supported by Ford & McCormack (1998) whose commentary on the dignity provided to older people in hospital and the skills required by nurses caring for older people stated:

> "The fundamental aspects of care, such as nutrition, hydration and continence promotion, are essential to the wellbeing of older people. Expert nurses know that enabling an older person with complex health and social care needs to receive sufficient nutrition and hydration is far from basic and requires a complex range of knowledge, skills and competence" (p.16).

It can be argued that any intervention with a patient is an important part of their care program and the level of expertise required can be measured to ensure the appropriateness of care delivered. Essentially, patients should be individually assessed and not stereotyped into a category of care, which has been seen to be demeaning to the patient and to staff.

Commenting upon the perceptions of care in nursing homes, Nay (1998) noted in a refereed article that nurses do care about their patients, but identified that the low status afforded to the care of older people was due to the lack of education in nursing and specifically about older people. This resulted in inappropriate practices which, "reflects an assumption that nurses 'know what is best' for older people and this results in residents at best being infantilized and at worst being totally objectified" (p. 406). The low status identified by the author and experienced in the nursing homes can be directed to aged care units in the hospital and especially in the acute hospital which has high profile areas such as emergency departments, operating theatres and high cost areas such as critical care. Wade (1999) stated that when an older person no longer requires to be in an acute unit, the skills and expertise alter and because of this "the glamour associated with technical care subsides and this expertise is perceived as inferior" (p. 341).

Interestingly, it was not only nurses who experienced a negative perception from their colleagues. Jones (1993) stated in her refereed article comments from a cardiologist who defined a geriatrician as "a doctor who is not good enough to be let loose on patients who really matter" (p. 214). Similarly, Evans (1997) in a refereed article describing the history of geriatric medicine noted that when the specialty of geriatrics was recognised in the United Kingdom in the 1950s, consultant geriatricians had a difficult time, were excluded from the main hospitals and had their access to private practice inhibited, "This medical apartheid contributed to a general perception of geriatric medicine as a refuge for doctors who had failed to make their way in some more desirable specialty" (p. 1076). It would appear that the opinion of geriatrics originally determined by medical staff in the 1950s would continue overseas and into the 21st century.

Nurses have stated that they do not necessarily value their own contribution and that the image conveyed by working in a ward dedicated to the care of older people is one of low status (Reed, 1994). The findings of studies that have examined RNs' attitudes towards old people have, in the majority, shown that it is the least desired career choice; implying that the work and those who work in aged care have a lower status than more acute areas of nursing (Courtney et al. 2000; Ford 1998; Hope 1994; Wilkes et al. 1998).

Contrary to opinions that aged care is a lower status to other clinical areas and in some way inferior, researchers have identified that older people have specific needs. It has been recognised that older people present with multiple physical and psychosocial

problems impacting on their health which during admission to hospital may remain undetected and untreated (AHMAC, 2004). Admission to hospital is a move from the familiar environment of home, residential facility or nursing home which may result in a loss of independence and a decline in functional status that may not show on admission (Murtaugh & Freiman, 1995) and which requires individualised care and assessment (Kenny, 1997; Joy, Carter, & Smith, 2000).

Because of the slower recovery rates in elderly people, they are seen as bed blockers. This does influence staff attitudes of the elderly and a clearer articulation of the aims of the organisation of its role and function from management is needed to help nurture more appropriate attitudes. It was also noted that staff with training and education in gerontology had more favourable attitudes towards the elderly.

In a study performed by Slevin (1989) (as cited in Slevin 1991) and reported in his unpublished PhD thesis in Ireland, 74% of RN's in the study had not attended a study day in the previous 2 years and 64% had not attended a study day since first qualifying. In a later study by Slevin (1991) he found similar links between education and attitudes in nursing staff. The study included a convenience sample of school students, nursing students and both registered and enrolled nurses in Ireland. The study used The Attitudes Towards the Elderly Questionnaire, an instrument locally designed to measure the attitudes of medical students towards the elderly. The findings showed the registered and enrolled nurses had a significant difference in mean scores to the school students and nursing students at the $P = < 0.01$ level. This would appear to support a proposition, listed as a purpose to the study, that professional socialisation, including professional education influences may lead to

more negative attitudes. The lack of continuing education, as identified in the earlier study may be influential in how RNs are prepared to meet the needs of older people. The author did caution against accepting conclusions based on a small scale study and suggested the most valuable outcome of the study was the indication for further research.

However, since then, more courses have been developed for nurses to access to support continuing education and training.

It has been suggested that nurses working in hospitalised aged care units require attributes and competencies to consider a persons age, individuality of a person (Wilkes et al. 1998); knowledge of the ageing process, and who can provide humanistic care (McCormack and Ford, 1999) and skills described by Stevens and Crouch (1997) as being:

> "a complex set of skills such as recognition of symptoms, signs, needs, intellectual and perceptual vigilance, theoretical knowledge of conditions… the ability to make decisions regarding appropriate strategies to meet needs and alleviate symptoms, the capacity to evaluate and modify such action. These are all high level professional capabilities and require intelligence, knowledge, training and experience for their full development" (p. 241).

Horton, (2005) writes the challenges for nurses working with the aged patient in the acute sector are numerous. A considerable number of elderly patients have co-morbidities. Often disparity exists between a diagnosis related to a disease process and one associated with the ageing process. Today, aged care factors are impacting on

all aspects of nursing. As well as the physiological aspects, these factors include such dynamics as social, economic, legal and ethical issues. However, nurses in aged care consider that they are not recognised as highly as other nurses.

Working in an area that is considered to be of lower status to other areas has a real chance of impacting upon patient outcomes, quality of care, motivation and recruitment and retention of nursing staff. Factors such as ageism, stereotyping the nature of the nursing work can influence the working capacity of the nurse and can, as McLafferty and Morrison (2004) identified, be a significant factor in shaping attitudes which will now be considered.

2.4. ATTITUDE OF NURSES TOWARDS OLDER PEOPLE

Attitudes can be described as being either positive or negative and have been well documented in health research. Information previously highlighted the fact that negative attitudes about older people abound and can be associated to ageist thinking. In this section attitudes of nurses will be explored through past and current nursing literature to identify other factors that influence attitudes.

Professional socialisation, defined as "acquiring the requisite knowledge and skills and also the sense of occupational identity and internalisation of occupational norms typical of the fully qualified practitioner" (Moore, 1970 as cited in du Toit, 1995, p 166) has been identified as a significant factor in shaping student nurses' attitudes (du Toit, 1995; McLafferty and Morrison, 2004; Slevin 1991; Stevens and Crouch, 1997).

Undergraduate nursing students have featured prominently in nursing research, and though student nurses' attitudes towards older people may be favourably changing (McKinaly & Cowan, 2003) previous studies demonstrated that nursing students, in general had negative attitudes towards older people (Battersby, Brackenreg, Ross, Shackleton & Stevens, 1992; Fox & Wold, 1996; Happell, 1999; Narikuzhy, 1999; Slevin, 1991; Stevens & Herbert, 1997). Aged care is not perceived by students as a professional area of nursing. Aged care nursing is perceived by students as an area which requires a low level of skill and knowledge (Battersby et al. 1992). Aged care nursing is considered to be boring and repetitious with insufficient challenge and excitement and students have described older people in this way, "elderly people are just so wrinkled and annoying and it is also very disgusting as you have to clean up messy things… I feel that working with the elderly continually would be very depressing" (Happell, 1999, p. 500). This description exemplifies how ill older people can be stereotyped very quickly and a negative attitude taken in reaction to the experience. It also highlights the need to prepare students for the different work experiences ahead of them.

Armstrong-Esther, Sandilands and Miller (1989) performed a study to determine the attitudes of RNs, nursing assistants and volunteers towards older people in acute care settings, and investigated the variations in types of interaction between staff and patients**.** The study was performed in the same hospital in three surgical and two medical units using Kogan's Old People Scale, specifically designed questionnaires and participant observation. Interestingly, the findings identified that volunteers had the most favourable attitude to the patients but by being a volunteer showed that the person had a positive attitude to begin with. In the responses from RNs**,** those who

rated basic care as lower in importance to patient well-being, an example being, talking to patients, showed a more positive attitude. The basic care identified by Armstrong et al. (1989) refers to the structure of work, similar to the routine geriatric style of work described by Baker (1978), which was unpopular with nurses, as opposed to other humanitarian interventions, like talking to patients which is considered interesting work. Other factors identified that may influence the nurse's attitude include life experiences. Nurses who had "frequent contact with parents had a less positive attitude" (p. 40). Less frequent contact caused parents to be idealised which was projected as positive attitudes towards the older patient, and this may be a motivator for nurses to move into aged care and obviously targets nurses at a certain age, meaning that the nurse would has been in the workforce for some time and be considered someone with years of life experience as an adult.

Lookinland and Anson (1995) reported in a refereed article their concern that future care givers may have less favourable attitudes to current care givers. There study was to describe and compare the attitudes of RNs and health career work study students who worked with elderly people in a Californian hospital, and to determine whether relevant demographic variables of the two groups were related to their attitudes. A survey approach was used in the comparative-descriptive-correlational study. The survey used was the Kogan's Attitudes Toward Old People Scale. A convenience sampling technique was used to invite the 82 RNs and 68 students**.** They found that the students in their study expressed significantly more unfavourable attitudes than RNs towards older people. The results showed that student's educational level and primary area of clinical work were significantly associated

($P < 0.05$) with students' mean negative scores. Lookinland and Anson suggested that student nurses learn the difference between the normal process of and the pathological conditions in older people and that by having exposure to well older people may improve their attitudes. The author's acknowledged a limitation of the study being the use of a single measurement tool and suggested further research using triangulation as a methodology.

Fox and Wold (1996) in their refereed article explored how the practice setting may influence student nurses' attitudes. They demonstrated the emergence of very positive and rewarding learning outcomes, particularly in relation to attitude change for student nurses placed in settings conducive to caring for older people. The study was conducted in the USA with one hundred and forty-four baccalaureate nursing students who were completing a gerontological nursing course. The participants completed a pre/post test questionnaire to assess key attitudes, a questionnaire to evaluate placement in different the health agencies and an instrument comprised of 3 questions to evaluate the course. These students recognised the need for aged care nursing facilities to have adequate skilled staffing, improved activities and an environment with home-like qualities. This is an important statement as many hospitals will maintain an acute clinical focus in the design of clinical areas. There are opportunities in designing specific units for older people with less clinical design and being more homelike. The authors acknowledged several limitations to study including influence from faculties upon the participants and a researcher designed evaluation tool.
Hope (1994) in a refereed article stated that "The fact of the matter is that care of older people is now within the remit of all nurses" (p. 611). Hope compared the attitude of 149 RNs working in different care settings in two health authorities in

Manchester, UK. The sample groups were from an acute medical ward and an acute care of the elderly patient ward and were equal in number. The purpose of the study was to examine the nurses' attitudes in different settings. The study demonstrated that elderly patient care nurses exhibit a more positive measured attitudinal disposition towards older people than their medical nursing counterparts. The nurses were asked to complete a modified Palmore's Facts on Aging Quiz to measure the nurse's knowledge about older people and the Kogan's Old People scale which asked positively and negatively framed questions about older people. The study identified that there was a relationship between the knowledge score and age of younger nurses who scored lower on the attitude scales. Also, the years worked in the specialty and the number of years as a qualified nurse influenced and promoted nurses' positive attitudes towards older people, similar to later findings in a study with RNs in nursing homes in Australia (Narikuzhy, 1999) and may suggest that older nurses may hold more positive attitudes. However, Conte (1995) in her study of RNs using the Kogan Old People Scale found no relationship between the years worked as an RN in an older people's unit and the attitude towards older people. It would seem reasonable to assume that nurses who stay in aged care and receive the continuous exposure to older people would have more positive attitudes as they are in an environment of their choice.

McKinlay and Cowan (2003) performed a study on 172 student nurses at three higher education institutions in Scotland. The study was to determine the student's attitude towards working with older people by drawing on participants' own understandings about what they found important working in aged care. McKinlay and Cowan believed that "previous studies had failed to distinguish attitudes towards older people

and attitudes towards working with older patients" (p. 300). The study used a theoretical and methodological approach informed by the theory of planned behaviour. This approach had not been employed previously in studies of nurses' attitudes towards working with older patients but had been used in other areas of health care research. The researchers developed specific questionnaires incorporating Likert-type scales, two vignettes and demographic questions designed using the theory of planned behaviour. The researchers found that participants generally had positive intentions towards and about working with older people. Their recommendations specifically suggest education to promote tolerance towards older patients, emphasise the potential for job satisfaction, for students to explore their own concerns about ageing and to emphasise the need to take account of carers and team partnership. McKinlay and Cowan did show that "student nurses' intentions towards working with older patients are mainly predicted by their attitudes" (p. 306). This finding confirms the importance of understanding the attitudes held by nursing students in particular and to assist in the formation of positive attitudes towards older people.

More recently, McLafferty & Morrison (2004) performed a study with RNs, nurse teachers and student nurses from hospitals and a school of nursing in Scotland. The aim of this study was to explore nurse's attitudes towards working with older people from different points of professional experience. The study used a qualitative design and participants were recruited using purposive sampling. Focus groups were used to collect data and to use the data to develop an attitudinal questionnaire. These methods were used to explore nurses' views of older adults in hospital and consider the contextual nature of those views. Ten themes were identified but five generated the most discussion and they were; looking after older adults, organisation of nursing care,

labeling older adults, student expectations of learning experiences in older adult settings and teacher influences on nursing students' attitudes. The findings importantly showed that RNs working in health care settings with older people wanted to be there, and of importance "that patients were being treated as individuals and that former institutionalizing approaches were declining in use" (p. 450). The study also found that though many of the RN's were very positive about their work and the nursing opportunities they had to offer student nurses, the previously mentioned concerns had the effect of turning some nurses away from the specialty. Other findings criticised the content of the pre-registration curriculum, which they perceived to "over-rely teaching the negative aspects of ageing" (p. 446) and the currency of teachers' knowledge. Nurses working in acute settings were seen as lacking a sense of humour when dealing with older people. The use of humour had previously been identified by Thorsteinsson (2002) as being pleasant, a way of lightening the atmosphere for patients and an attribute that showed the nurse to be caring. McLafferty & Morrison (2004) acknowledged that the small sample size may be a limitation to the study, but was congruent with qualitative research.

Nurses attitudes towards older people were importantly demonstrated in a study conducted in the USA by Jacelon (2002). The study was a grounded theory research project on the meaning of hospitalisation for elders which also found that staff attitudes were found to affect older people's dignity and autonomy. The study used was performed in three phases; on admission; on discharge and 2-4 weeks following hospital discharge. Participants included 5 patients, 4 family members and 6 registered nurses from a trauma centre of a rural hospital in the USA. Data was collected using audio taped interviews and participant observation which were qualitatively analysed. The author found "Staff attitudes that positively affected the

hospitalised elders dignity were attentiveness, connectedness, friendliness, helpfulness, unobtrusiveness and respectfulness" (p.229). The author acknowledge that the hospital being in a rural, middle class area of the USA with few minority patients may limit the use of the research context to a service with a similar demography. This study highlights the importance of providing positive and constructive attitudes, easily recognisable as caring attitudes as they will have an effect upon the older person.

A study performed by Helmuth (1995) explored the relationship between acute care nurses' attitudes toward older people, their attitudes toward the use of restraints and their actual use of restraints in several medical and surgical units. The study, reported in a refereed article, used a convenience sample of 52 RNs and licensed practical nurses from a Polyclinic Medical Centre in the USA. Three acute medical and surgical nursing units were chosen as they typically had a high parentage of elderly patients. The participants completed The Attitudes Toward the Aged Semantic Differential instrument, The Perceptions of Restraint Use Questionnaire and in addition each participant was interviewed using the Restraint Use Data Sheet. The study found that nurses holding negative attitudes towards older patients held positive attitudes towards restraint use However, Helmuth concluded that in this case the nurses' perceptions may not have been translated into behaviours that reflect attitudes. There was sufficient evidence that nurses used restraints for the purpose of maintaining patient safety. Importantly, this study recommended that whereas people in the past had looked at changing nurses' attitudes towards restraint use, other areas should be investigated, for instance using alternative methods other than restraints and strategies to improve the condition of patients. The same applies when considering

improving attitudes to older people, all lateral ideas in improving the individual care of the older patient should be considered which may influence nurses' attitudes.

From the literature it appears that in general, nursing staff have a positive attitude towards older people, but a negative attitude to the work. Also, attitudes can develop through a process of professional socialisation. Certain practices which evolved in the aged care units, such as routine geriatric care, as described by Baker (1978), preclude nurses from performing individualistic, patient centred care and causes depersonalised and rigid forms of patient activities. Although there is some evidence that these structures are changing it is the continuation of these structures which can produce the dissatisfaction and discontent leading to others' admonishment. Nurses have identified the need for more and continued change to such practices.

It is appropriate to consider what the patients identified as significant issues.

2.5. IMPORTANT FACTORS IDENTIFIED BY THE PATIENT

Older people have the same expectations and concerns about what will happen to them and want to express their opinions as individuals like everyone else. Being acknowledged (Draper, 1996; Koch et al.1995; Parker, 1991; Randers, Olson & Mattiasson, 2002), having needs attended to (Jones, 1993; Koch et al. 1995) and being allowed choice (Koch & Webb, 1996; McKain, Henderson, Kuys, Drake, Kerridge & Ahern, 2005; Scott, 2005) have been identified as important factors by patients and by staff on behalf of older patients. What has been acknowledged is that older people do have special needs and require care and treatment from experienced staff

knowledgeable in aged care practices. This highlighted the fact that nurses often perform the role of patient advocacy.

Nurses as advocates

Due to the position nursing has in the health and aged care sector, nurses are regularly communicating the patient's needs and are seen as being one of the greatest advocates for older people. The Macquarie Dictionary (Macquarie University, 1982) defines advocate as "one who pleads for or on behalf of another" (p.70). From the beginning of the formal health and aged care service in Australia, nurses have been seen as being the traditional advocates for the patients. Henderson, (1969) in her book describes one of the components of basic nursing care as being "*Helping Patient Communicate with Others – to Express his Needs and Feelings"* (p. 39). Within this description she asserts that the nurse is "inescapably an interpreter" (p. 40). The nurse has on many occasions been seen as the person who links the doctors' information to the patient.

Stevens (2003) examined, in an historical overview, the unique phenomenon of older people emerging as a social group in Australia, identifiable not only by chronological age but also by their specific needs and when nurses came to care for older people. Stevens (2003) indicated that the arrival of the Nightingale nurses gave society the skills and language for the elderly to emerge as a category within society with unique and special needs. Trained nurses were officially engaged and recognised in the care of the aged and infirm within government asylums long before they obtained the same official acceptance into the general public hospital system. Nurses were prominent in patient advocacy.

Snowball (1996) studied the understandings of advocacy in a group of 15 nurses in England. The study used an interpretive, qualitative research paradigm for the research design. The nurses were recruited using a non-probability purposive sampling technique in a large teaching hospital in two medical and surgical wards. The study used audio taped semi-structured interviews to elicit a narrative account of participants' perceptions, beliefs and values related to acting as an advocate for patients. The qualitative data identified categories supporting the concept of advocacy. The categories included the importance of the therapeutic relationship; nurse and patient shared common humanity and the cultural environment of care in which advocacy occurs as being key to advocacy. The participants took the notion of developing a therapeutic relationship with patients as the lynchpin to enabling advocacy. The study was identified as having limited scope and the findings not being generalisable due to being small-scale and exploratory. Also, that the group were an "atypical, 'enlightened' group working in a fairly unique clinical environment" (p. 74) which suggests further research is necessary.

Accepting as a premise that older people should be acknowledged as individuals will not only help the older patient but ensure health professionals begin the health assessment and continue the care planning in a respectful and sensitive manner to meet the individual's needs. Clearly, older people want to be recognised as individuals, to be consulted and be allowed to consider their choices about their health and the healthcare available to them. In that way there is more chance of cooperation and informed participation that should provide a better outcome for the patient and health service.

Being acknowledged as an individual

In a study performed by Randers and Mattiasson (2004) the autonomy and integrity resulting from interactions between older patients and nurses in real-life care situations was observed to gain a deepen understanding from an ethical perspective. The study was reported in a refereed journal and conducted in two elder care medical-surgical rehabilitation units in a hospital in Sweden. The participants included 7 RNs and 23 assistant nurses. The method used for data collection was participant observation which totaled 94 hours. The observational data collected considered the complexity of autonomy of dependent older people in the hospital setting and in six different situational cases. The authors used the theory of Collopy (1988) who identified and examined six polarities of autonomy and used Collopy's conceptual framework and content analysis for analysing the data collected. The findings indicated that "autonomy involves respect for patients in terms of their ability to choose, decide and take responsibility for their own lives … and stresses the intrinsic value of the patients … which marks their worth independently of others" (p. 69). The authors were able to confirm that "When older adults are allowed to be themselves, their unique personalities are respected. This implies recognition of older adults' rights to their own feelings, opinions, free will and ways of perceiving a specific situation" (p. 70). Importantly the authors asserted that all health care professionals have "an understanding and a confirmation of individual patients as unique human beings with the resources and abilities to master their own lives" (p. 70). The authors acknowledged that using participant observation of one researcher may create the possibility of observer bias. To minimise this, an inter-observer was used to strengthen the validly of the data and to reduce the risk of

observer influence, the observer wore the same uniform as the nurses to fit into the environment

Previously, Randers et al. (2002) reported an older man's lived experiences of being cared for in a geriatric context in which the majority of the patients were cognitively impaired. The findings indicate that this patient's basic needs for ethical care were not met. The staff did not see him as a unique individual with his own preferences, resources and abilities to master his life, as were the findings in previous studies (Draper, 1996; Koch et al. 1995; Koch & Webb, 1996; Parker, 1991).

This impersonal model may have encouraged routine geriatric care, first described by Baker, (1978) which removed the acknowledgment of the individual from the care. Understanding the individuality of the person is not just a nursing issue and was identified as being most important by Feinstein (2005), who reported, in a refereed journal article the thoughts and feelings of a medical intern during his interactions with a terminally ill patient. The weak voice of an elderly ill patient expressing her concern made the intern think, and he began to see the patient as a person. Acknowledging the older person's individuality demonstrates an ethical response by the nurse.

Tarlier (2004), wrote an article in a refereed journal to explore the moral and ethical foundations of nursing from the perspective of personal and public morals, and nurse-patient relationships as the reflection of ethical nursing knowledge. Talier argues that personal moral knowledge is transformed into ethical nursing knowledge and creates the possibility of responsive nurse–patient relationships, which can influence patient

outcomes. Tarlier described responsive relationships as being founded on three essential elements: respect, trust and mutuality and recognised that the three elements were grounded in ethical nursing knowledge.

One way of acknowledging and being responsive to another person is by way of personal communication. McCabe (2003) reported in a refereed journal a study performed to explore and produce statements relating to patients' experiences of how nurses communicate. The study used a hermeneutic phenomenological approach. Using purposeful sampling, eight patients in a general teaching hospital in the Republic of Ireland were interviewed. The age range of the patients was from mid 20's to early 70's, therefore the perspective was not necessarily age related. Data were collected using unstructured interviews. There were four themes identified in the findings which were; "lack of communication, attending, empathy and friendly nurses" (p. 41).

The study found that nurses can communicate well with patients who described behaviours such as "giving time and being there", "open/honest communication" and "genuineness" (p. 44) from the nurses. Patient's commented that nurses were not always patient focused in their communication but were sometime task focused and on other times were too busy to communicate. As well, McCabe noted that health care organisations did not appear to value or recognise the importance of nurses using a patient-centered approach when communicating with patients. It was also evident that nurses were not aware of how patients value nurse–patient interactions. Though nurses in general can demonstrate communication skills that meet patient needs, there

are environmental problems, for example, busyness of work and a lack of recognition from health care organisations that can cause barriers to effective communication.

If the nurse acknowledges the patient as an individual, it is more likely that individual patient needs will be met, with the potential of providing a more favourable outcome for the patient.

Having needs met

It has been widely acknowledged that older people receive a large proportion of health care delivery (AIHW 2006; Victorian Government Department of Human Services 2004) and that older people are stereotyped and marginalised (Baker, 1978; Palmore, 1992; Pursey and Luker, 1995; Stevens and Herbert, 1997) but are they treated differently and receive the required care? Jones (1993) in her refereed article writes that older people, and their health, are seen as different to that of others. In questioning society's attitudes to older people she emphasises that "older patients are people first" (p. 214). In arguing that older people must retain their rights to dignity, privacy and choice, Jones states that "older people are certainly not 'other people', they are just later on" (p. 215). This seems to be largely overlooked when older people present for healthcare. McKain, Henderson, Kuys, Drake, Kerridge and Ahern (2005) conducted a study in a 26-bed rehabilitation unit in a modern tertiary referral hospital in Australia and reported in a refereed journal. The intent was to learn what information patients receive prior to admission to the rehabilitation unit following transfer from an acute unit. Semi-structured interviews were undertaken with a convenient sample of nine patients shortly after transfer into a rehabilitation unit and with four of these patients after discharge. The findings showed that though the older

patients received very little information about what to expect as a patient in the rehabilitation unit they did not see this as being problematic. The study identified that though patients are often compliant with decisions made while they are inpatients their participation "as valuable partners in the system" (p. 709) could be reviewed to examine how they may become more actively engaged in their own program planning.

In a study to find determine whether demographic characteristics of patients were associated with different perceptions of the importance of and satisfaction with various aspects of nursing care, Chang et al (2003) found that older patients (aged >80 years) being cared for in aged care wards and older female patients have higher expectations of the importance of physical care, also supported by the findings of Hancock, Chang, Chenoweth, Clarke, Carroll and Jeon (2003). The study was conducted in five hospitals in Australia and two hundred and thirty-one patients were selected from ten geriatric and medical wards. Patients, some with the assistance of family members, completed the Caregiving Activities Survey which measures aspects of nursing practice. This provides useful information as it identifies what older patients consider to be the important factors of care. This study was followed up by the main researchers in a further study to develop, implement and evaluate a new model of care based on the initial findings. Glasson, Chang, Chenoweth, Hancock, Hall, Hill-Murray and Collier (2006) through an action research process stated significant improvements in older patient's activities of daily living from admission to discharge, knowledge of medication regimes and satisfaction in nursing care activities. The study was conducted in an acute medical ward located in a public hospital in Australia with forty one patients and thirteen nurses. The researchers used several assessment tools to measure patient improvements which included The Barthel

activity of daily living index (modified), a specially designed medication regime assessment, the Caregiving activities scale questionnaire, the use of Wadsworth's participatory action research process and field notes taken by the investigators. The study identified that "added focus on individual care promoted more positive feedback from older patients" (p. 595). The authors acknowledged that using only an acute medical ward and implementing only two issues was a limitation to the study.

In the current health system the quality of service provided is constantly reviewed. Assessing the quality of service is an indicator as to wether the provision of service occurs. Thorsteinsson (2002) reported a refereed journal a study conducted to investigate how individuals with chronic illnesses perceive the quality of nursing care in order to enhance the quality of care. A theoretical sample group of 11 hospitalised patients aged between 39-80 years of age were used. Data was collected through audio taped interviews of a set of questions developed by the researcher. The author found that by far the largest part of quality nursing care depends upon the personal qualities of the nurses who provide the care, this was described by the participating patients as being through their attitude, showing sensitivity to patients' needs, a genuine concern, trust and honesty, using humour, providing patient teaching and displaying a caring behaviour. The author recognised that a small sample size and the possibility of the nurse selecting patients may have been a limitation to the study.

Higgins, Fiveash, Parker, Lay, Rutter, Wamsley, Nancarrow and Henderson (1997) used a phenomenological methodology to interpret and understand the meanings of older people's experiences during acute hospitalisation. The analysis revealed that older people had difficulties with the unfamiliar, enduring and managing the hurt and

making sense of the experience. An example of the hurt that may occur is the lack of dignity given to the older patient. Jacelon (2003), in a grounded theory study of three phases of hospitalised elderly participants, identified maintaining dignity as the central focus. Dignity was found to have two attributes: self-dignity, the individual's sense of self-worth and interpersonal dignity, that attributed to the older person by others and manifested by the respect they received. The study was conducted in a hospital in the USA. Only five patients participated, but RNs and family members participated in the study. The researcher interviewed all participants during the admission, on discharge and on follow-up with the patients. Importantly, the findings identified that "a strong sense of dignity can sustain elderly persons through the challenges presented by hospitalisation" (p. 553). Nurses realising the importance of dignity in the hospital life of an n older patient and responding to it can bring about improved care for the patient.

Jacelon (2004) reported in a refereed journal a study conducted to describe the process that elders engaged in to survive the experience of hospitalisation. The study used a grounded theory design and was performed in three phases, on admission, on discharge and 2-4 weeks following hospital discharge. Participants included 5 patients, 4 family members and 6 registered nurses from a trauma centre of a rural hospital in the USA. Data was collected using audio taped interviews and participant observation which were qualitatively analysed. The findings showed that that "elders were actively engaged in creating meaning and employing strategies to affect the outcomes of hospitalisation" (p.554). This study showed that older people used strategies to manage personal integrity which emerged as "a dynamic intrinsic quality of individuals" (p.552). The author identified that personal health, dignity and

autonomy were specific properties of personal integrity. The author acknowledge that the hospital being in a rural, middle class area of the USA with few minority patients may limit the use of the research context to a service with a similar demography.

Dignity is a word often used when referring to the care of older people. Lack of dignity is an issue that that will mostly be reported. Jacelon, Connelly, Brown, Proulx & Vo (2004) conducted a study to develop a definition of dignity relating to older adults, which was reported in a refereed journal. Participants were recruited for focus groups using snowball sampling. Five focus groups were conducted at various settings: a private home, a Quaker meeting house, a classroom at a medical centre, and a conference room at an inner-city health clinic in the USA. The authors were able to propose the following as the conceptual definition of dignity from the data collected: "dignity is an inherent characteristic of being human, it can be felt as an attribute of the self, and is made manifest through behaviour that demonstrates respect for self and others" (p. 81). In describing dignity, the authors suggest that an individual's dignity is affected by the treatment received from others which is important for all healthcare workers when caring for and dealing with patients.

Giving respect will more likely ensure that the choice of a patient is acknowledged and adhered to.

Having a choice

Older people and nurses have recognised the importance of choice while being a patient. The study conducted by Koch et al. (1995) (previously described in this thesis) reported that patients wanted nursing care that would allow them to make their own

judgements based on adequate information, participation and self-direction. This problem has seemingly continued as Scott (2005), writing in a refereed journal about the care of older people asks "why is the patient being ignored in this day and age when patients' choice is seen as being very important?" (p. 278).

Personally, I have heard reported from time to time in public hospital aged care units examples of nursing practice that demonstrate the continuation of a modified routine style of care. One example is the practice of showering older rehabilitation patients in the morning was a matter of routine convenience for the staff and not necessarily what the patients wanted or needed. This is similar to an experience of an older person in the study conducted by Randers and Mattiasson (2004) (previously reported). A female patient reported how the nurse had asked her to be ready for bed by 8 o'clock in the evening, "She treated me just like the other patients, who are unable to decide what's best for them" (p. 66).

There appears to be a contradiction in what the patients and nurses believe should happen, that is providing respectful acknowledgment of the older patient as an individual, and what happens in reality. In a refereed paper written about the findings of a qualitative research project concerning the quality of life of older people in nursing homes and hospital wards in England, Draper (1996) identified the contradiction which may be applied to certain nursing care and nursing practices. The research sample consisted of 14 older people in a range of facilities managed by a single National Health Service Trust, (including long stay, day-hospital, acute rehabilitation and psychogeriatric) and 11 charge nurses/ward sisters from the same wards. The data was collected using a technique known as ethnographic interviewing.

All interviews were recorded on audio tape and transcribed verbatim for later analysis. Nursing staff interviewed during the course of this research argued that older people should be treated as individuals. In practice, this meant that older people should be granted the power to make decisions about the pattern of their daily lives. The research found that on the one hand, nurses strongly endorse the promotion of individuality through the facilitation of patient choice but on the other, they describe a range of mechanisms through which older people are effectively denied the opportunity to choose which Draper calls The Paradox of individuality. The author identified two kinds of justification for this: one that appeals to the greater good of the patient (the altruistic justification); and one that argues that the function of choice-limiting actions is to promote the smooth running of the institution (the sociological justification). This research identified that although nurses may have the intention of giving older patients a choice it does not mean the patient is able to control the situation so that there choice is delivered.

In a study conducted by Faulkner (2001) and reported in a refereed journal described how patient empowerment and disempowerment in hospital aged care units was measured. The principal aim of the study was to develop a valid and reliable measurement of patient empowerment and disempowerment. The study was conducted in three National Health Service Trust hospitals in England. Faulkner developed a “Patient Empowerment Scale” (p. 676) using 20 of the 98 nominated empowering and disempowering acts relevant to interactions between staff and older patients. A group of older patients scored the acts as being empowering or disempowering and the 20 acts with the highest score determined the Patient Empowerment Scale. The participating patients were asked to say how often they had

encountered the acts. The results showed a variation between the clinical specialities. The ward scoring lowest (the least empowering) was the elderly care rehabilitation unit. This also shed an inverse correlation between the participant age and exposure to empowering care. “These showed a significant negative relationship on the rehabilitation ward (site 1) (site 1, r =–0·70, d.f. 19, $P < 0·01$) indicating that as patient age increased there was a commensurate decrease in their exposure to empowering circumstances” (p. 681). Overall, the results showed that patients were more likely to encounter circumstances consistent with the development of increasing independence, than increasing dependence. However, as the age and disability of the patient increased the patient’s experienced an increase in disempowering and dependent interactions with nursing staff.

Identifying and understanding what is important to the patient is vital in being able to meet their needs. Being acknowledged as an individual, having needs met and being allowed choice have been identified as important factors, providing respectful care should ensure that these are met.

Nurses and nursing have an important role in this aspect of the patient’s continuum of care and is a key factor in marketing the role to those who are considering their future and for those who wish to make a change in their career.

With a greater understanding of the issues relating to the nurses and patients, consideration can be turned to the recruitment and retention of RNs.

2.6. RECRUITMENT AND RETENTION

Most managers would agree that the most important resource within an organisation is the people who work in it. Having effective management plans to recruit and retain staff is an essential strategic objective. The problem of nurse recruitment and retention has been an international concern (Burke, 2003; Carpenter et al., 2004; Hill & Walker 2004; Knowles, 2000; Numerof & Abrams 2004; Poduska, 2003) and has been raised in other studies relating to the care and management of older people (Happell, 1999; Lookinland & Anson, 1995; Pursey & Luker, 1995). Recruitment and retention of nursing staff in general is considered a complex problem (Drake, Dimon & Wheatley, 2001) and aspects of this will be highlighted in the following section.

According to Andrews and Dziegielewski, (2005) research shows "low levels of employment satisfaction prevalent among nurses" (p. 287). The American authors reported in a refereed journal their analysis of international literature on the subject of job satisfaction, nursing shortages and retention to formulate strategies and future courses of action designed to address the international nursing shortage. They concluded by acknowledging the issue as being complex and that nurse managers will require deal with n the complexity of issues outlined in this analysis and the demonstrated importance of nurse managers in assisting staff to deal with those influences, efforts to address the nursing shortage will require "additional resources and developmental research, directed towards exploring the factors related to the current shortage of nurses, and implementation of measures designed to improve the situation" (p. 293).

International projects have developed programs to improve nurse's job satisfaction, recruitment and retention with the aim of improving patient outcomes. The Magnet project started in 1983 and involved a group of American hospitals. Kramer & Schmalenberg (2005) wrote an article on the historical perspective of magnet hospitals. In the article which was reported in a refereed journal they stated that magnet hospitals had a reputation for "being a good place to work" (high nurse job satisfaction), patients received good care, for being "a good place to practice nursing" (high-quality care), and for recruiting (attraction) and retaining (retention) nurses" (p. 276).

American nurse leaders have been asked to embrace the Magnet Principles of Health Care to promote nurse recruitment and retention. The American Nurses Association established the Magnet recognition program in 1993 with the purpose of "recognising healthcare organisations that provide excellent nursing care" (Holloway, Hancock, Graf, Anton, Herrmann & Anderson-Shaw, 2005, p. 8). One such authority, The Oregon State Board of Nursing (2002) endorsed the use of Magnet Principles emphasising the administrative and clinical standards which achieve excellence in management philosophy and nursing practices. The authors of the article nominate improvements in the quality of patient care; leadership in promoting professional practice and attention to cultural and ethnic diversity of everyone in the health system. The article continues by stating "Facilities that have achieved Magnet status have been recognised for their ability to recruit and retain nurses while providing excellent patient care" (p. 1).

Similar strategies focusing on cultural changes were described by Poduska (2003) in a refereed article to drive nursing recruitment and retention initiatives in a 235-bed private, not-for-profit facility in the USA with success. The author reported in the article that the nursing staff at the hospital created a professional model of nursing care and displayed this as a star. The points of the star represented different aspects of the program and they were: "professional, learning, retention, recruitment, and compensation" (p. 13). Some years later Poduska (2005), wrote in a follow-up refereed article "the program also has improved patient outcomes, boosted market share, and created an employee culture of teamwork, empowerment, respect, integrity, and caring" (p. 223).

Magnet strategies are principles which most hospitals would embrace to improve all aspects of performance, however sustaining this type of program may be cost prohibitive to some hospitals which may need to address strategies singularly within budget allocations.

Other factors have been investigated to find evidence of benefits towards nurse recruitment and retention, namely, compensation and professional development.

Burke (2003), Carpenter et al. (2004), Hill & Walker (2004) and Poduska (2003) have identified being compensated sufficiently as a factor promoting recruitment and retention. Numerof and Abrams (2004) as management consultants reported in a refereed article that 27 different methods have been identified by staff in hospitals in the USA as retention strategies. The author's report that many hospitals were focusing on what she termed "The Compensation Trap" (p. 18), as hospitals predominantly

used short-term lures and incentives to attract and keep nurses. In their experience they note that though money and benefits are important base satisfiers for employees, they do not motivate behaviour over the long term. This is a difficult area to manage as it is usually out of the direct control of nursing management, but should be taken into consideration.

Professional development and succession planning strategies are seen as being motivators for remaining in an organisation (Carpenter et al., 2004, Hill & Walker 2004, Poduska, 2003), and yet despite the popularity of these methods approximately 11% offered preference to internal candidates when promotion opportunities arose and only approximately 22% systematically promoted career development, despite the fact that experience in hospital consulting demonstrates that hospitals that gave preferential treatment to internal, qualified candidates reported that it was the single most effective retention however (Numerof & Abrams, 2004).

Supporting the concept that professional development and supportive programs provide personal satisfaction, Bassi and Polifroni, (2005) wrote about the concept of the learning communities. The author's article in a refereed journal aimed to analyse the potential of the concept in increasing the recruitment and retention of new graduate nurses and returning practitioners to the nursing profession. This was considered through the use of orientation programs and facilitated professional support programs. The authors wrote that "incorporating learning communities into the healthcare organization decreases the number of nurses leaving nursing, fosters retention, and thus, enhances recruitment" (p. 103). The authors provided examples drawn, from international studies of the usefulness of supported programs in

establishing inclusiveness within the nurses. They summarise their analysis in stating "A learning community prevents isolation, solves problems, enhances professional growth, and fosters mutual respect and connectedness" (p. 109).

As well as focussing on qualified nurses, it is important to involve school students in the marketing strategies for nursing.

Hemsley-Brown and Foskett, (1999) reported in a refereed article a study conducted with young school aged people in England. Following pilot studies a sample group was selected with young people aged between 10-17 years, all were still at school and came from different areas within England. Qualitative and quantitative data was collected through focus groups and questionnaires. The focus groups used scripted enquiry that combined both open discussion of a range of issues. Group discussions were tape recorded and later transcribed verbatim. Individual questionnaires designed to address specific elements at particular points within the enquiry were completed. The authors found that though young people expressed admiration for the work of nurses, this was rarely matched by an envy of nurses, or a desire to become a nurse themselves. The main reason to be a nurse given by those choosing nursing was to help other people. The authors did acknowledge some limitation in the sampling method that may have introduced a slight bias against some ethnic minority children.

Erickson, Holm & Chelminiak, (2004) noted that though there had been a downturn in selecting nursing as a career this had not always been the case. They reported in a refereed article that 30 years ago a significant number of young people would have answered "Nurse" to the question "What do you want to be when you grow up?"

(p. 83). The authors reported that in 2004 “less than 5% of junior high school and high school students in the USA would consider a career in nursing” (p.83), which could be considered the same elsewhere in the world with the International concern on recruitment and retention. They identified that the public image of nursing, the stressful work environment, salary inadequacies, competing career options, low enrolment in nursing schools, an ageing workforce and dissatisfied nurses openly disparaging the profession as factors contributing to the nursing shortage. In the same article they reported on a study, requested by the chief nurse council of Partners Health Care in Boston, USA and conducted through an advertising firm to explore motivators and disincentives for choosing a nursing career and to identify what types of communication would motivate the target groups to the nursing profession. The study used both focus groups and telephone interviews to gather data from young people aged between 13 to 17 years and adults aged between 18 to 49 years who had considered switching careers. The focus groups had 45 participants who had been prescreened to achieve a representative sampling of the population and conducted 400 telephone interviews. The groups were selected using random-digit telephone dialing to telephone exchanges. The results showed that traditional efforts to reach younger people and adults thinking of career switching had not worked. The authors state that “nurses are the best source of positive information about the nursing profession” (p. 87) and that nurses should be conscious of their public image and share their stories to enlighten the community about the important contributions nurses make to healthcare. They suggested that improvements to recruitment and retention might improve if strategies were developed that included talking directly with young people and adults in a way that accurately reflects the benefits and rewards of a nursing career.

Erickson, Holm, Chelminiak & Ditomassi (2005) in a refereed article referring to the same study in Erickson, Holm & Chelminiak, (2004) questioned if nursing had an image that "scares off potential nursing students" (p. 46). The results showed that "only 5% of students and 3% of adults said they'd choose nursing as a career… that being happy at your job is the number one motivator for both students and adults… that only 35% of students and 33% of adults believe that nursing provides this benefit" (p.46). The authors recommended that nurses speak to young people and career-switchers about the reality of nursing through presentations at schools and hospital-based programs to "communicate the benefits of nursing, such as a sense of making a difference and benefiting people's lives" (p. 49).

An American program designed as a method of nurse recruitment that successfully involved high school students was described by Holloway and Halford (2004). The Exploration Program was conducted by the Methodist Medical Center's Center for Innovation and Clinical Advancement in Illinois 2002 and reported in a refereed article. The program was designed to increase student's awareness of nursing as a profession. The authors stated that "students need exposure to nursing's opportunities and responsibilities as they begin to express interest in a career" (p.24). A survey previously undertaken in a local High School showed that while 85% of students had considered a career choice, less than 30% thought seriously about nursing.

The program was conducted over one and half days and included the students discussing confidentiality, touring the nursing college, talking to current nursing students, completing their cardio-pulmonary resuscitation requirements, making a banner or poster for a Nurses Week display, attending sessions detailing the functions

of the brain, nursing technology and electronic medical records and shadowing a nurse on duty.

At the beginning of the program, about half of the participants indicated an interest in nursing. After the program, 93% of participants said that the Nursing Exploration Program increased their interest in nursing as a career. 93% of participants wanted additional contact with The Methodist College of Nursing. This indicates that early exposure of nursing to school students can increase their interest in nursing work and can be used as a marketing tool. Haight et al. (1994) found in their study with pre-registration nurses that grandparents created a positive role model for ageing and that exposure to well elderly people had a lasting effect on their attitudes towards older people. Early exposure to school students of older people in ill health may have the same effect of increasing interest in the care of older people.

Carpenter et al (2004) reported in a refereed article on the recruitment difficulties, and increased RN vacancies and turn over within the Carilion Health System, an integrated health delivery system in the Unite States consisting of several small rural hospitals. In 2000, the nurse executive chartered a system wide nursing recruitment and retention committee charged with evaluating the system's current state and developing and prioritizing strategies to mitigate the nursing shortage. The subcommittees identified that "the key elements contributing to the effectiveness of this program were its breadth and the deliberate effort to be inclusive of all levels of the organization" (p.5). The committees reported on outcomes that included nurses being involved in developing mentoring programs, a Career Advancement Program, careers programs for the youth, a Nursing Education Advisory Counsel and general

involvement in activities that affected their daily lives and clinical practice. These initiatives resulted in turnover rates dropping from 12.3% in 1999 to 7.43% in 2002, a 40% improvement. This led to a reduction in the vacancy rates and less pressure to recruit.

Being involved and participating in health strategies depends on the management style of leaders and managers. Dolan (2003) described in a refereed article a descriptive, correlational study conducted to identify the management styles of front-line nurse managers as perceived by staff and to evaluate the relationship of these styles to staff nurse job satisfaction. The author surveyed 98 RN's in a university-affiliated acute-care hospital in the USA. The participants completed two questionnaires; The Profile of Organisation Characteristics was used to identify the nurses' perceptions of their managers' management style and The Munson-Heda Staff Nurse Questionnaire was used to measure job satisfaction. Dolan identified that a vital factor for nurse satisfaction is the leadership provided by frontline managers. More specifically, the more participative the nurses perceived their managers' leadership style to be, the more satisfied they were. Dolan found that "The majority of respondents perceived their manager to have a consultative management style, which reflects the manager's use of staff ideas and opinions and their frequent involvement of staff in decision making" (p.95), and it was this factor that provided greater job satisfaction. It would appear that consultative management styles would include collaboration between major stakeholders.

Uunderstanding and developing collaborative skills and communication styles was an imperative identified by Coeling & Cukr (2000) to promote perceptions of

collaboration, quality and nurse satisfaction. The authors, in a refereed article assert that “Collaboration has been identified as an essential factor in providing quality care in health care settings” (p. 72**).** However, in their literature search they claim that many health care professionals fail to collaborate with one reason being the failure to use communication styles that facilitate collaboration. The authors refer to a study conducted to increase understanding of nurse-physician collaboration and to determine whether usage or non-usage of communicator styles were associated with interactions described by nurses as being “collaborative, rather than noncollaborative in nature”(p. 66), improving the quality of care, and/or increasing nurse satisfaction through the use of Norton’s Communicator Styles. The study was conducted in ambulatory and inpatient sites at medical centers, teaching hospitals, and community hospitals in Ohio, USA. The study included two waves of data collection from 65 nurses who were preparing to be either nurse practitioners or clinical nurse specialists. The participants were asked to complete an assignment following group class discussion on the topics of collaboration and communication. Class discussion included a review of three of Norton's Communicator Styles; dominant, attentive and contentious. The assignment asked the participants to consider what they had learned based on daily interactions with a physician. In the assignment the participants were asked to indicate their perceptions of communicator styles, collaboration, and impact on quality care and nurse satisfaction. The participants used interactions that occurred during course work or as an RN in paid employment. The data was measured using an investigator-developed instrument. The findings showed that that physician usage or non-usage of the three communicator styles resulted in highly significant differences (P = .000) for the three outcomes, namely, perceptions of collaboration, quality of care, and satisfaction with the interaction for three styles. Specifically, usage of an

attentive style and non-usage of a contentious or dominant style resulted in significantly greater perceptions of collaboration, improved quality of care, and increased nurse satisfaction. The study was limited by using a nonrandom sample and limited variables. It was recommended that random samples and other variables that may influence collaboration be used in future research.

Similarly, Rosentein (2002) suggests that daily interactions between nurses and physicians strongly influence nurses' morale and that there is a direct link between disruptive physician behaviour and nurse satisfaction and retention. This was established following a survey which considered the relationships between nurses and physicians. The survey, reported in a refereed article was conducted in 84 hospitals and community facilities managed by a National Health Service group in the USA. Participants in the survey were drawn from a convenience sample and included nurses, physicians, and executives. The study used The Nurse-Physician Relationship Survey, a tool specially designed to assess how participants "viewed nurse-physician relationships, disruptive physician behavior, the institutional response to such behavior, and how such behavior affected nurse satisfaction, morale, and retention." (p. 26). The survey consisted of 24 items using the Likert-type responses. Following the analysis of the first 1,200 responses from nurses, physicians, and hospital executives it was found that "daily interactions between nurses and physicians strongly influence nurses' morale" (p. 26). Although the respondents saw a direct link between disruptive physician behavior and nurse satisfaction and retention, the groups were unable to agree potential solutions. The study report acknowledged two primary limitations. Firstly, the nonrandom convenience sampling permitted respondent bias, and secondly, the survey was examined for face validity only. The author suggested

that future studies should test the content validity and reliability of the instrument and employ random sampling techniques.

The collection of studies reported in this thesis about nurse recruitment and retention are important information for decision makers developing nursing programs and nursing as a career. The Nursing Standard (1999) reported that the British Government had been accused of giving would-be nurses unrealistic expectations of the profession. An information pack used in the recruitment drive portrayed nursing as a dynamic career with "unlimited horizons" (p. 7). Even though there were more than 11,000 calls for further information with a third of respondents considering returning to nursing, union officials were concerned that the campaign painted an idealistic image of nursing which the British National Health Service would have difficulty delivering.

In Australia, The New South Wales Health Department (Knowles, 2000) in a non-refereed report stated that recruitment and retention of nurses was a high priority of the Government and that they were committed to a program of change through recruitment, retention, educational and promotional strategies. The author acknowledged there were societal and workforce issues impacting on nursing recruitment and retention. A comprehensive action plan was implemented with strategies aimed at improving nurses' satisfaction in their workplace. Strategies need to address the personal needs and expectations of nurses relating to the work they do. Therefore, it is worthwhile to consider the relationship between people's personality types and the environment, in which they live and work.

Holland (1973) described in his book the vocational choice theory he developed to explain how personality types result from the individuals' development experiences. Out of these experiences, the individual learns to prefer some activities over others. Later some of these activities develop into strong interests, which direct the individual to develop skills, called competencies, in those areas. Finally, the person's interests and competencies create a particular disposition to perceive, think and behave in certain ways. For instance, if someone resembles the social type, he is most likely to seek out social occupations such as teaching, social work or religious ministry (Holland, 1973). Although individuals typically have characteristics of most of the types in varying degrees, one of the characteristics tends to dominate so that they can be classified as primarily representing one personality category
(Avery, & Baker, 1990).

Holland describes six personality and environment types as being; realistic, investigative, artistic, social, enterprising and conventional. These are expressed in a geometric model shaped as a hexagon. The relationship between each of the types correlates to where each type is on the hexagon.

The pairing of people and environments leads to outcomes that can predict and understand the personality types and environment models. The fit between the person and the environment can also be used to predict educational choice and achievement, personal competence and social behaviour. These include vocational choice, vocational stability and achievement, personal competence, social behaviour and susceptibility to influence. In writing about person-job fit strategies in his book, Furham (2005) noted that "productivity and satisfaction are directly related to the fit

between the characteristics of the individual and the demands of the job" (p.116). Traditionally, support and guidance in this area of job and career advice has not been widely available to nurses and could assist in the alignment of nurses to certain areas of practice.

Holland's theory proposes that individuals search for environments that will let them exercise their skills and abilities, express their attitudes and values, and take on agreeable problems and roles. This can occur at different levels of consciousness and over a period of time. They also illustrate how personal development channels goals, vocational choice and mobility. Theories such as Holland's vocational choice theory may assist managers in the processes involved in nurse recruitment, selection and retention. Developing strategies specific for aged care nursing requires managers to understand what environment would best suit the nurse, which would also be advantageous for the nurse.

Developing lasting and effective strategies to counteract the shortages of nurses is challenging and should be performed in a collaborative manner nationally and internationally. In a report aimed at assisting American nurse leaders shape the future of healthcare through creative and innovative leadership, Gamble (2002) reported in a refereed article that the Philippine Government supported their surplus nurses in the country migrating to the USA. This was seen as an appropriate strategy which would benefit both countries. However, Nelson (2004) writes to remind others that the efforts of some to implement strategies may cause burden on others and be likened to 'international poaching' as stated in the title of refereed article. He reports that developed nations are increasingly dependent on overseas workers to help solve

nursing shortages and that nurse poaching depletes poor nations of much-needed staff and means there are few incentives for rich countries to retain native workers. This is an ethical issue that all countries will be challenged with for many more years to come.

There is an imperative to ensure the sustainability of nurses as an essential component of the health industry. In particular it is important for nurses to understand the elderly as a group in order to provide for the many different special needs they have. Butler (1980) predicted that by the middle of the 1990s and beyond, 75% of all nursing work time in acute settings will be spent with older people. That prediction has been realised and the challenge of recruiting nurses who are both competently and willingly prepared to work with older people is before us.

It would appear that most hospitals and services have developed and implemented marketing strategies for nurses in general and this needs to proceed and concentrate on areas of interest and especially aged care nursing. Research has identified what nurses consider are motivators or the reasons why they work in certain hospitals, and what needs to occur is for nurses and managers to know what would attract and retain individual nurses within aged care nursing in order to match them to the clinical environment. The aim of this research is to address this gap in current knowledge.

In Summary

The literature review identified six aspects, which may influence the positive and negative views of RNs caring for older people in public hospital and the attraction of RNs to the specialty.

Ageism was identified as being a persistent belief that prejudiced older people as a group and has been seen to perpetuate the views of many in society, and influencing many people in the health and aged care services.

Stereotypical views of older people as a group have been identified as promoting structures in health and aged care practices, in particular nursing practices that removed the personal care and the individuality of the older person. These beliefs and practices have predisposed an image of aged care as an area, which required less skilled staff and was considered to be of lower status than other clinical specialties.

The attitudes of health and aged care staff have, in the past, been identified as being a factor in the continued negative image of aged care, but these appear to be changing with positive findings in recent studies with nurses. The views of older patients and advocating nurses were considered and can assist in developing positive behaviours desired for aged care nursing.

Finally, problems associated with the recruitment and retention, in general of RNs was explored which has a flow on effect to aged care as a specialty. Aged care has been seen as an area which does not appeal as a career choice to health professionals,

subsequently affecting those who have chosen aged care as a specialty and the recruitment and retention of nurses.

These factors were considered as data was collected from the participants and used to compare findings from other studies and authoritative theories to assist in answering the research questions.

Chapter 3 follows and details the methodological approach, ethical considerations and the methods used in the collection and analysis of the data.

3. CHAPTER 3 – METHODOLOGY AND METHOD

In this chapter, the study design will be described in three parts. The first part will describe the qualitative methodological approach used, which is naturalistic inquiry, the second part will take into account the ethical considerations and the third part will describe in detail the different methods used to collect and analyse the data.

3.1. NATURALISTIC INQUIRY

This study applied a qualitative methodology as the research involved exploring the views and opinions of RNs working with older people in public hospital aged care units. Mays and Pope (2000) described qualitative research as trying to "interpret social phenomena (interactions, behaviours, etc.) in terms of the meanings people bring to them" (p. 3) and the qualitative researcher as seeking illumination, understanding, and extrapolation to similar situations (Hoepfl, 1997).

Lincoln and Guba (1985) in their book recommend naturalistic inquiry when research is undertaken in the natural setting, when the researcher elects and others elect to be the human instrument and when other qualitative methods for data collection are used. The recommendations above are contained within a list of fourteen operational characteristics which also include tacit knowledge, purposive sampling, inductive analysis and special criteria for trustworthiness as part of the research plan. The methods used to collect participant data are explained further in section 3.3.

Naturalistic inquiry was used as the study processes matched the characteristics of this qualitative approach. Lincoln and Guba (1985) in describing naturalistic inquiry wrote

in their book that while traditional techniques for ensuring reliability, validity and generalisability may not apply to qualitative studies, other quality standards may serve similar purposes. These alternative standards include the concepts of credibility, dependability, transferability and confirmability to establish trustworthiness. My project utilised these concepts during the data collection and analysis phases of the study. To ensure credible findings were produced I used triangulation with the two different methods of a questionnaire and participant interviews. The interviews followed the questionnaire and allowed the participants to delve further into the semi-structured questions and provide rich information about the study topic. The data collected in the two instruments supported each other enhancing the credibility of the findings.

Lincoln and Guba (1985) recommend the use of an "inquiry audit" (p. 317) as a technique for dependability and credibility. For my own benefit also, I maintained an accurate record of the processes I engaged in from the beginning of the study. These were in the form of personal notes which included discussions with academic supervisors and colleague and notes *about* the many features of the context of the study. Also, NVivo enabled me to make memos as I listened to and then transcribed the verbal interviews. I was able to revisit these and further absorb and immerse myself into the rich data provided by the participants. In so doing I was able to maintain an accurate account of my research journey. The construction of an audit trail can enhance the credibility and dependability of a research study (Sandelowski, 1986; Koch, 2004, 2006; Wolf, 2003). Lincoln and Guba (1985) in explaining the relationship between the conventional standards and those developed for the qualitative researcher stated, "Since there can be no validity without reliability (and

thus no credibility without dependability), a demonstration of the former is sufficient to establish the latter" (p. 316).

Another method mentioned by Lincoln and Guba (1985) is the member check, which is a process of feeding back to the persons who provided the information or counterpart persons, for purposes of scrutiny. The purpose of this is to obtain confirmation that the reports derived from the findings captured the data as constructed by the informants and to "correct, amend or extend it" (p. 236) so as to enhance credibility of the data and findings. In my position as Director of Nursing I was able to access staff in the units in which the participating RNs worked to discuss nursing issues. These sessions involved formal and informal discussions about matters related to nursing practice, nursing older people, recruitment and retention and the ability for me to provide preliminary presentations of my findings. These presentations always brought recognition from the RNs that the findings confirmed their own concerns about the reality of the issues concerning their roles and practice in nursing older people and the difficult situation of RN recruitment and retention.

In writing about their own experiences, Appleton and King (1997) wrote "a naturalistic inquiry should be stimulated through the experiences, interest and knowledge of the investigator. The researcher's personal and intuitive knowledge of a field can inform and guide the inquiry process" (p. 18). In my study the personal knowledge and experience gained over 30 years of working in nursing and, in particular aged care nursing would greatly assist my application of intuitive knowledge and guidance of the process.

Hakim (1987) in her book writes that qualitative research is concerned with the individuals' own accounts of their attitudes, motivations and behaviours which can offer richly descriptive reports of perceptions, beliefs, views and feelings. Naturalistic inquiry values greatly what participants have to say. Participants are assisted to insightfully recall their feelings, thoughts and beliefs and this process was used in my study. Subjective data is then thoroughly analysed by way of interpreting what meaning can be identified to provide new knowledge about the research question. Naturalistic inquiry acknowledges the importance of the research contexts which describe the features of the research setting; however, because they are contextualised to the setting, they are not generalisable to other contexts and settings.

Limitations relating to the application of this methodology in my study have been mentioned in section 3.9.

3.2. ETHICAL CONSIDERATIONS

This study was entered for approval to the Human Ethics Committee of the University of Western Sydney, and relevant Ethics Committees of the Area Health Service and participating hospitals. All Committees approved the study to proceed with RNs within their facilities.

There were ethical considerations which needed to be taken into consideration, therefore I consulted the National Health and Medical Research (NH&MRC) Guidelines (1999) to ensure all requisites, relevant to the study were addressed. Relevant elements within the guidelines will now be explained.

The values and benefits of the project were fully considered to ensure that nurses were being asked to participate in a study that could bring new knowledge to nursing with the potential to improve the recruitment and retention of RNs within the specialty of aged care.

As participating nurses were required, sensitivity to their needs was of prime concern. In planning the data collection my role as the researcher was discussed. I was a Director of Nursing of a participating hospital and would be known to others in the sample group. A concern was whether participants might not speak openly during an interview in my presence. In writing about interviewing Clifford and Gough (1990) wrote that "Staff asked to participate in a research study are thought to have a choice. The staff may not see it that way if the person undertaking the research is a senior member of nursing management" (p. 83). Considering that my involvement may influence the outcome of the interview process, an experienced nurse was recruited to undertake this part of the project. The person engaged had retired from her senior nursing role the year prior to the data collection. Though her substantial role was within an area health service in which 2 of the hospitals were situated, it was agreed to be a very low risk that any nurse may be affected by her role as research assistant. The research assistant was chosen due to her long experience in nursing as a nurse, educator and manager and her previous experience and involvement in research projects. No formal training was provided or considered necessary for the telephone interviewing process. Prior to the project discussions relating to the interview process, questions and the available prompts were undertaken.

Participants were not made aware of the identity of the research assistant until she made the first contact. During the study there were no participants who withdrew after identifying the research assistant.

Participants were provided with all relevant information about the research. A package was given to each nurse in the units which contained a Consent Form to undertake a Telephone Interview (see Appendix A), a Participant Information Sheet (see Appendix C) and a Questionnaire (see Appendix D). The name of a contact person from the participating hospital was provided as well as a contact number for the University of Western Sydney Human Research Ethics Committee. The Nursing Unit Managers provided further details.

All participants freely entered the project by volunteering to answer the questionnaire and take part in the telephone interview following information they read on the consent form and the participant information sheet, therefore there was no pressure applied to nurses to participate. To maintain anonymity, nurses agreeing to participate were asked to leave the completed package in a box situated within the hospital unit and there were no identifying indictors to compromise participant privacy. All participants were referred to in the text with a pseudonym.

Participants were informed that there were no expected physical or psychological risks and that they may withdraw form the telephone interview at any time.

I stored all study-related data in a locked cabinet to help ensure confidentiality and privacy of all participants. All data will be kept for the statutory 5 years as stated in

the NH&MR Guidelines (1999). Appleton and King (1997) note that participants being studied in these contexts (natural settings) are potentially vulnerable to exploitation through naive disclosure. Throughout the research process, participants remained anonymous and no identifiable information was made available.

3.3. METHODS AND QUALITATIVE TOOLS

In contrast to 'methodology', the term 'method' is used purely to describe specific data collecting and analysis techniques. The methods, therefore, form part of the methodology of the study. In choosing the data collection methods Wilson (1989) in her book recommended that the researcher read widely to investigate how other researchers collect and measure their data. In this study, a triangulation of methods for data collection were used including structured questionnaires and telephone interviews which was similar to other qualitative studies previously undertaken and reviewed. In using several tools the study receives data, which can be supported and corroborated by either tool. This provides justification to the data. Two different tools were chosen, questionnaires and telephone interviews. The questionnaires provided written data formatted with semi-structured questions whereas the telephone interviews had questions, which allowed the participant to openly explore the question and the research assistant to probe further into the answer. Using both the written and verbal mode of collecting data respected participant preferences, especially those who would be reluctant to undertake an interview. The data analysis utilised NVivo V.2, a recognised qualitative text-based data analysing program to organise and manage the data during the study.

3.3.1. The questionnaire

The questionnaire was developed from the research question and informed by the literature. I piloted the questionnaire at the hospital I worked. The participants included 3 nurse managers, 4 nursing unit managers, 1 nurse educator and 4 registered nurses. I first informed them of my research and following a brief discussion asked them to read and complete the questionnaire providing me with feedback, especially about the relevance of the questions, the available space to write answers and any other comments they wished to offer. I received positive feedback from all participants and in subsequent discussions, decided to remove a question which was very similar to another causing duplication.

The final version of the questionnaire was formatted into an A5 booklet (see Appendix D). There are strengths and weaknesses attached to using questionnaires. The strengths in a questionnaire are that the participant can clearly see what questions are to be answered and that they can be completed at their convenience. As the researcher I was able to construct the questionnaire to answer the research questions. The weakness of this questionnaire is that some participants might have felt limited with the space available and additional paper was provided.

The questionnaire had mostly open-ended questions to allow participants to freely express what ever it was they wanted to say about the question. Other demographic data was by tick box. The questions aimed at eliciting the following information;

- Demographic data about the sample group e.g. age group, nursing experience and educational background.

- The attraction to nursing and aged care nursing.
- How interest is maintained in nursing older people.
- The difference, (if any) in nursing older people.
- The interesting aspects of nursing older people.
- The least liked aspects of nursing older people.
- The changes necessary in nursing practice to attract more RNs.
- Participants' intention of leaving aged care nursing.

The questionnaire is considered a method of self reporting, which is a method of obtaining data from participants by using them as informants, especially when they are considered to have a level of knowledge that is authoritative. Roberts and Taylor (1998) wrote in their book that self-reporting is ideal for situations where the subject cannot be measured by an instrument or observed. This is the case in this study as the opinions and views of the RNs cannot be satisfactorily observed or measured by an instrument. In this situation it is appropriate to use a tool which will allow the participant to self-report information about attitudes, feelings and beliefs of their experiences of nursing older people.

3.3.2. The telephone interview

When the methods of the study were first discussed, focus groups were considered the preferred mode of data collection following the questionnaire. In discussions with senior nursing colleagues it was suggested that, at that time, focus groups may be too difficult to arrange due to the work imperatives caused by the shortage of regular nurses in the workplace. It was then decided to use the telephone interview. The strengths and advantages of telephone interviews are that they are versatile, they can

be performed at different locations, which is convenient and less time consuming for the research assistant in particular. The participant may feel more relaxed and less intimidated not speaking in front of a group or into a tape recorder. The weaknesses are that the non verbal cues are not detected and that the rapport between the research assistant and participant may not as easily be formed as with a face to face interview.

The questions for the telephone interviews were developed to complement the questionnaire. The four questions were:

1. Think back to the time when you were deciding to nurse older people and tell me what was the attraction for you?
2. What did you find interesting about the idea of nursing older people?
3. What do you like least about nursing older people?
4. What would you like to change to improve the recruitment and retention of RNs in aged care units?

A list of prompts was developed for the interviewer to assist the participants without influencing the outcome (see Appendix E).

Lincoln and Guba (1985) state that "Triangulation of data is crucially important in naturalistic studies" (p. 283) and is likely to improve the probability that findings and interpretations be found credible. One such mode within the technique of triangulation is the use of multiple and different methods (Denzin, 1978). In my study it was agreed to use the two different methods of questionnaire and interview by audio taping.

Naturalistic inquiry mostly utilises qualitative methods. Lincoln and Guba (1985) state that qualitative methods "are more sensitive to and adaptable to the many mutually shaping influences and value patterns that may be encountered" (p. 40) in the naturalistic inquiry and that the human is inclined towards methods such as "looking, listening, speaking, reading and the like" (p. 199) that are normal human activities. The questionnaire was chosen as it could reach many participants in an efficient and effective manner. Focus groups were the second method of choice, but when it was decided not to continue with this instrument the audiotaped interview was chosen to follow the questionnaires which compliment each other within the triangulated approach. The audiotaped interview was recommended by Lincoln and Guba (1985) as it enabled the investigator to later reproduce exactly the data as it became evident, they said "clearly the greatest fidelity can be obtained using audio or video recordings" (p. 240) also, "unimpeachable data source; assuring completeness; providing the opportunity for review as often as necessary to assure that full understanding has been achieved; providing the opportunity for later review" (p. 271). Further information relating to the use of the questionnaire and audiotaped interviews are given in sections 3.3.1. and 3.3.2.

The questions were the same but given in a different format and under different circumstances. The interview enabled the interviewer (human instrument) to use the characteristics of responsiveness, adaptability, holistic emphasis, knowledge base expansion, exploration of atypical or idiosyncratic responses and clarification and summarisation as explained by Lincoln and Guba (1985), in this way participant's could delve into their personal and professional experiences to fully answer the questions. Using different methods is allowable as "the imperfection of one is

canceled out by the strengths of another" (Lincoln & Guba, 1985, p. 306). Mays and Pope (1996) in their book reported the successful use of using different means (for instance, comparing oral testimony with written records)" (p. 14) in a qualitative study of the effects of the introduction of general management into the National Health Service in England.

The interviews used semi-structured questioning with the intention of exploring the participant's information. Roberts and Taylor (1998) describe the qualitative interview as being a conversation in which the interviewer invites the participant to talk, encouraging a free flow of words and ideas. The interview questions allow the participant to verbalise their views, feelings and beliefs that may not be expressed in writing on the questionnaire. This may be due to the participant not having sufficient space to write his/her thoughts, or may be due to the fact that some people can express themselves better through the spoken word.

Telephone interviews assist participants consolidate their understanding, knowledge and experience of their particular area of work experience, in this case, working in an inpatient unit with older people. It was considered that this would provide more accurate and informed data for the study.

The interview data can be collected in various ways. For this study the information was collected using an audio-tape. Lincoln and Guba (1985) believe audio-taping is a mode with many advantages such as "providing unimpeachable data source: assuring completeness and providing the opportunity to review as often as necessary to assure the full understanding has been achieved" (p. 271).

Individuals and the community are protected by The Commonwealth of Australia Telecommunications Act 1997 which states, as part of an object, "to provide appropriate community safeguards in relation to telecommunications activities" (3(2) (h)). Audio-taping a telephone conversation is an activity that requires consent from the person being interviewed and authorisation for the interviewer to use the recorded information. The Act clarifies that a person may disclose information to another person for the purposes connected with research (285(1A) (iv)) and that the person given authority to use the information must do so for that purpose (299A(2) (a) (b) (c)) that is, to record as a research study.

All participants were provided information about the purpose and intent of recording the interviews prior to the interviews taking place. The documents which provided this information were the letter of Introduction to Prospective Institutions, Participant Information Sheet and specifically the Consent Form.

The study was conducted over 4 different hospital sites, which will be described below.

3.4. SETTING OF THE STUDY

The 4 public hospitals chosen all had specific units that provide care and treatment for older people. To gain access to the research site it was necessary to gain approval from the respective Ethics Committees. Initial ethics approval was provided by the University of Western Sydney Ethics Review Committee, then by relevant Ethics Committees of the Area Health Service and participating hospitals.

3.4.1. Selection criteria for sites

The selection criterion for the sites was a unit within a public hospital specifically caring for older people. To explain the reasons for the criteria one must consider the purpose and context of the study. The study was designed to collect data about the positive and negative aspects of aged care nursing from RNs working with older people in specialised units within the public hospital. My interest in this study was due to the increasing difficulty of recruiting RNs to specialty units caring for older people**.** All units specialising in the care of older people within my locality were considered. There were 3 hospitals known as specialty services for older people, and a tertiary referral hospital used, with nine separate units involved from the four participating hospitals.

The hospitals were chosen using purposive sampling. The sites chosen were in a convenient locality to me and the research assistant for the purposes of data collection. Within the sample units there was an accessible group of 98 RNs. The hospitals have each been given a pseudonym and a brief description of each hospital is given below.

3.4.2. Hospital A

Hospital A is a public hospital under the care of the Uniting Church, classified as an Affiliated Healthcare Organisation within the New South Wales Health Care Act 1990 and had 72 operational beds. Braeside is recognised as a subacute facility specialising in aged care psychiatry, rehabilitation and palliative care. The hospital is co-located with a District Public Hospital in the Sydney West Area Health Service. The Aged Care Psychiatry Unit comprising of 16 beds and Aged Care Rehabilitation Unit comprising 36 beds participated.

3.4.3. Hospital B

Hospital B is a public hospital and classified as an Affiliated Healthcare Organisation within the New South Wales Health Care Act 1990 and had 68 beds. Hospital B is recognised as a sub-acute facility specialising in aged care psychiatry, rehabilitation and palliative care. The hospital is located within a Sydney metropolitan Area Health Service. The units within the sample were the Aged Care Psychiatry Unit with 20 beds and Aged Care Rehabilitation Unit had 29 beds.

3.4.4. Hospital C

Hospital C is a public hospital and classified as an Affiliated Healthcare Organisation within the New South Wales Health Care Act 1990 and had 77 beds. Hospital C provides sub-acute services in aged care and medical rehabilitation, acute aged care psychiatry and palliative care. The hospital is a facility within a Sydney metropolitan Area Health Service. The units within the sample were the Aged Care Psychiatry unit comprising 15 beds and the Aged Care Assessment and Rehabilitation Units comprising 20 beds.

3.4.5. Hospital D

Hospital D is a tertiary teaching public hospital within a Sydney metropolitan Area Health Service and had 600 beds. The aged care units within the sample were the Aged Care Psychiatry Unit with 8 beds, the Aged Care Rehabilitation Unit had 25 beds and Aged Care Medical Unit had 28 beds. The number of aged care beds comprised a small proportion of the total hospital beds.

3.5. SAMPLE

Wilson (1989) asserts that sampling is a vital part of the research process, choosing a sample group will influence the findings and the interpretation of them and that a sample is a subset of the population, drawn from the population. The population is the total group that meets the selection criteria (see 3.6.1) and is referred to as the target population.

This study interviewed RNs. As it would have been difficult to include all nurses who work in specialised units of public hospitals that care for older people, it was necessary to limit the sample group of RNs. The sample came from an accessible population that was feasible to study, in the sense that they were geographically accessible and that the specialised units were limited in number. It was important to ensure all participants could be contacted during the study.

Wilson (1989) identifies that there are two major approaches to sampling, probability and non-probability sampling. Probability sampling is the more rigorous. If probability sampling was used in this case, every nurse in the given population would have an equal chance to participate, usually through random selection for inclusion in the sample. Due to certain limitations, which included restricting the hospitals to a certain locality; knowing that there was an accessible group of hospital units and RNs, and having set criteria for the participants, the non-probability approach was used. This method can be considered a sample of convenience which, according to Clifford and Gough (1990) is not uncommon. Purposive sampling was used with every RN in each of the participating units who met the criteria being given a package. It was understood that in this purposive sample, the participants would be considered

representative of the sample group and not necessarily providing a generalised view of all RNs in such specialised units.

3.5.1. Selection criteria for RNs

The selection criteria directly relate to the purpose of the study as described in Chapter 1.

The following criteria were chosen:

1. The nurse must be an RN currently working in a specialised unit for the care of older people in a public hospital.
2. The Nursing Unit must specialise exclusively in the care of older people.
3. The nurses must be employed in either a full-time or part-time position and not classified as a casual nurse or other similar classification.

The selection criteria were based on the research questions as given in Chapter 1. The study was investigating the views and opinions of RNs, a group identified as being difficult to recruit to the aged care specialty. Participants were required to be working in the specialty of aged care to ensure that their views were current and relate to the practice and issues at the time of the study. It was considered important that only nurses in full-time or part-time employment be participants. Nurses employed on a casual, pool or agency basis could be hard to contact.

It is acknowledged that nurses on general adult units regularly nurse older people. The intention was to specifically investigate nurses in aged care units to collect their opinions and views for the purposes already stated.

3.5.2. Recruitment of RNs

The initial contact was made with the Director of Nursing of the hospital and the Nursing Unit Managers of the participating units who were also given a comprehensive presentation to inform them of the purpose and scope of the study. At this meeting they were able to seek clarification of any issues relating to the study and become familiar with its aim and purpose. It was important to gain the support of the senior staff that would assist in distributing the participant packages and answering any initial queries from the nurses. At the meeting, sufficient participation packages were left with the Nursing Unit Manager to be given to an agreed number of nurses. It was important to emphasise that if any packages were not given out, they should be returned so that the distribution was accurately recorded.

3.6. DATA COLLECTION

This phase commenced with the distribution of the research packages and concluded following receipt of the last questionnaire and telephone interview. During this phase I remained in contact with the research assistant, and contact people at the hospitals. As questionnaires and telephone interviews were received I transcribed data directly into the NVivo electronic tool. On receipt of the consent form the research assistant contacted the RN to arrange a convenient time to conduct an interview.

3.6.1. Distribution of packages

The distribution of packages within each nursing unit was determined by the number of RNs available to respond. The packages were given to the Nursing Unit Manager to

give to fulltime and part-time nurses. It was hoped that as many RNs as possible would participate. Each Nursing Unit Manager provided a definite number of RNs eligible to participate, and I provided the exact number of packages. The Nursing Unit Managers informed the RNs that the packages were available to be collected from a given place within the ward or unit. Each Nursing Unit Manager was asked to remind RNs that the packages were available and to ask RNs to take a package if they were willing to participate. Eventually all 98 packages were taken. As the questionnaires were anonymous no record was kept of the nurses who took the packages. However, those nurses willing to participate in the telephone interview voluntarily completed the consent form and gave contact details.

Of the 98 packages distributed during August and September 2003, 30 (30.6%) questionnaires were returned completed. There were two reasons identified for the lower than expected return rate and they were:

- Recognised pressures and difficulties nurses were experiencing at the time.
- The distribution may have been disrupted with a Nursing Unit Manager moving out of the unit during the collection phase.

On several occasions I requested nursing unit managers to remind staff to return questionnaires if they were still willing to participate, this had some effect with 1 or 2 questionnaires returning on each occasion, these were eventually taken by other RNs. Nursing Unit Mangers informed me that nurses had been asked to return questionnaires even if they did not want to participate.

From those who returned the questionnaire 14 (46.6%) telephone interviews were performed.

3.6.2. Telephone interviews

The research assistant arranged interviews at the convenience of the participant. As the telephone interviews took place it was becoming obvious from the response rate that they would be much less than the return rate for the questionnaires. I contacted several sites to inquire from the contact people as to the response from staff in relation to the request for participation. The response from the Nursing Unit Managers was that staff responded positively and were keen to participate. Nursing Unit Managers were asked if they would remind staff to return questionnaires and consent forms if they had not already done so, this would act as a reminder to those who had intent to participate, but for some reason had not. Nursing Unit Managers related that not all staff wished to undertake a telephone interview at home in their own time, the reason given was that once the nurse left work, it was preferable not to have their personal, non work time interrupted. This was understandable, and with the approval of the supervisors, the Directors of Nursing agreed to allow participants to undertake the interview during working hours, where this was a participant's preference.

Denzin & Lincoln (2000) in their book write about the importance of data being collected in a naturalistic setting. It was the preference of the majority of participants to be interviewed at their home where they knew they would be assured quietness, privacy and a place to relax and talk. In discussions with the interviewer the importance of the conversational tone in building a rapport with the participant was

identified, and it was agreed that the research methodology would not be compromised.

The interviewer began the interview by introducing herself and explaining the forthcoming interview procedure, after which the formal questioning commenced. The interviewer used the prompts on occasions as a means of eliciting data from the participant. When it seemed apparent that the participant had finished responding, the interviewer would ask if there was anything else the participant would like to say. Often this in itself was a prompt for the participant to offer more information. When it was obvious that there were no further responses to the questions, the interview was closed and the participant was thanked for participating. A copy of the names of each participant involved in taped telephone interviews was kept. The consent forms, which included participant names and telephone contact details, were returned to me with the taped telephone interviews.

Transcriptions of the telephone interviews were entered into NVivo which, as a data management tool assisted me to analyse participant data.

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3.7. DATA ANALYSIS USING NVIVO

The first process was to transcribe the data from the questionnaires and telephone interviews and import them into NVivo, enabling the data to be readily coded and retrieved.

I coded the questionnaires and telephone interviews sequentially. All questionnaires and telephone interviews had been read on many occasions, which enabled me to understand what each participant had written or said. In reading the text over and over I was able to make better sense of the text and find more meanings within the written word, within the sentence and the paragraph. As well, even though electronic coding was being used reading the text from a manuscript allowed me to link words and phrases using highlighters and pens which were then copied into NVivo at a later date. In so doing, I continued to follow the naturalistic approach of allowing themes to emerge from the text.

During the first readings I identified many common ideas which were coded within the database. An idea or theme in NVivo is known as a ‘node’. These nodes initially identified were independent of each other and were classified as being ‘free nodes’. A node was created when a word or phrase within the text suggested a meaning and related to the question, an example is given below. At one point within the process there were 53 free nodes alphabetically listed for choice during the coding. This list was reduced as codes were able to be merged into others with similar meanings. As the nodes were created passages from the transcripts were listed into the database. At any time I could review a node and read all the passages listed within the node. This was a powerful way of gaining an understanding of frequency of data received. I then

began to analyse each of the questions within the questionnaire and telephone interviews. For each question the same process was used. The data would be read and the coding process followed until an exhaustive list of passages within the nodes had been created. Many of the passages were listed in other nodes, this was not a problem as many issues were closely linked. For example, nodes were identified and listed in the following way:

> *"I find them more appreciative of any care given. It is interesting to see older people finding means and ways to cope with their disabilities, and I enjoy caring for them, gives me a sense of satisfaction". (Tim, questionnaire)*

In this passage 'appreciative' and 'satisfying' were coded as nodes.

As the questions were considered, the list of free nodes was referred to. This became an easy way to identify emerging themes. When a theme became apparent, other concepts and ideas in the form of nodes were identified. A different set of nodes was now to be created which are referred to as a tree node. A tree node can create a set that has child or sibling nodes, similar to the use of major themes and sub themes. For example, when asked "What are the most interesting aspects of nursing older people?" there were three of the free nodes which were most commonly coded, they were;

- Like for older people
- Complex clinical conditions
- Life stories

NVivo assists the researcher to link the nodes to develop themes. Nodes can be linked together to help form ideas and eventually themes within a schematic model. When a theme became clear it was depicted as the center of the model. To help understand the

relationship of ideas and concepts, the representative node was located within the data base and linked schematically. Eventually, a model was created which helped me to thematically conceptualise the relationship of the data. The themes assisted in developing recommendations and suggestions for further investigations.

3.8. RIGOR OF THE STUDY

Rigor has been described by Roberts and Taylor (1998) in the following way, ”rigor means the strictness in judgment and conduct, which must be used to ensure that the successive steps in a project have been set out clearly and undertaken with scrupulous attention to detail” (p. 172). This allows the project to be scrutinised by others for evidence of methodological accuracy and worthiness.

Roberts and Taylor (1998) believe that qualitative research is no less rigorous than quantitative research, the difference is in the words used to demonstrate the ways of making explicit the overall accuracy and worthiness of the study.

Lincoln & Guba (1985) suggested renaming validity and reliability to credibility, transferability, dependability and confirmability, which would meet the needs of qualitative research and would bring about trustworthiness of a study. They also reported that naturalistic studies had been criticised for being under disciplined and guilty of “sloppy” (p. 267) research as studies did not adopt the conventional terms of validity and reliability in establishing rigor. The new terms suggested by Guba and Lincoln (1981) in their book reflect the people-orientated nature of qualitative research. The reasons for this are that the assumptions, methods and processes of qualitative and quantitative research differ.

Many qualitative authors choose to use the new terms as parallel operational terms to be used instead of dominant positivist language. Though these four criteria remain universally accepted amongst qualitative researchers, similar terms such as believable and plausible, suggested by Koch & Harrington (1997) have been used and applied to nursing studies.

Audio-taping participant interviews as a data collection tool has been used by other researchers. Koch et al (1995) described using audio-taping in a study with nurses who were recalling their experiences of working with older people. In their study reported in a refereed journal, the researchers asserted that the audio-taped interview provided a guarantee of at least verbal accuracy which supported the rigor of their study. In my study, the participants were audiotaped using a cassette recorder attached to the telephone. The playback quality was very good and easily audible when transcribing.

Certain verification techniques have been suggested to assist researchers (Burns & Grove, 1997, Lincoln & Guba, 1985) of which several were used in this study. Descriptive vividness requires researchers clearly present the study so that "the reader has a sense of personally experiencing the event" (Burns & Grove, 1997, p. 665). I was careful to ensure that the data collected were presented within the context of the study. This preceded a clear description of the participants, the sites to be used and the experience of collecting the data. Importantly, the participant sample was representative of the sample population to be surveyed. Checking for representativeness (Burns & Grove, 1997) and reducing the possibility of bias from the researcher was achieved by including all RNs who worked in the sample units**.**

The sample units were representative of the patient population served as they were the only specific units within the locality of the study.

Checking for researcher effects, as identified by Burns & Grove (1997) in their book and ensuring the participants were not influenced in any way by my presence was reduced by having nursing unit managers coordinate the distribution of the questionnaires and the research assistant perform the telephone interviews.

Burns & Grove (1997) emphasise the significance of the procedural rigor applied in selected procedures, especially the application of the data collection. I developed qualitative tools following a piloted trial and peer review to ensure the tools supported the research question. Lincoln and Guba (1985) suggested the use of triangulation of data for use in qualitative studies. Triangulation of data was carried out in this study with telephone interviews following the completion of the questionnaires. The telephone interviews followed the written questionnaires with corroborating questions for the participants. The intention was to enable participants to delve further into their experiences and understandings of aged care nursing in the hospital so as to give a more thorough account of the research question, which did occur. The questionnaires completed by the participants and audio-taped interviews provided accurate descriptors and accounts of the study data which were then transcribed verbatim, so preserving the written and spoken word as advocated by Holloway and Wheeler in their book, (1996) and Koch and Harrington, (1997).

Weighing the evidence (Burns & Grove, 1997) describes how during the process relevant information can be captured and conclusions made from the large amounts of

data collected. I spent a considerable time reading and coding the data into categories to elicit the relevant meanings to the context of the study. The questionnaires and audio-tapes were transcribed into electronic documents, in so doing, every written and spoken word was recorded. Holloway and Wheeler (1996) in their book recommend that before analysing the data, researchers must preserve the words of the people they interview as accurately as possible. An appropriate method of recording interview data is tape-recording. For words that were legibly or auditory difficult to decipher, the research assistant was asked to confirm and all queries were resolved. Through out this process, concepts and themes emerged providing further meaning to support the eventual interpretations. The strength of the evidence was determined by comparing what was found with other studies performed.

During the analysis stage I was able to make notes within NVivo about the questionnaires and telephone interviews, which assisted me in understanding the perspective of the participants' written and verbal accounts.

Mays and Pope (1995) claimed that, the basic strategy to ensure rigor in qualitative research is systematic and self-conscious research design, data collection, interpretation and communication. I believed that by following closely a systematic approach from the commencement of the study I was able to successfully achieve the necessary rigor.

3.9. METHODOLOGICAL LIMITATIONS

As I progressed through the study, limitations of the study were identified.

At the time the data collection was to commence the public hospital system was experiencing a significant shortage of RNs in full-time and part-time employment. Initially it was intended that focus groups would be held during work hours to obtain information from participants. To attempt to recruit nurses to focus groups during a time of increased pressure and time constraints seemed futile. The decision was made to use audio-taping. The advantage of focus groups would have been that nurses could have benefited from hearing similar experiences from each other, this may have prompted others to remember similar events or encourage others to speak who would have otherwise not verbalised their experiences for one reason or another. It would have been less labour intensive for the research assistant. On the other hand, focus groups may have restricted some participants to openly discuss issues.

When considering the facilitator for the interviews it was agreed that an assistant be engaged. As discussed earlier in the section considering ethical considerations, it was considered that my position might influence the input or preparedness to participate for prospective participants who wished to remain anonymous. However, it became obvious that not having direct involvement in the interview process meant that I relied totally on the research assistant's expertise. Denzin and Lincoln (2000) believe the researcher should engage in a real conversation with the participant, because it treats the respondent as an equal, and allows him or her to express personal feelings and therefore represent a more realistic picture than can be uncovered using traditional techniques. Even though there was absolute faith in the performance of the research

assistant, I felt some detachment from the process. As stated previously under ethical considerations the research assistant, although at the time of the data collection was retired, had previously worked as a senior nurse in managing nursing education and research practice. This was assessed as being a very low risk to participant influence, but nevertheless is considered a limitation. The research assistant was chosen due to her long experience in nursing as a nurse, educator and manager and her previous experience and involvement in research projects. No formal training was provided or considered necessary for the telephone interviewing process. Prior to the project discussions relating to the interview process, questions and the available prompts were undertaken. The role of the interviewer is very important and can influence the data in the manner in which the questions are asked, or not asked. This became an issue for me when analysing the data. There were occasions when listening to the interviews that I would have liked the prompts used more often to explore a participant's response. This limitation highlights the need to provide training in interview techniques and undertake trial run-throughs with critique to ensure optimal use of the interviewer and the instrument.

Follow-ups with certain participants would have been preferable but did not occur. Unfortunately, due to personal reasons there was a delay in transcribing the recorded taped interviews conducted by the research assistant. When analysing the data there were occasions when I felt that I would have like to have explored a particular topic further, but I felt that the time that had past since the interview, being approximately 6 months and more may have proved difficult in arranging follow-up meetings. This was a limitation to the research is recognized and disclosed.

A limitation with a self-reporting questionnaire is the possibility of impression management that may occur with responses from participants when dealing with qualitative data. The truth which the researcher searchers for is the truth for the participant as they see it. In giving account of themselves, people may want to present a favourable impression. All information received through this method is filtered and the social desirability of the responses is one criterion upon which respondents may choose their answers. The findings of this study are not generalisable, as the interpretations of these responses were determined within the context of the study.

The response rate may have been affected by senior nurses involved in the distribution of the questionnaire packages taking extended leave during the process. I was able to return to redistribute packages, but this did not seem to improve the return rate.

It is recognised that the findings of the study relate to the participating nurses' experiences of aged care, and that generalisation cannot be made due partly to the low response rate of the nurses.

In Summary

This chapter gave a brief consideration of the qualitative methodology and the benefits of using naturalistic inquiry. Ethical aspects of the study were considered and the process used to meet ethical requirements. The methods and qualitative tools were described and how they benefited the study by collecting, eliciting, and assisting in managing the analysis of the data.

The sample was described and contextualised the participants and participating hospitals in relation to the study. A detailed description of the research process relating to the data collection and analysis was provided. The rigor applied to the study was discussed supporting the research process undertaken. Finally, methodological limitations were given especially for this study recognising that generalisation of the findings cannot be made.

Chapter 4 follows and discusses in detail the findings from the data collection and data analysis, which include the sample description and the nurses' responses.

4. CHAPTER 4 – STUDY FINDINGS

4.1 SAMPLE DESCRIPTION

From the 98 packages sent out to the nurses, 30 (30%) questionnaires were returned, 26 (87%) respondents were female and 4 (13%) were male. Of those who completed a questionnaire 14 (46%) agreed to participate in a telephone interview. Fifteen (50%) worked in an aged care psychiatry unit, 11 (36%) in an aged care rehabilitation unit and 4 (13%) in an acute aged care medical unit. The data from the questionnaires and telephone interviews have been identified accordingly.

The data recorded from the participants will be described in relation to the title of the study. For the purpose of privacy and confidentiality pseudonyms were given to each of the participants when quotations are used from the recorded data.

4.2 NURSES' RESPONSES FOR QUESTIONNAIRES AND TELEPHONE INTERVIEWS

The questionnaire sought demographic data about the sample group, specifically, age group, nursing experience and educational background. The participants were also asked questions relating to nursing older people both in the questionnaire and telephone interview.

The participants were asked in the questionnaire the following questions:

- What has maintained your interest in nursing older people?
- In your experience is nursing older people over 65 years of age any different than nursing younger people less than 65 years of age?

- In your experience what are the most interesting aspects of nursing older people?
- What do you like least about nursing older people?
- What would you change in your area of practice to make nursing older people more interesting in order to attract more registered nurses to work in the specialty?
- What particular differences did you experience between nursing older people and nursing people in non-aged care units?
- Are you considering, within the next year, leaving the specialty of nursing older people? If so, why and what would make you stay?
- Why did you become a nurse?

The four questions in the telephone interview were:

1. Think back to the time when you were deciding to nurse older people and tell me what was the attraction for you?
2. What did you find interesting about the idea of nursing older people?
3. What do you like least about nursing older people?
4. What would you like to change to improve the recruitment and retention of RNs in aged care units?

- Think back to the time when you were deciding to nurse older people and tell me about it?
- What do find interesting in nursing older people?
- What do you like least about nursing older people?
- What would you like to change to improve recruitment and retention of RNs in aged care?

4.2.1 RNs' previous nursing experience

Of the participant sample 90% had more than 10 years experience as an RN and 48% had more than 10 years experience specific to aged care (in total 75% had more than 5 years experience) see Table 4.1.

Table 4.1 Experience in years as RN and RN in aged care (from questionnaires)

Years of experience	As RN	As RN in Aged Care
< than 1 year	0	1
1 – 5 years	1	7
6 – 10 tears	2	8
> than 10 years	27	14
TOTAL RNs	**30**	**30**

This sample group can be considered an experienced group of RNs, not only in the number of years as a RN, but also in the specialty of aged care nursing. The participating RNs had a broad range of experiences in nursing as can be seen in Table 4.2. The table shows the number of RNs working in a specialty in the previous 5 years before entering aged care and the number of RNs who had different specialty experience. The responses represent multiple responses from RNs as they may have worked in more than one specialty area.

Table 4.2 Specialty nursing experience (from questionnaires)

Specialty nursing areas	Previous 5 years before aged care (n)	More than 5 years experience in other specialty (n)
Community	0	4
Drug & Alcohol	1	2
Development Disability	4	2
Emergency Department	1	8
Intensive Care/High Dependency	2	9
Medical/Surgical	4	18
Mental Health	4	10
Industrial	2	1
Oncology/Palliative care	2	5
Operating Theatres	0	2
Paediatrics	2	5
Rehabilitation	8	8
Residential Services	0	3

4.2.2 Continuing education

The participants demonstrated a commitment to ongoing education specific to nursing older people. Ten of the participants (33%) had gained post basic qualifications from Graduate Certificate to Masters Degree level and two of the participants had more than one qualification.

Table 4.3 RN Qualifications specific to aged care (from questionnaires)

Qualification	Institution	N
Master of Nursing (Medical)	Not specified	1
Advanced Diploma in Psychiatry of Old Age	NSW Institute of Psychiatry	1
Certificate in Gerontology	NSW College of Nursing	2
Certificate in Gerontology	Concord Hospital	1
Business Management in Aged Care	TAFE	1
Family Therapy	NSW Health Department	1
Certificate in Medical Aged Care	Area Health Service	1
Certificate in Nurse Management	University of Technology, Sydney	1
Diploma in Psychiatry of Old Age	NSW Institute of Psychiatry	2
Aged Care Certificate	Not specified	1

Other ways in which the participants updated their knowledge was through education and training in the care of older people, with 66% identifying reading journals as being the most popular, followed by attending internal and external workshops and seminars.

4.2.3 RNs' attraction to nursing

The nine most frequently mentioned reasons for being attracted to nursing are listed in Table 4.4.

Table 4.4 Participant reasons for becoming a nurse (questionnaires)

Reason	N of responses	% of participants
Desire to help others	18	60
Family or friends Influence	10	33.3
Being a caring person	9	30
Nursing highly regarded	7	23.3
Interest in health	7	23.3
Always wanted to be a nurse	4	13
Influence through personal experience	3	10
Considered a rewarding job	3	10
Ability to look after own family as a nurse	3	10

There were 15 other reasons given by participants that did not get more than 2 participant responses for example, "to move from the country to the city" and "to meet other people". The number of responses relate to the number of participants who gave the particular reason. Some participants gave several reasons which scored a response, for example, Vicki who worked in aged care psychiatry with over 10 years nursing experience in aged care wrote "Several nurses in the family including my mother, special interest in health issues and a desire to help other people".

The desire to help others (60%) and being a caring person (30%) are two attributes that characterise nurses in the nursing profession. These two attributes were clearly identified as being the main reason for choosing nursing as a career.

4.2.4 RNs' attraction and interest in nursing older people

The participants were asked in the questionnaire what attracted them specifically to nursing older people. There were 17 participants (56%) who actively chose to work with older people and moved from another specialty for the following reasons:

> *I had worked in nursing homes previously, wanted more experience in seeing older [people] recover from strokes, fractured neck of femur, heart conditions. (Toni, questionnaire)*

> *It started when I applied to work 2 days a week in a nursing home and have learnt to like caring for elderly patients. I am amazed by older persons' experiences in life! Elderly people are honest, interesting and sometimes helpless and I felt I needed to help them in a way that I could. I did gerontology. (Robyn, questionnaire)*

> *I was looking for a change in direction in my career after working after specialising for 9½ years in paediatrics and mixed adult surgical. Also, I've always been caring for elderly in mixed medical, surgical cardiac and accident and emergency. (Kathy, questionnaire)*

The three participants above had previously been working in the nursing home sector where they acquired their interest, the other participants made a conscious decision to move from a non-aged care specific unit to work with older people. This deliberate change of work area does demonstrate positive aspects of work that attracts RNs to it.

Toni describes how she wanted more acute and sub acute experience, which was unavailable to her in the nursing home and would provide her with more clinical challenges. Kathy moved from the acute sector where she had experience with older patients which supported her attraction to the specialty. The participants showed a positive perspective in the way they wrote about the work and the patients.

The participants were asked in the telephone interview to think back to the time when they were deciding to nurse older people and to speak about it. Seven participants (50%) said that it was out of convenience that they began working in aged care, such as:

> *It was the convenience of where I was living at the time and not having to retrain, because I hadn't worked for ten years. (Vicki, telephone)*

> *To be quite honest it was the hours I had to work with older people in an aged care facility and my children were only very young and I think because of the hours and the shifts I was offered. (Robyn, telephone)*

There were 3 responses like Robyn of participants choosing the work in an aged care unit as it suited the family circumstances at the time.

4.2.5 Interesting aspects of nursing older people

There were two questions in the questionnaire and one in the telephone interview asking for participants' views on the most interesting aspects and those that maintain their interest in nursing older people. From the participants' questionnaire responses 90% recorded statements that were able to be categorised into three interesting aspects listed below:

- Liking for nursing older people
- Life stories they relate
- Complex clinical and psychosocial situations

The remaining10% of participants each identified that teamwork maintained their interest. Several comments referred directly to the team, which included allied health and medical staff, but the quotation below from Mary linked teamwork with patient care and when asked, “What maintains your interest in nursing older people?” answered:

> *The colleagues I work with, collaborative teamwork makes management of patient more effective. (Mary, questionnaire)*

Having collaborative teamwork can produce effective patient management, and this approach is valued and can be considered a motivator at work.

The former group described a genuine liking for older people and nursing older people, the interactions principally portrayed in the life stories they related and the involvement in complex clinical and psychosocial situations. There was an overlapping of other interesting aspects which will be identified.

4.2.5.1 Liking for nursing older people

The participants described many different reasons for liking older people and the nursing care involved. The more common reasons were the special qualities older people have, the special needs they present with, interactions which occur in different

ways which engender a feeling of respect, making a difference, being satisfied and having a genuine liking for older people.

Liking for older people

The participants used the terms “enjoy,” “love” and “liking” when describing their feelings towards the patients and the work. In total, 46% of the participants responded in this way. The following passages show how there is a genuine affection for the older person.

> *I enjoy working with the older person. I think I understand them more than the younger person. (Tim, questionnaire)*

And,

> *My genuine love of older people whom I have a lot of time for.*
> *(Mary, questionnaire)*

The enjoyment described in the above two quotations relates to having a general understanding of older people and a willingness to spend time with them. In the next passage Terri enjoys the interactions with patients and their families, aspects of the RN role, which have been identified as enormously important in working with older people:

> *I enjoy people and I think aged care in particular is where you get to interact with people and I think that’s a huge plus and also the significant issues that face older people and therefore their families. It’s their wealth of experience, they as people present much more interesting and diverse sort of approach to life. So they as people have had such broad experience particularly older*

> *people at this point who've lived through things like the world war and the depression and the mechanisation and space involvement of our age and now really the IT stuff, I'm amazed. (Terri, telephone)*

The next quotation considers the RN's role in rehabilitation:

> *They are a lovely group to look after, and it's lovely to see people come in who have lost all their support links and who are depressed and to see them blossom and grow and to actually make a difference in their lives, and I really enjoy that aspect of it. (Barbara, telephone)*

Barbara identifies holistic aspects of her work, realising that many older people are admitted with social problems that may have triggered their admission. Her enjoyment can be noticed in the rehabilitation and restorative aspects of her nursing role in the acute aged care psychiatry unit.

In the next quotation, Kathy is answering the question "Do you enjoy your work?" She explains that although some tasks may be unpleasant, there is more to it than just the tasks and they do not deter her from the main work that she enjoys:

> *Most days yes, [I do enjoy my work], I have the odd day when I think, "What on earth am I doing here, and why am I cleaning up this vomit, this poo (sic) or whatever," but those moments are rare. Most of the time I enjoy my job because it has become my life's career and it's not just the job. (Kathy, telephone)*

Participants' realising that the work they do has meaning and there is more in the work and the job than just the actions and tasks they perform leads into the subject of making a difference through patient care.

Making a difference

Making a difference to the situation of the patients was identified as a factor in choosing this specialty of nursing. The term 'Making a difference' has been used to describe the contribution nurses make to the health service, notably, the NSW Nurses Association campaign in 2003, (Holmes, 2003). In making a difference, the participants describe a proactive and committed approach to their work. The next quotation from Stella describes this as a main attraction:

> *OK, the attraction for nursing older people was trying to make a difference in their lives and hopefully make them well enough to continue their life outside in the community. I think older people have a lot more to give. They're more interesting, done more things in their lives, and they need someone to look after them. It's challenging, because they have all the aged complaints as well. Usually it's the reason they have been admitted, and so you have your hands-on nursing as far as medical things, so you keep that aspect of your profession going, and then you've got the other side as well, where hopefully, as I said, you can make a difference. (Stella, telephone)*

Stella identifies that the care and treatment provided as an inpatient is most important to the success of a comfortable post hospitalisation period, and that can make a big difference.

In support of the previous quotation, Lyn enjoys the experience of knowing that she has made a difference and that her contributions have improved the patients' condition:

> *In rehab you see the patient's progress from full assist to their independence which makes me feel better. It makes you feel you have made a contribution to that change. (Lyn, telephone)*

Some people are spurred on by personal experience, wanting to contribute and improve services for others:

> *I work because I enjoy it. I'd been involved in caring for my own mother, she had cancer and was admitted to a nursing home and the care which she received there was very poor and I felt that from my own experience of nursing, I'd been a nurse for 15 years, from that point I thought, this can be done better. (Terri, telephone)*

The reason can also be proactive, as in the next quotation where Stella recognises that the patient could be one of her parents and is spurred on to ensure patients receive what she would like for her own family.

> *…but I also feel that if it was my mother or father I would like to think they was (sic) somewhere where they were being looked after in a really positive healthy and placid way, so I guess I just enjoy it for those reasons. (Stella, telephone)*

Making a difference to the patient's condition is an important aspect for these participants and has been demonstrated through nursing care which was described in a proper and dignified way. Participants recognise that making a difference is a satisfying and rewarding aspect of their work.

Satisfying work

In the questionnaires 23.3% of participants identified the work as being satisfying and another 10% identified the work as being rewarding. Feeling satisfied and/or rewarded for nursing the patients was identified in the manner patients responded to care and the effort patients made in their treatment. Some examples were acknowledging how appreciative the patients were, nominated by 26.6% of participants and how grateful the patients were, nominated by 13.3% of the participants in the questionnaires. These attributes were restated in the telephone interviews, but could have been by the same participant in the questionnaire.

In the next quotation, Jill explains how satisfaction and reward are brought about through the improvement made by the older person during their hospitalisation and return to their own home. Regaining independence following an illness and attempting to return the patient to the level of functioning prior to an illness is the primary goal of rehabilitation. So often, older people succumb to an illness or accident which eventuates in their referral to an aged care service due to their inability to regain former functioning. The determination and willingness of both the older patient and the nursing staff through rehabilitation to independence results in rewarding and satisfying feelings:

> *Older people are important members of our society. To help them continue to live in their own houses, to be as independent as possible in a safe and secure environment is very rewarding and satisfying. (Jill, telephone)*

Below, Mark describes another positive attribute of the older person, the appreciation shown towards the nurse, this is demonstrated in the way the older person responds to him:

> *It is emotionally rewarding. They say they have missed my smile on my days off. They smile when I say "Hello". (Mark, questionnaire)*

And;

> *I find them more appreciative of any care given. It is interesting to see older people finding means and ways to cope with their disabilities, and I enjoy caring for them, gives me a sense of satisfaction. (Nadia, questionnaire)*

And again;

> *They are very grateful for care and respond to the gentle touch. (Mary, questionnaire)*

Debbie, in the next quotation is definite in her commitment to work in aged care:

> *It is challenging, very rewarding, and I feel I have more to offer older people. (Debbie, questionnaire)*

The next quotation relates personal satisfaction with a greater understanding of the patient. Sharon believes that she can learn from the older person, which enables her to appreciate the patient more. This gives her even more insight into her own personal life and a greater appreciation of what she has:

> *The amount of satisfaction you receive and the amount of learning from the elderly enables you to appreciate all they have done and been through which makes you appreciate what you have today. (Sharon, questionnaire)*

Participants described the work as being satisfying and rewarding, but as the next quotation notes, it is considered 'hard work', which needs to be recognised and supported:

> *Nursing older people is hard work. It is all interesting and rewarding professionally, but we need recognition, support and reward. (Jill, questionnaire)*

In the quotations above, there were several examples of what makes the work satisfying and rewarding. They included, the willingness and determination of patients during the rehabilitation phase; the responses provided by the older person through smiles and appreciation shown towards the nurse and the ways and means the older person finds to 'cope' with disabilities they have. These are some of the special qualities older people possess that can influence and inspire others in what they do.

4.2.5.2 Life stories older people tell

The participants described the interactions with older people as enjoyable, particularly when the older person was relaying personal information about their lives. These "life stories" were prominent throughout the questionnaires and telephone interviews. Of the 30 participants who completed a questionnaire, (60%) identified life stories as an interesting aspect of the work.

In this passage, Sharna recognises the importance of personal interaction through verbal communication with the patient:

> *I find them more interesting to talk to about their lives, especially when attending to them. I've found that when you listen to their lifestyle and how they have coped with various problems and so on, for instance, if they have had the same minor ailments and so on, a younger person would rush off to the doctor, whereas an older person would tell you all the various ways they've treated themselves. Amazing! It's all very interesting. (Sharna, telephone)*

It is at such times that the life stories of the patients can play a part in the therapeutic role in the nurse-patient relationship. Basic care tasks undertaken by the nurse, such as providing a wash, assisting to dress or to have a meal, could be considered mundane and lowly. However, it is at these times the patient can feel vulnerable. When the nurse reciprocates by enjoying the conversation, speaking in a comforting manner and listening to the patient the wellness feeling within the patient can increase.
In this passage Stella combines the attraction to nursing older people with the interactions with older people:

> *OK, the attraction for nursing older people was trying to make a difference in their lives and hopefully make them well enough to continue their life outside in the community. I think older people have a lot more to give. They're more interesting, have done more things in their lives, and they need someone to look after them. I just find them extremely interesting, their life experiences and you know, when you get the time to talk to them they open up and they blossom and you get the feeling that they're very lonely and they love to tell their story, and I learn things from their experiences and hopefully I help them. (Stella, telephone)*

Loneliness occurs in people of all ages, but may be a particular problem in the elderly (Donaldson, 1996). Within the study, loneliness was linked to a coded textual reference termed 'social isolation' which 33% of the participants identified as a problem for the older person. Stella considers that loneliness may be a reason older people verbalise their life story which, as she stated,

> *I can learn things from their experiences and hopefully help them. (Stella, questionnaire)*

These interactions involve the RN in the psychosocial areas of the patient's needs, but unless the story was told, the needs may never be identified.

In this passage Robyn in her telephone interview suggested using verbal interactions for different purposes:

> *I think we have to somehow show the elderly as the interesting people that they are. That may be by getting them to relate their stories, yeah, not allowing them to be just this lost person in a bed, to allow them to have a personality, have a character, that makes them interesting and that makes people connect with them. You know how interesting people can be, not only in their youthful stage but in their elder years as well. (Robyn, telephone)*

Robyn also alludes to the plight of some older people in hospital with staff *"allowing them to be just this lost person in a bed."* Many participating RNs reported that older people become socially isolated when at home. The irony is that patients can also be lost and isolated in the presence of a busy hospital unit.

In the next quotation Jenny in her telephone interview refers to the stories patients tell. She recalls the stories of wartime:

> *I admire how some patients have survived multiple emotional traumas in their lives and are still managing to live full lives in the community. For example, we have had holocaust victims who have shared their stories. Some older people have a wonderful, rich life full of experiences, and are willing to share their story, and this can be special to listen to them talk. Often, time constraints limit nurses from developing a rapport with patients and listening to their lives. This can be frustrating. It isn't the fact that we haven't got the*

time, but I believe the patient would benefit greatly from being able to talk and share those times. (Jenny, telephone)

Other participants reported wartime stories; whilst other stories were also told, which Jenny described as "wonderful, rich life experiences" and these were happily shared with anyone willing to listen. In a quotation provided earlier, Sharna related that she enjoyed listening to these stories while she attended the patient. This would seem a recommendable way of forming and improving the nurse/patient relationship. Jenny indicates that not having the time to spend listening to patients is not necessarily because they don't have the time. This may be due to RNs not having an interest in listening, or not realising the importance of the conversation or they might not have the skills to engage the patient. There are many factors which prevent the RN from interacting with the patient, however, listening to patients and hearing the stories they tell has been identified as an interesting aspect of nursing older people by these participants.

4.2.5.3 Complex clinical and psychosocial illnesses

In the questionnaires, 56.6% of the participants used terms such as "complexity of medical problems", "comorbidities" defined as "coexisting disease state" (Miller & Keane, 1987, p. 282) "acute medical problems" and "variety of diagnoses" to describe the complex clinical and psychosocial illnesses of the patients. Others used "age related illnesses" to describe that there was a variety of diagnoses within the patient population.

In the following telephone interview extract, Terri identifies the comorbidities that present in the aged care rehabilitation unit where she works, the comparison with

younger patients being treated for single illnesses, and the recognition that nurses in aged care are required to maintain current nursing knowledge on a broad range of nursing care competencies.

> *There's a lot more areas to be involved in. I've found it a professional challenge to keep on top of, I mean, if you've got someone who's 30 and they have a fractured femur from a skiing accident or they've got diabetes, they've either got some trauma or they've got a medical condition, but often their medical condition is uncomplicated by eight other medical conditions; whereas an elderly person is more likely to have as a minimum sort of six or seven. I was just reading some stats the other day that said, it was looking at an acute aged care unit and the mean of medical problems that each of these patients had was eleven, and I thought, yes, that required you to professionally keep clinically abreast of what's going on, and it's far more challenging than learning about your one specialty. (Terri, telephone)*

Participants identified how problems associated with the natural course of the ageing process combined with ill health complicate the care and treatment of older people. Tracey, responding to what are the most interesting aspects of nursing older people wrote:

> *It's the challenge of nursing the multiple medical problems associated with older people. (Tracey, questionnaire)*

In the next quotation Toni identifies the comorbidities with a surgical patient following a fall resulting in a fractured femur, which has been identified as a major issue for older people with between one and three percent of people over 65 years hospitalised for falls each year (Sydney West Area Health Services, 2005).

> *The challenges as older people usually have multiple issues and problems that need addressing. You care for the whole person, not a specific problem, e.g., fracture NOF [neck of femur]. (Toni, questionnaire)*

The complex conditions challenge participants to use all their previous experience:

> *Their problems are complex and require you to draw on your past. You need a very broad knowledge base dealing with older people, and it can draw in a lot of those different areas of knowledge. (Julie, telephone)*

Tim's questionnaire response identified some of the normal ageing problems, such as sensory impairments, and psychosocial concerns, such as loneliness that may be overlooked by staff, but should be addressed during admission:

> *They are different in many ways. Older people lose control of normal functions, have more chronic diseases, sensory impairments, more complex medical history, difficult lifestyles, more loneliness and isolation, physical and psychological changes. (Tim, questionnaire)*

In the questionnaires 36.6% of participants wrote that older people required more time when RNs were attending to their care or when they were performing a task themselves. The next few quotations give examples:

> *More time is needed to understand their life up until now. They need more time to explain how they feel. (Robert, questionnaire)*
>
> *Caring for older people needs time and patience to assist with basic needs, they become slower as their age affects their illness. (Robyn, questionnaire)*
>
> *Older people need more quality time. (Lyn, questionnaire)*
>
> *Take more time with the elderly, can't hurry them. (Kathy, questionnaire)*

In this next quotation Kathy describes how hospital aged care nursing is different from that experienced in the nursing home in relation to complex care and emphasises the need for RNs to be skilled to meet the challenges appropriate to the care required:

> *I think you've got to offer them more skills to start off with. There are a number of nurses in the system who went into aged care for many similar reasons that I did, thinking it would be an easier job, but now we're getting more and more acute patients in rehab [rehabilitation]…. They're pushing patients through quicker and they're often not really ready, and you've got to deal with other medical problems along the way before you can get them ready. So I think nurses need a real update on their clinical skills and should not be afraid to challenge their clinical skills, but if they've gone there for an easy job, they won't find it there. They'd better go to a nursing home because you know in rehab, you have to be focussing on rehab, and if you want to just be involved in the basic nursing care of patients in a nursing home, that's the place to be. I think nurses have to examine that side of themselves and make a decision of well, where do I want to be? I think that people need to make that decision and I think for the sake of patients they need to make that decision as well themselves, because they owe it to the patients to give them good care. (Kathy, telephone)*

In the next two quotations, the participants affirm that aged care is a learning area, which involves different types of technical nursing and expertise:

> *I think there's a lot you can learn from other staff who have been there for years. People think that you don't learn skills but you do. I mean, you still look after central lines, tracheotomies, drains and things like that, not as much as other wards, but. (Jill, telephone)*

> *I think comorbidities of patients can make these patients very difficult to care for, especially in the mentally ill when cognitive impairment may prevent good history taking and symptom reporting. Yes, comorbidities makes the work that much more challenging and interesting, but it is difficult and can get you down when things are bad, it's frustrating as you juggle priorities of care. Because of the complicated nature of older people's physical and mental health needs, RNs in particular are required in greater numbers to ensure safe and accurate practice and early interventions when their conditions change. You must remember that nurses are the only category of staff who are with the patient in the unit over a 24-hour period. Other staff come and go, but it is the nurses who remain to provide the constant observation necessary. (Jenny, telephone)*

The participants in general spoke about the care being complex due to a combination of ageing, medical and psychosocial problems common to older patients and requiring experienced RNs to be skilled to meet the acute, sub acute and specialised aged care needs of older patients.

4.2.6 Differences in nursing older people

The questionnaire asked if nursing people over 65 years was any different from nursing people less than 65 years of age, 77% answered "Yes," 17% answered "No" and 7% did not respond.

The "Yes" responses identified problems relating to the ageing process and problems complicated by the ageing process. The problems identified were labour intensity and associated medical problems. Both of these have been identified in other responses.

Labour intensity has been reported under the least liked aspects (see 4.2.7) and associated medical problems under complex clinical and psychosocial illnesses (see 4.2.5.3).

4.2.7 The least liked aspects of nursing older people

The participants were asked in both the questionnaire and telephone interview what was the least liked aspect of nursing older people. Participants mentioned several aspects and these have been listed into the following three categories;

1. Relating to the patient (4.2.7.1)
    - Ageing process
    - Loneliness
2. Relating to the work (4.2.7.2)
    - Labour intensiveness and heaviness
    - Difficult behaviours
3. Attitudes towards the older person (4.2.7.3)
    - Lack of respect
    - Lack of community support
    - Difficult relatives

4.2.7.1 Relating to the patient

Two aspects about the patient were mentioned, the ageing process, and loneliness experienced by the patient. Several participants said that there seemed to be a general impression that nursing older people was not popular:

> *Well, yeah, it's not the sexy area at all. I don't know how long I might stay. It's very difficult. (Julie, telephone)*

The ageing process

The participants reported seeing older people succumb to a conspicuous and inevitable process and gave examples of how some were unable to care for themselves, being left alone and perhaps despairing:

> *Seeing people no longer able to care for themselves, having to leave their family home and eventually go into care. (Sharon, questionnaire)*
>
> *When an elderly person lives alone after a spouse died; family members not caring for them; when they die alone. (Robyn, questionnaire)*
>
> *Sometimes they give up…. when they say they are too old. (Rob, questionnaire)*

These issues can be upsetting for the nursing staff who can find that these situations are emotionally challenging.

Loneliness

Some participants mentioned the loneliness that often comes with age:

> *Seeing how lonely a lot of them are, especially when their spouses have died and their children are too busy with their own lives. (Mark, questionnaire)*

Rob also commented on loneliness as being the result of many factors:

> *You often find they come in really lonely. They're very lonely at home. They live at home alone with no home care. Often they're malnourished. Sometimes they've been abused. I've seen quite a few come in and they have drug addicted relatives who come in and abuse them in the hospital, and I think, well if they'll do that here, what are they like at home? (Rob, telephone)*

This difficult aspect of older people's lives is concerning and upsetting for many RNs, which is a normal response from a care-centered individual. Although RNs work

within a multidisciplinary team, it is often the RNs who 'find out about' this pervasive situation.

4.2.7.2 Relating to the work

In particular, two aspects of the work were identified, labour intensiveness/heaviness and dealing with difficult behaviours.

Labour intensiveness and heaviness

Heaviness of the work was mentioned by 57% of the telephone participants, other references were made in the questionnaires. The term heaviness is most often used by nurses and others when describing a variety of situations, tasks, the type of patients being nursed and the number of occasions that tasks and other activities are performed. The participants attributed heaviness mainly to the dependency of the older patient requiring assistance in many of the activities of daily living. Heaviness was exacerbated when the patient had a physical disability or showed signs of difficult behaviour, such as aggression. The following quotations describe heaviness:

> *I just cut back on the number of shifts I was doing, simply because I was exhausted, and despite them [management] saying it's no lifting, you have to, there's no way you can avoid lifting and supporting people. (Nadia, telephone)*

Nadia felt she had to restrict the amount of work she was doing. Mary supported Nadia's claim:

> *There is a lot of manual handling and it is much heavier. Tasks take longer time to perform. They require much more in the way of assistance with ADLs. (Mary, questionnaire)*

Michelle confirmed the labour intensity this way:

> *They (the patients) are much more dependent on staff for normal daily activities, e.g., assistance with incontinence, movement, sponging or showering, they can be totally dependent upon the nurse. Feeding, regularly turning, confusion, aggression, dementia and helping them transfer and walk, all takes time and staff. (Michelle, questionnaire)*

The next two quotations succinctly capture one of the dependency issues described by participants as "heaviness". This relates directly to the effort needed to perform the tasks, for example, in transferring a patient from a chair to the bed, and the number of staff required to perform the task:

> *Older people are physically heavy compared to younger people.*
>
> *(Terri, questionnaire)*

And again;

> *There is a much higher level of physical dependence when elderly people are unwell. It is much more physically demanding, especially when mental health issues are combined with medical problems. (Elaine, questionnaire)*

In general, participants described the tasks involved in nursing older people as being heavy and labour intensive.

Difficult behaviours

The most frequently mentioned difficult behaviours related to patients diagnosed with dementia and with confusion and aggression.

Behaviours related to patients with dementia

Nadia, referring to the aged care psychiatry unit in which she worked, described a difficult situation, one to which many RNs could relate:

> *One time I had to keep a priest from going to church, he was quite disruptive and it was quite difficult for me to stand between him and the church, he just saw me as someone keeping him away from his God, no I don't like that sort of thing. (Nadia, telephone)*

Aggression

Episodes of physical and verbal aggression were described as challenging behaviours. Although participants knew the reason for the behaviour, it was still difficult to accept and manage.

> *I think the thing I like least is the abuse. I guess those who have very problematic challenging behaviours, who are either verbally or physically aggressive and even though it is a result of either dementia or Alzheimer's, half the time they're not aware of what they are doing. Nevertheless, that is probably the aspect of it what I like the least. (Stella, telephone)*

Other participants said the following about aggression and its effect upon nursing older people:

> *Aggressive and difficult behaviour makes caring for this age group a real challenge. Having to struggle with patients to administer drugs or attend to personal care. (Pam, questionnaire)*

I don't like playing the 'policeman' with aggressive patients. Being a male and working mostly with female staff I often am called upon to play that role. (Sean, questionnaire)

It's easy to get sick of the physical and verbal abuse, patients spitting, kicking, biting and punching. (Jenny, telephone)

4.2.7.3 Attitudes towards the older person

The participants described the difficultly of having to deal with the attitudes of others towards older people. This in itself was difficult for the participants, who had so often expressed sentiments of like and respect for their older patients and mentioned this in the reasons for liking older people. Having to hear and experience what nurses perceived as lack of respect and indifferent attitudes from others brought out the human, caring response of the participants. Three specific issues were identified relating to the attitude of other people and they were lack of respect from the general public, lack of community support and uncaring relatives.

Lack of respect

Participants did mention that a lack of respect was shown from the general public and, occasionally health care staff. Below, Mary is concerned that insufficient staffing levels may trigger comments from students:

I think younger nurses need to work with the older person before saying they don't like working with them "as they're difficult, old and smelly" and so on. That is, they have preconceived ideas but usually they like working with them once on the wards. I also feel the mix of staff at times can have an unnerving effect. (Mary, questionnaire)

Other comments reflected the perception about community disrespect for older people, as in the next response:

> *We live in a society in which youth is the valued age. The elderly tend to become isolated and alienated. I have a goal in life to help them. (Jill, questionnaire)*

This perception is contrasted by Sean's experience of a different culture. This was part of the telephone interview and demonstrates the concern participants have about community attitudes:

> *Sean: I'm in contact with a lot of Asian culture and I went to a New Year's celebration, and what surprised me was at the end of the celebration, they got the oldest people in the community to get up and give a talk about the things that they learnt through life, and the kids sat there and listened. It was such a wonderful thing to see…maybe it needs to be a social thing rather a community thing, rather than aiming specifically at nursing, maybe if we can increase the amount of respect that society has for the elderly.*
>
> *Research Assistant: How do you do that, increase community respect for the elderly?*
>
> *Sean: Well the biggest influence on families is television at the moment, and I think you have to display elderly people in good supportive roles, in positive lives rather than people who get in the way, and people who are problems. I don't know, they have to be portrayed differently through the media to develop some respect.*

Research Assistant: So what you're saying is that we need to change community attitudes towards the elderly and then perhaps by doing that we will make it more attractive for nurses to go into the specialty?

Sean: Yes, sure.

Lack of respect and the next section, lack of community support seem to be closely connected.

Lack of community support

Participants commented on the lack of community support:

There's a lack of a general support system for good ongoing care. A general lack of good facilities. (Nadia, questionnaire)

Everyone is aware that the standards of care could and should be better, especially in the aged care sector: more quality staff to help meet their goals, better finance to meet their needs, more efficient community services to prevent boredom and loneliness, the enemies of the elderly. Better nursing homes are needed. (Jill, questionnaire)

There is a constant reduction in community support. (Robert, questionnaire)

There is the belief that support is lacking at a senior level and that more funding could be made available:

Even the Government and politicians take them [older people] for granted. There's a lot of fund raising done towards younger people but not for the older person: In general there's a general lack of community support. (Sharna, questionnaire)

According to Rebecca:

> *The psychosocial impact of aging in a youth-orientated society results in some older people existing in tragic circumstances. We now see older people in Third World living standards in a First World country. (Rebecca, questionnaire)*

A lack of support can occur within the family setting, this may cause difficulties between the staff and families.

Difficult relatives

Participants mentioned problems associated with families. Some participants spoke about situations which portrayed relatives as uncaring. Other examples implied suspicion or even evidence of abuse or neglect of the older person, perpetrated by people close to them. Other examples related to situations were the families were considered to interfere with the management of the patients. This term refers to how the families can involve themselves in the care and treatment of the patient in ways that may be contrary to the decisions of the health care staff. Examples of relatives appearing uncaring include:

> *Relatives who neglect and take them for granted just because they're old. (Sharna, questionnaire)*

Examples of patients who may suffer abuse or neglect from people close to them include:

> *They frequently have abusive demanding relatives, at least in psychiatry. We create dependence by 'doing' for the patients. This is not always beneficial for them. (Stella, questionnaire)*

Hearing of family members taking advantage of them. (Mark, questionnaire)

Examples of relatives considered to be interfering with the patient's treatment program unhelpfully:

Their relatives become involved in the care and are not always helpful. (Mary, questionnaire).

Participants suggested that relatives find it hard to accept their loved one's succumbing to the normal ageing process and finding activities difficult to perform. Often families search for a different answer to the problem and want to hear of a medical condition causing their relative to be the way they are:

Some families don't understand the process of aging and cognitive impairment. Some families don't accept that not everything can be cured. (Elaine, questionnaire)

RNs become involved in every facet of the patient's life which includes events occurring before admission, everything occurring during admission and preparations for life after admission. Even though other health care staff take a primary role in certain matters, for example, a social worker dealing with the social needs of the patient, the nurse is intimately involved as she or he needs to deal with such issues as they arise after normal hours of business in the absence of the primary case manager. Therefore, family education is often performed by the nurse, which may cause confrontation with the relatives:

Helping families to appreciate their elderly family members, this is not always possible if the family is dysfunctional.

Building relationships through narrative therapy in an informal situation that is non-threatening to the patient. (Kath, questionnaire)

Families try to get as much information as possible with the best intentions and interest for the patient. Participants commented on how this can still be difficult, especially when older patients relay different messages and the communication isn't clear between the staff and the family. Some patients and relatives can easily be labeled as troublesome, because of communication mistakes between parties:

As everywhere, there can be difficult patients, but with the older patient they can sometimes make it very difficult by 'telling tales' to relatives who usually believe them before checking it out. Staff have to account for themselves. I find the older person's relatives very demanding at times, despite excellent nursing care and you can rapidly feel very dejected rapidly. (Mary, questionnaire)

At times the difficult families we have to deal with. (Carol, questionnaire)

However, some participants believed that relatives appreciate what nurses do, as stated in the next description from Rebecca who was working in an acute age care psychiatry unit:

Not all the family understand why things are done, you do a bit of explanation and once they understand all the things, they are very appreciative. (Rebecca, telephone)

This last example from Rebecca confirms that interacting with relatives and carers and providing explanations and education may result in gratitude and appreciation and benefit the patients' care and staff members' wellbeing.

4.2.8 What needs to change to make nursing older people more attractive to RNs

The participants were asked in the questionnaire if they intended to leave aged care within the next 12 months. Though 87% answered “No”, 13% answered “Yes”. The reasons each participant gave for intending to leave related to the heaviness of the work, the lack of support to assist in tasks relating to heaviness and one participant was concerned about the skill mix of nurses. The support concerns are addressed below.

The participants were asked to suggest how to attract and maintain the interest of RNs in the specialty of nursing older people. The following were suggested:

1. Change people’s attitudes towards older people (4.2.8.1)
2. Support (4.2.8.2)
    - Education and training
    - Assistance with nursing tasks
3. Recognition (4.2.8.3)
4. Advertising (4.2.8.4)

4.2.8.1 Change people’s attitudes towards older people

Nurses working with older people in general have a caring and understanding attitude towards them. However, there are some attitudes that could be considered ageist and remain a difficulty, and possibly an obstruction to some nurses entering the specialty. Some of these comments have been made earlier within the study, but the following comment from Jenny suggests that some nurses draw on previous experiences:

I think that nurses in this area need to be mature, to have some life experiences under their belts to manage the many different issues that might arise. Nurses need to be patient and show self control. There is a great need to be able to work with other people. (Jenny, telephone)

4.2.8.2 Support

Of the participants 65% mentioned the word 'support' at some stage during the questionnaire or telephone interview describing it as being provided through education, training and with specific tasks with the patients:

Education and training

Having formal post basic and tertiary courses available is generally recognised as being important to the career structure of nurses, and most would list education and training as being a major factor in the recruitment and retention of RNs in the workforce. In this study, participants not only listed the formal education and training as being important but also informal and "on the job support," guidance and direction that senior nurses provide. The following quotations suggest increased in-service education within the hospital:

More in depth classroom discussion about geriatric nursing so junior nurses and students will become more aware of geriatric management.
(Sharna, questionnaire)

Regular internal education of about 15 minutes… discussion or lecture about twice a week about old people behaviours. (Rob, questionnaire)

I'd like more intellectual challenges such as presentation of case studies.
(Rebecca, questionnaire)

Some suggested more informal, on the job training with experienced nurses offering guidance and support in the following ways:

> *Having a resource person available at all times for support.*
>
> *(Nadia, questionnaire)*

> *Explaining to younger nurses the knowledge you gain, e.g. medications and particular syndromes. (Helen, questionnaire)*

> *Let them [junior and student nurses] know how rewarding it is when you chat for a couple of minutes with them [patients]. Older people tell great stories. (Mark, questionnaire)*

The following comment captures what many think is required to support nurses working in aged care:

> *Probably to enhance the positive aspects of this field (aged care) onto nurses and nursing, support, collaborative teamwork and education is needed. (Pam, questionnaire)*

Assistance with nursing tasks

Some participants, when responding to various questions, mentioned the need for nurses to have assistance with their nursing role. This suggestion often related to the times when participants spoke and wrote about the heaviness and the complexity of the work with 60% of participants suggesting more assistance with the patient care activities, especially related to manual handling. This would assist by enabling nurses perform the nursing tasks specific to their role in a more efficient and effective manner.

More help in turning people. Wards-people would be very helpful. (Lyn, questionnaire)

And,

I think support in the general care… having wards-men to come and help with the patients would be helpful. (Julie, telephone)

Some participants, acknowledging the need for nursing support, were concerned to ensure that the nursing skill mix necessary to support safe patient care practice is not eroded, and that support staff work with sufficient guidance and supervision, the following was said:

Increase the RN:EN ratios to ensure there are more trained nurses. (Tracey, questionnaire)

Have enough nurses in the unit, as caring for the elderly needs time and patience. Nurses can't push them as they get slower and slower relating to their physical conditions. So having enough nurses who could sit down and listen to them, as the elderly need this type of care as well as physical care. Having more support for nurses so that nurses can provide direct nursing care is a challenge for management. (Robyn, questionnaire)

It comes back to the utilisation of other staff to do the work of a trained nurse. We have AINs and wards-people who are providing direct patient care. These levels of personnel should be kept to simple tasks and not relied upon to perform direct care unless directly supervised by and RN or EN. I think it's the insufficient funding and availability of agency and casual staff that means they provide hands-on care as part of the hospital establishment. (Jenny, telephone)

4.2.8.3 Recognition of work performed

Participants mentioned that recognition of the work they perform would be satisfying and probably assist in retaining staff. Examples of participants describing the work as being complex, heavy, challenging and having to deal with difficult behaviours have already been given. The combination of these aspects of work can be very demanding on the individual nurse, and the nurses suggest that their effort be recognised:

> *Nursing older people is hard work. It is all interesting and rewarding professionally, but we need recognition, support and reward.*
> *(Jill, questionnaire)*

There were several suggestions as to how recognition could be presented and an example of how recognition could involve simply being listened to:

> *I think to be listened to would be great recognition, having a say in the appropriate medication, especially in relation to patients with dementia, and to prevent aggression. (Jenny, telephone)*

And:

> *Having a say in the colour of uniform and design, annual events for staff, long service awards, nurse award, even ward decoration competitions.*
> *(Clare, questionnaire)*

Participants suggested that giving more recognition of the work they do and to be recognised as part of the team for decision making will improve their status and recruiting potential.

4.2.8.4 Advertising

> *More positive advertising to show other RNs the benefits of nursing the elderly. (Ann, questionnaire)*

According to participants, to recruit and retain nurses there has to be adequate advertising, which cannot be limited to newspaper advertisements. The participants clearly referred to promoting the specialty as an area of expertise which is challenging, offering diversity and the ability to interact with fascinating individuals, which can provide personal and professional satisfaction. Unfortunately, there is a belief that it does not offer enough of a challenge:

> *A lot of people don't see it as challenging nursing but I do see it as challenging. (Pam, telephone)*

Terri maintained that some staff retain the ageist notion that older people may not provide a clinical challenge because they are just getting older. Instead she notes that the older person as an individual patient, can present with medical and psychosocial problems, which can be a great challenge for nursing and medical staff:

> *I think we need to promote the fact that nursing older people does offer diversity, that it offers challenge, that you're not dealing with somebody who has simply become aged, demented and immobile. You're actually dealing with somebody who has a fascinating personal history and an overlay and a fascinating medical history. (Terri, telephone)*

One of the more common, appealing aspects identified by the participants working with older people was that they are very interesting people who were willing to share their stories. This made the work as a nurse very interesting, but it has not been promoted in this way. Robyn suggested referring to older people in this way:

> *I think the new grads (graduates) need to see an enthusiastic older nurse who has been working in the specialty talking about nursing older people and what the rewards can be…. It is very important to teach younger staff in the wards because aged care…. is certainly not seen as a glamour area of nursing. (Robyn, telephone)*

And:

> *I think we need to be involved in training, to give the nurse coming through in their training an opportunity to see, to desensitize them to nursing the elderly, a lot of them have this preconceived notion that it's not at all what they are interested in. (Rob, telephone)*

The participants suggest that having staff involved is a way of advertising what aged care can offer.

In Summary

Chapter 4 considered the findings from the study data. The sample of 30 RNs who completed the questionnaire and participated in the telephone interviews were mostly female with 13% being male. Most of the RNs had worked in aged care for over 5 years and one in three had completed a post basic qualification relevant to nursing and aged care.

The two most frequently stated reasons for becoming a nurse were, a desire to help others and as a result of the influence of family and friends. More than half of the participants made a conscious decision to move into aged care from another specialty.

The participants identified three key areas that maintained their interest in aged care. They were having a liking for nursing older people which included having a genuine liking of older people, making a difference to the care of older people and the work being seen as satisfying; hearing the life stories older patients have to tell and being involved in the complex clinical and psychosocial aspects of care and treatment.

As many as 77% believed there was a difference in nursing older people other than younger people. There were three least liked aspects of nursing older people. The first was identified as being problems related to the patient, as in conditions related to the ageing process and the loneliness experienced in older peoples' lives. The second related to the nursing work, such as the labour intensiveness and heaviness of the work and difficult behaviours exhibited by the patients. The third related to the attitudes other people display towards older people, described in more detail as the lack of respect, lack of community support and attitudes that are sometimes manifested by the relatives.

The participants provided constructive suggestions to make aged care nursing more attractive to RNs and they were in the provision of further support to nurses, for example in education and training and by giving assistance with nursing tasks. Recognising the work aged care RNs perform was also mentioned, as was advertising the specialty to mature nurses and in assisting to change the general attitude of others towards older people. In the quotation below Pam provides the collective thought into a statement:

Enhance the positive aspects of this type of nursing. (Pam, questionnaire)

Eventhough most of the participants intended to remain in aged care nursing during the 12 months post survey, four were seriously considering leaving to another specialty due to the heaviness of the work and the nursing skill mix.

Chapter 5 follows and will discuss the findings, relating then to the literature review to provide meaning for the reader and to draw conclusions for recommendations and further research for improved practice.

5. CHAPTER 5 – DISCUSSION & CONCLUSION

In this chapter it is my intention to provide meaning to the data provided by the participants described in the findings in Chapter 4. In doing this, I will relate the findings to the research question to show that I have achieved my stated aims. The importance of the findings will be argued, not merely by stating that they are important, but by relating them to previous studies and the real-world situation that gave rise to the study. The chapter will finish with conclusions and recommendations drawn from the study findings.

The purpose of this study was to ask RNs working in hospital aged care units to identify the positive and negative aspects of aged care nursing with the intention of informing recruitment and retention strategies for this specialty.
This study was based on the following three research questions:

1. What are the interesting factors identified by RNs nursing older persons in public hospital aged care units?
2. What did RNs identify in nursing practice which need change to attract RNs back into areas specialising in nursing older people?
3. What makes nursing older people less attractive to RNs compared with other areas of nursing?

In order to answer the research questions, 4 aged care units in Metropolitan Sydney were selectively chosen, and with the permission of hospital management, 30 questionnaires and 14 telephone interviews were completed with RNs.

In summary, 86% of participants were female and 14% were male. Ninety per cent reported more than 10 years experience as an RN and 48% had more than 10 years experience specific to aged care (in total 75% had more than 5 years experience in aged care nursing). Post registration qualifications relating to nursing older people had been gained by 33% ranging from Graduate Certificate to Masters Degree.

The study identified positive aspects that attracted the participants to, and maintained their interest in aged care nursing. Participants identified that they had genuine feelings of liking towards older people which often came from the individual qualities older people possess, particularly the personal stories older people tell. These were seen to be an aspect of the person which provided reciprocity during nurse-patient interactions and helped form nurse-patient relationships. The study also found that the complex clinical and psychosocial nature of the patient's illness was an interesting aspect of work. Clinical complexity has not been acknowledged in the past as an aspect of aged care and has often been branded as an area of low status. In all, 56% of the participants described the provision of aged care as being a complex specialty.

There were negative aspects to the work which, like the positive aspects relate both to the older patient and to the nursing practice. Seeing the patient managing aspects of growing older and succumbing to adverse conditions, for example, reduced functionality in movement and capability of managing ADLs; dealing with the loneliness that many older patients experienced and which await them post discharge from hospital; dealing with the work which was described as physically heavy and demanding; dealing with difficult patient behaviours as in aggressive incidents;

dealing with difficult relatives and the lack of respect and support shown to older people.

The discussion section will continue by considering how the findings in this study answered the research questions.

5.1. WHAT ARE THE INTERESTING FACTORS IDENTIFIED BY RNS NURSING OLDER PERSONS IN PUBLIC HOSPITAL AGED CARE UNITS?

The responses identified that participants had a general positive feeling towards older people and that 90% identified aspects that could be categorised into a liking for nursing older people, listening to the stories they tell and being involved in the complex clinical and psychosocial care. The text in the questionnaires and telephone interviews revealed many different words, phrases and characteristics about older people which the researcher refers to as “a liking for older people”. These include enjoyment, making a difference, respect and satisfaction. Nurses spoke of other qualities displayed by older people, such as “being appreciative” and “saying hello”. This theme may not seem unusual, however, the data elicited from the participating nurses and the findings demonstrate that, in general, the participants had a positive attitude towards older people. The RNs’ positive findings from this study support previous studies (Hope, 1994; McLafferty & Morrison, 2004; Routaslo et al. 2004) with RNs working specifically in hospital aged care units and who also demonstrated positive attitudes towards older people.

Genuine liking towards older people

Attraction to working with older people was reported by 56% who actively moved from another specialty to work in aged care for purposes of making a difference and because of having a genuine like of older people. This seems reasonable as 60% recorded a desire to help others as the main reason for becoming a nurse. The participants identified making a difference to patient care was a factor in the decision to work in aged care. Having a personal experience, for example with a parent requiring further assistance or professional care, and making a conscious decision through an understanding that the work would fit their personality and skills.

The emphasis in this finding is that 46% of participants mentioned the patients in an affectionate manner. The terms "love" and "liking for" were used in explaining the patient and the care provided to them. This is a motivator to work in the specialty and a driver to sustain a person in the role. In the following passage Mary, who had recently started work in a Geriatric Medical Unit tells of her genuine likeness and affection for older people and the work she does:

> *My genuine love of older people whom I have a lot of time for. I love working with the elderly, and have a real affinity for them. I feel they deserve lots of TLC and respect and I'm able to offer this. I worked in an aged care facility for 15 years before moving into acute care, and loved it. (Mary, q*uestionnaire)

In using the word "genuine" Mary emphasis's her personal feelings towards her patients. Earthy (1993) in a refereed article speculated that four factors would influence students' decisions to work in gerontological nursing which one of which

included "a genuine interest in older people" (p. 11). This supports the statements made by Mary about her like for older people.

Tarlier (2004) asserts that genuineness, like sincerity are a prerequisite to developing trust. In this way the nurses' personal moral character becomes an important issue in establishing trust which will greatly improve the nurse-patient relationship. Participants in this study demonstrated the same positive behaviours identified by McCabe (2004) in her study as contributors to effective communication with patients. Behaviours described as "giving time and being there", "open/honest communication" and "genuineness" (p. 45) were experienced by patients and were found to promote a patient centered approach to the communication and nurse-patient interactions. These behaviours are particularly useful during interactions with older people who have been identified as having special needs, which these behaviours respond to. These will enhance the reciprocity, which many nurse-patient relationships enjoy. Tarlier (2004) believes that responsive relationships are founded on three essential elements; "respect, trust and mutuality" (p. 230) and that reciprocity is used "to express the concept of mutuality" (p. 236) which she then describes as a "two-way quality of trust" (p. 238). The RNs in my study saw themselves engaged in responsive relationships with their patients and spoke about respect for the patient, which they believed was reciprocated.

Attitudes are a very important aspect within the role of heath professionals and the delivery of health care, particularly for nurses. Vecchio, Hearn and Southey (1992) in their book define an attitude in relation to organisational behaviour as "an idea with emotion that predisposes a set of actions to a specific group of stimuli" (p. 660). By

including the word "emotion" the authors emphasise how attitudes impact greatly on the feelings, thoughts and beliefs of the individual. Attitudes can therefore determine the manner in which people interact with one another and the views people have about others. It is the positive attitude shown by the participants in this study that identify them as professional care givers. In providing this to their patients the nurses optimise the chance of the patient reciprocating, which could increase the intrinsic factors relating to job satisfaction and continue the reciprocation of positive attitude contained within the nurse patient relationship. In displaying these positive attitudes it is likely that patients will respond in a similar manner.

Importantly, Vecchio et al (1992) describe that there are three essential components to an attitude, and the most critical feature, the affective, is reflected in such comments as "I like" and "having a liking for". This was a common term used by the participants in this study to describe their feelings towards their patients and the work.

Attitudes can be influenced by other factors, such as by external factors (Courtney et al. 2000) and can be acquired through learning (Vecchio et al. 1992). Fox and Wold (1996), in their study with student nurses demonstrated that attitudes can be changed. They claimed students nurses' attitudes were significantly improved after a concentrated course on gerontological concepts which were measured using a qualitative and quantitative questionnaire of their making, which supports more recent study findings of student nurses' positive attitudes towards older people (McKinlay & Cowan, 2003). Participants in this study identified that student nurses changed their attitudes towards the older patients from the beginning of a placement to the end. In

this study Rob, describes the same phenomenon in which students on placement changed their views:

> *I know they (the students) all leave with a different idea than what they came with, they say they really love the ward and they love the old people, and I think to myself that's different to a few weeks ago when you came here.*
> *(Rob, telephone)*

Rob worked in aged care psychiatry and had more than 10 years experience in the specialty. In his role as student facilitator he explained how students are exposed to many varied situations which include their own personal interactions with patients and observation of other staff interactions with patients. All of these situations would have influenced the students greatly in shaping their attitude of older people as patients. This may have been due to the role modeling provided by the experienced RNs and suggests that the same approach may benefit newly registered nurses working in aged care. Earthy (1993) believed that having good role models was an influencing factor for students to take interest in gerontological nursing. In my research the RNs noted how some students changed their attitude and opinion of aged care nursing during their clinical placements. I would speculate that it was the RNs who were seen by the students to be good role models and made their placements interesting.

Other reasons for liking older people were based on personal experiences and the feedback received from the patient, for example:

> *It is emotionally rewarding. They say they have missed my smile on my days off. They smile when I say "Hello." (Mark, questionnaire)*

The patients were seen as being appreciative, respectful and thankful for the care received, in Mark's case this made the work rewarding for him. This can result in RNs reciprocating their feelings which can be generally termed, respect for the older person.

Respect for the older person

The attitudes individuals have about others are shown in the way they interact with them. Nursing practice is a discipline dependent upon the interactions with others, in particular, our patients and establishing good relationships lies at the core of nurses' constructions of practice (Melia, 1981). Respect is defined by The St Michael Oxford Dictionary (1981) as "admiration felt towards a person or thing that has good qualities or achievements, politeness arising from this" (p. 596) Identifying respect is a major factor in the attitude shown by the participants in this study.

Within this definition of respect are certain attributes, namely "admiration, good qualities and achievements" of a person or thing. These attributes were mentioned on many occasions by the responding nurses and were listed in the NVivo database as 'Qualities of the Older Person'.

Admiration was identified by the participants who recognised the contribution given by older people to society in general. Many spoke about listening to the war time experiences and admired how older people managed through those most difficult times. In mentioning war time experiences the participants were acknowledging and respecting that their survival was also an achievement.

In the next reference Robyn, who worked in an Aged Care Rehabilitation Unit writes about these experiences and realises that some older people have no one to talk with and are pleased to talk about themselves when they have the chance:

> *When you sit with them and listen to them, as often they don't have anyone to listen to them. Their life experiences amaze me. They coped well with difficult situations in life, e.g. war and hunger. (Robyn, questionnaire*)

Not all RNs referred to wartime experiences. Many admired the effort and pride older people took in maintaining, on a daily basis their personal grooming and hygiene. Clare, who worked in aged care rehabilitation and had more than 6 years experience in the specialty, recognised that such activities are important to older people in ensuring personal pride and dignity are maintained, as stated in the following quotation:

> *They (older patients) maintain self-grooming…..they are sensitive to their well-being e.g. by being continent of urine/faeces. They still have a certain degree of independence, e.g. walking, looking after their ADLs. (Clare, questionnaire)*

In the next example Mark, an RN with more than 6 years experience in Aged Care Psychiatry illustrates admirable qualities of older people as "being appreciative" and "not complaining". Mark mentions these qualities juxtaposed to the achievement of living through war and the social struggle in the subsequent years of The Social Depression following World War 1:

> *Older people have been through tough times, e.g. war and depression. They have more patience. They are appreciative. They don't complain or expect as*

much as younger people today. They show others a lot of respect. (Mark, questionnaire)

Mark makes a connection between the special qualities and the lived experiences, mentioned here as patience, appreciation, respect and wartime experiences, perhaps with one influencing the other.

The next quote describes how, on a day to day basis older people appear to manage by improvising to deal with certain situations, perhaps issues that are due to the normal ageing process:

The way they cope with problems and improvise to cope with situations. Their desire to be independent. More understanding, accepting and helpful towards others' problems/situations. (Nadia, questionnaire)

What is clear is that the RNs in this study in general respected and acknowledged the views, experiences and achievements of older people. Many participants went on to say that listening to their patients gave them personal satisfaction and that they learned something from the interactions, as stated below by Sharon:

The amount of satisfaction you receive and the amount of learning from the elderly enables you to appreciate all they have done and have been through and makes you appreciate what you have today. They are an honest group of patients. They are full of good and bad experiences in their lives. It's our chance to give something back. They have given all their lives to the country and now it's our chance to give them something back to make their lives

> *happier or brighter. I can learn a lot from my elderly patients. (Sharon, telephone)*

The above passage from Sharon was typical of many participants in the study who recognise the worth of the individual by admitting how they had learned from their patients. This illustrates how the participants showed great respect for the older person and in the following passage Rob demonstrates a positive attitude in his remarks:

> *I really feel affection for older people, but I feel they deserve a lot of respect and I have a lot of time for them. (Rob, telephone)*

Another way the participants demonstrated their respect was through being an advocate. Traditionally RNs have been acknowledged as patient advocates ever since the first trained nurses arrived from Ireland and England in 1838, who particularly advocated for the destitute in their own homes at a time when older people's special needs were recognised as a social category (Stevens, 2003).

Throughout history and continuing today, nurses highlight specific needs of those needing care, and in particular, the needs of older people with issues such as loneliness, marginalisation, abuse and the fear of becoming a forgotten group. The respect, positive attitude and personal liking the participants identify in this study demonstrates their advocacy and, in particular, their stance against ageist ideas on behalf of their patients. This is a task many feel obliged to take and accept the responsibility knowingly. The following passages are an example of the nurse as advocate:

> *In society in which youth is the valued age, the elderly tend to become isolated and alienated. I have a goal in life to help them. (Jill, questionnaire)*

In this passage Jill recognises how elderly people have become isolated and alienated which will cause loneliness. Having a goal in life to help them can be achieved in many different ways by the RN. Cooper (2005, p.43) defines the role of the nurse as being a person who assists in the "restoration of a person to a meaningful life through caring and coaching", which involves assessing and improving performance. In the geriatric medical unit in which Jill worked she could fulfill this role as coach by assessing her patients, developing and assist in implementing plans for personal and health improvement. The concept of the nurse as a "coach" complements the role which requires the nurse to engage in a therapeutic relationship with the patient. The coaching will require close and meaningful personal interaction, with the nurse drawing on all the experiences formed throughout his or her professional and personal years of life.

In the next passage Julie, who worked in an aged care psychiatry unit had real concerns and a protectionist view on how to care for the elderly in a society which, at times can lack compassion:

> *I think it raises a very important issue about compassion in society for those who are vulnerable, and I put the elderly in that category…if we in society cannot look after these vulnerable groups then we are not civilized. (Julie, telephone)*

A genuine liking for older people and the respectful manner which the RNs, in this study demonstrated are strengthened through interactions that occur between the RN and patient. Lookinland & Anson (1995) found in their study that older people were seen as being wise and interesting people with lots of stories about themselves to tell. Participants in this study support those findings and considered this as an attraction to working in aged care.

Patients telling their stories

A total of 60 % of participants in this study reported that patients found personal interactions with nurses to be very enjoyable and useful, in particular, by telling stories about life events and generally enjoying conversation. This was identified as an interesting aspect of the RN's work. This can be epitomised in the following quotation:

> *I think we have to somehow show the elderly as the interesting people that they are. That may be by getting them to relate their stories, yeah, not allowing them to be just this lost person in a bed. (Robyn, telephone)*

Seeing the older patient as an interesting person through conversational techniques has been highlighted in research studies. Thorsteinsson (2002) identified that patients told fascinating, humorous and sad stories and that the manner in which nurses showed interest and genuine concern was important to the patients. Similarly, McCormack (2003) in a study with older patients and nurses using conversational analysis developed a framework for a person-centered practice in which respect for patient's values is essential. Respect for persons is central to the notion of person-centeredness and is rooted in the mutual respect and sympathetic benevolence. The research suggested that by using biographical accounts, narrative and stories, patients

may be assisted to find meaning in the care they receive which may help them tolerate the incongruity of their illness and plan for the future. Participants in this study described the willingness for older people to use their stories and narrative to communicate to others which may well assist them to tolerate their illness and find some meaning to their life experience.

Patient-centered care focuses the nurse on the patient receiving the care. McCabe (2003) found that by using a patient-centered approach when communicating ensured the delivery of quality patient care. Her study found that nurses can communicate well with patients, contrary to some reports that nurses were task-centered. The author also noted that many organisations did not value or recognise the importance of nurses using a patient-centered approach when communicating with patients to ensure the delivery of quality care. The participants in this study recognised the value of conversation with the patients. In seeing the person within the patient, and connecting through the avenue of conversation, participants believed a better patient outcome based on quality care was possible.

Aged care in nursing homes and residential services have benefited from the valued practice of reminiscence therapy (Gibb, Morris & Gleisberg, 1997). This has not been an established practice for public hospital inpatient aged care units, however, it is appropriate to consider the benefits of such a practice and would require the support of medical colleagues. To make such a program viable a service would need to demonstrate that a practice would provide positive patient outcomes, for example, improved mood, identification of further psychosocial problems and hospital outcomes, for example, reduced length of stay. For those patients who are able to participate, using similar sessions may provide diversional and social interaction

which may demonstrate an improvement to the patient by assisting in the therapeutic process. For instance, in aged care rehabilitation services older patients are encouraged to remain out of bed, dress in day clothes and move to different areas of the hospital. As well as the physical therapy programs provided, diversional activities are employed. Patients may eat in a central dining room and meet to watch television in a central lounge. Informally patients are meeting and mingling. Conversations occur as normal. The participating nurses in this study reported the willingness and readiness for the patients to speak about themselves and of 'memories of days gone by'. More involvement would ensure that the patient was not a 'lost person in bed' and has the potential to improve patient wellbeing for those who would benefit from such activity. The intentions of the participating RNs were to ensure the patients were not 'Busy Doing Nothing', as in the title an article written by Nolan (1995). In the article the author suggested that "if the quality of care elderly patients receive (in hospital) is to improve, nursing staff must see the provision of activity as an integral part of their role and function" (p. 528).

From the participants' information it can be identified that a reciprocal relationship occurs with patients who find the interactions and interventions useful and nurses finding them interesting for several reasons. Firstly they helped participants understand the patients more in the context of their age that is, being older people with fascinating lives and history. Secondly, they made the work more interesting. Participants reported using this approach during their usual interventions with patients for example, when attending to activities of daily living. Interacting with the patient fulfills the fundamental concept of caring for a person. When attending to a patient the RN is taught to assess and observe all aspects of the person's physical, psychosocial

and spiritual needs. This is more likely achieved through conversation and astute observations. The RN is therefore regularly engaging in personal interactions, enhancing the situation of a rapport which RNs are encouraged to develop within the nurse-patient relationship. This will help bring about hope within the patient which, in the opinion of Forbes (1994) "generates energy that enables individuals to cope with numerous problems and losses, overcome obstacles in life, and continue functioning during chronic illness. Hope thrives in the context of a caring relationship" (p. 5). The RNs in my study realised the importance of continuing a relationship built on respect and allowing open communication with their patients. This would help the patient maintain interest in their own health gain and enhance the likelihood of hope being sustained by the patient.

Patient-centered care focuses the nurse on the patient receiving the care. McCabe (2003) found that by using a patient-centered approach when communicating ensured the delivery of quality patient care. Her study found that nurses can communicate well with patients, contrary to some reports that nurses were task-centered. The author also noted that many organisations did not value or recognize the importance of nurses using a patient-centered approach when communicating with patients to ensure the delivery of quality care. The participants in this study reported that in general they enjoyed communicating with older patients and importantly, it could occur during routine tasks, as in the following quote:

> *I find them* (patients*) more interesting to talk to about their lives, especially when attending to them. I've found that when you listen to their lifestyle and how they have coped with various problems and so on…. amazing, it's all very interesting'. (Sharna, telephone)*

Such caring is patient centered and will maintain the hope the patients need.

This is considered a beneficial situation which may influence and promote the patient's well being and participants in this study reported patients liking the interactions.

While conducting a study with older patients and nurses to investigate the emotional labour of nursing, Smith (1992) writes in her book, "When I asked patients to describe a "good" nurse they were more likely to talk about attitudes and feelings rather than technical competence" (p. 16). This emphasis's the humanistic approach of the RN's role as outlined by the participants in their personal interactions. It also identifies that patients have certain needs that may be overlooked. Participants in my study reported the same fact that patients require staff to be responsive to their needs which many termed special needs of the older person. Participants described these special needs as, for instance allowing the patient more time to perform tasks such as, transferring from bed to chair, mobilising in the unit and eating a meal. These require RNs to be tolerant, display patience and understanding, which are, in them selves special qualities of a person. Participants believe that RNs require these qualities to meet the special needs of older patients and believe that they are acquired through different experiences in life and a working knowledge of aged care.

Participants in this study demonstrated that they acknowledged patients as individuals and planned to meet the individual's needs. In this way the findings support those by McLafferty & Morrison (2004) who performed a study with RNs, nurse teachers and

student nurses to identify factors which may influence attitudes and beliefs both negatively and positively about older people. Findings showed that RNs in the older people's settings displayed positive attitudes to the patients and were satisfied to be there, that they provided individualised care and that former institutionalising approaches were declining. The interactions which participants in this study reported that maintain their interest were centered around the individualised care provided to the patients, supporting the notion that former institutionalising approaches are declining.

Encouraging and facilitating older people to converse in structured and unstructured sessions with other inpatients and with RNs and evaluating the use of these sessions by measuring patient outcomes is one way of improving patients' programs and maintaining RN interest as identified by participants in this study. This patient intervention and activity demonstrates a change in the structure of nursing care which has been occurring for some time.

Participants acknowledged the need for individualised care as each patient presents different health and ageing problems.

Complex clinical and psychosocial care

In describing health and ageing problems of the patients, 56.6% of participants identified that admitted patients usually presented with a combination of medical, psychosocial and age related problems. These participants affirm that aged care nursing is challenging and requires RNs to be skilled to meet the acute, sub acute and specialised aged care needs of older patients. Recognition of the clinical complexity in

aged care had been developing over time with nurse researchers identifying this phenomenon and with government agencies describing it as such,

> Older people commonly have multiple medical, physical and psychosocial problems impacting on their health. In a hospital setting where care tends to focus on the main medical reason for admission, many of these problems can remain undetected and, hence untreated (AHMAC, 2005, p. 2).

This confirms participants' experiences of older patients' admission to hospital, as Tracy stated,

> *It's the challenge of nursing the multiple medical problems associated with older people. (Tracey, questionnaire)*

The clinical complexity in aged care requires RNs with expertise in acute, and sub acute aged care nursing to manage the individual care requirements. The increased incidences of disabilities ranging from hearing loss, arthritis, stroke and other cardiovascular diseases and musculoskeletal problems that afflict older people (AIHW, 2006) compound the complexity of nursing care. These compromise older people's general well being and can have an effect on the risk of an older person having a fall, which is a major cause of injury-related preventable hospitalisation and loss of independence among older people (SWAHS, 2005). Recognition of the skills required to risk assess, observe and plan patient care is important to RNs. The RNs in my study expressed the need for this recognition to be advertised which may assist in the recruitment of RNs in the future.

Wilkes et al (1998), investigating nurses' knowledge about older people in acute hospitals, found that nurses in their study had deficiencies in attributes that relate to

knowledge about aspects of older people's characteristics, taking into consideration the age and individuality of a person which posed implications for the nurses' clinical practice. Participants in this study reported that 33% had gained formal post registration qualifications ranging from graduate certificate to masters degree, as well as attending aged care specific in-services, seminars and reading nursing journals to maintain current knowledge. The participants in my study identified the continuing need to attend effective learning programs. Management's support of this will be attractive to RNs considering aged care nursing. Providing nursing education programs and developing new models of care within the hospital will help meet the clinical challenges RNs have to manage (Hancock et al, 2003).

In recognising the complex nature of aged care the myth that older patients require nothing more than basic care as opposed to technical care has been challenged. The care must meet the needs of the patient and if the problems are complex, expertise to manage the problems must be commensurate. The skills required have been identified by researchers, for example Stevens and Crouch (1997) assert the skills as being:

> "a complex set of skills such as recognition of symptoms, signs, needs, intellectual and perceptual vigilance, theoretical knowledge of conditions… the ability to make decisions regarding appropriate strategies to meet needs and alleviate symptoms, the capacity to evaluate and modify such action. These are all high level professional capabilities and require intelligence, knowledge, training and experience for their full development" (p. 241).

Researchers have different views on whether aged care nursing is solely in the hands of specialist aged care nurses, or within the scope of all nurses. McCormack & Ford

(1999) believe there is a role for the gerontological nurse specialist with key attributes based on a framework that includes holistic knowledge and practice, saliency, knowing the patient and moral agency and to demonstrate knowledge and skill of working with older people from a variety of perspectives. The key attributes nominated by Stevens and Crouch (1997) and McCormack & Ford (1999) would serve as comprehensive measurements within a tool for the selection of RNs applying for aged care nursing.

On the other hand Wilkes et al (1998) investigating RNs' attitude and knowledge of older people in acute settings concluded that "the care of older people must not be considered only the province of a specialist group of nurses" (p. 16). This recommendation is based on the fact of the growing number of older patients admitted to acute hospitals and occupying hospital beds with a majority of RNs caring for older people on a daily basis. It is also supported by McKinlay & Cowan (2003) who state that due to the increasing ageing population "the care of the older person will become an increasingly important part of the nurse's remit" (p. 298).

The participants in this study, who all worked exclusively with older people, showed similar attributes in their care of their patients as listed above. The RNs provided holistic care and knowledge by synthesising the broad knowledge they had through years of different nursing experience and applying it to patient care. Knowing the patient as a person and individualising the care, saliency was achieved as the RNs considered both the tangible and intangible aspects of the patient's complex clinical and psychosocial condition. This occurred in an approach that maintained the dignity and respect of the patient demonstrating moral agency.

It is clear that RNs in aged care require a comprehensive set of skills to meet the care requirements of the patients in their care. Older people have special needs, and RNs must be able to implement patent care "taking into consideration the age and individuality of that person" (Wilkes et al, 1998, p. 15). The participants in this study articulated the fact that older people are likely to have comorbidities that make the clinical presentation complex. Some of these are age related, such as dementia and disabilities, which cannot be overlooked or left untreated. Clinical problems are more noticeable than the psychosocial problems which may not be assessed and can be left unmanaged. RNs working in specialised units should be urged to seek specialisation if it is available. RNs in general adult units should be encouraged to attend courses specifically related to aged care for skill enhancement.

One of the longstanding images of aged care nursing has been a stagnant area for patients who required no more than basic care and staff who, for whatever reason did not work in the highly technical acute clinical areas of the hospital, resulting in an undeserved reputation that aged care was an area of low status. It can be argued that all patients who are admitted to hospital receive some type of basic care with assistance to bodily functions that they would normally attend to, if it wasn't for their special circumstance. Older people, due to the ageing process can require more assistance than younger people. Basic care occurs as part of the total care of the patient. Lawler (1991) asserts that "basic care is profoundly important to the well-being and recovery of the patient" (p.32). The participants in my study acknowledged the importance of basic care and combined it with the ongoing assessment and

attention to the individual's well-being through continuing conversation and finding out a little bit more about the patient, as Vicki recalls:

> *I find them more interesting to talk to about their life and especially when attending to them. (Vick, telephone)*

Using this approach, Vicki recognises the opportunity to continue the total care of the patient, which can occur through observing, assessing, listening, supporting, and at the same time, dignifying the individualised care needs of the patient. This gives meaning to the care and tasks performed. These intangible aspects of practice should receive more prominence as part of the RN role with a clear descriptor of what the role of the RN is within each interaction, as this will give meaning and significance to the work.

The established role of clinical nurse specialist has been in place in New South Wales, Australia for some time. Professional and tertiary education facilities have recognised courses to provide the necessary education and training for RNs. Ensuring RNs avail themselves of this professional development is a significant matter of policy development for health care services. The advanced knowledge acquired can guide and direct team members whose impetus will bring about the necessary changes to practice. Junior staff and students will find the work no longer boring or the patients uninteresting, as they continue to gain further experience in their professional career.

5.2. WHAT DID RNS IDENTIFY IN NURSING PRACTICE WHICH NEEDS CHANGE TO ATTRACT RNS BACK INTO AREAS SPECIALISING IN NURSING OLDER PEOPLE?

The participants identified that a change in people's attitude, increased availability of education and training, the provision of support, recognition of the complexity of the work and better advertising were necessary to entice RNs into the specialty. Education and training and recognition of the complexity of aged care were discussed in the previous section of this chapter.

Change people's attitude

Other people's views on aged care have been discussed and have the potential to change as the recognition of the complex nature of the specialty continues, and this appears to be the case. Promising new research has shown that student nurses, who were widely reported to have negative attitudes about aged care and who are the future workforce have been found to have a positive attitude towards working with older people (McKinlay & Cowan, 2003), and that there is evidence that former institutionalising nursing care approaches are declining (McLafferty & Morrison, 2004) giving way to individualized care with the nurse increasingly focusing on the psychosocial aspects of nursing care.

In general, the participants in this study demonstrated a positive view about older people, similar to more recent studies performed with RNs (McLafferty & Morrison, 2004; Routasalo et al., 2004).The participants in this study spoke about many different

qualities they observed in older people that helped them form positive feelings and views. These participants noticed that more students were also changing their views about older people during their placements in hospital. This positive change may be credited to the experienced RNs working with older people and who students can model the interactive approach RNs have with their patients. As previously mentioned, role modeling is identified as being an important factor in the development of the student nurses which was supported by Earthy (1993). This can influence the professional socialisation students receive in the workplace, and improve their attitude towards older patients. Identifying student nurses as having a more positive attitude does provide RNs more satisfaction in their work, as they can see the benefits students received from the practice area. RNs view aged care as an important training area for student nurses; it acknowledges and recognises the skills of the RN and their role in student preceptorship and learning.

One aspect of the RN which has emerged through the literature search and in my research study relates to the mature RN. This presented to me the question of whether maturity affects the ability of the RN to work effectively with older people and could suggest that older RNs are more equipped and better suited, in general to nurse older people.

I use the word maturity to describe the stage in the RNs' career in which the experiences from all the previous years, being the personal life experiences and professional clinical experiences combine to help the RN understand, as Angus and Nay (2003) describe "the professional healthcare needs of the acutely sick and complex extreme old person" (p. 130).

The RNs in my study had on average over 10 years experience working with older people. This meant that they were drawing on many different experiences to assist them in their decision making. An important observation the nurses made was that the maturity of the nurse was a factor in assisting them to fully appreciate the patient as an older person with a health problem and to empathise with them about their concerns and feelings. Maturity described the number of years working experience, chronological age and life experience. This blend of experience was considered an advantage and, in some way playing a part in forming the disposition of the RN to have a liking for nursing older people. Specifically relating to the role of the RN, Jenny made this remark when being asked "What needs to change":

> *I think that nurses in this area need to be mature, to have some life experiences under their belts to manage the many different issues that might arise. Nurses need to be patient and show self control. (Jenny, telephone)*

This interesting comment does capture the essence of what many participants were alluding to, that the nurse in an aged care unit needs to be able to understand the patient and the many specific needs that older people present with that require the patience, tolerance and understanding of a skilled nurse. If these are attributes which usually develop over time, then it may be appropriate to search for these attributes in the recruiting process and to assist the nurse by producing a person-job fit.

In my definition of maturity there will always be the question of whether newly graduated RN's are suited to managing the care of older people in specialised units. New RN graduates have a huge opportunity within the many areas of nursing practice. The decision to work in aged care specialty units should be taken carefully. Earthy

(1993) speculated that four factors would influence students' decisions to work in gerontological nursing which included "a genuine interest in older people, a solid gerontological nursing knowledge base, good role models… and more exposure to the elderly in a variety of settings" (pp. 11-12). These factors either individually or in total feature in many of the studies previously mentioned and notably, a genuine liking for older people was a major factor in my study (section 4.2.5.1). The factors identified by Earthy (1993) do recommend the RN have further gerontological nursing knowledge suggesting more than that made available in an undergraduate program and to have a further period of time exposed to the practice of nursing older people in different settings. These experiences would logically enhance the developing skills and expertise of the RN to compliment the interest in and desire to work with older people.

In other previous studies considering the attitude of nurses towards older people researchers have included the demographic variable of the age of the nurse and in some studies found that this was not a factor (Armstrong-Esther et al, 1989; Lookinland & Anson 1995). Contrary to these findings age as a demographic variable has been shown to relate to nurses' attitude towards older people, and in some studies (Quinn-Krach & Van Hoozer, 1988; Haight et al, 1994; Hope, 1994) showing older nurses and students having a more positive attitude. The reasons for this have been related to previous exposure to older people in either personal or professional life experiences, although this has been refuted in other studies mentioned above.

What has been identified is that the RN needs to be able to relate to the older person and it was suggested that work and life experiences enhance the ability to relate to and

understand older people. Recognising that newly graduated nurses have the opportunity to experience many different avenues within nursing practice, the emphasis for recruitment and retention may lie with the mature and experienced RN.

I suggest that the RN's age as a variable may have influence upon other variables such as previous experiences with older people both personally and professionally and further knowledge of older people's health issues. These may affect the RNs' interest in working with older people and warrants further investigation.

Advertising

Advertising has become a focus within many public hospital facilities either as a hospital initiative or in conjunction with an area health service. Although advertising occurs, the material being advertised needs to reflect what happens in practice. In the quotation from Terri, prospective RNs need to know the many different facets of the role:

> *I think we need to promote the fact that nursing older people does offer diversity, that it offers challenge. (Terri, telephone)*

The concern is that advertising, whether in newspaper, journal or the more popular DVD presentations for larger events needs to advertise the true story, as Terri sees it.

With the current shortage in most clinical areas, a lot of advertising occurs. The suggestion from these finding is that there may be a target group of mature aged RNs who could consider the move to age care the right choice.

Linked to advertising and the selection and recruitment process is the need to assist RNs in understanding if aged care is the right place for them. Some participants did make an active choice to move to aged care, and it has been established that certain attributes will assist the RN in caring for older people. This indicates that the recruitment and selection process may be improved through a mechanism to assist nurses in finding the suitable RN role. Furham (2005) in his book noted that "productivity and satisfaction are directly related to the fit between the characteristics of the individual and the demands of the job" (p.116). Providing clearer information about the RN role in aged care would give prospective RNs a better understanding of the role and the ability to decide if a person-job fit existed**.** The different aspects of interesting work identified by these participants could be used in marketing and recruitment.

5.3. WHAT MAKES NURSING OLDER PEOPLE LESS ATTRACTIVE TO RNS COMPARED WITH OTHER AREAS OF NURSING?

When asked if there was a difference in nursing older people and people in other non aged care units, 76% answered "Yes", 17% answered "No" and 7% did not respond. Clearly, participants recognised a difference which they identified as work related labour intensity and patient related associated medical and age related problems.

Associated medical and age related problems

In Australia there is approximately 1% of the population suffering with Dementia (NSW Department of Health, 2006). On a more regular basis RNs are caring for people with dementia related symptoms and problems related to confusion, incontinence and aggression. These are aspects of the nursing care which will not

readily disappear. These usually occur as adverse conditions associated with other medical and age related illnesses. These challenges demand nursing specialists to evaluate current practice to identify best practice management. In nursing units and wards, the casemix of patients can quickly change so that there might be a high percentage of patients with these types of condition in the unit at any one time. Performing these nursing tasks will remain less popular than tasks which include more pleasant interactions with the patients, such as assisting a patient with a wash in which conversation can take place. The nursing management of these conditions is covered within the curriculum offered by the professional and continuing education and training courses available for nursing older people. Having an understanding why these behaviours occur and the relevance of attending to certain tasks could also be part of an ongoing hospital education program.

5.4 CONCLUSION

The participants in this study provided their views on the positive and negative aspects of nursing older people in aged care public hospital units. The data provides relevant information for suggested improvements to nursing practice and in particular recruitment and retention processes.

There were two positive aspects relating to nursing practice that can enhance the role of the RN, providing further interest, job satisfaction and improvements to recruitment and retention. Personal interactions involving patients telling their stories and the complex clinical and psychosocial illnesses patients present with provide diversity of experience and clinical challenge. They both require advanced practice skills and personal qualities, which match the special needs of older people.

The negative aspects of aged care nursing are focused on the labour intensity due to the lack of independence which affect many older people, and the difficult behaviours which adversely accompany age related problems.

Recruitment of RNs into the specialty has been considered a challenge and is difficult to compete with other clinical specialties. As RNs find career choices in areas which are of interest using personal and professional expertise as a guide, the findings of this study suggest that the RN role in aged care is one that would suit mature nurses whose expertise has developed through work and life experiences.

From the findings of this study the following conclusions can be drawn.

5.4.1 Recruitment and retention

The processes involved in the recruitment and retention of RNs should consider how to assist prospective applicants in making a person-job fit understanding the RN role in aged care. Major features of the process should include:

Advertising and marketing.

Undergraduate nursing students and newly registered nurses are keen to experience the variety of health services showcased during their learning and training program. In New South Wales, Australia the usual entrance to the workforce for newly registered nurses is by way of a transitional program available in many private and public hospitals with some programs conducted at specialty and aged care services. This is a time when the new practitioner can put into practice the newly acquired skills,

working in many different specialties of the health service and gaining valuable personal and professional expertise incrementally. The opportunity to work in so many different areas is an advantage that does not present to other health practitioners, and so many are advised to seek the opportunities.

Another finding of this study suggests that aged care nursing may be suited to mature aged RNs who have work and life experiences, which will assist in applying the attributes required to care for older people. To appeal to the mature RNs, advertising and marketing should include photographs of mature RNs with statements that reflect and acknowledge the RNs who have chosen aged care after having years of personal and professional experiences making them suited to the aged care RN role.

Selection process

In assisting nurses with their decision to consider the role of an RN in aged care, a formalised process would be advisable. Holland (1973) writing about vocational theories asserts that people search for environments that will let them exercise their skills and abilities, express their attitudes and values, and take on agreeable problems and roles. The usual method of selection in RN recruitment is through an interview. Whether that is sufficient to assist the RN in making a choice is arguable. The interview process carries an element of risk in that an interview is usually performed within a short time period and assessed following a series of verbal questions. Currently, RNs do not undertake an assessment with an evaluated tool to test their compliance and competency for key attributes that identify prerequisites necessary for the aged care RNs. Having an assessment tool would not only assist managers in their selection decision but assist the RN who is considering the RN role in aged care.

As previously mentioned, the key attributes of an aged care nurse identified by Stevens and Crouch (1997) and McCormack & Ford (1999) could comprehensively be used within a framework for RN selection. The process in deciding if a person-job fit occurs is one that needs further investigation specifically for the aged care RN role.

RN job description

The RN job description should comprehensively describe the role of the aged care RN including interesting and unique features of the work with older people. Emphasis should be placed on the provision of individualised total care and that basic care is fundamental to the improved well being of the older patient. Job descriptions should be based on a standard set of competencies for the aged care RN which reflect the nursing activities and be evaluated through a performance management tool.

The job description should include desirable attributes that will assist the RN meet the special needs of the older person which include, patience, tolerance and understanding of the age related processes (other attributes can be included), and would complement national competency standards for RNs.

5.4.2 Patients' life stories

The participants confirmed that talking with older patients provides benefits for the patient and the RN. Unfortunately, this is not practiced as often as RNs and patients would like and is usually restricted through difficulties related to workload and staffing problems.

Residential aged care services have used structured reminiscence therapy for older people with dementia with success. In the hospital, structured activities tend to be provided for social and recreational activity; although they may be useful, they may not address intangible problems that older people present with. Providing time for RNs to generally converse and discuss aspects of the older patient's health status and psychosocial problems will support the continuum of care and ongoing assessment during the older patient's length of stay. The RN is appropriately placed to conduct such assessments, which could be relayed back to the healthcare team.

Whilst the patient is in hospital this can be facilitated in the following way:

1. Promote the use of individual interactions between RNs and patients based on conversation and which may benefit the patient with a positive outcome.
2. Provide more time for the RN to interact with patients for the purpose of providing quality time with the patients in which observation and assessment can be performed.
3. Ensure nursing policies require RNs to document interactions in the patient clinical file for the benefit of the patient's progress and other team members.
4. Establish programs, which include the opportunity for patients to converse, if not already in place.

To evaluate the benefit of programs patient health outcomes could be measured. If the hospital implements a structured program a measuring tool could be developed with clinical and performance indicators to measure effectiveness, for example, patient satisfaction and length of stay. This requires further investigation relating to the implementation and evaluation of effective programs.

5.4.3 Training and development

Older people present with complex clinical and psychosocial illnesses that challenge the skills of the RN. Participants in this study did identify that ongoing education and training is required. The skills and competencies are in two specific areas, clinical and psychosocial. Clinical competencies require the RN to care for patients who are classified as more acute, requiring technical care associated with their clinical illness, for example, post surgical, medical and rehabilitation care techniques. These can be maintained through hospital in-service and locally prepared case histories and presentations.

Skills required to care for older people, as described above, and which require conversational skills and the acquisition of certain attributes to manage older patients are not usually offered within mainstream nursing education. External programs can be accessed but hospitals and RNs may feel prohibited by the cost of programs. These can be locally developed to meet the specific needs of RNs or particular service needs, depending upon the clinical specialty, for example, psychiatry or rehabilitation. The advantage of locally prepared sessions and programs is that they can be specific, provide only what is required, be conducted when time permits, be offered to all RNs over a given time and are less costly.

In Summary

The participants in this study have identified aspects of nursing care and qualities within older people that make the role of the RN interesting in aged care. Their views support the growing acknowledgment that older people commonly have many complex clinical and psychosocial illnesses that require skilled staff to meet the

special needs. Older people are admitted to specialised units in a more acute clinical state of illness driven by the shorter length of stays in the acute hospital. The skills required by an aged care RN are those which will meet the health and ageing needs of the patient due to the complex comorbidities that can exist with each patient. The aged care RN has an interest in caring for the holistic needs of the patient which extend beyond the clinical nature of the presenting illness, and require careful assessment, observation and unique interactions of care delivery. Additionally, participants identified that having maturity, developed through different clinical experiences and through life experiences will provide attributes, which will support the RN in the challenging role of an aged care nurse.

Recommendations and suggestions have been made relating to advertising and marketing focussing on the recruitment of mature aged nurses and the identification and description of key RN attributes in nursing older people to be included in job descriptions. Further research has been suggested in considering a process that incorporates an assessment tool, which will assist in the selection of the aged care RN.

Recommendations and suggestions have been made to involve the RN in ongoing assessment of the older patient's psychosocial problems through conversation either in structured or unstructured sessions. Further research has been suggested in the development of programs that utilise the RN in conversation with the older patient which can evaluate clinical and performance indicators, using a measuring tool.

Recommendations and suggestions have been made about the skills required by the aged care RN. Special qualities and attributes should be identified, acknowledged and

recognised as major contributors to the skill set of RNs in caring effectively for the older person. These attributes can be discussed locally and RNs assisted by their mentors or whoever provides clinical responsibility for their professional and personal development.

Participants have identified negative aspects to aged care nursing that support other researchers' findings and are inherent within the nursing management of ill older people. These provide challenges for RNs and managers to identify best practice methods to approach the clinical and management issues.

The RN in aged care is an essential member of the aged care team, utilising advanced general nursing skills and additional skills that are required to provide respectful and dignified care to older people. These skills are also required to teach nursing students and nurses entering the specialty for the first time to assist them as they learn the craft and skill of being an aged care nurse.

Personal reflections from the perspective of a director of nursing

The predicted increase in the aged population challenges all nurses to consider the implications this will bring to the models of aged care nursing in all health and aged care services. In the future, acute hospitals will have higher ratios of older people as inpatients, which will challenge the ability to maintain the average length of stay at current levels. In this scenario and in my view, the sub-acute hospitals will become vitally important to the smooth running of the health services, in particular the acute hospitals, as there will always be pressure to transfer older people from acute care to make way for the non-aged care patient. This may result in sub-acute hospitals

receiving patients who require more acute care than currently provided a situation that many nurses believe to be now happening. I believe that the past synonymous image of aged care being stagnant and lacking interest, and aged care nurses lacking nursing skills is quickly disappearing. Aged care services, like other clinical services are advancing through research and technology. There is now recognition at government levels that age care is challenging and that care, treatment and management required for older people can be complex. (AHMAC, 2004).

I believe the sub-acute hospitals will provide a model of care required to meet the special needs of older people. The stereotypical and routinised geriatric care described by Baker (1978) and further evidenced in public hospitals in subsequent decades (Koch et al. 1995; Pursey & Luker, 1995), has been seen to be declining. The new era provides programs and care which recognise the individualised clinical and management needs of older people, where staff enjoy their work (McLafferty & Morrison, 2004; Routasalo et al. 2004) enhancing the probability of care and treatment leading to positive clinical outcomes.

Nursing professional programs have been developed through tertiary and industry collaboration to provide RNs the opportunity to advance their clinical skills and management expertise in aged care nursing. However, the temptation to ensure that courses provide the most current knowledge and evidenced based clinical care and treatment, may preclude the inclusion of highlighting personal attributes identified as qualities of the aged care nurse. Humanitarian traits such as patience, tolerance and understanding; key components in the nurse patient relationship particularly when caring for the older person, can be overlooked as inherent qualities of every person. If

this is correct, a nurse in a hectic, busy and understaffed aged care unit may still find it difficult to show these qualities in the delivery of care. Quality attributes must be discussed within the aged care nursing curriculum as being key components in providing effective care to the older person. Matching these qualities in the workplace with prospective nurse applicants is not easily identified within a brief verbal interview. Consideration of how nurses and managers can be assisted to correctly find a person-job fit with a nurse and aged care nursing is necessary. This research suggests that mature nurses, judged by the years of experience in nursing and personal life experiences have the ability to use these qualities more easily during the daily interactions with older people. Recruitment and retention strategies targeting such nurses are suggested. If it is acknowledged that mature or older nurses are more suited to the aged care specialty, the recruitment program will have a larger cohort of candidates to choose from. People may consider making career changing decisions as they identify in themselves the attributes and qualities which they feel they could share in a working experience and environment, and really make a difference to the health and aged care service to older people. RNs not currently working as RNs may consider a refresher program such as the Re-Connect Strategy (NSW Health, 2002) with “paid nursing employment opportunities and individualised, tailored support” (p. 2). RNs could gain immediate entrance to aged care nursing and utilise their many life experiencing skills in the care of older people. Similarly, other people who have not worked in the health industry may consider training as RNs and transporting their equivalent skills into nursing and especially aged care nursing.

Support should be given to the nursing clinical leaders graduating from professional courses to consider the models of care required for the safe provision of care. Older

people require care that is planned and delivered in an individualised module, which most nursing models aim to provide. The challenge for nurse managers will be the reality that the provision of safe, dignified and individualised care may require more nurses and support staff than currently provided. A factor that includes affording older people and nurses more time to perform tasks during the restorative period of the patients' admission will challenge the resources available to the hospital. In competition with the politically charged and technologically focussed acute services, the priority aged care resources have historically held within the hospital threatens the ability to provide such services. By maintaining separate aged care facilities, resources may be protected and outcomes evidenced to support new models of care.

This research study took longer than expected, and during the process I was able to observe changes to service provision, clinical practices, the health status of older people being admitted to sub-acute hospitals and staff management which I have expressed in my reflections.

This was an exciting and interesting learning experience. I believe this will benefit me in my current position by enabling me to direct and manage a nursing service with a skilled nursing workforce, which is willing and determined to meet the special health and aged care needs of the older people we serve.

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7 GLOSSARY

Aged care – a specialty of medicine and nursing care specifically caring for persons over 65 years.

ADL's – activities of daily living, actions and events that usually occur throughout the day e.g. attending the bathroom and having a meal.

Attitude –'a prevailing and consistent tendency to react in a given way, describable as being positive or negative and having important motivational consequences' (Lefrancois, 1980 p. 561).

Basic care – is associated with the physical needs of the patient, e.g. assisting the patient with bathing, dressing and at meal times (Stevens & Crouch, 1995).

Co-morbidity - a coexisting disease state (Miller & Keane, 1987, p. 282)

Complexity – refers to the difficulty associated to the medical and nursing care of a patient or group of patients.

Hospital separations – the occasion a person leaves hospital either through discharge or death.

Maturity – a state of a person judged in terms of chronological age and experiences in personal and professional life.

Older person – a person over the age of 65 years.

Professional socialisation – the process by which individuals acquire the values, attitudes, morals, knowledge and skills espoused by the group (Goldenberg & Iwasiw, 1993, p. 4)

Psychosocial problems – problems that are psychological and social in nature.

Registered nurse (RNs) – a nurse who meets the criteria set by New South Wales Nursing & Midwifery Board.

Routine geriatric care - the impersonal and rigid way of organising care, where everything is geared to getting the work done with the maximum economy of human resources (Baker, 1978).

Technical care – is determined by the disease process and the medical interventions that follow (Stevens & Crouch, 1995).

Units – name given to hospital settings that accommodate hospitalised patients, means also 'ward' in a hospital.

8 APPENDIXES

Locked Bag 1797
Penrith South DC NSW 1797 Australia

School of Nursing, Family & Community Health

University of Western Sydney
Bringing knowledge to life

Please sign this form and return it in the self addressed envelope

CONSENT FOR INTERVIEW FORM

Research topic: Positive aspects of Nursing Older People: Data Gathered from Registered Nurses Working in Specialised Units Within Public Hospitals

This form is to indicate your consent to be interviewed on the telephone, and to have the information from the audiotaped interview included anonymously in the project: **'Positive aspects of Nursing Older People: Data Gathered from Registered Nurses Working in Specialised Units Within Public Hospitals'**, as outlined in the enclosed Information Sheet.

The information obtained from the interview may be included in various publications or conference presentations. Your name will not be used. Pseudonyms will be used when discussing or writing up the information you provide.

STATEMENT OF CONSENT

I, the undersigned, have read my copy of the Information Sheet, and have had the opportunity to contact the researcher to discuss any queries. I hereby consent to be interviewed, and to have ***my taped interview*** *used as outlined above, as part of this research project. I understand that I may withdraw from the project at any time without question or adverse consequences. I have retained my copy of the Consent form.*

Name: ……..
Address (optional): ……..
Phone (work, home, or mobile): ……..
e-mail : ……..
Signature: ……..
Date: ……..

Please note: You may withdraw from the project at any time, and you may also withdraw your permission to have your material used in the project. You are not required to give any reasons if you withdraw from the project. Your decision will be respected. If you experience distress during the interview, the interview will be terminated if necessary, and counseling can be arranged.

NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers (Tel: 02 4570 1136). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix B

Locked Bag 1797
Penrith South DC NSW 1797 Australia

School of Nursing, Family & Community Health

University of Western Sydney
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LETTER OF INTRODUCTION TO PROSPECTIVE INSTITUTION

Research topic: Positive aspects of Nursing Older People: Data Gathered from Registered Nurses Working in Specialised Units Within Public Hospitals

John Geoghegan
St Joseph's Hospital
Normanby Road
Auburn NSW 2144

Dear Director of Nursing**,**

My name is John Geoghegan and I am currently enrolled in a Masters of Nursing (Honours) at the University of Western Sydney.

I am presently involved in a research project, the title of the research is;
'The Positive Aspects of Nursing Older People: data gathered from registered nurses working in specialised units within public hospitals'

I have received ethics approval from The University of Western Sydney Nepean Human Ethics Review Committee, Western Sydney Area Health Service Human Ethics Research Committee and the Hope HealthCare Limited Health, Research and Ethics Committee and have received permission to approach the Director of Nursing and registered nurses working in units that specialise in nursing older people, eg, Aged Care Psychiatry Units.

To investigate the title of the research project I require registered nurses to complete a questionnaire and participate in an audiotaped telephone interview. I have attached for your information a copy of the Participant Information Form, Participant Questionnaire and Participant Consent to Interview Form. As agreed, …has been nominated to liaise with me on this research project. The HHL HREC also recommend that staff should be able to perform this during hospital hours and not considered to be overtime.

I would appreciate you forwarding the questionnaire, information for participants and consent form to registered nurses working in specialised units, which care for older people, inviting them to participate in the research. The form titled Information to Participant explains how participation in the project is voluntary, that the participant may withdraw at any time and that there is no requirement or penalty for not participating. When the results of the research have been finalised, I will be happy to furnish you and participants in the project with a summary of the report.

I appreciate your consideration of this request and, should you wish to discuss any further issues, I am contactable directly on 97490270.

Yours faithfully,

John Geoghegan

NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers (Tel: 02 4570 1136). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix C

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Penrith South DC NSW 1797 Australia

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PARTICIPANT INFORMATION

Research topic: Positive aspects of Nursing Older People: Data Gathered from Registered Nurses Working in Specialised Units Within Public Hospitals

John Geoghegan
St Joseph's Hospital
Normanby Road
Auburn NSW 2144

Dear Nurse,

My name is John Geoghegan. I am undertaking a Masters of Health Science (Honours) at the University of Western Sydney, and have ethics approval from Hope Health Care Human Ethics Committee to conduct a nursing research project.

The title of my project is, 'The Positive Aspects of Nursing Older People: data gathered from registered nurses working in specialised units within public hospitals'.

My supervisor is Professor Helen Ledwidge, Associate Professor, University of Western Sydney.

What is the Purpose of the Study?
The purpose of the study is to record the positive aspects of nursing older people, as reported by registered nurses in specialised units of public hospitals. I would like to record the reasons why you nurse older people and what aspects of the care make your experience satisfying and enjoyable. The results from this study may, for instance, be used to recommend changes to nursing practice, especially in relation to how nurses react and behave towards older people, and in the recruitment and retention of registered nurses into the area of nursing older people.

Who will be asked to enter the Study?
Registered nurses who nurse older people in specialised units within public hospitals, for example, Geriatric Medical Units or Aged Care Psychiatry Units.

What will happen in the Study?
Participants will be asked to complete a questionnaire and/or participate in a telephone interview.

If you agree to participate in answering the questionnaire, please complete and return in the self addressed envelope.

Please turnover.

If you agree to participate in a telephone interview, please read and sign the consent form, and return it in the self addressed envelope, a form is attached for your information. You will be contacted within 2 weeks of returning your completed consent form so that a convenient time may be arranged to call you. The telephone interview will last no longer than 30 minutes. You may withdraw from the study at any time without giving a reason as you are under no obligation to participate.

Are there any Risks?
There are no physical or psychological risks to you as a participant and you will not be identified in any way.

Contact person at your hospital.
Ms Sue Miller, Director of Nursing, has agreed to be the contact person to liaise with me about any issues relating to the research.

Thankyou for considering to participate in this research project and should wish to discuss the process any further, please do not hesitate in contacting me on the numbers listed below.

John Geoghegan
Tel. (02) 9749 0270
Fax. (02) 9646 2391
email. John_Geoghegan@wsahs.nsw.gov.au

NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers (Tel: 02 4570 1136). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

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Positive aspects of Nursing Older People: Data Gathered from Registered Nurses Working in Specialised Units within Public Hospitals

QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS BELOW:

1. Are you male or female? ☐ Male ☐ Female

2. Why did you become a nurse?

_____

_____

3. What age did you enter nursing?

☐ 17-20 ☐ 21-25 ☐ 26-30 ☐ 31-35 ☐ 36-40
☐ 41-45
☐ More than 46

4. Have long have you been nursing as a registered nurse?
☐ Less than 1yr ☐ 1-5yrs ☐6-10yrs ☐ More than 10yrs

5. How many years have you been nursing older people in a specialised unit/ward?

☐ Less than 1yr ☐ 1-5yrs ☐6-10yrs ☐ More than 10yrs

6. What nursing qualification(s) specific to caring for the older person do you have and from which Institution did you attain it/them? (e.g. Graduate Certificate in Aged Care)

Qualification	Institution
1.	
2.	
3.	
4.	

7. During the last 2 years, how have you updated your knowledge, education and training in the specialised care of the older person? (e.g. through journals, seminars, conferences)

8. What attracted you to work in a unit specialising in the care of older people?

9. What has maintained your interest in nursing older people?

10. In your experience, is nursing people over 65 years of age any different than nursing people less than 65 years of age? If you answered yes please state why.

11. In your experience, what are the most interesting aspects of nursing older people?

12. What do you like least about nursing older people?

13. What would you change in your area of practice to make nursing older people more interesting in order to attract more registered nurses to work in this specialty?

_____

_____

14. Please indicate all other areas of nursing you have worked in since qualifying as a registered nurse, and the number of years it has been since you practiced in that area?

Area of Nursing	How long ago did you work there?	
□ Community	□ Less than 5 yrs ago	□ More than 5yrs ago
□ Emergency Department	□ Less than 5 yrs ago	□ More than 5yrs ago
□ Developmental Disability	□ Less than 5 yrs ago	□ More than 5yrs ago
□ ICU/HDU	□ Less than 5 yrs ago	□ More than 5yrs ago
□ Medical/Surgical	□ Less than 5 yrs ago	□ More than 5yrs ago
□ Mental health	□ Less than 5 yrs ago	□ More than 5yrs ago
□ Midwifery	□ Less than 5 yrs ago	□ More than 5yrs ago
□ Oncology/Palliative care	□ Less than 5 yrs ago	□ More than 5yrs ago
□ Paediatrics	□ Less than 5 yrs ago	□ More than 5yrs ago
□ Rehabilitation	□ Less than 5 yrs ago	□ More than 5yrs ago
□ Theatre	□ Less than 5 yrs ago	□ More than 5yrs ago
Other_____	□ Less than 5 yrs ago	□ More than 5yrs ago
Other_____	□ Less than 5 yrs ago	□ More than 5yrs ago
Other_____	□ Less than 5 yrs ago	□ More than 5yrs ago
Other_____	□ Less than 5 yrs ago	□ More than 5yrs ago
Other_____	□ Less than 5 yrs ago	□ More than 5yrs ago

16. What particular differences did you experience between nursing older people and nursing people in the other non-aged care specialties listed above?

_____

_____

_____

17. Are you considering, within the next year, leaving the specialty of nursing older people? If so, why, and what would make you stay?

_____

_____

_____

18. What specialty within aged care nursing are you currently working in (e.g. psychogeriatric unit)?

Are you willing to discuss these questions further in a confidential tape-recorded 30 minute telephone interview to provide greater depth of meaning?

If yes, please complete the attached Consent for Interview Form and return to me with this Questionnaire in the envelope supplied, I will then arrange for a research assistant to contact you by telephone.

Thank you for your time and cooperation.

Please place questionnaire in stamped addressed envelope and return to John

Geoghegan by 30 July 2003.

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Penrith South DC NSW 1797 Australia

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TELEPHONE INTERVIEW - Prompts

The questions below will be asked of each participant involved in a telephone interview. This form will not be given to participants but is for use by the interviewer.

Q.1. Think back to the time you were deciding to nurse older people and tell me what was the attraction for you?

Prompts:

The experiences that influence decision making
Relationships with co-workers or supervisors
Opinions about how older people are cared for
Dissatisfaction with other areas of nursing
Job satisfaction
Standards of patient care
Patient advocacy
Personal experiences of caring for older people
Desire for personal growth

Q.2. What do you find interesting about the idea of nursing older people?

Prompts:

Positive effects:
Being satisfied with work, job satisfaction
Feeling well within self
Able to relate to older person
Finding older people pleasurable to work with
Enjoying what older people can offer, eg. Stories, histories.
Age related illnesses
Opportunity for increased knowledge
Different from other areas of nursing eg. general medicine and surgery

Q.3. What do you like least about nursing older people?

Prompts:

Negative effects:
Not stimulating
Upsetting
Depressing
Physically more demanding

Q.4. What would you like to change to improve the recruitment and retention of RNs in aged care units?

Prompts:

Education opportunities
Skill mix
Nursing practices
Salary improvement
Rosters
Flexibility

Thank participant and inform he/she that he/she will receive feedback as to the outcome of the telephone interview.

This Project has been approved by the UWS Human Ethics Review Committee and the Western Sydney Human Research Ethics Committee