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Getting Research into Practice

The Senses Framework:

Improving Care For Older People
Through a Relationship-Centred Approach

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Welcome back to the GRIP - 'Getting Research into Practice' Reports

This is the second of the occasional Getting Research into Practice (GRIP) reports that showcase studies of particular interest and relevance to current multidisciplinary debates in health and social care. The subject of this report, improving the care of older people and promoting work in this field as an attractive career option, could hardly be more topical or important.

Older people are major users of services but, despite several recent initiatives such as the National Service Framework for Older People, there remain widespread concerns about the quality of care they receive. Indeed, the last few weeks have seen the launch of a new Government campaign to ensure that older people receive dignified and sensitive care. The fact that such a campaign is needed speaks volumes about the work that is still required if quality is to be improved across the board.

Older people often have complex needs arising from long term conditions that challenge a health care system that still focuses predominantly on cure. Consequently, working with older people has never had a particularly high status and does not have the quodos associated with more 'hi tech' areas. Difficulties in recruiting and retaining high quality staff have not been helped by the lack of an appropriate framework to give direction to practice and education. To make matters worse, the emphasis on individual autonomy and independence beloved of policy makers does not reflect the interdependencies that mark society today. This report describes the evolution of a framework for practice, the Senses Framework, that has emerged over several years and has been developed in close collaboration with older people, family carers, practitioners and students. The use of this framework within a relationship-centred approach to care is described, and it is suggested that this can provide a better way of 'enriching' the care older people receive, whilst also paying close attention to the needs of family and paid carers. We hope that its publication will mark an important step forward in improving the status of this vital area of practice.

GRIP Editorial Team

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EXECUTIVE SUMMARY

- Responding appropriately to the health care needs of older people and those with long standing conditions represents the greatest future challenge to health and social care systems globally.

- Work with older people is generally not an attractive career option, and recruiting and retaining sufficient staff to provide the quality and amount of care required is a concern worldwide.

- Modern day health care is dominated by a curative or restorative model, with 'success' being defined largely in these terms.

- A wide range of disciplines across the field of health and social care lack an appropriate framework for practice with older people when cure or restoration of function are not achievable.

- Within nursing, caring is often seen as the defining attribute of the profession but successive studies over the last 40 years have indicated that gerontological nursing has failed to find its 'proper focus'.

- The former English National Board for Nursing, Midwifery and Health Visiting (ENB) was concerned that:

  – existing education at both pre and post-registration levels did not provide practitioners with the knowledge, skills and attitudes they needed to care effectively for older people;

  – students did not find gerontological nursing an attractive future career option.

- The ENB commissioned a 3½ year project entitled 'Longitudinal study of the effectiveness of educational preparation to meet the needs of older people and their carers' to see if it would be possible to identify an 'epistemology' of practice to guide the education of nurses working with older people, and to provide a sense of therapeutic direction for nurses in their day-to-day work.

- The study, summarised in this report, was termed AGEIN (Advancing Gerontological Education in Nursing) by the project team and is the largest project of its kind ever completed.

- AGEIN was a multi-method, multi-phase project with both conceptual and empirical elements:

  – The conceptual phase comprised a systematic, explicit and reproducible synthesis of the existing theoretical and empirical literature involving an initial consideration of some 22,000 references and a more detailed reading of approximately 2,500.

  – The empirical phase included:

    a) Detailed surveys with both students (n = 718) and qualified staff (n = 1500) using purposively designed questionnaires to explore their knowledge of the situation of older people in the UK and their perception of work with such people.

b) Longitudinal focus groups (n = 67) with students in 4 case study sites over a 3 year period.

c) Visits to 33 clinical placement areas identified by students as providing a 'good' learning experience.

d) Studies of post-registration education in gerontological nursing (not reported here).

e) A series of detailed workshops with practitioners, older people and family carers to refine the emerging results.

■ The conceptual phase, together with empirical work from a related project 'Dignity on the Ward' (Davies et al 1999), identified the Senses Framework as a potential framework for practice. These studies suggest that in the best care environments all participants experience a Sense of:

Security – to feel safe
Belonging – to feel part of things
Continuity – to experience links and connection
Purpose – to have a goal(s) to aspire to
Achievement – to make progress towards these goals
Significance – to feel that you matter as a person

■ The potential value of the Senses to understanding students' experience of work with older people was explored over the course of their training.

■ The detailed surveys revealed that students generally had positive feelings towards older people but were put off work with this group largely on the basis of negative practice experiences.

■ Analysis of the extensive data revealed the existence of what we term 'impoverished' environments of care in which students where exposed to ageist attitudes and poor standards of care which discouraged them from working with older people.

■ Conversely, if students experienced 'enriched' environments of care, this could 'transform' their view of gerontological nursing. Indeed students who rated their practice placements as positive were far more likely to: perceive work with older people as interesting, challenging and stimulating; actively state that they would want to work with older people when they qualified; be far less likely to see work with older people as having a negative effect on their future careers.

■ Enriched environments of care could be understood in terms of the Senses Framework. In such environments students experience:

– A Sense of Security and feel safe to explore the nursing role in an enabling and supportive learning environment.

– A Sense of Belonging as part of the 'ward team', who are valued on the placement and encouraged to be part of things.

– A Sense of Continuity, with there being links between theory and practice, enhanced by consistent support from a named mentor.

- A Sense of Purpose in that their own goals and learning needs were recognised by the placement and accorded some priority.

- A Sense of Achievement so that they could meet their learning objectives and then go on to explore other aspects of working with older people.

- A Sense of Significance in that they 'mattered' and their contribution to the placement was also seen to matter.

■ The AGEIN project identified numerous practical ways in which the Senses could be created for students (see Table 9 on pages 116-122).

■ While the Senses are not intended to be hierarchical, the study suggested that they tend to occur in a sequence. Early in their training, and on each placement, students need to feel secure and that they belong, this was initially the most important attribute of an enriched environment. If students were not made to feel safe and were not welcomed on the placement then they learned little, and their Sense of Purpose and Achievement was simply to 'survive' the placement and move on. In such placements students did not feel significant.

■ On placements where students were made to feel safe quickly, and felt part of the team, then they addressed their own learning needs rapidly and soon went on to explore a much more diverse set of opportunities which provided them with a far broader and more positive view of work with older people.

■ The data also suggested that the 'focus' of students attention and effort varied.

■ The initial focus was on 'self', and students found it difficult to move beyond this unless they experienced a Sense of Security and Belonging.

■ Once students felt safe and that they belonged, their focus shifted to the 'course' requirements, which largely revolved around their learning objectives for their placements. These initially defined a student's Sense of Purpose and Achievement. If students had confidence that their learning objectives could be achieved, then they widen their Sense of Purpose and Achievement to focus on:

- Professional care – where they explored the values and practices that refined their developing 'vision' of nursing

- Patient as focus – where attention was turned to the medical need of the patient

- Person as focus – where students saw beyond an individual's medical needs and learned to value the 'person behind the condition'

■ If placements actively encouraged students to explore 'person as focus', then they were more likely to develop an holistic view of nursing and see gerontological nursing as a positive career choice.

■ The creation of an 'enriched' environment of learning and care, as defined by the Senses Framework, has the potential to 'transform' students' views of what constitutes nursing, especially in relation to older people.

- The relevance of the Senses were also explored with a range of other stakeholders (practitioners, older people, family carers) in interactive workshops and the Framework was refined and developed further as a result. It received strong support from all of these groups.

- The Senses are more likely to be achieved when they are applied in the context of a relationship-centred approach to care, rather than a person-centred model.

- The term relationship-centred care was originally coined in the US by a task force established to review the suitability of the American health care system to meet the health challenges of the future (Tresolini and the Pew Fetzer Task Force 1994). They concluded that the current individual, disease and cure based system was inadequate and instead proposed an alternative model based on a relationship-centred approach that addresses the social, economic, environmental, cultural and political contexts of health and also captured *'the interaction among people as the foundation of any therapeutic or healing activity'*.

- These interactions are reflected in multiple sets of relationships between: practitioners and patients/families; practitioners and communities; and multidisciplinary groups of practitioners. The aim of the task force was to create a *'transformed approach to health care, an approach that has at its centre the relationships within and among persons within which truly comprehensive and contemporary care can occur'*.

- The task force argued that the three dimensions of relationship-centred care outlined above creates a more integrated and comprehensive view which ensures a balance between the needs of patients and families, communities and practitioners.

- They also concluded that there was a need for further research to *'explicate the dimensions of relationship-centred care'*. We believe that the Senses Framework captures these dimensions, and in asserting that enriched care environments can only exist when all parties experience the Senses it achieves the 'balance' that relationship-centred care requires.

- The factors needed to create the Senses, and therefore enriched care environments, have been explored in a range of contexts, including: acute hospitals; community settings; care homes; and to a lesser extent, when working with people with dementia.

- Although most of the empirical work with the Senses Framework has been completed with nurses it is potentially of relevance across disciplines and care settings.

- The Senses and relationship-centred care can provide a framework for education and practice to ensure the creation of 'enriched' environments of care in which the needs of all groups are accorded equal value, status and significance.

INTRODUCTION: WHAT IS THIS REPORT ABOUT?

Clearly, nurses working on geriatric wards are not to blame for their lack of knowledge and skill. These nurses are the product of a training system that taught them a series of tasks and neglected to provide adequate information about care of the elderly. The central problem in geriatric nursing is the central problem in all nursing, 'nurses do not know why they do what they do.'

(Wells 1980, p129)

'Nurses working with older people have always experienced difficulties in articulating the knowledge, skills and expertise underpinning their practice and their impact on patient care.'

(McCormack 2001, p290)

The above two quotations were written over 20 years apart, and during that period numerous studies have explored *'why nurses do what they do'*, many of them focussing on nursing older people. However, apart from a change in language, with 'gerontological nursing' replacing 'geriatric nursing', and 'older people' now being preferred to 'the elderly', the quotations would suggest that little has changed. The question therefore remains, are we really any closer to *'articulating the knowledge, skills and expertise'* that nurses use, or should use, when working with older people? We would like to suggest that considerable progress has indeed been made, and in this report we will describe both an approach to work with older people and their families: Relationship-Centred Care (Tresolini and the Pew Fetzer Task Force 1994) and a framework: the Senses Framework (Nolan 1997, Davies et al 1999, Nolan et al 2001, 2002, 2004) that we believe can inform the education and training of practitioners, and also provide a means of working more closely with older people and their families in a way that values the contribution that everybody makes.

As was noted in the Foreword, this publication is the second of the GRIP (Getting Research into Practice) reports, the aim of which is to make the results of research available to as wide an audience as possible. Therefore, the intention is that GRIP reports are produced in a format and style that is accessible and easy to read, and which highlights the ways in which research and practice can help to inform each other. Although most of the work upon which this report is based focussed on the nursing role, the content is relevant to a far wider audience. Indeed we believe that it will be of interest to practitioners across the field of health and social care. This report is therefore partly about how practitioners can work in partnership with older people and their family carers to ensure that they receive the best possible care, based on a 'whole systems' approach in which all agencies work closely together. Achieving 'joined up' working is a major policy goal but, despite considerable recent progress, a great deal remains to be done before genuine partnerships are formed (Audit Commission 2004a, DoH 2006).

Such partnerships are more likely to succeed when people communicate well, and in order to do so they *'must operate with the same concepts and use the same vocabulary'* (Zgola 1999). We hope that this report will provide a set of concepts and ideas that are relevant, not only to practitioners, but also to older people and their families, and that 'speak' to them in a language that they understand.

Primarily, therefore, we describe a framework for practice and education, the Senses Framework, that we believe can provide greater therapeutic direction for practitioners

working with older people and their family carers. This brief introduction sets the scene by presenting an outline of the major study upon which this report is based.

Background to this report: The AGEIN Project

This report draws mainly on the results of a 3½ year longitudinal study commissioned by the English National Board for Nursing, Midwifery and Health Visiting (ENB). The title of the full study was called 'Longitudinal study of the effectiveness of educational preparation to meet the needs of older people and their carers', but the Project Team (the authors of this publication and other colleagues) referred to the study as AGEIN (Advancing Gerontological Education in Nursing), and this will be used throughout this report.

To the best of our knowledge AGEIN is the largest study of its kind ever undertaken, but it is not our intention to provide a detailed account of the methods used here. For interested readers a brief description can be found in the Appendices, and those wanting more detail are referred to Nolan et al (2001, 2002).

The AGEIN Project had a number of goals. The overall aim was to explore how education and training can help to develop a knowledge base to inform work with older people, whilst also promoting a positive predisposition toward such work. The ENB considered this particularly important for two reasons. Firstly, it was concerned that the existing educational preparation of nurses, at both pre-registration and post-registration levels, did not provide the knowledge and skills that practitioners needed. Secondly, there was growing evidence to suggest that many nurses did not find work with older people an attractive career option and this caused considerable difficulties in recruiting newly qualified staff to work in the field, and also in retaining sufficient staff to provide the quality and level of care required. These two issues remain a major concern, particularly given the increasing numbers of older people.

Indeed, as the World Health Organisation (2006) has recently noted, such is the shortage of skilled gerontological workers in the developed world that staff are being recruited from developing countries, exacerbating shortfalls there. In response to WHO's call for action AGE (2006), the European Older People's Platform has urged worldwide efforts to improve access to appropriate training for work with older people for all health and social care practitioners, as well as family carers. The contents of this report, and the findings of the AGEIN study, could therefore hardly be more timely or significant.

AGEIN was a multi-method, multi-phase longitudinal study with several components, some of which were undertaken concurrently, some consecutively. It comprised both conceptual and empirical elements as follows:

- The conceptual phase involved a comprehensive consideration of the existing theoretical and empirical literature in relation to the care of older people, that was systematic, explicit and reproducible (Nolan et al 1997).

  This focussed on six areas: acute and rehabilitative care; community care; continuing care; palliative care; mental health; learning difficulties (see Appendix 1 for search strategy and Nolan 2001 for a full account). Over 22,000 references were initially identified and approximately 2500 read in more detail. The results of the review were published in a book 'Working with older people and their families' (Nolan et al 2001), in which we suggested that a framework, the Senses Framework, might provide an appropriate model

to shape gerontological nursing practice and education. The first section of this report briefly summarises the results of the conceptual phase of AGEIN and traces the emergence of the Senses Framework up to the point that the detailed empirical phase of the AGEIN project began.

■ The empirical phase of AGEIN comprised several elements:

– Detailed surveys of student nurses (n = 718) in four selected schools of nursing, and qualified nurses (n = 1500) (see Nolan et al 2002) using specially designed questionnaires to test both their knowledge about the situation of older people living in the UK, and their perceptions of working with older people as a nurse. In this report we focus mainly on students' perceptions of work with older people, and the influence that prior experience of working with older people had on these perceptions (see Appendix 2 for a copy of the questionnaire used).

– In-depth case studies in four purposively selected schools of nursing that involved longitudinal focus groups over a 3 year period with students at differing points in their training, and visits to clinical placements that students had identified as providing 'good' learning experiences (see Appendix 3 for a brief description of methods employed).

– AGEIN also explored the post-registration preparation of practitioners to work with older people, with a particular focus on community based nurses. This work is not considered in this report (see Nolan et al 2002 for a detailed account).

– The relevance of the Senses Framework was further explored in a series of interactive workshops involving qualified and unqualified practitioners from a range of disciplines, as well as older people, and family carers.

On the basis of data from the questionnaires, focus groups, and observational visits we identified what we termed 'impoverished' and 'enriched' environments of care (Nolan et al 2002, Brown 2006), and were able to relate the characteristics of an 'enriched' environment to the Senses Framework. An overview of an enriched environment, and the relevance of the Senses to creating such an environment, lie at the heart of this report.

In summary, this report distils key aspects of the AGEIN study, with a particular emphasis on factors influencing students' perceptions of work with older people, and suggests that the Senses Framework provides a means of understanding how an 'enriched' environment of care can be created. Subsequently, we argue that rather than the present focus on person-centred care (DoH 2001), relationship-centred care (Tresolini and the Pew Fetzer Taskforce 1994) provides a more appropriate value base for work with older people and their families. The relevance of the Senses Framework to relationship-centred care is discussed, and evaluated in the light of recent literature. Developments to the Senses Framework and relationship-centred care are briefly addressed, and future developments are suggested.
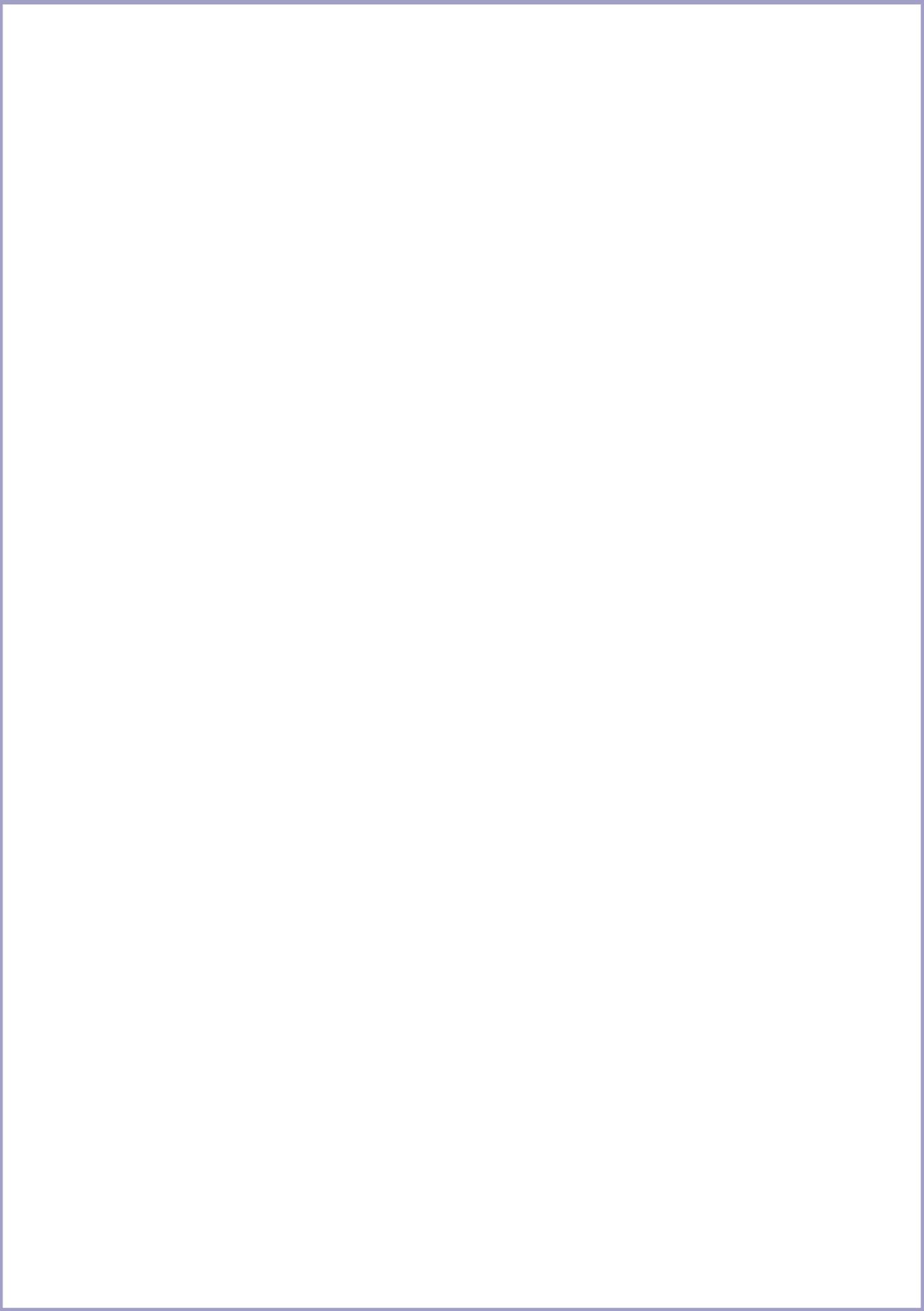
WORKING WITH OLDER PEOPLE: DO WE NEED A FRAMEWORK FOR PRACTICE?

The relatively marginalised position that older people occupy in modern day health and social care systems is best understood in the context of geriatric medicine and, in particular, the influence that the 'medical model' of care has exerted on our views of what constitute successful treatment (Wilkin and Hughes 1986, Evers 1991). Wilkin and Hughes (1986) argue that the emergence of geriatric medicine as a distinct speciality has been the single most important contribution of the National Health Service (NHS) to the care of older people, but that it had both positive and negative effects. In their brief but insightful account they attribute the ascendancy of the current hospital based system of care to the voluntary hospitals of the 1800's, which became centres for scientific medicine, the training of doctors, and the treatment of acutely ill patients. At this time *'the old and chronically ill'* were termed the 'incurables' and consigned to the 'workhouse'. The success of the voluntary hospitals in treating acute conditions saw the evolution of a professional elite, the hospital consultants, which implicitly reinforced a 'cure' based health care system. Wilkin and Hughes (1986) contend that from its inception the goals of the NHS in the UK were never explicitly stated, and that consequently the then dominant curative/medical model was adopted by default. Interestingly, ageist attitudes were evident from the inception of the NHS, with the Beveridge Report warning about the resource implications of being 'lavish to old age'. Similarly, recognition of geriatric medicine as a medical speciality was heavily resisted by acute medicine and surgery who, according to Felstein (1969), could see *'no value in spending time, money, energy and bed space on redundant senior members of society'.* Indeed, probably the only reason that geriatric medicine was eventually recognised was that it offered a solution to a growing problem for acute medicine and surgery; how to discharge the elderly 'bed blockers' (Wilkin and Hughes 1986). The pejorative language of the 1800's, which labelled older people the 'incurables', had been replaced by an equally negative term by the mid 1900's. However, it was here that geriatric medicine was seen to serve a useful purpose by allowing acute specialities to discharge older people who were 'medically' fit, but because of complex social needs could not be sent home.

The urgent challenge for the new speciality of geriatric medicine was to find an alternative measure of 'success' for older people who could not be 'cured'. This they did by applying the principles of rehabilitation:

> *'This* [defining success] *they have achieved by substituting rehabilitation for cure. Medical interventions in geriatric medicine operate on a continuum between dependence and independence rather than health and illness. The medical model has been shifted in the direction of a functional conception of health. In this way it is possible to achieve success measured in terms of patient throughput.'*
>
> (Wilkin and Hughes 1986)

It was against this background that the concept of 'progressive patient care' emerged, comprising a three stage system in which patients moved as needed from acute wards, to rehabilitation wards, and eventually to continuing care. The watchwords of geriatric medicine became 'function and independence' with progressive patient care emphasising *'the capacity of old people to lead independent lives so that continued dependency comes to be regarded as failure'* (Wilkin and Hughes 1986).

At the time that the AGEIN project began, worrying parallels to the above logic were evident in the wider gerontological literature, with the concept of 'successful ageing' being one of the main areas of theoretical interest (Minkler 1996, Scheidt et al 1999, Nolan 2001). Scheidt et al (1999) pose the intriguing question: *'what's not to like about successful ageing?'*.

However, as Minkler (1996) argues, the answer depends largely on who defines 'success' and the criteria that are applied. Scheidt et al (1999) contend that current definitions of successful ageing focus largely on the absence of disease and high levels of physical and mental functioning, thus creating a vision of 'super-ageing' based on physically fit, creative and active older people (Feldman 1999). This further marginalises frail older people who cannot meet such criteria, and reinforces dependency as a sign of failure. Such concerns are particularly relevant to practice disciplines.

For example, the impact that progressive patient care had on nursing was significant, especially for practitioners working in continuing care settings. In the first major piece of nursing research on the care of older people in the UK, Doreen Norton and colleagues (Norton et al 1962) argued that the care of the 'irremediable' patient was 'true nursing' and that there was a need to establish a new approach to work with older people that would help to realise nursing's full potential. However, successive studies over the last 40 years have demonstrated that such a new approach has proved elusive and that gerontological nursing is still *'uncritically rooted in a curative model'* (Kelly et al 2005). This is amply illustrated below.

Wells (1980), following a major study in the 1970's, concluded that *'nurses in geriatric wards work very hard and are well meaning. However, they work very hard at, and are well being about, the wrong things'*. In a powerful critique of work outside of acute care settings Evers (1981a, b, 1991) argued that nurses working with older people were left with the work that no one else wanted but lacked the legitimate authority to change things, consequently such patients were subjected to *'aimless residual care'* (Evers 1991). The failure to articulate appropriate goals for long stay patients (Evers 1991) resulted in nurses defining success in terms of *'good geriatric care'* (Reed and Bond 1991) characterised by *'getting things done and keeping things tidy'*. In summarising the state of play by the mid 1980's, Kitson (1986) concluded that *'without exception studies showed that care is depersonalised, routine orientated and lacking in goal direction'*. She called for the development of a geriatric model of nursing to *'organise, control and direct care'* (Kitson 1991).

However, as Nolan (1996) argued, most models of nursing, with their primary emphasis on problem solving, implicitly mimic the medical model. In reviewing the existing knowledge base for gerontological nursing Nolan (1996) contended that an appropriate approach must:

■ start from the perspectives of older people themselves;

■ be less abstract than existing models, and be presented in a way that practitioners could easily relate to;

■ abandon nursings' search for a unique body of knowledge, and develop an approach that is relevant to a multidisciplinary audience, of both qualified and unqualified staff.

The latter point is important, for whilst the AGEIN project was mainly about nursing, older people receive care from a varied group of practitioners, most of whom also have negative views of work with older people and lack an appropriate framework for practice (Lee et al 2003, Gonyea 2004, Askham 2005). Interestingly the discipline of gerontology as a whole has been described as being *'data rich but theory poor'* (Bengston et al 1997), and one of the

major goals of AGEIN was to articulate a relevant practice framework that would address the deficiencies identified above, and meet the criteria suggested by Nolan (1996). This seemed particularly important because, as Barker et al (1997) had asserted of psychiatric nursing, we felt that work with older people had yet to find its 'proper focus'. Just prior to the start of the AGEIN project this conclusion was reinforced by two recently completed ENB studies, demonstrating that the education of student nurses concentrated predominantly on 'hi-tech' care, paying little attention to the needs of older people, or those with chronic illness, irrespective of their age (Davies et al 1997, Nolan et al 1997).

It was against this backdrop that the conceptual phase of the AGEIN project began, the aim of which was to explore as widely as possible the existing knowledge bases about the care of older people and, from an older person's perspective, to consider what comprised both a good quality of life, and a good quality of care. The literature on quality of care was considered in six related areas: acute/rehabilitative care; community care; mental health in later life; palliative care; older people with learning disabilities; and care homes (see Appendix 1).

At the time the review began the delivery of health and social care was changing in fundamental ways. People were becoming increasingly well informed, their expectations of services were rising, and they no longer had 'blind trust' in professional expertise. Indeed service users and carers began actively seeking equal status (Barnes 1999). However, while considerable policy emphasis was placed on creating partnerships between service providers, older people, and their family carers, the latter two groups still remained largely marginal figures in important decisions about their treatment and care (Audit Commission 1997, Health Advisory Service 2000 1998). Consequently, widespread concerns about the quality of care older people were receiving resulted in the launch of the National Service Framework (NSF) for Older People (DoH 2001), and the needs of older people were very influential in shaping the Government's plans for the 'new NHS' (DoH 2000).

The launch of a new plan for the National Health Service (NHS) in England (DoH 2000) marked the most radical series of reforms to the NHS since its formation in 1948. The far-reaching changes that were envisaged recognised that services needed to be more responsive to future health challenges, particularly those posed by the growing numbers of older people. Fuelled by increasing concerns that older people were not receiving the quality of care that they required (HAS 2000 1998), a key aim of the plan was to eliminate ageism and to create a culture in which any form of discrimination based on the age of an individual became 'unacceptable'. A year later the National Service Framework (NSF) for Older People (DoH 2001) was announced, which for the first time set national standards of care for older people in England. Two closely linked principles lie at the heart of the NSF: the promotion of person-centred care, and the rooting out of age discrimination in the NHS.

Several recent reports (Audit Commission 2004a, b, c, DoH 2004, 2006) suggest that there has been considerable progress towards meeting these goals, but also make it clear that much still needs to be done if older people and their families are to play a full and active role in shaping health and social care. There is, we are told, a need for a 'fundamental shift' in the way that we think about older people (Audit Commission 2004a), and greater recognition that:

> *'A key aspect of the partnership between health and social care staff and older people and their carers is the sharing of information, knowledge and power.'*
>
> (Audit Commission 2004c, p38)

However, as Marion Barnes (1999) suggests, such a shift in emphasis poses a 'fundamental challenge' to the view that professional knowledge is in any way better than the knowledge held by older people and their carers. One of the main purposes of the conceptual phase of the AGEIN project was to explore the existing literature in order to see what older people themselves considered important, particularly in respect of their quality of life and quality of care, and to consider if this could help inform an appropriate practice framework for work with older people. We begin here by summarising the literature on quality of life and quality of care for older people that emerged from the conceptual phase of AGEIN.

Quality of life, quality of care

'The findings reported at this congress led us to a profound concern for the future prospects for quality of life of older people everywhere.'

(Adelaide Declaration on Ageing, IAG 1998)

'The drive to place quality at the heart of the NHS is not about ticking checklists – it is about changing thinking.'

(DoH 1998)

McKee (1999) argues that it is important to distinguish between quality of life and quality of care, and for frail older people in particular it is essential not simply to reduce quality of life to quality of care. Nevertheless, many older people need support to maintain a good quality of life and reciprocal and positive caring relationships have the potential to make a real difference to the life they experience. The ways in which care is understood and provided is therefore a major consideration, and one on which there is little consensus (Davies 1998). The review wanted to consider issues relating to both quality of life and quality of care for frail older people and their carers in the context of the current policy of community care (Davies 1995).

A policy of community care is underpinned by important principles such as dignity, independence and autonomy that are widely accepted as being inherently 'good', even though what they actually mean and how they can realistically be achieved is far from clear (Williamson 1992). The aim of health care policy over the last decade has been to focus on what 'really counts' for patients (DoH 1997) so that measures of quality and outcome genuinely reflect the priorities of individuals, their carers and families (DoH 1998). Such goals have been reaffirmed recently (Audit Commission 2004a, b, c), as has recognition of the work that remains to be done if we are to more fully understand the needs and wishes of older people.

Globally the primary objective of care programmes for older people is to maintain individuals in their chosen environment, most usually their own home (International Association of Gerontology 1998). However, doing so whilst also ensuring an acceptable quality of life, especially for frail older people, represents a significant challenge (Audit Commission 2004c). Indeed questions have long been raised about the quality of life that frail older people living in the community enjoy, and the types of support that may be necessary to promote this (Lawton et al 1995).

Kane (1999) argues that we need to identify a broader set of aims that recognise a number of subjective and less tangible outcomes that older people see as important. Services therefore

should not simply focus on goals such as remediation and compensation, but capitalise upon older peoples' residual strengths and abilities (Kivnick and Murray 1997). Minkler (1996) stresses the need to identify what helps to reinforce a sense of identity and purpose in older age, and she questions the largely uncritical acceptance of aims such as promoting independence and successful ageing, arguing instead for a greater focus on interdependence (Minkler 1996).

Towards a wider view of 'quality of life'

There is now greater recognition that prolonging life at any cost is less important than the quality of life lived (Clark 1995), and therefore increasing attention has been given to the way in which quality of life is defined and measured (Renwick et al 1996, Brown et al 1996, Haas 1999). Indeed quality of life is currently one of the most important outcomes of health and social care, particularly when cure is no longer an option (Martlew 1996, O'Boyle 1997).

However, while Renwick et al (1996) suggest that quality of life may provide a potentially unifying concept in gerontology, there is little agreement as to what this really means (Bowling 1995, Farquhar 1995, Hanestad 1996, Haas 1999). Although there is now widespread acceptance that quality of life is complex and involves both objective and subjective elements (Farquhar 1995, Woodend et al 1997, O'Boyle 1997, Powell-Lawton 1997, Haas 1999), existing definitions are often based on the views of younger people (Stoats et al 1993, O'Boyle 1997, Reed and Clarke 1999) and are underpinned by taken-for-granted notions such as autonomy and independence (Farquhar 1995).

Debates about the relevance of ideas such as independence are increasingly more important with Holstein and Minkler (2003) arguing that the last decade has seen the emergence of a 'new gerontology' based on 'successful' ageing, that is defined exclusively by:

- the avoidance of disease and disability;

- the maintenance of high levels of physical and cognitive functioning;

- an active engagement with life.

According to Holstein and Minkler (2003), within the 'new gerontology' successful ageing equates with active engagement with life, and this requires high levels of physical and cognitive functioning. In essence, therefore, effective functioning has **become** successful ageing. Holstein and Minkler (2003) believe that this promotes an impoverished view of what might be seen as a 'good old age'. The results of our review support such a conclusion, and also suggest that to focus on function alone perpetuates an impoverished view of what constitutes good care.

The importance attached to physical functioning, mainly as measured by the Activities of Daily Living (ADL), is often so deeply embedded with health care practice that the relevance of such an approach is rarely challenged. Consequently, an ADL 'research tradition' has emerged that equates a 'successful' outcome with functional ability (Porter 1995). As a result quality of life is judged primarily on objective criteria (Farquhar 1995, Wistow 1995, O'Boyle 1997, Haas 1999), and if subjective elements are included at all these are often based on the views of researchers (Day and Jankey 1996), with patients'/carers' perceptions rarely being adequately addressed (Chesson et al 1996). This is a matter of concern as there are often 'striking

discrepancies' between the views of professionals and those of disabled individuals (Loew and Rapin 1994, Livingston et al 1998, O'Boyle 1997, Reed and Clarke 1999) who frequently have differing values and goals (Clark 1995, Clark 1996). It has therefore been argued that existing measures of quality of life often 'lose the human being' (Kivnick and Murray 1997), and that we need to move beyond 'statistical sophistication' (Bowling 1995) towards a model of quality of life which treats the older person as a 'full partner' (O'Boyle 1997).

Important questions in relation to a good quality of life for older people are *what gives life value and meaning?'* (Loew and Rapin 1994, Clark 1995, Clark 1996, Prager 1997, Hanestad 1996) and *'what is required to sustain, or if necessary reconstruct, a serviceable sense of self?'* (Charmaz 1983, Powell-Lawton 1997). Questions such as *'who am I'* are particularly important to a better understanding of later life (Minkler 1996, Phillipson and Biggs 1998), and answering such questions requires a qualitative approach (Stoats et al 1993, Bowling 1995, O'Boyle 1997) that captures personal views (Peters 1995, Johnson and Barer 1997). For older people in particular, quality of life indicators should include attention to their life history (biography) (Clark 1996) in order to capture a sense of their past, present and future (O'Boyle 1997). The focus should not be primarily on the problems of ageing but instead promote a more balanced approach that recognises both the limitations and potential that ageing presents (Clark 1995, Fontana 1995, Wenger 1997, Kivnick and Murray 1997, Thorne and Paterson 1998). Only in this way will a more sophisticated understanding of what 'successful ageing' means emerge (Wenger 1997, Baltes and Carstensen 1996).

What is quality of life and successful ageing?

Coleman (1997), one of the foremost psychologists of ageing in the UK, believes that too little attention has been given to the psychological aspects of ageing and suggests four areas in which further work is needed. These are:

- recognition of the importance of a life span perspective;

- a consideration of development in later life with a focus on 'ordinary' as opposed to 'exceptional' ageing;

- more study of the individual life, instead of looking at what is statistically 'normal';

- a better appreciation of the challenges that frailty poses to our understanding of what makes for a 'meaningful' life.

The latter point is important as, despite the increasing frailty associated with advanced older age, most people manage to sustain a positive view of their quality of life. Such findings represent a 'puzzle' (Brändstädter and Greve 1994), and authors such as Minkler (1996) argue that there is a need to explore 'meaning' in later life if we are to understand how older people adapt positively to the limitations that ageing inevitably imposes (Loew and Rapin 1994, Wenger 1997, O'Boyle 1997). A number of theories identified in the review offer potential explanations and highlight the role of subjective perceptions and interpretations (see, for example, Brändstädter and Greve 1994, Baltes and Carstensen 1996, Renwick and Brown 1996, Johnson and Barer 1997, Nilsson et al 1998, or see Nolan et al 2001 for a review).

The literature reviewed suggested that a clearer view of what older people see as important is emerging, and that quality of life:

- is a complex concept of many parts;

- comprises both objective and subjective elements, which are more or less important depending upon personal values and culture;

- is dynamic and changes according to the stage of the life course;

- is ultimately a subjective and individual experience.

We therefore need to consider the implications of such a view of quality of life for the design, delivery and evaluation of services for frail older people across care environments, if an appropriate practice framework, informed by the views of older people themselves, is to emerge.

Promoting quality care and quality services for older people

The current emphasis on developing services that reflect the wishes of users and carers, rather than the perceptions of care providers (DoH 1997, DoH 1998, DoH 2001, Audit Commission 2004a, b, c), highlights the importance of paying more attention to individual values and goals.

Kane (1999) argues we need a more ambitious goal than simply keeping someone in their own home, and Redfern (1999) has called for us to reconsider what we mean by 'therapeutic activity' with frail older people. We believe that there is now a clear enough understanding of what comprises a 'good life' in older age from a subjective viewpoint to provide a way forward.

However, while it is essential to consider what 'counts' for older people and their family carers, we also believe that a good quality of care is unlikely to be achieved and sustained unless paid carers also enjoy and value their work. Ageist attitudes and the devaluing of work with older people are still all too apparent in both the health and social care systems (Health Advisory Service 2000 1998, DoH 2001, Lee et al 2003, Gonyea 2004). Therefore to be useful any framework for care must also pay attention to the views of staff and suggest ways in which work with older people can be given greater status and value. As a result of our initial review of the literature (Nolan et al 2001) we suggested that the Senses Framework, originally proposed by Nolan (1997), might help to address the needs of both older people and service providers.

Nolan (1997) was concerned with the lack of a therapeutic rationale for work in long-term care settings with older people and identified six Senses that he believed might both provide a clearer direction for staff and improve the care older people received. The term Sense was chosen deliberately to reflect the subjective and perceptual nature of important determinants of care for both older people and staff. An overview of the Senses, as originally defined, is presented in Table 1.

Table 1: The Six Senses

A Sense of Security

For older people: Attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort.

For staff: To feel free from physical threat, rebuke or censure. To have secure conditions of employment. To have the emotional demand of work recognised and to work within a supportive culture.

A Sense of Continuity

For older people: Recognition and value of personal biography. Skilful use of knowledge of the past to help contextualise present and future.

For staff: Positive experience of work with older people from an early stage of career, exposure to positive role models and good environments of care.

A Sense of Belonging

For older people: Opportunities to form meaningful relationships, to feel part of a community or group as desired.

For staff: To feel part of a team with a recognised contribution, to belong to a peer group, a community of gerontological practitioners.

A Sense of Purpose

For older people: Opportunities to engage in purposeful activity, the constructive passage of time, to be able to pursue goals and challenging pursuits.

For staff: To have a sense of therapeutic direction, a clear set of goals to aspire to.

A Sense of Fulfilment

For older people: Opportunities to meet meaningful and valued goals, to feel satisfied with one's efforts.

For staff: To be able to provide good care, to feel satisfied with one's efforts.

A Sense of Significance

For older people: To feel recognised and valued as a person of worth, that one's actions and existence is of importance, that you 'matter'.

For staff: To feel that gerontological practice is valued and important, that your work and efforts 'matter'.

(Based on Nolan 1997)

Okay in theory, but do they work in practice? Initial testing of the Senses Framework

As we used our reviews of the literature to elaborate upon the Senses Framework the opportunity arose to test its relevance in helping to explain how good quality services for older people might be provided. When the AGEIN project was in its early stages several of the project team were involved in another study exploring those factors that influence the delivery of high quality care for older people in acute care settings.

Following in the wake of the 'Not because they're old' report (HAS 2000 1998), which highlighted serious deficiencies in the acute care older people receive, Help the Aged and the Order of St John's Trust commissioned a study to identify the characteristics of acute care environments in which older people considered that they had received good or excellent care. A successful tender was submitted by one of the AGEIN Project team (SD), supported by two others (MN and JB). The aims of this study, called the 'Dignity on the Ward' project, were to:

- describe and analyse patient experiences within a number of settings providing acute care for older people;

- investigate professional roles within each setting and identify processes for effective multi-disciplinary team functioning;

- where possible, link positive patient experiences with specific structural, organisational and cultural factors within each setting, such as an agreed and explicit approach to care;

- make recommendations about the ways in which better care for older people in acute hospitals might be facilitated by ensuring that best practice is made explicit and shared across care environments.

In addressing these aims the team sought to identify areas defined by older people themselves as providing 'excellent' care. To do so a range of advocacy and similar groups for older people such as Community Health Councils were consulted. In this way 37 areas providing acute care for older people were nominated and data were collected from 24, 10 by means of site visits, complemented by written questionnaires to a further 14. Six of these visits lasted a day, whereas four spanned several days and involved detailed interviews and focus groups, together with periods of non-participant observation, documentary analysis and self-completion questionnaires.

Alongside this empirical phase, a detailed review of the literature on 'dignity' was completed, the main themes of which are presented in Table 2.

Table 2: Key Themes from the Literature Review on Dignity

- Dignity, although difficult to define is essentially about feelings of personal worth and identity and is necessary for a good quality of life. Both dignity and quality of life are basically subjective phenomena requiring that practitioners understand the values and preferences of older people. In other words there is a need to 'know' the patient.

- 'Knowing' the patient is based on a personal, professional relationship appropriate to a given context of care. The quality of this relationship appears fundamental to the delivery of optimum care.

- In an acute environment direct care delivery provides the main purpose for staff/patient interaction. Competent technical care is essential but the value of fundamental personal care must be more fully acknowledged.

- Involvement in direct personal care provides experienced practitioners with opportunities to promote dignity while making skilled assessments of patient need. Standards of care required of others are also made explicit by such actions.

- 'Zero tolerance' of poor care is best achieved via clearly communicated expectations in a supportive rather than punitive culture.

- Promoting and maintaining best practice requires both personal commitment and organisational support, with a certain minimum level of resources.

From Davies et al (1999)

The aim of the main study was to explore the above themes in relation to ensuring dignity in care for older people. The combination of site visits to 10 units, including 4 detailed case studies, and written evidence from a further 14, generated large amounts of data from a wide range of staff representing the multi-disciplinary team, from consultant medical staff, through senior ward managers, nurses, professions allied to medicine, social workers, care and therapy assistants, ward clerks and domestics. These data were complemented by questionnaires, periods of non-participant observation (across 24 hours in the case study sites) and documentary analysis. Interviews were also conducted with 37 patients and 21 carers, with written information being collected from 24 former patients.

Analysis of the data suggested that the very different clinical environments studied shared four common characteristics. It was clear that each ward:

- *Valued 'fundamental' practice* by giving priority to the essential care needs of older people such as help with personal hygiene, nutrition and going to the toilet, and involved senior staff in such direct care delivery.

- *Fostered a stable environment* but also encouraged staff to challenge the way things were done.

- *Established clear and equitable therapeutic goals* and ensured that older people had the same access to services as younger people, that clear treatment goals were established in consultation with older people and family carers, and that these goals were regularly reviewed.

■ *Had an explicit and shared set of values* leading to an agreed philosophy of care that clearly identified the standards of care expected for both patients and staff.

It became apparent that in combination the above factors were essential to developing what we termed 'a positive culture of care' (Davies et al 1999). Although the study had not intended to develop the Senses further, the more the team examined the data the clearer it became that the Senses were extremely useful in understanding how many complex factors interacted so as to raise the standard of care from adequate to good, or even excellent. This is summarised in Figure 1.

Figure 1: Factors Promoting and Sustaining a 'Positive Culture' in the Acute Care of Older People

BASIC PRE-REQUISITES

ADEQUATE STAFFING LEVELS   EFFECTIVE LEADERSHIP

COORDINATION BETWEEN DIFFERENT SERVICE MODELS

Positive culture of care

■ valuing fundamental practice
■ fostering stability while embracing challenge
■ clear therapeutic goals
■ commitment to an explicit set of values
  – partnerships in care
  – choice and dignity
  – developing staff

Essential care practices aimed at:

■ continuity of care from pre-admission to discharge
■ involving patients and families in care planning and care delivery
■ involving local communities in service development
■ ensuring access to expert practitioners
■ meeting the needs of older patients with confusion/dementia
■ meeting the needs of older people from ethnic minorities
■ maintaining dignity through attention to small details

EXPERIENCES OF CARE   EXPERIENCES OF CARING

SECURITY
BELONGING
CONTINUITY
PURPOSE
ACHIEVEMENT
SIGNIFICANCE

Adapted from Davies et al (1999)

Excitingly, the study not only confirmed that the Senses helped to capture important elements of positive experiences of care in acute settings for older people, their families and staff, but also illuminated how each Sense could be created for each of these groups. This is summarised in Table 3.

Table 3: Factors shaping the experience of 'care' for older people, their families and staff

FACTORS CREATING A SENSE OF	FOR OLDER PEOPLE AND THEIR FAMILIES	FOR STAFF
Security	Rapid access to a hospital bed when needed Provision of regular, clear information Visibility of nursing staff, senior staff delivering care and central nurses station ensuring that staff are visible Access to 'experts' such as medical consultants and clinical nurse specialists Regularly asking the older person how they feel Risk assessment in negotiation with the older person Support after discharge e.g. telephone calls, discharge support	Structured mechanisms for clinical supervision and mentorship Experienced staff available for role-modelling and problem solving Freedom to challenge poor practice without censure Known boundaries within which to operate Having clear and explicit goals
Belonging	Staff using their preferred name Recognition of importance of relationships with other patients Families encouraged to participate in care as appropriate Being treated like family Having designated members of staff to co-ordinate care Flexible visiting times Tea and coffee available for patients and visitors	Core team of stable staff Blurring of roles Clear sense of belonging to a team Strategies for keeping staff informed e.g. team briefing, computerised information systems

Continuity	Team nursing/named nursing as the system for organising care Wards having designated therapy staff Access to schemes aimed at enabling an older person to avoid hospital admission unless absolutely necessary e.g. Rapid Response scheme Continuity of support following discharge Partnership programmes involving family carers in care-giving Communication sheets to assist discharge Phone calls after discharge Liaison with home care services Staff taking time to get to know the older person	Team nursing/named nursing as the system for organising care Wards having designated therapy staff Integrated multidisciplinary documentation encouraging continuity of communication Limiting the number of medical teams providing care to one ward Explicit process for inducting new members of staff
Purpose	Regular meetings with staff to discuss progress Self-medication programmes Use of care contracts Mutually agreed goals of care. Being a genuine partner in planning and evaluation	Clear therapeutic rationale for care. Investing resources in creating effective leadership Regular appraisal and goal-setting for all staff All staff encouraged to review practice and suggest improvements (e.g. critical incident audit)
Achievement	Being involved in review of progress Feedback Evaluation carried out with the older person Care plans and progress sheets accessible	Recognition of effort e.g. award schemes Designating additional responsibilities e.g. link nurse roles Being able to provide best possible care
Significance	Equity of access to medical/therapy care Being involved in care planning and evaluation e.g. bedside handover, biographical assessment Resources invested in making the environment comfortable and attractive	Investment in personal professional development Opinions valued and listened to Adequate equipment to carry out role Work with older people valued and recognised as important

The Dignity on the Ward project therefore provided extensive empirical evidence of the value of the Senses Framework in an acute setting. However, what was missing at this stage was a more detailed consideration of the views of family carers, and a better understanding of the interactions between three key groups: older people, their family carers, and service providers.

From dyad to triad – incorporating the views of family carers

Since the 1990s both the research and policy literatures have stressed the value of creating partnerships between professionals and service users and consequently far greater attention has been paid to the nature and quality of the relationships between these groups. Similar attention has been given to the relationships between family carers and those who they support (see Nolan et al 2003 for an extensive review). However, generally speaking, the main focus has been on 'dyadic' relationships, that is those between two sets of people, for example, professionals and older people or older people and family carers and, to a lesser extent, family carers and professionals. More recently there has been increasing recognition of the importance of accounting for the views of all groups, so called 'triadic' relationships (Brandon and Jack 1997, McKee 1999, Qureshi et al 2000, Fortinsky 2001). Consequently, as Dolton (2003) points out, we need ways of better understanding the dynamics of triadic relationships.

The Senses Framework, as initially described, did not incorporate the views of family carers and we considered it essential that it did. Therefore, an important part of the conceptual phase of the AGEIN project was to address the interactions between older people, family carers and professionals (see Brown et al 2001 for a fuller account). Here we consider the position of family carers in particular.

Family carers lie 'at the heart of community care' (Warner and Wexler 1998) and it is estimated that they provide approximately 80% of the support needed to maintain frail or disabled individuals at home (Walker 1995). The recent trends towards empowerment and partnership with older people are also apparent in the literature relating to family carers (Askham 1998). However, despite the introduction of the Carers (Recognition and Services) Act in England (DoH 1995), which provided carers with a statutory right to an assessment of their needs, several studies have suggested that carers often remain marginal figures, rarely consulted or provided with the information and support they require (Warner and Wexler 1998, Henwood 1998, Fruin 1998, Robinson and Williams 1999).

Widespread concern over the piecemeal and largely inadequate implementation of the Carers Act resulted in the launch of the Carers National Strategy (DoH 1999), which was intended to mark a 'decisive change' in policy and practice, including proposals that should enable carers to:

- choose to care (or not);

- be adequately prepared to care;

- receive relevant help at an appropriate stage;

- be enabled to care without detriment to their inclusion in society or to their health.

The strategy placed particular emphasis on providing support at key transition points, notably at the beginning and end of care and in helping carers to develop the skills and competencies they need. However, most fundamental of all was the notion of choice, with the stated intention of the strategy being to *'support people who choose to be carers'* (DoH 1999).

However, stating such aims is deceptively easy; achieving them is quite another matter. As Twigg and Atkin (1994) suggested, most agencies and practitioners lack a clear rationale for working with family carers beyond maintaining carers in their role and thereby implicitly using them as resources. If progress is to be made there is a need for a more holistic approach to meeting carers' needs, as was recently reaffirmed in a major review of support for family carers, which concluded that the current situation 'is not satisfactory' (Audit Commission 2004d), and called for a more clearly articulated approach, particularly with regard to assessment.

Assessing and responding to carers' needs

As Twigg and Atkin (1994) argued, the root of many problems lies in the fact that service agencies and professionals generally lack an explicit rationale for work with family carers and consequently tend to adopt one of four largely implicit models, these are:

- **Carers as resources** – where the aim of support is instrumental, that is to maintain the carer in their role.

- **Carers as co-workers** – where although there is greater recognition of the carers' individual needs the main aim is still instrumental.

- **Carers as co-clients** – where it is difficult to distinguish the needs of the carer from those of the user.

- **The superseded carer** – where the aim of formal services is to replace the carer.

It has been suggested that while these models might be appropriate in some circumstances none are adequate as a primary basis for intervention (Nolan et al 1996) as they fail to reflect the ideals of empowerment, partnership and choice, which are now being promoted. Underpinning such notions is the principle that all parties, in this case older people, family carers and professionals, bring something of value to an encounter and that views should be shared in moving towards a common goal. The literature would suggest that this is often not the case, and that professional and family carers frequently have differing and not necessarily complementary goals and sources of knowledge. For instance, Harvath et al (1994) argue that professionals have what they term 'cosmopolitan' knowledge, that is a generalised understanding of a condition, for example stroke. Carers on the other hand have 'local knowledge' based on their unique understanding of the person having suffered a stroke.

What is required is a model that helps to reconcile potential differences and more adequately reflects a partnership and empowerment approach. One such approach is the 'carers as experts' model described by Nolan et al (1996). Central to this are a number of basic assumptions which can be summarised as follows:

- While an assessment of the difficulties of caring is important a full understanding will not be achieved unless attention is also given to the nature of past and present relationships,

the satisfactions or rewards of caring and the range of coping and other resources, such as income, housing and social support, that carers can draw upon.

■ The stresses or difficulties of care can best be understood from a subjective rather than an objective perspective. This means that the circumstances of care are less important than a carer's perception of them.

■ It is essential to consider both a carer's willingness and ability to care. Some family members may not really want to care but may feel obliged to do so. Conversely while many family members may be willing to care they may lack the necessary skills and abilities.

■ While recognising the importance of services such as respite care, in-home support and so on the primary purpose of the 'carers as experts' approach is to help carers to attain the necessary competencies, skills and resources to provide care of good quality without detriment to their own health. In this context helping a carer to give up care is a legitimate aim.

■ 'Carers as experts' recognises the changing demands of care and the way in which skills and expertise develop over time. A temporal dimension is therefore crucial, and this suggests varying degrees of 'partnership'. For carers new to their role professional carers are likely to be 'senior partners' in possession of important knowledge of a 'cosmopolitan nature', which is needed to help the carer understand the demands they are likely to face. Conversely experienced carers, many of whom will have learned their skills by trial and error, often have a far better grasp of their situation than professionals and acknowledgement of this is vital to a partnership approach. At a later stage the balance may shift again so, for example, if it is necessary to choose a nursing home, carers may go back to a 'novice' stage, probably never having had to select a home before. They will therefore need additional help and support. Recognising and achieving such a balance is the crux of the 'carers as experts' model.

It was this model that influenced our thinking when incorporating the views of family carers into the Senses Framework.

Bringing it all together

On the basis of our detailed consideration of the literature, early data collection at the AGEIN case study sites, and the evidence from the 'Dignity on the Ward' project (Davies et al 1999), it became apparent that the Senses Framework had the potential to bring together the perspectives of older people, professionals and family carers, in a way that was consistent both with emerging theory and recent studies that had explored what older people wanted from services.

The detailed literature reviews within the 'Working with older people' book (Nolan et al 2001) had identified particular gaps in our understanding in key areas, especially in relation to palliative care for older people (see Seymour and Hanson 2001), learning disabilities in older age (see Grant 2001) and, with the exception of dementia, a dearth of attention to mental health in older age (see Ferguson and Keady 2001). The reviews also highlighted that, for older people generally, a more subtle but potentially pernicious form of discrimination was emerging. This concerned the emphasis placed on the promotion of autonomy and

independence as the watchwords of health and social care policy (Dalley 2000). If, as Scheidt et al (1999) contend, successful ageing is understood only in terms of autonomy and independence, then there is likely to be an ever more narrow view that makes a virtue out of being healthy, and conversely potentially lays blame at the door of those who are not. As Feldman (1999) suggests, the risk is that we create a vision of 'super ageing' to which few people can actually aspire (Williams 2000). Although this might make a change from the 'misery' (Scheidt et al 1999) or deficit (Reed et al 2003) view of ageing, it may effectively exclude the most vulnerable members of society from 'ageing well'.

It is therefore encouraging to note that there has recently been an unequivocal reaffirmation of the belief that any focus on the well being of older people *'must aim to achieve the outcomes that older people see as most important',* and also explicit recognition of the fact that promoting a view of independence based primarily on the ability to *'do things for myself'* is not adequate (Audit Commission 2004b). Rather it is suggested that the focus should shift to the 'interdependence' that is crucially important to older people (Audit Commission 2004b).

Certainly all the literature that we considered stressed the importance of any framework reflecting the subjective experiences of those giving and receiving care in order to capture and build upon feelings of reciprocity (Atkinson 1998). Atkinson (1998) argues that the need to feel special and valued is universal, and this is true of all those in caring relationships. Essentially therefore caring, in all its manifestations, has to be valued and accorded status (Adams et al 1998, Davies 1998). This is often not the case, with an increasing priority given to technical as opposed to basic (fundamental) care (Cluff and Binstock 2001). Paradoxically, at a time when person-centred care is promoted so actively Dalley (2000) contends that the delivery of care is becoming increasingly task-focussed with the personal and humane qualities being 'singularly absent'.

Treatment without care is poor and often ineffective treatment (Fitzgerald 1999) and the importance of combining proficient technical care, considerate basic (fundamental) care and good interpersonal care were consistent themes throughout our reviews. In combination these elements can elevate safe care to good or even excellent care (Davies et al 1999), and it is such care that is highly regarded by older people and their family carers. Kendig and Brooke (1999) suggest that while policy focuses largely on populations, care is primarily concerned with the *'preferences, resources and situations of individuals'.* Therefore health and social care professionals need to appreciate the goals that arise from the personal experiences and interpretations of older people who use two main criteria to define the quality of home care they receive:

- Adequacy – is it sufficient for its purpose.

- Affirmation – of their unique identity – good care reinforces rather than threatens their sense of who they are.

In considering the basis for poor care in hospital settings Coyle (1999) provided a remarkably similar description, suggesting that the notion of *'personal identity threat'* captures deficient care from a patient's perspective. Coyle argues that personal identity is threatened by care which: dehumanises the patient by failing to accord them value and respect their subjective experiences; disempowers patients by limiting their ability to exert control; and devalues the patient as a person. According to Coyle (1999), practitioners must be particularly sensitive to issues relating to patient's feelings of personal worth and value.

To provide good care the recipient has in some way to 'matter' and there is a need to *value the person in the present with all their disabilities and restrictions'* (Adams et al 1998). Equally important, however, is that both the care given and the caregiver are also valued and seen to 'matter' (Adams et al 1998, Davies 1998). This is increasingly rare in health and social care, particularly, as Davies (2001) notes, in already devalued environments such as care homes where the work itself is the subject of 'multiple negative statuses' (Adams et al 1998).

Following our detailed review of the literature we noted a number of important conclusions. These being:

■ That if services are to improve there is a need to appreciate that good care accommodates the perspectives of all parties involved so that none is disadvantaged. As Brechin (1998a) notes, care is centred around interpersonal relationships which impact on the identity and sense of self of everyone involved. Good care should therefore reinforce rather than detract from personal identity (Coyle 1999, Kendig and Brooke 1999). This is as true of those giving care as of those receiving it. Giving care can be difficult, onerous and stressful as the extensive literature on family care attests, but it is also often satisfying (see Nolan et al 1996, Grant et al 1998).

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

■ Good care means recognising and valuing differing forms of 'expertise' so that none is privileged above the other. Professional carers must therefore value the expertise that older people and family carers possess but this does not mean devaluing the central role of the 'outsider' expert. It must be appreciated therefore that an empowered client or carer is potentially very threatening to professional carers.

Easterbrook (1999) believes that what is wanted by older people is person-centred care delivered by person-centred staff who are well motivated, well trained and who value their work. However, for people to value their work such work has also to be valued, both by society and by those in receipt of care. It is this delicate set of interrelationships that need to be better understood, and the initial work on the AGEIN project suggested that the Senses Framework provided a potential way forward, as it seeks to elaborate upon the 'personal meanings' that care relationships create for all involved.

We argued (Nolan et al 2001) that any framework seeking to explore personal meanings must be sensitive enough to account for individual variation, yet be specific enough to identify meaningful indicators of key concepts, while also being relevant to differing groups of people who both receive or provide care. Furthermore, in addition to facilitating new insights, any framework should be easily understood by everyone, and be capable of practical application. As Brechin (1998b) suggests in exploring the core attributes of care it is important not to get lost in the realm of abstract speculation. On the basis of our consideration of the literature (Nolan et al 2001), and the work of the Dignity Project (Davies et al 1999), the Senses Framework was felt to meet these criteria.

Earlier we briefly outlined the Senses Framework, as originally proposed by Nolan (1997), and suggested that it provides a potentially greater sense of therapeutic direction for staff working within continuing care settings. The framework was utilised by Davies et al (1999) in their study exploring good practice in the acute hospital care of older people and the results provided strong empirical support for its major constituents, although a Sense of Fulfilment was changed to a Sense of Achievement as this was seen by participants as more meaningful. Importantly however the study also identified numerous ways in which each sense might be achieved.

On the basis of our reviews completed for the AGEIN project, and the work of Davies et al (1999), it seemed to us that the Senses potentially had more widespread relevance to older people, family carers, and formal carers across a range of settings. Furthermore, there was a high degree of 'convergence' between the Senses Framework and the major themes which emerged repeatedly at various points throughout our reviews, and during a number of other studies exploring what older people want from services.

In Table 4 we 'map' existing theories and a number of empirical studies onto the Senses Framework, and provide an indication of where in Nolan et al (2001) a more complete description can be found. This table suggests that there is considerable convergence and provides yet further theoretical and empirical support for the Senses. Apart from the work of Davies et al (1999), which explicitly used the Senses Framework, the results of the focus groups exploring community-based services with older and disabled people, carers and professionals conducted by Easterbrook (1999) and Farrell et al (1999) can be meaningfully interpreted in terms of the Senses, as indeed can the conclusions of the detailed study by Redfern and Norman (1999) that highlighted the parameters of good quality care in acute hospitals as perceived by patients and nurses.

As a result of the above studies, and our reviews, a more detailed description of the Senses, as they were understood at the end of the conceptual phase of AGEIN, are presented in Table 5.

At the heart of the AGEIN project was the desire to explore, further refine, and empirically test the Senses Framework, particularly with respect to the experiences of student nurses, but also in relation to qualified nurses, older people and their carers. An account of the work with student nurses follows shortly. However, before this, attention is turned to what student nurses think about working with older people.

Table 4: A Comparison of the Senses with Existing Theoretical Frameworks and Recent Empirical Studies (Adapted from Nolan et al 2001)

Senses	Theoretical Frameworks				Service Delivery				
	Chapter 1* Steverink et al 1998	Chapter 1* Nilsson et al 1998	Chapter 1* Renwick & Brown 1996	Chapter 2* Liaschenko 1997	Chapter 3* Redfern & Norman 1999	Chapter 3* Davies et al 1999	Chapter 4* Easterbrook 1999, Farrell et al 1999	Chapter 5* Bowsher 1994	Chapter 5* Davies 2001
Security	Comfort (Physical well being)			Space	Keep promises Trust/ confidence Monitor care	Visibility of staff Access to 'experts' as needed	Confidence in staff, competent and safe care		Reduce vulnerability/ powerlessness
Belonging	Affection (Social well being)	Personal relationships	Belonging	Space	Homely ward atmosphere Use of affection and humour	Recognise important relationships with other patients Treated as family	Person-centred care delivered by person centred workers Focus on interpersonal relationships	Develop/ maintain positive social networks/ climates	Create a sense of community
Continuity		Positive links between past and present	Being	Temporality	Maintenance of important routines Continuity of care	Named/team nursing. Post-discharge follow up	Single point of contact Continuity of carer Integrated services Understanding of life history	Generate interesting stories about lives	Maintain links with family/ community
Purpose	Stimulation (Physical well being)	Activity	Becoming	Agency	Provide activity to reduce boredom	Mutually agreed goals	Clarity of goals and purpose	Develop competencies	Shared activities to create a community
Achievement	Behavioural confirmation (Social well being)	Activity	Becoming	Agency	Opportunities to achieve goals	Regular feedback on progress, being included in review	Involve older people	Attain important/ valued goals	Maintain identity
Significance	Status (Social well being)	Strong personal beliefs	Being – psychological and spiritual identity		Reinforce identity and personhood	Equity of access to care. Fully involved in care	Listen to expertise and voice Value older people	Experience satisfaction and positive effect	Maintain identity

*NB Chapter numbers refer to the relevant chapter in Nolan et al (2001) where a more detailed account of the relevant theory/empirical work can be found

Table 5: The Six Senses in the Context of Caring Relationships

A Sense of Security

For older people: Attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort. To receive competent and sensitive care.

For staff: To feel free from physical threat, rebuke or censure. To have secure conditions of employment. To have the emotional demands of work recognised and to work within a supportive but challenging culture.

For family carers: To feel confident in knowledge and ability to provide good care (To do caring well – Schumacher et al 1998) without detriment to personal well-being. To have adequate support networks and timely help when required. To be able to relinquish care when appropriate.

A Sense of Continuity

For older people: Recognition and value of personal biography; skilful use of knowledge of the past to help contextualise present and future. Seamless, consistent care delivered within an established relationship by known people

For staff: Positive experience of work with older people from an early stage of career, exposure to good role models and environments of care. Expectations and standards of care communicated clearly and consistently.

For Family Carers: To maintain shared pleasures/pursuits with the care recipient. To be able to provide competent standards of care, whether delivered by self or others, to ensure that personal standards of care are maintained by others, to maintain involvement in care across care environments as desired/appropriate.

A Sense of Belonging

For older people: Opportunities to maintain and/or form meaningful and reciprocal relationships, to feel part of a community or group as desired.

For staff: To feel part of a team with a recognised and valued contribution, to belong to a peer group, a community of gerontological practitioners.

For family carers: To be able to maintain/improve valued relationships, to be able to confide in trusted individuals to feel that you're not 'in this alone'.

Table 5: continued

A Sense of Purpose

For older people: Opportunities to engage in purposeful activity facilitating the constructive passage of time, to be able to identify and pursue goals and challenges, to exercise discretionary choice.

For staff: To have a sense of therapeutic direction, a clear set of goals to which to aspire.

For family carers: To maintain the dignity and integrity, well-being and 'personhood' of the care recipient, to pursue (re)constructive/reciprocal care (Nolan et al 1996).

A Sense of Achievement

For older people: Opportunities to meet meaningful and valued goals, to feel satisfied with ones efforts, to make a recognised and valued contribution, to make progress towards therapeutic goals as appropriate.

For staff: To be able to provide good care, to feel satisfied with ones efforts, to contribute towards therapeutic goals as appropriate, to use skills and ability to the full.

For family carers: To feel that you have provided the best possible care, to know you've 'done your best', to meet challenges successfully, to develop new skills and abilities.

A Sense of Significance

For older people: To feel recognised and valued as a person of worth, that one's actions and existence are of importance, that you 'matter'.

For staff: To feel that gerontological practice is valued and important, that your work and efforts 'matter'.

For family carers: To feel that one's caring efforts are valued and appreciated, to experience an enhanced sense of self.

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

WHAT DO STUDENT NURSES THINK ABOUT WORKING WITH OLDER PEOPLE?

Despite the confident assertion by early pioneers, such as Doreen Norton and colleagues, that 'geriatric' nursing is true nursing (Norton et al 1962), work with older people has long been recognised as being amongst the least popular career options for student nurses (Delora and Moses 1969, Hooper 1979). Little has changed over the years (Fagerberg 1998 Happell 2002, McKinley and Cowan 2003, Avortri 2004, Briscoe 2004), and gerontological nursing is still described in the literature as being unchallenging, 'lo-tech' and unrewarding (Happell 2002) compared to areas such as accident and emergency nursing, or surgical nursing (Fagerberg 1998). However, recent studies have suggested that student nurses do not necessarily have negative attitudes about older people themselves, but rather negative attitudes towards working in gerontological nursing (Fagerberg 1998, McKinley and Cowan 2003). At the time AGEIN began we argued that what was needed was not another study that looked at students' attitudes towards older people, but instead a better understanding of students' perceptions of work in the field of gerontological nursing. Consequently, the type of questions we wanted to address were as follows:

- How do student nurses 'feel' about working with older people, do they see such work as interesting and exciting, or unstimulating and boring?

- Would student nurses choose to work with older people when they qualify, and what do they think the impact that working with older people would have on their careers?

- What factors influence students' feelings about working with older people, and their likely future career intentions?

This required a different methodological approach to earlier studies that had used 'off the shelf' attitude questionnaires such as Kogan's Older Peoples Scale, or the Palmore Facts on Aging Quiz. In order to tap into students' perceptions we considered it essential that a new questionnaire was designed that was thoroughly grounded in the experiences of students themselves.

A number of potentially significant issues had been raised during the first round of interviews and focus groups at the case study sites, and these were used as the basis for designing a new questionnaire. The items were piloted with several groups of nurses to see if they were easy to understand and viewed as relevant. Following this process 15 items were selected which covered three broad areas addressing: student nurses' perceptions of working with older people in general; their intentions to work with older people when they qualified; and the perceived consequences of working with older people in terms of future career prospects and job satisfaction. For each statement such as *'nursing older people is challenging and stimulating'*, students indicated their agreement on a five point Likert scale from strongly agree to strongly disagree (see Nolan et al 2002 for a full account).

In addition to the structured items the questionnaires contained space for further comment and a range of demographic and other data including age, gender and ethnicity, as well as qualifications and branch of nursing. The questionnaire also had sections exploring students' experience of working with older people prior to starting their training and whether they currently worked with older people over and above their clinical placements. We asked for details of the type of work that they had undertaken and whether they found this a positive or negative experience. As will become apparent, the nature of students' prior or current

experience provided extremely useful information. (A full copy of the questionnaire can be found in Appendix 2).

Students' perceptions of work with older people: quantitative data

Before considering the ways in which students perceive work with older people we briefly describe the nature of the sample. The main student characteristics are presented in Table 6 and, as will be seen, they were a diverse group. As might be anticipated the majority were female, although almost 1 in 5 was male. Similarly, over 80% were white. The age range covered a broad spectrum, as did the qualifications students held, with approximately 50% having 'A' Levels or above as their highest qualification prior to entry. All of these variables provide important contextual data. However, what is probably most interesting in the context of the project as a whole is the number of students who had experience of work with older people before starting their training. As will be seen, 63% of students had worked with older people in some formal context, while almost all (94%) had some form of contact, such as caring for a family member (one in three) to voluntary work or school experience. Moreover, 34% of students currently worked with older people as a care assistant whilst completing their training. The potential influence of such prior and current experience was of particular interest to the project team, and, as will become clear, proved to be highly influential.

Students' perceptions of working with older people are presented in Table 7 where items have been arranged to correspond with the three broad areas of: perceptions of work with older people in general; personal disposition/experiences of work with older people; and perceived consequences of work with older people. A consideration of these data paints an overall very positive picture. For example, 8 out of 10 students (82%) disagreed that nursing older people is just basic care and does not require much skill, while conversely only 9% disagreed with the statement that such nursing is a highly skilled job. Similarly, the vast majority of respondents considered nursing older people to be interesting (69%) and that it provided a challenge (64%). There was little agreement with the idea that older nurses find it easier to have rapport with older people and virtually no agreement with the statement that nurses' work with older people because they cannot cope with hi-tech care.

Table 6: Student Nurses' Sample Characteristics (n=718)

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

Branch	%	Qualifications (high level)	%
Adult	61	NVQ/Access	22
Child	8	'O' Level/GCSE	21
Learning Disability	5	'A' Level	25
Mental Health	25	City Guild/HNC	4
		Diploma	12
		Degree	9
		Higher Degree	1
		Other	7

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

Table 7: Students' Perceptions of Working with Older People (n=718)

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
	%	%	%	%	%
Students' perceptions of working with older people in general					
Nursing older people is mainly about basic care - it does not require much skill	2	8	8	49	33
Nursing older people is challenging and stimulating	17	47	25	10	2
Nurses work with older people because they cannot cope with hi-tech care	2	3	8	36	52
The older you are the easier it is to have a good rapport with older people	3	14	16	46	22
Nursing older people is a highly skilled job	13	47	31	8	1
I think older people are really interesting to nurse	21	48	22	7	2
Students' personal disposition towards work with older people					
I would definitely consider working with older people when I qualify	12	28	34	17	9
I am really looking forward to my first placement with older people	10	31	39	15	5
I am really anxious about my first placement with older people	3	13	24	39	21
Working with older people does not appeal to me at all	5	12	23	35	24
Students' perceptions of the consequences of working with older people					
Work with older people is a dead-end job	2	2	11	41	43
Working with older people has a high status	2	10	38	33	16
Once you work with older people it is difficult to get a job elsewhere	2	8	26	381	27
Nursing older people provides little satisfaction as they rarely get better	2	6	12	51	30
Working with older people is not a good career move	1	5	22	46	26

Overall these responses clearly indicate that students in the sample were favourably disposed towards work with older people in general. However, there were still significant numbers who were yet to decide whether older people are interesting to nurse (22%), whether such work is challenging or stimulating (25%), and if it requires high levels of skill (31%). This suggests two immediate challenges for educational programmes. One is to maintain the positive initial disposition towards older people displayed by the majority of students, and the other is to convince those that are as of yet undecided that working with older people is indeed interesting, challenging, stimulating and skilful.

The positive tone of the first set of statements was further reinforced in the remainder of the questionnaire, but once again there was quite a large section of the student body who were undecided. So, for instance, only 17% stated that working with older people did not appeal to them at all and 40% would definitely consider working with older people when they qualified. However, nearly a quarter (23%) were undecided as to the appeal of working with older people and a third (34%) do not know if they would consider such work upon qualification. The latter figure might be anticipated, as for many respondents it would be too early in their careers to decide if they wanted to work in any particular field, but the fact that a quarter of students were not sure of the 'appeal' of nursing older people does suggest that there is much that could be done to make this area of work more attractive. The data also suggest the possible importance of careful preparation for placements with there being quite high levels of anticipatory anxiety in evidence. For example, 4 out of every 10 students (39%) were uncertain if they were looking forward to their first placement with older people (20% were not looking forward to it) and a quarter (24%) were unsure as to whether they were anxious about their placement or not. These are issues that we will discuss later in light of the case study results.

The final set of statements were concerned with the possible future consequences of working with older people, such as the potential impact on careers, job satisfaction and the perceived status of gerontological nursing. Consistent with the previous sections the overall impression was that students viewed work with older people in a largely favourable light. The impact on future career was seen as limited (only 4% thought its a dead-end job, only 6% thought that it was not a good career move and only 10% felt that once you work with older people it is difficult to get a job elsewhere), although as might be anticipated, there were still quite large numbers who were unsure. Reassuringly, 8 out of 10 students disagreed that it is difficult to gain satisfaction from working with older people. However, the one item on the questionnaire that suggested a major factor potentially inhibiting students from work with older people is the perceived status of gerontological nursing. Only 12% of students thought that work in this area had a high status, half felt that it didn't (49%) and 4 out of 10 (38%) were uncertain.

Taken together these results are encouraging, but they also pose a number of challenges. If students enter the profession fairly inclined (or at least not in large numbers, disinclined) to work with older people it is essential that their training reinforces these views and also persuades those who are undecided that such work indeed represents a challenging, skilful and rewarding career. This suggests that placements should be carefully planned with this in mind. A critical variable, however, is likely to be the perceived status of the work, which is seen as low. Having identified some key messages from the quantitative data, attention is now turned to the important themes found in the qualitative comments.

Hearing the students' voices: messages from the qualitative data

Despite the relatively short time in which students had to complete the questionnaire (these were administered during a formal classroom session in order to maximise response rates), substantial volumes of qualitative data were nevertheless obtained. Sixty percent of students added further comments, and these were often extensive. This gives some indication of the importance that students' attached to the subject. Students' comments were subject to a detailed content analysis that identified a number of themes, providing valuable insights and adding a further layer of interpretation to the quantitative analysis. Despite their varied nature one issue was common and further reinforced the impression from the quantitative analysis: that is whether or not students wished to work with older people when they qualified, their views of older people themselves were on the whole very positive. However, despite these largely positive attitudes, the experiences students had when working with older people, whether prior or current, often either put them off work in the area when they qualified, or created doubts in their minds. This was particularly so when students witnessed, and were exposed to, poor standards of care. A consideration of students' experiences lies at the heart of this section and highlights the fact that the type and range of experiences to which students are exposed, whether as part of their studies or not, often determines whether they are likely to consider gerontological nursing as a career when they qualify.

However, it is also important to recognise that some students have no desire to work with older people, not necessarily because of negative views or experiences, but simply because other areas of work are more appealing. This is reflected in two themes from the qualitative data that we termed 'not for me' and 'pastures anew'.

'Not for me'

This theme is largely self-explanatory and indicates that for certain students work with older people simply was 'not for them'. This was unrelated to any negative views about older people themselves but rather reflected students' desire to work in other areas. Many students responding in this way were studying on the child branch and as such had already chosen their preferred area of nursing.

'Pastures anew'

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

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

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

'I work for an agency and I always tell them not to send me to a nursing or residential home for work. I have worked with older people before, I know how hard it is to look after them. I would not think of pursuing a career in that field. I work sometimes with older people when I have no other work available (eg working with young people). I hate working with older people because they are very hard to look after.'

The perception that work with older people is 'hard' surfaced a number of times, with the above respondent adding that:

'This is just not my opinion but also the opinion of my colleagues and friends.'

Indeed, even amongst those individuals who had decided that they definitely wanted to work with older people, such work was still perceived as 'hard':

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

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

Several students used words such as 'heavy demanding work', 'depressing', 'degrading', 'bored', 'frustrating', 'unstimulating', 'not challenging' which convey a very negative perception of working with older people. It would seem that for students a great deal turns on the belief, or otherwise, that they can have some kind of positive impact. That is, at the end of the day, is it 'worth it'? This is succinctly captured in the following quote:

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

Those students who had already had a positive experience of working with older people, or could conceive of it as stimulating and rewarding, gave a much more positive view:

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

Quite clearly the idea of being able to 'make a difference' is an important one and this often hinges on quite small but subtle factors, with students who feel able to 'relate' to older people at an interpersonal level reporting far greater satisfaction.

'After working with older people for 5 years I found it a very valuable experience. Even the smallest smile or the thankfulness of the older people when you've helped them to be a little more independent made my job very worthwhile and very enjoyable, especially when you have time to sit and listen to their stories of when they were young and of events that happened in yesteryear. Just spending a little time listening I find makes the biggest impression on older people and of how they view your caring ability.'

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

'I feel that the elderly are a pleasure to work with. They are usually very helpful and kind. Some people who have not yet worked with older people tend to be a bit prejudiced and expect the work to be boring. I find working with the elderly very challenging and very rewarding, especially with the client group that I have already worked with (elderly people with dementia and Alzheimer's disease, or such like). Some people are scared/frightened about working with these people, but with the right attitude and approach, I find them gentle, caring, loving etc (on the whole anyway!).'

The quote above is particularly telling with its talk of 'prejudice' and 'boredom', 'scared/frightened' but also of the 'right attitude and approach'. The discussion so far has focussed mainly on two distinct groups: those students who have made their mind up that work with older people was 'not for me', and at the opposite end of the spectrum those who, at this point in their training at least, held the opposite view. However, the majority of students sat somewhere in between these extremes and still had an open mind about where their future might lie. One of the challenges therefore is for the educational experience to which students are exposed to build on and sustain the enthusiasm amongst those who see a future in working with older people and to win the 'hearts and minds' of those who are still uncertain. In other words, is it possible to overcome 'prejudice', 'boredom', 'fear' and create a view that gerontological nursing is a field in which it is indeed possible to 'make a difference'. Although the data here cannot provide any definitive answers, they do nevertheless give some potentially telling insights as to the challenges that need to be addressed. These are reflected in the following themes:

- Ageism is alive and well

- In my experience

- Impoverished environments

Ageism is alive and well

The literature describes several ways in which ageism exists in today's society, and indeed stamping out ageism is one of the main goals of the National Service Framework (DoH 2001). Our data indicate that ageism is something of which students are well aware. Broadly speaking they identified ageism operating at three levels, the first two explicit and the third

more implicit. At the most general level many respondents commented on the ageist attitudes of society at large:

> 'Dignity doesn't only apply to younger people. Unfortunately, in today's society, people tend to be unable to hang on to their dignity due to the attitudes displayed in todays 'fast world'. We should just remember – one day we may reach old age ourselves!'

> 'I have not yet had the opportunity to work with older people, but I have great respect for them and think that British society undervalues the elderly in a way that is unacceptable. I hope that my mind does not change when I go out into practice. At the moment I am fascinated about the problems related to an ageing society and would be very happy to be a part of the continuing care of older people.'

The above sentiments indicate a high level of awareness and a quite subtle appreciation of the ways in which society undervalues older people. However, this does not seem to have prejudiced these students against work in the area, in fact quite the contrary, with the above individuals definitely considering a future working with older people. On the other hand, such a decision could be influenced one way or the other by the experiences to which students were exposed. The quote below is therefore a cause for concern, it indicates that students often witness ageism in the care that older people receive:

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

The very positive attitudes towards work with older people captured above are encouraging, but conversely other respondents suggested that, notwithstanding their own regard for older people, this was not always reflected either in the care that older people received from others, nor in the lack of value or status given to gerontological nursing:

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

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

> Many have commented that working with older people is job suicide and I have noticed that there does not seem to be the same job opportunities. However, from recent placements it has been noted that things appear to be improving with the development of areas such as memory clinics and the introduction of admiral nurses. However, until the situation improves to a level where opportunities with older people are the same as working within the general adult population, it is still very off-putting.'

It is interesting to note that comments such as these reinforce the role and influence of

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

In my experience

As noted above, this theme is concerned with the effects, positive or negative, of working with older people as experienced by students in the project. Once again the data below provide telling insights into the importance of a positive placement experience. The first comment is from a respondent who, according to the more structured section of the questionnaire, was definitely not looking forward to her first placement with older people, but for whom a positive placement had transformed her views so that she subsequently strongly agreed that nursing older people was stimulating and challenging, was a highly skilled job, and found older people really interesting to nurse:

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

Similar 'transformative' experiences are reflected below:

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

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

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

> 'Prior to commencing the Dip HE in Nursing I thoroughly enjoyed working with the elderly. However, I have so far worked on all my placements with the elderly and I feel that I have gained sufficient experience in patients over 65 years. I do not wish to work with the elderly when I qualify because of the poor practice in health care settings I have experienced throughout my practical placements.'

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

Although several of the students who recounted such experiences had indicated that this had convinced them that work with older people was 'not for me', the final comment above reinforces the variability of experience and highlights the major influence that a 'dynamic attitude' can exert. Unfortunately the final theme here, that of 'impoverished environments', provides compelling evidence that students, whether as a result of placements during their course or because of working in care settings to supplement their bursary, are often exposed to standards and environments of care so poor that the negative effects are hard to over state.

Impoverished environments

It will be apparent by now that despite the relatively short time that students had to complete the questionnaire that extensive volumes of qualitative data were collected. Nowhere was this more apparent than in those comments which captured what we have termed 'impoverished environments' (Nolan et al 2002). Both the volume of data on this topic, and its content, clearly indicated that students were deeply affected by some of the conditions, attitudes and standards of care to which they were exposed:

> *'I find that the areas where I've worked the staff were over-worked, under-appreciated and under-paid. Their contribution wasn't valued so consequently patient care suffered. Therapeutic touch and communication was limited by trained staff, carers just saw to their physical needs. It was like they came there to end their days peacefully, even though dignity and respect were at the bottom of the pile with regards to skills.'*

> *'...feel it is a job really without satisfactory outcome. I found it very sad as I couldn't give them what I felt they needed and deserved. I felt they were belittled and were knowingly ignored for some basic needs.'*

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

Exploring the influence of experience

A number of telling insights about the way that students perceive work with older people emerged from the quantitative and qualitative data with both reinforcing the importance of students feeling that they can 'make a difference'. The students' prior and current experience of work with older people and their exposure to what we have termed 'impoverished environments' was also highly influential. We therefore wanted to explore further the

potential influences of past or present experiences. One component of the questionnaire asked students to indicate whether or not they had previous and/or current experience of working with older people and also to tell us whether this experience was very positive, quite positive, quite negative or very negative. Given the obvious influence of experience it was decided to explore the effects of experience (positive or negative) on students' perceptions of work with older people compared to other potentially interesting variables such as their gender or age.

A series of tables were therefore computed to test for the presence of potentially significant relationships. This proved to be highly instructive, further reinforcing the vital part played by experience and its influence on students' general feelings towards work with older people, their predisposition to consider gerontological nursing upon qualifying and their views of the likely consequences of work with older people on their career prospects.

However, before considering the influences of experience attention is given to other variables such as gender and age. Men were more likely than women to feel that gerontological nursing was not a good career move (29% v's 14% .01) and to see gerontological nursing as a dead-end job (9% v's 3% .01). Women on the other hand were more likely to think that older people are interesting to nurse (71% v's 56% .05) and that work with older people has a high status (13% v's 8% .02). Although these differences do reach statistical significance they are generally quite small and the percentages involved are also relatively low.

Somewhat larger and slightly more varied differences were found by age when the sample was divided into 3 age groups (under 30, 30-39, 40+). From these analyses it emerged that:

- older students as opposed to younger students were less likely to see work with older people as having a high status (.00000);

- older students when compared with younger students were more likely to perceive problems in getting a job elsewhere after working with older people (.03);

- older students when compared to younger students were more likely to see gerontological nursing as a poor career move (.0005).

These data would suggest that older students have a consistently more negative view of gerontological nursing in terms of its likely impact on their future careers than do younger students. Reasons for this are unclear. It may be that younger students are naturally more optimistic and less 'world weary' than older students who are more likely to have worked in care settings for longer periods of time and possibly to base their estimate on their own experience. Conversely, younger students, especially those aged under 30, were more likely to be apprehensive about their first placement (.02).

However, it was when the nature of past and present experience of work with older people was explored that potentially the most telling differences emerged. From these analyses two clear and compelling conclusions can be drawn. Firstly, it seems that students who had either former or current experience of work with older people were consistently more likely to record favourable dispositions towards working in the area. However, the critical variable seemed to be whether this experience had been a positive one or not. The correlation between a positive experience and a positive predisposition towards older people was quite startling and while it is not possible to infer causation from correlational data the fact that these results accord so closely with the entirely independent qualitative analysis reinforces

the central role of experience in shaping predispositions towards work with older people.

If we compare students with prior positive experience of work with older people to those with no such experience it emerges that:

■ those who have had a positive experience are far more likely to see work with older people as interesting (79% v's 33% .00000) and challenging and stimulating (73% v's 33% .0001);

■ this positive view is also apparent when predispositions to work with older people are considered as students who see their experience of work with older people as positive are far more likely to: consider working with older people when they qualify (49% v's 10% .00000); to look forward to their first placement (50% v's 15% .00000); and are far less likely to agree that work with older people does not appeal to them (8% v's 58% .00000);

■ this trend continues when the perceived impact of work with older people is addressed with those students having a positive experience being far less likely to agree that it is difficult to get a job elsewhere once you have worked with older people (7% v's 28% .0005) and also far more likely to disagree that such work is a dead-end job (89% v's 63% .00000).

Together with the qualitative analyses, these data reaffirm that prior experience and whether or not this is viewed positively, are major influences on students' feelings about work with older people. This has potentially significant implications which will be considered further when the data from the case studies have been presented in the next chapter. As we noted above, similar data were collected from qualified staff and, whilst we do not intend to discuss these in detail here, the conclusions from both the qualitative and quantitative data further reinforce the pivotal role played by experience, and also highlight the continued existence of impoverished environments of care (see Nolan et al 2002 for a full account).

LESSONS FROM THE CASE STUDIES: WHAT MAKES FOR AN 'ENRICHED ENVIRONMENT' OF CARE?

The main aim of the case studies, conducted in four Schools of Nursing in England, was to provide a rich description of the educational experience of pre–registration nursing students, thus allowing for detailed insights to emerge into the ways in which they develop their knowledge, beliefs, attitudes and caring behaviours with older people. Building on the conceptual phase of the study, and the survey data, this section explores further the notion of 'impoverished environments' and their opposite 'enriched environments', and considers whether such environments can be understood in terms of the Senses Framework. As may be recalled from the introduction, the main types of data collection used in the case studies were detailed focus groups with students at several points in their training, together with visits to care environments that students had identified as 'good' placements in respect of both their learning and the care delivered to older people. Readers interested in the detailed description of the case study sites are referred to the original report (Nolan et al 2002). Further details on the nature of the focus groups and the placements visited can be found in Appendix 3. Our main aim here is to provide an account of this phase of the study.

Data analysis

Although the intention was not to impose any existing theoretical model on the early focus groups, it was hoped that the Senses Framework identified in the conceptual phase might generate ideas that could be explored further and their relevance to students probed. In the event it was not necessary for us to introduce the Senses, as students spontaneously identified several of these Senses themselves without the need for prompting, often using the same words as coined by the team. They therefore talked about needing to be 'safe' and 'secure' and to feel that they 'belonged' in practice environments. Because of the obvious relevance of the Senses to the students these were deliberately introduced into later focus groups and students were invited to comment critically both on their importance and their dimensions and properties. In this way a detailed understanding of the Senses, as they relate to the students' experience of work with older people, emerged over the life of the project. In analysing how these Senses were experienced by students a four stage approach was adopted. We therefore wanted to explore:

- Factors that helped to create each Sense.

- Factors that worked against each Sense.

- Positive consequences of each Sense – students' descriptions of how they felt when they experienced a Sense in a positive way, for example, what were the positive dimensions of feeling secure during a placement?

- Negative consequences of each Sense – students' descriptions of how they felt when the Sense was either not present or was experienced in a negative manner, for example, what was it like not to feel secure?

In this way the Senses were used to help to structure the analysis while also being subjected to empirical testing and further refinement in light of the on-going data collection. This allowed us to seek links and connections and map the range and nature of factors that influenced the students' experiences. In this way it was possible to articulate and understand

the major factors influencing students' experiences, both of their nurse training in general, and of work with older people in particular, in terms of the Senses themselves. We also wanted to see if an 'enriched environment' of care could be understood using the Senses Framework.

The Senses therefore provided an analytic and theoretical lens via which to more fully appreciate what students saw as important elements of their placements. The data reinforced the pivotal role of the placement experience for, despite all our efforts to get students to talk about life in the university, the classroom experience was considered by them to have had much less of an impact than their practice placements. As the study unfolded it became evident that the ways in which the Senses were created and achieved for students was overwhelmingly a result of their experiences in practice placements and their interactions with staff, patients and relatives during such placements.

Reflecting the main goals of the study we consistently asked students for their views on their experiences of learning to care for older people. However, they found it difficult to separate this from their overall experience of learning to care generally. Therefore, it became clear that many of the issues raised by students did not apply only to one client group, and had wider relevance across the student experience as a whole. This is significant as, consistent with the survey results, it became clear that it was not older people that created difficulties for students but rather their experience of such work that exerted a considerable influence on future career options. This was summed up by one of the students as follows:

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

In exploring *'what determines if you like working in a place'* the findings from this phase of the study begin with an overview of the Senses as they were perceived by the students, together with a detailed description of each Sense and the ways in which they are either created or inhibited by factors operating in the practice environment to create an 'enriched environment'. However, although all the Senses were important to students throughout their training, it became apparent that some were more relevant at certain points in time, which changed as the programme unfolded. At the end of this chapter we therefore consider the relative importance of the Senses over time, and indicate how an 'enriched environment' for student learning can be created.

Overview of the Senses as perceived by student nurses

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

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

The data from the visits to practice placements also suggested that students needed to feel safe and secure before the other Senses could be experienced. Therefore, in presenting the results here the Senses will be considered in the following order: Security, Belonging, Continuity, Purpose, Achievement and Significance.

A Sense of Security

Factors that contribute to fostering a Sense of Security

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

A Sense of Security might therefore be defined as:

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

This notion of recognising vulnerability (or potential vulnerability), while at the same time promoting confidence, was an important balancing act that was a characteristic of the best learning environments. Indeed, for students, knowing that they had someone to turn to if things

were not going well, or when they had been exposed to poor practice, was an essential attribute of a 'secure' environment, and the role of the mentor was crucial (see later). However, fostering of a Sense of Security was not just a facet of the practice environment, and although relatively little reference was made to the influence of the school or university throughout the AGEIN project, the need for careful preparation for placements was very important.

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

- Being well prepared

- Feeling supported

- Having help to 'talk things through'

Being well prepared

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

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

Feeling supported

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

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

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

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

Help to 'talk things through'

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

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

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

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

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

Feeling secure

It was often difficult for students to capture in their own words what it was like to feel secure;

perhaps the word itself is descriptive enough. However, many found it all too easy to describe what it was like to work in an environment which did not promote a Sense of Security. An indication of the range of disparate emotions that resulted is provided below:

- Feeling paranoid, emotionally unprepared

- Feeling unsupported

- Feeling intimidated

- Feeling of too much responsibility or not knowing who to turn to

- Not wanting to go back

- Feeling like going off sick

- Feeling anxious, apprehensive, terrified, scared or alone

- You feel worried

- Feeling shocked

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

Factors inhibiting a Sense of Security

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

- Feeling unprepared

- Feeling unsupported

- Feeling that staff lacked the requisite knowledge and skill.

Feeling unprepared

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

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

Unfortunately the data suggested that there were few concerted efforts to portray a more positive view of older people. Many students had difficulty discussing the theoretical content of their course relating to older people that they had received in the classroom, or in identifying how theory was applied in practice settings. When pressed, some students could identify isolated sessions (frequently around elder abuse), often given by a particular person

who was enthusiastic about the care of older people. However, for the majority it seemed that the care of older people was 'touched on' within classroom sessions when other topics such as diabetes were discussed.

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

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

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

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

Feeling unsupported

The vital role played by the mentor was one of the key factors that helped to provide students with an all-important Sense of Security once on the wards. Moreover, as has already been discussed, being secure helped students to feel free to challenge care and to explore their role without threat of censure, rebuke or appearing foolish. Unfortunately, this experience was by no means universal, and several students were allocated a mentor with whom they had little contact through illness, shift patterns or holidays. In such circumstances emotions such as feeling 'alone', 'scared', 'overwhelmed' or 'not knowing who to turn to' surfaced. For others there was the feeling that their mentor was not interested in teaching and this threatened one of the fundamental elements of a Sense of Security, being able to take 'safe risks':

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

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

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

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

Feeling that staff lack the requisite knowledge and skills

One critical attribute of a 'safe' environment is that students felt they were working with staff who, not only had a passion for their area of practice, but were also skilled practitioners. While this was evident in the 'better' placements, students often questioned the ability of staff, especially as they became more experienced, knowledgeable and confident themselves. Particular problems were identified in relation to older people with organic mental health or cognitive deficits, and those with challenging behaviour. Students frequently expressed concerns that staff tended to focus on 'containing' patients rather than using a more therapeutic approach:

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

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

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

A Sense of Belonging

Factors that contribute to fostering a Sense of Belonging

Given the need for students to change placements on a regular basis, the ability to 'fit into' different environments, while at the same time feeling part of something, was another key indicator of a quality placement. Therefore, following the creation of a Sense of Security it was important for students to feel that they 'belonged'. Although students 'belong' to several groups, some more permanent, such as their branch cohort, and others, especially on the wards and clinical areas, more transient, it was the latter in which the need to 'belong' was seen as paramount, especially at the beginning of each new placement. A 'Sense of Belonging' can therefore be defined as:

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

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

- Being made to feel welcome

- Accessing the 'team spirit'

- Clear leadership

- Playing your part

- Identifying with older people

Being made to feel welcome

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

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

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

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

Accessing the 'team spirit'

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

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

If staff were happy students also felt that patients were more likely to be happy, and this in turn helped students to settle in and 'be happy' going to work:

> *Because they* [staff] *were happy at work they were better with the patients. You are going into work happy, the staff were all great, having a laugh, getting on with the job, and you had happy patients.*

Being made to feel welcome and creating a happy atmosphere are not 'chance' happenings, but rather part of the 'culture' of the unit. Culture is of course multi-faceted and subject to many influences, but a 'positive culture of care' is characteristic of areas that provide good quality care for older people (Davies et al 1999), with the role and influence of the placement leader being crucial.

Students were finely attuned to this, and soon picked up on the influence of the ward leader in creating and sustaining a positive 'team spirit':

> *As soon as I get there, just the aura of the sister, she was quite friendly, she welcomed me going into the theatre, I felt really part of the team, as if I belonged there.*

However, the role of the leader was not confined to fostering a happy atmosphere, it was also essential that they demonstrated clear leadership.

Clear leadership

One of the primary ways in which the ward or placement leader could demonstrate clear leadership was to get out onto the ward and lead by example. This was even more effective if there was a deliberate attempt to involve students from the outset.

> *Part of the team, we were part of the team, and the ward manager, she was part of it and she would chip in. She didn't just sit at the desk all day, and she would take her turn in teaching one of us most times. We would sit down for ten minutes, or if you wanted to ask her something then you could always approach her and she would arrange things that she thought you'd find interesting. You were brought into it, and accepted as part of the team. But to be accepted as part of the team you have to prove that you are willing to be for a start.*

Moreover, while students recognised and responded to a happy atmosphere, they also acknowledged the importance of there being boundaries established. This did not necessarily mean creating a punitive ethos, but rather one in which people knew where they stood but were also well supported:

> *She was strict but really she was supportively strict, if you know what I mean. She didn't like anything slacking, if you were caught hanging around as a student she'd have you. She was the one that was very particular about fluid charts and diet charts. I never saw her going off on one or being nasty but if you did anything wrong you knew about it. I went on break with one of the staff nurses who said that she* [sister] *always supported her staff, she really appreciated her staff and they felt valued... Yes it's the first place I have felt like that. In other places you would be left to your own devices. I like to feel that there is support there if you need it but you can stand on your own two feet.*

These type of placements enabled students to feel that they were playing their part and contributing to the ward.

Playing your part

An essential part of students' Sense of Belonging was feeling that they were contributing to the ward during their stay. It was important that students felt that they could play a part as early as possible, as this set the tone for most of the placement and helped to create a Sense of Purpose and Achievement later on.

Students' feelings that they belonged and contributed were enhanced when they were introduced to the wider multidisciplinary team and were also told that staff could learn from them, as well as the other way around:

> *Staff nurse introduced me to everyone and she was telling me everything she was doing and when the doctors come around to their ward rounds they call me and I join the other teams and we all go to do the rounds. So you really got to feel like one of them. Yes I did in a way because you know I was with them.*

> *She said* [the sister] *when we went on the ward that we learn from you as well, anything we could offer, new ideas. She said we love having students and she really meant it.*

> *Best thing is you go onto the ward and a sister comes up, if you've got any new research that you got your hands on bring it in and we'll see if we can use it. They're the best.*

All of the above factors played a key role in helping students to feel that they 'belonged' on a particular placement. However, in respect of influencing their perceptions of work with older people, probably the single most important factor in 'belonging' was the extent to which students could identify with older people.

Identifying with older people

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

> *I would work with older people out of choice only because of the fact that personally for me they know its amazing what they know about, you can have great conversations and learn things. I know a lot and couldn't work out how you did a stitch pattern a lady came and said you need to do that and to do that. And we just had an awfully good time. You don't expect to have a good time when you are on duty. They are interesting to work with.*

Some students also recognised the importance of getting to know and supporting patients' relatives, and drawing on their knowledge as part of the process of identifying more closely with older people:

For me I find that I spend a long time talking to relatives, not because they want anything from you but so that I can find out what I need to know. Like sometimes you talk to people and they are not quite all there and you can ask does she like things this way or that way. They can give you explanations sometimes for behaviours. Absolutely, rather than you going on and on treating everybody exactly the same, you can find out about their lives.

This more holistic Sense of Belonging was characteristic of the better student placements and provided students with a far more rounded and complete view of the situation and circumstances of older people. This could 'transform' students' views of the potential of gerontological nursing:

I think that it's really wrong seeing getting older as going down hill. I think nursing the elderly is totally dynamic, but I think it just needs to be recognised.

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

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

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

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

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

- Feeling like a lone voice, feeling like a spare part

- Feeling like you don't fit in, not feeling part of the team

- Feeling resentment or annoyance from others

- Feeling you are in the wrong place

- Feeling you are attached to the wrong people

- Feeling like a stranger, feeling like an outsider

- Feeling anxious

Two factors in particular could seriously reduce a students' Sense of Belonging, these were:

- Not being made welcome

- Being treated like a pair of hands

Not being made welcome

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

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

In contrast to the better placements where students were encouraged to share their knowledge with qualified staff, other areas appeared to find this threatening. Students soon picked up on this:

> Some places greet you open armed and want to talk to you about theory and what you've done. Others don't want anything to do with you because you're going to challenge their practice.

Such feelings were exacerbated in placements where students were treated like a pair of hands.

Being treated like a pair of hands

In wards where students felt that they were being treated like a pair of hands they were only accepted and seen as useful when they were filling in the gaps created by staff shortages or a general lack of resources. Students understandably felt that they learned little in such environments:

> I had a mentor that was basically not interested in teaching students at all and I don't think it was personal she just couldn't be bothered… To be honest, I felt like she was just using me as an extra pair of hands.

> I thought the placement was irrelevant, we didn't need to do it. We didn't learn to do it, I didn't particularly learn anything, we went there as just another pair of hands and not there to learn anything.

Such placements were often not conducive to getting to know people but, were rather more concerned with getting things done 'on time'.

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

Belonging: A wider perspective

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

I feel part of the mental health group

Do you feel part of the school of nursing?

More so the group I think, because of the divide between adult nursing and mental health. It's unfortunate, but there it is.

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

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

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

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

A Sense of Continuity: Forging connections

The nursing literature is replete with talk of the 'theory-practice gap', and the 'distance' that exists between what students are taught 'in the school' and what they experience 'out on the wards'. The hoped-for 'seamless' transition of theory to practice is rarely apparent, and given the importance of the practice arena and the subtle but powerful influences to which students are exposed, it is little wonder that it is often the ward view of 'how things get done' that prevails. Perhaps this was strongest for students who had previous experience. However, such prior experiences are in some ways 'random' in that they are not part of a 'structured' programme and therefore individuals interpret and respond to stimuli in their own way. It might be expected that the experience as students on a programme of training would be less 'random' and that their theory/practice encounters would be designed with clear and shared goals in mind. In other words, it would be reasonable to expect an element of continuity or connection between theoretical inputs and practical experiences, which would help to forge a coherent sense of what constitutes 'nursing', especially with respect to nursing older people.

A Sense of Continuity might therefore be broadly defined as:

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

Unfortunately this was not always the case, and students recounted numerous instances where they experienced anything but a Sense of Continuity. Participants identified three things as being important to creating a Sense of Continuity. These are:

- A shared understanding between the 'school' and the ward as to the purpose of the placement and the links between theory and practice.

- Consistent relationships with mentors.

- Experiencing consistent standards of care based on a clear philosophy.

In many ways a Sense of Continuity pervades the Senses Framework itself, as the Senses are interlinked and in part interdependent. For example, students are unlikely to feel totally secure if they do not feel that they belong, nor, as will be seen later, can a Sense of Purpose be entirely divorced from a Sense of Achievement. In this respect a Sense of Continuity, as the name reflects, is the thread that links the other Senses. The reverse also applies; a feeling of discontinuity is potentially threatening or undermining of the other Senses. The data suggested that the inability to forge the links and connections essential to a Sense of Continuity often undermined the students' experiences of their training. Continuity might therefore be seen as the 'piece of string' that students could grasp if they felt that they were losing their way, and follow it back to places that they know. Students who did not experience continuity described a range of emotions such as feeling:

- Frustrated

- Losing interest

- Worried

- Like giving up

- Like being on a production line

- Isolated

- In the dark

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

Creating a shared understanding between ward and school, making links between theory and practice

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

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

However, numerous factors militated against students' ability to span the theory-practice gap, with several feeling that the programme itself was disjointed and that there was little in the way of shared understanding between nursing as taught and nursing as witnessed. Often students formed the impression that ward staff did not value theory or that the theory taught bore little resemblance to what went on during placements. Such feelings of 'disconnection' were exacerbated when the timing of the theoretical input did not coincide with the practice placement:

You do your practical on the placements and you come back into school and they tell you how to do things that you have done on the ward. You have to do them to gain your clinical outcomes on the ward but you are anxious because you know that you have not been given the information regarding these clinical practices before going on the ward. What's the point in telling us afterwards?

Moreover, as has already been noted, the fact that by and large any theoretical input relating to older people was interspersed throughout the course meant that many students did not relate it to their placement. It could be argued that designing the course in this way, with the input on older people being 'threaded' through the programme, would enhance continuity. On the other hand, if this input is too well 'hidden' then students find it difficult to identify with. Indeed, it was often seen as fragmented:

We have class discussion and it [caring for older people] *will just be brought up on the off chance… Its fragmenting I think. Certainly if you thought about it a little bit more and co-ordinating it so that you had some theory before you went on placement it would be nice, but it doesn't always work that way.*

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

I think there is a big gap I don't think the lecturers spend enough time out on the wards. They come out and see us for 10 minutes and ask if everything is okay, any problems? But they don't see the ward. Why don't they send them into nursing homes and then they'd understand what we really need to know.

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

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

nurses four days a week and the other day with the qualified staff, and they genuinely believed it.

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

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

Although such instances were by no means universal, neither were they isolated. At the opposite end of the spectrum were the placements characterised by excellent communication between school and ward, where the links and connections were made explicit. Most placements, however, fell somewhere in between and there is little doubt that greater clarity and communication would have done much to improve the continuity that students experienced.

The other two central elements of a Sense of Continuity, consistent relationships with mentors and exposure to a clear philosophy of care, together form bridges to the other Senses, the former to a Sense of Belonging, and the latter to a Sense of Purpose. The mentor is a key figure in creating both a Sense of Security and of Belonging and therefore it is hardly surprising that students who had consistent contact with a mentor were able to make 'links and connections' more effectively than those who did not.

Consistent relationships with mentors

The importance of relationships between students, staff, patients, and, to a lesser extent, relatives has already been alluded to, and is essential to establishing an initial Sense of Security and Belonging. However, in terms of continuity of relationships, the most important bond was that created between the student and their mentor. Mentors who could define their role and that of their student were highly valued:

But I knew what my role was. My mentor actually said to all the health care assistants that I was working with her and nobody else. It was nice I mucked in anyway, but the fact that she actually defined my role, because it is often a fuzzy area.

In particular, students wanted mentors to devote time to them as individuals, and to take both formal and informal opportunities to enhance their learning. This sort of continuity greatly enhanced students' Senses of Purpose and Achievement as well. Furthermore, students soon picked up on the fact that staff who had time for students, also tended to have time for patients, further reinforcing the reciprocal relationships in the best placement areas:

A good placement is determined by how the staff treat you. If the staff have got time for the students they have got time for the patients, it's wonderful.

However, continuity of relationships between student and mentor was by no means guaranteed, and in such circumstances the fragile balance of student learning was easily upset:

My mentor was working three days a week and two of these were at the weekend, and she said because I haven't seen you doing the actual nursing care I can't give you a very good mark.

Another factor exerting a considerable influence on student learning and continuity was the extent to which they experienced a clear and consistent philosophy of care. Once again the ward leader was a key figure here.

Experiencing a clear and consistent philosophy of care

One of the key findings to emerge from the 'Dignity on the Ward' project (Davies et al 1999) was the importance of a consistent philosophy of care in helping to provide excellent care for older people. Data from the present study attest to the role of a consistent philosophy in helping to establish a Sense of Continuity for students. Such a philosophy need not necessarily be written, rather it was more important that students saw it enacted in practice. Once again the role of the placement leader in establishing expectations and in setting the 'tone' for the whole student experience was central:

> *Sister allowed you to get on with your job, she wasn't breathing down your neck. She* [sister] *would make it plain what was expected, she would then listen to what we had got to say from the placement, it was a very mutual relationship and she was fair. She also had a good sense of humour, her staff were so motivated and enthusiastic and really, really genuine.*

As noted earlier, senior placement staff who maintained a real 'presence' on their unit were particularly valued. This was noted to have beneficial effects for all concerned, including patients themselves:

> *Sister was very motivated, she actually got out there and worked with the patients and did the care herself. And I think if staff see a ward sister being prepared to get out and do it you feel like doing it, rather than someone who sits in the office shuffling paper. I think it was the way she spoke to patients as well. The patients were more motivated, they were mobilising a lot quicker. They all got up and out of their beds, got dressed and they were encouraged to sit round the table for their meals.*

Sometimes an element of 'strictness' was noted, but providing this was not punitive then this was also seen as a positive feature of the placement:

> *The ward I'm thinking of, the ward sister wouldn't entertain it* [patient care] *any other way. None of the staff would dream of doing it any other way. But she's knowledgeable and motivated and it's just a good atmosphere. And she's not disliked for it, they all have the utmost respect for her.*

Students particularly picked up on the importance that was given to the interpersonal aspects of care, especially when role-modelled by senior staff:

> *I think the leader has got to be interested and then the rest of the staff will be underneath, will be able to talk to the elderly. We were taught how to talk to people when I was there. Some people can't talk to older people.*

The idea of a 'living philosophy' captured in the section above in many ways underpins a Sense of Purpose, which, with respect to older people, is perhaps one of the most critical senses of all.

Having something to aim for: Creating a Sense of Purpose

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

Following the work with the Senses Framework in acute care settings (Davies et al 1999), a Sense of Purpose for qualified staff was defined as *'a sense of therapeutic direction, a clear set of goals to which to aspire'.* The student data would support this, as for them purpose meant largely *'having something to aim for'.* This Sense of Purpose was linked to an agreed set of goals both for older people and for students. It is interesting to note that this marks a subtle change in emphasis, where the focus shifts from being primarily on the student and more firmly locates the older person centre stage. Therefore the early Senses of Security and Belonging which students sought referred mainly to their own need to feel safe and to be part of things. At one level this was the overriding 'purpose' of early placements, and was essential in helping students to settle into their role and to begin to explore what it means to be a 'nurse'. As noted above, the best environments created these 'Senses' rapidly, thereby allowing students to shift their focus towards the patients' needs.

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

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

This growing emphasis on the importance of the patient experience was reinforced in the best placement areas, and the relative importance of patient as opposed to student orientation is reflected in the factors seen to enhance a students' Sense of Purpose, especially in relation to older people. These included:

- Patients experiencing individualised care.

- Students being helped to appreciate the 'small things', and encouraged to get to know older people.

- Staff having a passion for their work and being genuine.

- Staff recognising students' learning needs.

Patients experiencing individualised care

The type of care that most impressed students focussed on the older person, rather than the convenience of the ward or the institution. As students' vision of nursing began to mature

they appreciated the efforts staff made to provide individualised care for older people. Students provided several examples of this, often turning on apparently simple things, such as encouraging patients to be independent or providing choices as to the way that their day was structured:

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

> *I worked in an excellent one* [ward]*, if they wanted to stay in bed in the morning then they stayed in bed. They are not rushed out of bed. If they want their breakfast at 1 o'clock they can.*

As students observed care they became increasingly aware of the important difference that apparently small and seemingly insignificant actions could make on the quality of life and quality of care that older people experienced. This reinforced the value students placed on recognising older people as individuals and getting to know them, that had been important to creating an initial Sense of Belonging.

Valuing the 'small things' and getting to know older people

It was during placements, often with the subtle guidance of staff, that students began to appreciate and value the small things, the often seemingly inconsequential interactions that nevertheless enhanced relationships:

> *I have worked in rehabilitation where it was not the same every day but the key was forging relationships with people, therapeutic relationships where you were seeing tiny small goals. Where it is not going to work out that people get better and go home.*

Encouraging older people to engage in meaningful and enjoyable activity now assumed greater importance, whereas in the past this might have been viewed as a role not suitable for nurses to undertake:

> *I was in a place where there were things happening nearly every day. They had the big bingo cards that are easy to see and people could make a mark. It didn't matter what kind of mark. And they'd play cards one day. There was something planned for them nearly everyday. It was so different from the hospital where everybody was just sat in bed.*

Engagement in such activities not only reinforced its importance for students, but also helped them to locate the older person with reference to 'who' they were:

> *But the placement I was on was very much person-centred so there was a lot of positive stuff going on, therapy and stuff like that. They* [older patients] *were looked at as a whole, as people rather than someone who has sort of played their role in society and is no longer any use.*

The realisation that 'small things' could in reality make a big difference, even in the absence of cure or functional recovery, began to dawn on many of the students. It is difficult to capture the almost imperceptible ways in which such a realisation occurred, but the importance of allowing students the space and time to get to know older people cannot be overestimated. For some this had a profound, almost existential effect, not only their perceptions of nursing, but their view on themselves as a person:

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

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

Positive placements rarely just 'happened' but rather reflected a philosophy of care which valued older people, and in which the 'small things' were seen as important and accorded status. Staff on such placements also demonstrated a 'passion' for their work and were perceived by students to be 'genuine' in their commitment to older people.

Staff demonstrating a passion for their work and being genuine in their commitment to older people

Staff demonstrated their passion and genuineness in several differing ways. For example, students were impressed when senior staff had actively chosen to give up work in 'high status' areas to work with older people:

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

Other less tangible ways of staff demonstrating their passion for their work exerted a powerful effect on students. These often turned on day-to-day interactions and the fact that senior staff actually delivered care. Such enthusiasm appeared contagious:

People not just there for a job, but are actually interested in what they are doing.

They were great, they'd show me everything you could think of. The patients were treated brilliantly, an exceptional ward. They probably all cared but they all had this enthusiasm, and there was an urgency about the enthusiasm and everything was done for the patient. You could feel it when you went in, there was an atmosphere on that ward, everyone picked that up, everybody stuck in and there was that kind of urgency and enthusiasm about it.

Her staff were so motivated and enthusiastic and really, really genuine.

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

It is important for this profession that you want to belong to a profession that cares, because you want to do your best.

The sister and ward manager have to be seen to be caring for the elderly patients not just for that patient but for the whole consensus of elderly care.

Students did not necessarily have to agree with everything that the ward could offer to benefit from the enthusiasm of staff:

Even though I sometimes clashed with my mentor, the rapport that she had with some of the people on the ward was brilliant, and she was no spring chicken but every day she was fascinated by each person. And she would point it out to me. Every day she was enthusiastic about what she was doing.

However, it was not just patient related factors that influenced students' Sense of Purpose, as they also had learning needs of their own to consider, and they valued placements that gave these some priority.

Staff recognising students' learning needs

As students attained a Sense of Security and Belonging their focus shifted more towards the concerns of the patients, but participants still indicated that they wanted to be seen as an important part of the 'ward team' (part of belonging). One way in which this could be achieved was by having a clear Sense of Purpose, that is knowing what their role was, and by staff recognising and giving some priority to students' learning needs. This could be enhanced in several ways and, as noted earlier, students particularly appreciated it when they were not simply seen as a 'pair of hands' and where, despite staff shortages or other potential constraints, ward staff attended to their learning needs:

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

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

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

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

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

At a point further down the line students wanted to be able to demonstrate their growing skills, and part of feeling secure was to work in an environment where challenge was not just

permitted but also encouraged. In some of the better environments students were able to question practice, and this added a further layer to their Sense of Purpose:

> *But I did try and do it in a nice way you know. I made the sister actually come and look at his bottom, and she looked and she couldn't deny the fact that he was red. She said 'we have been putting cream on' and I said that research would say it's the worst thing to put on his bottom.*

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

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

- Feeling frustrated, feeling annoyed

- Feeling exploited

- Feeling shocked at the lack of resources

- Feeling undermined, annoyed and confused

- Feeling sidelined and unsupported

- Dreading it

- Feeling intimidated and confused

- Feeling as though you are wasting your time, wondering what is the point

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

- Staff not treating older people as individuals

- Staff being disenchanted and complacent about their care

- Staff not understanding what was expected of students

Staff not treating older people as individuals

Just as students witnessed staff respecting the vulnerability of older people in the better placement areas, those that were relatively more impoverished failed to recognise and support the needs of older patients. This often involved people being given limited choice, and being denied what students began to see as basic freedoms:

> *And they said, when he asked if he could go to his room, no it's not time yet. Well it's supposed to be his home, he should be able to go to his room. It was the same with*

> *the man that wanted to go for a smoke, they were always putting him off, it didn't stop them though, when they wanted to go for one. The nurse in charge just ignored it.*

By reducing patient choice, even in the most mundane aspects of life, students increasingly felt that staff were fostering dependence in older people, and described incidences of infantilisation:

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

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

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

The ability of staff to discern the needs of older people impressed students on the more enriched placements, but was notably absent in the poorer areas. Just as students believed that staff in the former areas demonstrated their commitment and enthusiasm by the passion and genuineness they displayed towards their work, in the poorer areas students felt that staff had become disenchanted and complacent.

Staff being disenchanted and complacent about their care

If students were to experience a Sense of Purpose on their placements it was important that staff conveyed their own Sense of Purpose to students. However, it seemed that in many cases this did not happen:

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

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

> *Basically they* [physiotherapists and occupational therapists] *were doing all this work in the rehab of the elderly but then the nurses hadn't the time or the knowledge to do it. Sometimes they did just not want to do it, you know. The physio would come and show someone what to do, and once that was documented that's fine. But the thing that I found quite a lot of was nurses were writing 'care as planned' in the care plans and when you query it they say 'well its as planned'. But it has not been done, it's been said, it's been documented but it hasn't actually been implemented, which to us you shouldn't do.*

This lack of direction and enthusiasm in some practice areas reinforced the impression that working with older people had low status, confirming the suspicions of some students that it required little skill. Some informants therefore talked of 'elderly wards' as being *'the end of the line'* or *'holding bays',* and of caring for people with dementia as *'baby-sitting'.* Others, however, pointed to a lack of shared understanding and philosophy between staff and

students in relation to the care of older people. Focus group participants gave a variety of examples of this, such as staff not considering talking to patients as legitimate work, and students being concerned about the lack of support for family members and carers.

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

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

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

In such circumstances students struggled to develop or maintain their own Sense of Purpose, especially if staff did not understand what was expected of students. It was then difficult for them to maintain their motivation, or to see the point of the placement.

Staff not understanding what was expected of students

As noted earlier, in many respects a perceived Sense of Purpose for students was increasingly related to the quality of patient care that they witnessed. However, ensuring that students' own learning needs were recognised and addressed was also a key feature of better placement areas. The reverse was the case in impoverished environments, where it seemed that staff has little understanding of what students were expected to achieve on the placement:

> *We will have one session in school on any basic skill like moving and handling or blood pressure, or whatever we are expecting to be learning and practising in clinical areas, and they are supposed to be teaching us too and I get the impression that some people don't appreciate that. They think student nurses sort of come out pre-packaged knowing everything we are supposed to do on their placement and it is not like that.*

Some mentors often had little enthusiasm for their role and, although promises were made to students, these were sometimes not met:

> *She* [mentor] *just wasn't keen, she just really wasn't keen. She didn't want to share the information, she didn't want to let me so anything. I had to like stand there and watch. She would maybe let me serve the dinner if I was good* [laughter].

In such environments students were not encouraged to demonstrate their knowledge and understanding, and when they tried to this was frequently ignored:

> *They only had those little pink* [mouth wash] *tablets and we were told* [in school], *research has shown that they were stripping the lining of the mouth and what have you. So I said I don't think they are recommended any more. We just have to use water. Well I just felt that he almost didn't really care. It wasn't really that important to him. I*

> *felt it was important.*

In marked contrast to the positive learning environments, where the ward leader was seen to set the example, the failure to encourage students to contribute to the work of the ward was attributed to poor leadership and associated with an overall lack of a learning culture for all staff:

> *Yes, but we went with our ideas and things like that and they didn't want to know. It's the management.*

Paradoxically, in such instances students could see it as their role to try and ensure that basic standards of care were maintained:

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

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

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

Students used a number of tactics of 'placement management', such as trying to fit in, using humour to change practice, getting to know staff, and learning how to approach them in order to achieve their goals. These tactics related both to their needs as students, but importantly as students matured, also to the needs of older people. However, despite their best efforts, students sometimes found it difficult to change things and this could reinforce the futility of work in some environments. When informants felt that their management techniques were failing they resorted to more radical measures such as going off sick, or refusing to go back to an unsatisfactory placement.

The idea of 'placement management' is closely linked to a Sense of Purpose on a number of levels. In the best areas students had no need to resort to such measures, as staff were aware of their needs and the placement was structured, not only to ensure that their clinical objectives were met, but importantly that students were exposed to positive and affirming experiences of work with older people. In the worse case scenario 'placement management' was a matter of survival, with students directing their efforts to meeting their course

objectives with the least difficulty and disruption so that, at a minimum, they 'achieved' the required objectives. This was essential to pass the programme, but little else could be achieved in the 'impoverished environments' to which some students were exposed. However, at the opposite end of the continuum some students were able to achieve so much more and it is how to create such a Sense of Achievement that is now considered.

'Am I getting anywhere?': Experiencing a Sense of Achievement

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

However, this scenario was certainly not the 'norm', and most students tended to be able to 'manage' their training, much in the way that they 'manage' their placements, by qualifying, developing and maintaining their own 'standards'. However, it is the influence that their training has on these standards that is important and, particularly with respect to older people, whether their training created and sustained a positive perception of such work, or reinforced an existing negative one. Experiencing a Sense of Achievement was important if students were to develop a broader conception of what it meant to 'be a nurse', and in this regard a Sense of Achievement can be defined as:

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

At the most basic level achievement was related to 'passing the course'.

Passing the course

For many students, particularly those who had little prior experience of studying, or for whom the academic component proved challenging, their main goal was simply to 'pass the course':

> *I think the academic side of it. Me coming in as a mature student with a family, my basic study skills were not perhaps what younger peoples would have been. For me to pass all my assignments, that has been a real sense of achievement for me. That is something I have built on and developed.*

The sense of personal achievement that many students got from proving themselves in the above manner was significant, and helped to enhance their confidence and self-esteem. However, in the final analysis one of the key dimensions of achievement for students was to

feel good about themselves in relation to what they had done, and to perceive that they had actually *'made a difference'* to the care they provided.

Making a difference

The data from the survey phase of the AGEIN project (see earlier and Nolan et al 2002) had indicated the significance students placed on being able to 'make a difference' to the lives of older people because of the care that they were involved in providing. This was reinforced by the focus groups and the placement visits, with students believing that they could personally make a difference, often despite the system. Sometimes this involved an element of personal sacrifice on the part of the individual student. The quotes below reflect these sentiments:

> *I feel that I can make a difference. I have made a difference so far with quite a few peoples' lives. Yeah, some people do say that to me 'what's the point because you are just one person'. But at the end of the day I say I could be that person one day, trying to educate thousands of other people, which is what they need.*

> *I used to go there* [a nursing home where she had previously been employed as a care assistant] *on my weekends off to do a music group with the residents, who would choose the music that we would play. I was absolutely shattered after working two nights with no sleep in between, but it's really good because the patients were benefiting from it. It was absolutely brilliant.*

Despite being exposed to often poor standards of care, or scepticism from others, the above quotes suggest that some students maintained the belief that their efforts could really 'make a difference'. The feeling that you could make a difference was more readily created and sustained in more enriched care environments, and experience of a good placement could help to 'inspire' students:

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

Several factors contributed to students finding placements 'inspiring', and these included:

- Older people receiving high standards of care, delivered by knowledgeable staff

- Students having their contribution acknowledged

- Staff sharing their knowledge with students

Older people receiving high standards of care, delivered by knowledgeable staff

Not surprisingly inspiring placements were the antithesis of the impoverished environment, and where areas in which older people received the highest standards of care, delivered by knowledgeable and skilled staff who themselves got a Sense of Achievement from their work that they communicated to students:

> *Apart from that the care they got was fantastic. The bell would go and they would be there like that. Feeding, which to me is so important, they were on the ball with that, it was as and when* [they wanted]. *I don't know… the autonomy was there… they were dressed, they weren't left in the bed or anything like that. They had choice, which is so important.*

Students generally recognised that such work was never easy, with the notion of 'hard but rewarding' being very much to the fore, underpinned, as noted above, by the belief that you could indeed 'make a difference'. For example, seeing an older person achieve something when the student had been involved in their care and being able to challenge and influence care made students feel *'trusted'* and *'satisfied'*.

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

From comments such as these it was apparent that such achievements were intrinsically rewarding. However, they also helped to cement students' feelings of making a positive contribution, especially when their contribution was recognised by other staff, patients and their relatives.

Having your contribution recognised by others, and staff sharing their knowledge

Although the intrinsic rewards of delivering good care were sufficient for some students, having their contribution acknowledged by others further enabled students to feel good about themselves, not in an egotistical or self-centred way, but rather because of more altruistic concerns. Having your contribution recognised did not necessarily require overt thanks, with the reactions of patients with dementia being seen as particularly satisfying:

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

In addition to the subtle form of recognition captured above, students also valued their efforts being appreciated by colleagues, particularly support workers with whom they had worked closely, and also patients' families:

> *The auxiliaries were very, very keen to involve me in everything they do, and ask my opinion on what not.*

> *Patients' families as well, when they come up and thank you for what you have done, because it shows that you have been noticed, not just by the ward.*

As important as the above factors were in enhancing a students' Sense of Achievement, it was when qualified staff sought their opinion that students really began to feel like a fledgling nurse:

> *I do. As you go on yes. They* [staff] *sort of talk to you and tell you everything that is going on, asking you what you think of the patients.*

Another way of acknowledging the importance of students, and making them feel that they were contributing was by staff sharing their knowledge with students, and making them feel that their learning was important:

> *She was there no matter what she was doing, she will explain it to you. She will get a sister to help to do things, explain exactly what she is doing, why they are doing it step by step. She gave us research, so we learned how to analyse patients.*

The subtle ways in which the Senses interact in order to help students gain a Sense of Achievement is eloquently captured in the following quote. Here the student describes a 'brilliant' placement where a Sense of Belonging and Achievement combine seamlessly to ensure that the student did not want to leave:

> *I had a brilliant placement for 8 weeks, it went so quick. You don't want to leave. You were made to feel really welcome, you were given some responsibility, you were given some power over what you were doing yourself with the clients and it was like they respect me, they can see how far my training is and how developed it is. So you managed to feel like you had achieved with a client and within the team. You feel as if you had achieved something here and that again comes back to belonging because it makes you feel like you belong.*

Whatever its source, a Sense of Achievement resulted in a range of positive outcomes with students feeling that they could contribute in a meaningful way, that they liked working with older people, and could see the work as rewarding, although it was often still described as being hard. Those students who had very strong feelings of achievement often used words such as *'amazing'* or *'inspiring'* to capture their experience. However, as with all the other Senses, Achievement was by no means universal and two factors in particular inhibited or reduced students' feelings of being able to achieve, these were:

■ Exposure to poor standards of care

■ The lack of a learning culture on the wards

Exposure to poor standards of care

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

> *I was on the outpatient clinics and I found that the elderly had early appointments and they* [staff] *knew full well that they would be waiting for ambulances. The appointments would be at 10:00 and they still hadn't been seen by 12:30 the ambulance would come at 11:45 and they wouldn't wait. So you had to rebook it and then they are sitting there till 6:00 at night, they are sitting in the wheelchairs and have no food … They only usually see to people who are diabetic, there isn't enough nursing staff to go out to the area to check on them. They are just left there. You find they start to get upset. Especially if it's their first appointment they think they have been forgotten. It's only when the clinics have closed that they say 'oh you're still here'.*

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

> *They were waking these old ladies up at sometimes 5 o'clock in the morning to get a*

> *percentage of them up and dressed and wheeled in front of the television in the lounge. I was so horrified I haven't worked in elderly care since.*

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

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

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

Some students attempted to change things, even if they were only on placement for a very short period of time:

> *I asked the sister, the ward sister, don't they have cushions, so she said 'yes'. I said well none of them are sitting on cushions. So anyway, I went into this room and there was a room full of cushions. I mean they were all filthy! I got about four out and I had to wipe them all down and I put these patients on cushions. They were a bit against me doing it because they have always sat in the chair like that and I said well I am only here a week, let's see if there is any improvement with them for a week.*

As noted earlier, in the better learning environments students' efforts to change things were encouraged and they felt enabled to challenge the status quo. Unfortunately in poorer placements the opposite occurred and there was seen to be a lack of a learning culture in the unit.

Absence of a learning culture

The other main aspect of the ward environment that reduced a Sense of Achievement was when there was no culture of learning for the qualified staff or others on the ward. Most of the better learning environments for students also created opportunities for all staff on the ward to develop and grow. Where this was absent then students felt that they had little to learn from the ward, but at the same time could not demonstrate their own knowledge for fear of being seen as a threat to the staff on the unit. Conversely, others felt that they brought new insights to the ward and that the presence of students helped to maintain standards:

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

However, the lack of a student-centred culture on the wards was often reflected by the fact

that staff had little appreciation of what the students learned or how they could be helped to get the most from their placement. Although the following example does not relate to older people, it nevertheless highlights the difficulties that many students faced:

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

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

A Sense of Significance: 'Do I matter?'

For students a Sense of Significance existed at several levels, not only relating to quality of care. Therefore, although the need to give good care was central to a Sense of Purpose and Achievement, and figured prominently in terms of creating a Sense of Significance, for most students the primary need, especially at the start of their training, was for them to feel that **they** mattered. That is, that they were not viewed simply as a pair of hands but as individuals with needs and expectations of their own. Feeling significant hinged largely on students being made to feel that they had a valued contribution to make to the ward, rather than just being seen as a drain on ward resources. Students themselves need to feel *'cared for'* and *'valued'*. Without this it was difficult for them to feel significant:

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

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

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

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

- Feeling the staff are interested in you

- Feeling cared for

- Getting a buzz

- Feeling you have something to offer the staff

- It feels fantastic

- Feeling noticed by relatives

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

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

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

In many respects, therefore, a Sense of Significance arose from a combination of all the other Senses interacting in such a way as to create and maintain the belief that what students did 'mattered'. It is difficult, if not impossible, to divorce this from the feeling that older people matter, as do the staff who work with them. This reinforces the reciprocal and dynamic way that the Senses interact. However, the major factors seeming to enhance or diminish a Sense of Significance, and hence create an enriched or impoverished environment were:

- Attitudes towards older people

- Whether students felt valued

- Whether work with older people was valued

Attitudes towards older people

The survey data from the AGEIN project indicated that students often felt exposed to ageism in their training and work with older people in an extra-curricular context (see earlier and Nolan et al 2002). This was also evident in the focus group and placement visit data.

Students cited several examples of ageism that they had encountered, some demonstrated by society as a whole, some evident in the environments in which they had worked with older people, and some held by the staff with whom they worked:

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

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

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

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

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

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

Although such sentiments were not reinforced within the academic component of the course, the fact that students often considered that those elements relating to older people were 'tagged on' to other sessions, almost as an afterthought, did little to directly counter or reverse negative perceptions. Indeed recent work (McLafferty and Morrison 2004) has even suggested that the theoretical component of training programmes might perpetuate the negative stereotype that older people face inevitable decline, with there being no real therapeutic purpose in working with them.

Exposure to negative attitudes towards older people were therefore a major factor reducing a student's Sense of Significance. This could be compounded when students themselves did not feel valued.

Are students valued?

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

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

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

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

Is work with older people valued?

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

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

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

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

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

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

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

The detailed case studies demonstrated the relevance of the Senses to a better understanding of a positive learning experience for students, and also to the creation of an enriched environment. This is discussed more fully, and related to the concept of relationship-centred care later. Before that, however, attention is briefly turned to the way that student experienced the Senses rather differently over time, and how a number of different 'foci' of students' attention were identified.

Mapping the Senses over time

As the data analysis progressed and students' views were sought in an iterative way, it became clear that the Senses, whilst all important, might be more or less to the fore at differing points in the students' training. This first came to light amongst students who were nearing qualification. Here, the Senses of Security and Belonging become paramount once again. Therefore largely irrespective of which client group students wanted to work with upon qualification, a Sense of Security and a Sense of Belonging became important elements of the students' psyche as qualification neared. Several students therefore opted to seek employment in areas where they had a prior positive experience, and felt that they belonged and would feel safe as a newly qualified practitioner:

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

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

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

The varying importance of the differing Senses as students progressed through their training prompted a re-analysis of data to see if it were possible to identify a temporal framework that might help to explain the way that students develop both a concept of ageing, and the knowledge, skills and attitudes needed to work with older people (see Brown 2006 for a more detailed description).

The foci

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

■ Self as focus

■ Course as focus

■ Professional care as focus

■ Patient as focus

■ Person as focus.

Self as focus

Self as focus is pre-eminent during the early stages of training and reflects students' needs to adapt to the new environment in which they find themselves. At this time a Sense of Security and a Sense of Belonging are therefore to the fore. Students are forging relationships and need to begin to feel 'a part' of something and to 'find their feet'. This applies both to the university context and to the clinical environment. Initially the university is the main focus and, as noted earlier, there are numerous barriers to student nurses feeling that they 'belong' in the university as a whole. Their main allegiance therefore is towards fellow nursing students, particularly those in the branch of which they are part. This feeling of branch affiliation is evident throughout the first year of the nursing course, known as the common foundation programme (CFP) when students studying all branches are taught together, and is reinforced as students move to their own branch programme.

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

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

Course as focus

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

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

Therefore, even though they might feel relatively secure in terms of their relationships with peers, the course itself posed a threat for several, and their Sense of Purpose and

Achievement was defined largely in terms of needing to pass assignments. For some this remained an overriding concern throughout their training.

Professional care as focus

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

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

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

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

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

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

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

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

Patient as focus

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

feeling that you can make a difference is one of the main sources of job satisfaction and reward in nursing. In its absence the significance of nursing is diminished. At an intuitive level, therefore, the patient is always the driving force behind good care.

However, the patient as focus for students was is still largely rooted in a biomedical view of nursing, in which cure or restoration of function are the overriding aims. For example, students feel the need to understand how to care for the patient with a myocardial infarction, or an insulin-dependent diabetic with an infection. Of course this is appropriate in many instances, but, as was discussed in some detail earlier, for a growing number of older people such a vision of 'success' condemns as failures those who cannot meet such criteria. Moreover, even within a curative, acute environment, good care can only become excellent care when a wider view is adopted, that locates the person outside their condition and views them in the context of their broader life (Davies et al 1999). This is particularly relevant to the care of older people, and students who were most likely to work in this area developed a growing sense that patient as focus was not sufficient.

Person as focus

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

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

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

Interestingly, our data also suggest that as they neared qualification students tend to revert, temporarily at least, to self as focus, and needed to feel secure and that they belonged in their new role as qualified nurse if they are to deliver good care as rapidly as possible (see Table 8).

Achieving person as focus

It is important to reiterate at this point that, in proposing these five foci and their temporal sequencing, that we do not see them as being discrete, nor is each one entirely superseded as the next focus emerges. Indeed, it is suggested that all the foci will continue to exert an influence and will resurface in various combinations over time. Furthermore, it is not suggested that they operate in a simple linear fashion, nor even that they are necessary or sufficient conditions for a given individual to realise person as focus. There are undoubtedly individuals who, despite exposure to impoverished environments, will still wish to go on and work with older people and will develop a concept of care based on the person as focus. Conversely, there will be those who experience only positive care environments but who may

never grasp the subtle factors that help promote a person as focus approach to care.

What is proposed, however, is that the various foci, when interpreted relative to the Senses and considered longitudinally over time, provide a very useful device through which to begin better to understand the various factors likely to influence the emergence of person as focus

Figure 2: Influence of the Senses on student focus
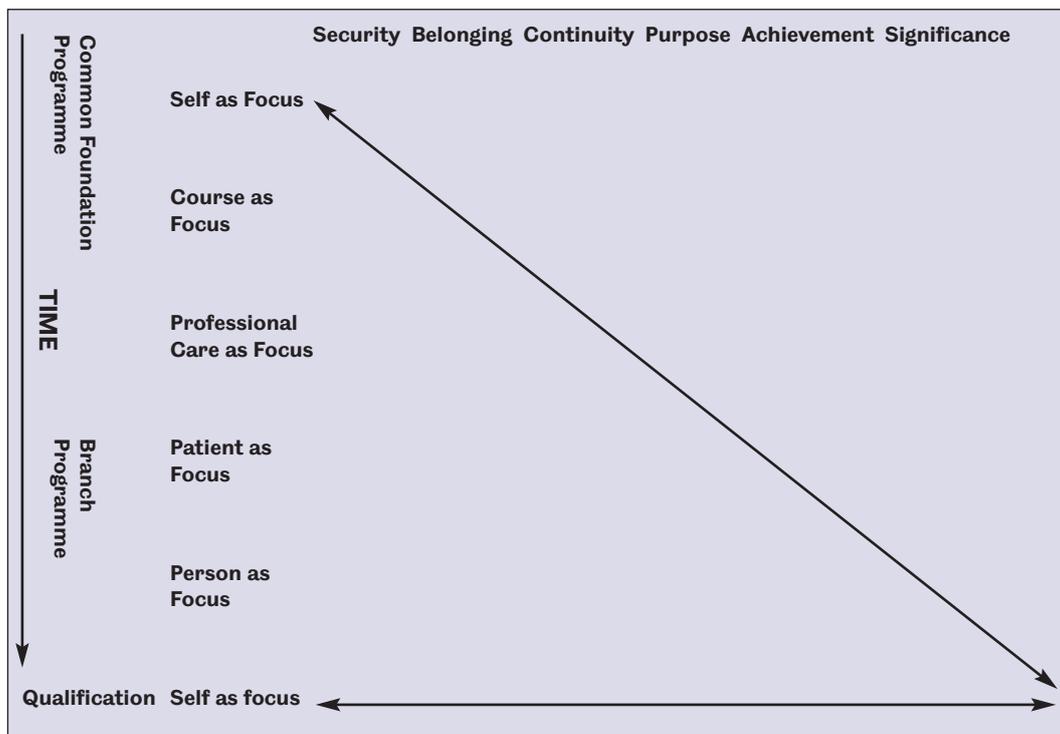
Table 8: Students' change of focus over time

TIME		
Self as focus	This is dominant during the early part of the programme or placement as students strive to establish relationships and feel part of both the university and the placement areas. Experiencing a Sense of Security and Belonging are most important at this time.	
Course as focus	As time passes students have to adapt to the demands of the course. Many are surprised at the amount of academic work required and struggle if they have not studied at this level before, or for some time. Their Sense of Purpose and Achievement is dominated by the need to 'pass the course'. For some this remains their prime concern throughout their training. Learning objectives exert a similar influence during individual placements.	
Professional care as focus	As placements become more frequent and longer, students compare their initial vision of 'good care' with that experienced on the wards. Their notions of care evolve and students begin to challenge poor care, particularly in 'enriched' environments where they feel 'safe' to do so. Continued exposure to 'impoverished' environments can lead to disillusionment with nursing, or a given field of practice, often care of older people.	
Patient as focus	Students develop a largely biomedical, hi-tech vision of nursing, reinforced by the taught content of the programme, and what is seen as being high status in clinical areas. Understanding signs, symptoms and syndromes become the main focus for students' Sense of Purpose, Achievement and Significance. If reinforced this remains the dominant value that students hold as they qualify.	
Person as focus	In 'enriched' environments, where high quality person-centred care is provided, students begin to appreciate the value of seemingly small and inconsequential actions that can really 'make a difference'. If these are reinforced then they become incorporated into the students' maturing vision of what nursing is about.	
Self as focus	As students qualify and move into their first post, 'self as focus' becomes central again, and they need to feel secure and that they belong in their new role before they can develop further.	

(Adapted from Nolan et al 2002, Brown 2006)
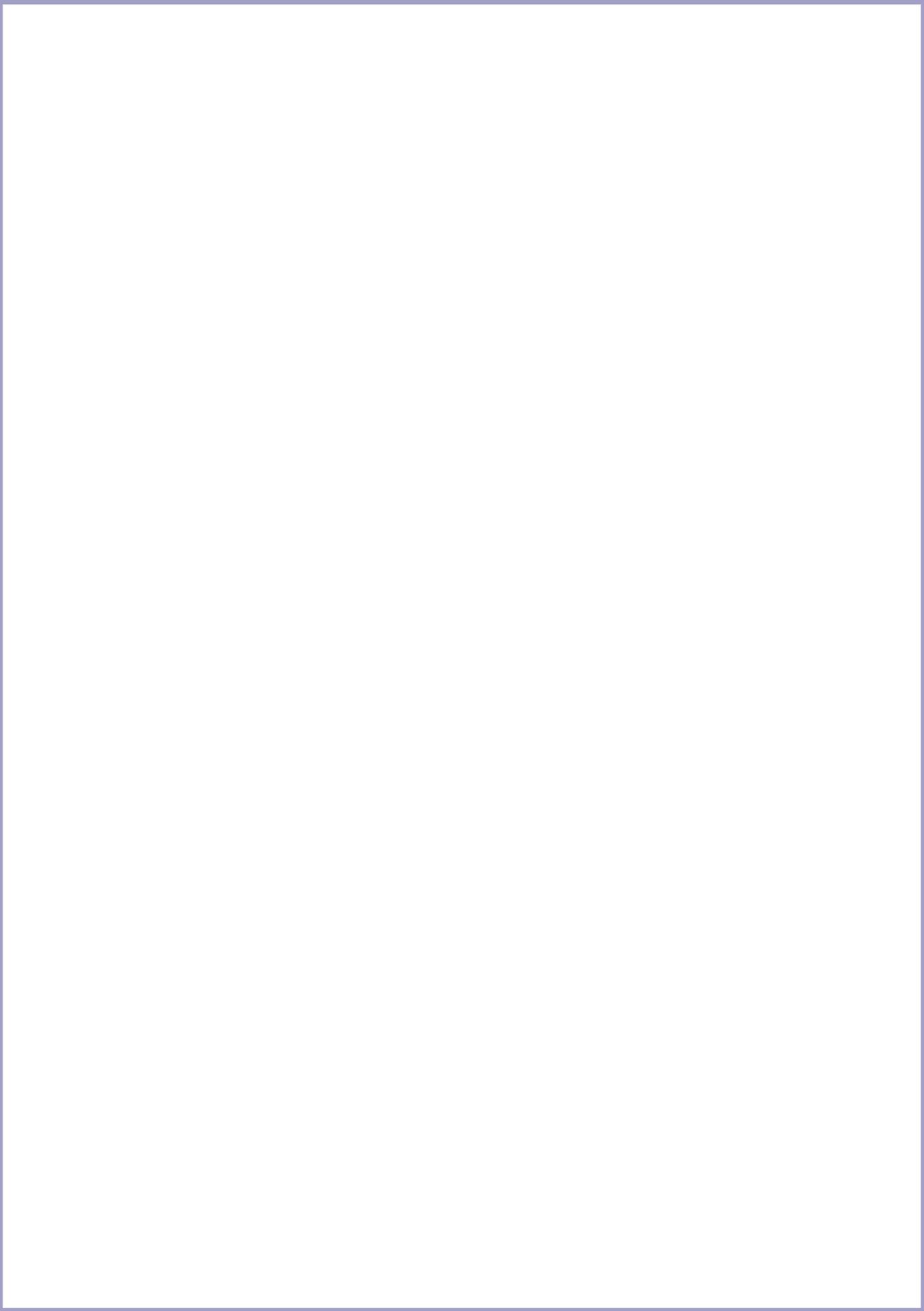
MAKING THE SEEMINGLY INSIGNIFICANT SIGNIFICANT: ESTABLISHING THE RELEVANCE OF THE SENSES TO OTHER GROUPS

The extensive synthesis of the literature that we undertook at the start of the AGEIN project allowed us to elaborate upon and further refine the original Senses Framework, and to consider its relevance with regard to both the recent theoretical literature on the needs of older people and family carers, and a number of studies that had directly sought the views of older people themselves. As we discussed earlier, we were fortunate in that during the initial stages of AGEIN several of us were also involved in a separate study 'Dignity on the Ward' (Davies et al 1999). This allowed us to explore the relevance of the Senses to several key groups of people (older people, qualified staff from a variety of disciplines, and family carers). This study provided strong empirical support for the Senses, as well as allowing us to identify a number of factors that helped to create the Senses within an acute hospital setting.

The results from the AGEIN project also gave us confidence that the Senses illuminate important dimensions of the students' clinical placements and provide markers that help to differentiate between what we have called 'enriched' as opposed to 'impoverished' environments of care (see Nolan et al 2002, Brown 2006). However, we also considered it essential to 'test out' our understanding of the Senses on other groups of staff, family carers and, where possible, older people themselves.

It was therefore decided to hold a series of 'consensus workshops' with the aim of presenting the Senses as they were currently understood to participants and inviting critical comment using a participative style in an effort to achieve a shared understanding. Those attending the workshops were not viewed as research 'subjects' but rather as 'experts' in their own right. They therefore had an important contribution to make both in determining if the Senses were 'relevant' and in elaborating further upon their dimensions.

Suitable participants were identified using a variety of means, some planned, others occurring more by chance. The main workshops were organised either using contacts in the case study areas where good links had been forged with key clinicians, or by identifying individuals who had volunteered following 'expert' study days for clinicians working with older people organised by the ENB. The AGEIN workshops involved either established groups, or individuals who were previously unknown to each other.

Eventually seven workshops were organised as follows:

- Workshop one – involved 11 participants from community or community hospital settings and, in addition to clinical staff, comprised operational managers, staff development personnel, and a social worker.

- Workshop two – comprised a range of staff from a hospital providing rehabilitation for older people. The hospital in question was shortly to be amalgamated with a larger DGH and was reappraising its philosophy of care in preparation for the move. Participants at this workshop included the senior nurse manager, a consultant physician and 12 clinical staff from senior ward sisters through to nursing auxiliaries.

- Workshop three – focussed on older people with mental health problems and brought together a multi-disciplinary team providing a range of services. Included in the nine participants were

managers and clinicians from nursing backgrounds, a research/audit nurse, and a head of OT services.

- Workshop four – again concentrated on mental health services within an established team who provided in-patient and day hospital facilities, as well as community based services. Nineteen people attended this workshop spanning a range of personnel from a Consultant in Old Age Psychiatry to nursing auxiliaries (5). In addition to clinical nurses and their managers, an occupational therapist also attended.

- Workshop five – was smaller and comprised a consultant nurse for older people and three experienced ward sisters in acute/intermediate care settings. This differed somewhat in format from the others, resembling a focus group interview rather than a workshop.

The above meetings were all organised specifically for the AGEIN project. The final two events were more fortuitous and workshops were 'bolted on' to other organised activities.

- Workshop six – was organised as part of a more general study day attended by 42 people from the private sector. Attendees ranged from nursing assistants/care assistants through second and first level nurses to managers and owners. Approximately a third were care assistants.

- Workshop seven – was a part of a national conference organised by 'Help the Aged', when the Senses were explored with a group of some 80 attendees, including not only older people, but also lay and professional carers. The latter were from a diverse multi-disciplinary background.

The first four workshops all followed a similar format but varied in length, with the first two lasting an afternoon, the third a morning and the fourth being held over an extended lunch hour. The first two were organised on consecutive days followed by a gap of time before the second two. During the intervening period amendments were made to the Senses based on the feedback from the first two workshops, so that the second set of participants commented on an elaborated set of Senses. The second round of workshops also followed on consecutive days and once again the Senses were amended in light of the comments received.

Each workshop began with a brief presentation by members of the project team (2 members went to each of the first four workshops) in which the aims of the AGEIN study were outlined and the work to date described. It was explained to the participants that they had been invited as 'critical friends' with acknowledged expertise in the care of older people and that we wanted an honest appraisal of the potential value of the Senses.

In order to stimulate discussion the workshop participants were divided into small groups and each group was asked to consider a complete 'set' of Senses relating to one of three interest groups: older people; staff and family carers. Each group of participants was then asked to address three issues:

- Did they feel that the Senses were relevant and that they reflected important aspects of care?

- Did the definition of each Sense 'speak' to them, that is, was it easily understandable and was the definition written in an appropriate language?

■ Were there any glaring omissions, either within any of the Senses, or were there important areas that the Senses did not cover?

Participants were given a sheet with the definition of each Sense for the three interest groups, although groups were asked to focus on only one of these. Alongside each definition was space in which to record their discussions, both to help structure feedback and to provide a written record for the project team to aid their analysis. An example of the worksheet for a Sense of Security is given below.

A Sense of Security

For older people Skilled attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort. To receive competent and sensitive care in an environment that is supportive but accepts risk.	
For staff To feel free from physical threat, rebuke or censure. To have secure conditions of employment. To have the emotional and physical demands of work recognised and to work within a supportive but challenging culture.	
For family carers To have the knowledge and ability to provide good care without detriment to personal well being. To have adequate support networks and timely help when required. To be able to give up care when appropriate.	

This format worked extremely well and generated lively discussion, following which each of the Senses was considered in turn, with feedback provided by the three groups who had respectively considered the Senses in relation to older people, staff and family carers. Discussion and feedback was tape-recorded for later analyses but also noted on flip charts, providing participants with an overview of the unfolding discussion.

Overall there was very strong endorsement for the Senses, which were seen as highly relevant to each of the three stakeholder groups. The level of enthusiasm was obvious from the rich discussion that occurred. However, the groups thought that the language used to describe the Senses was a bit 'heavy going' in places, especially for older people and their carers. Some 'fine tuning' was therefore suggested, as were subtle changes in emphasis, and some additions to the definitions. For example, it was generally agreed that some of the longer definitions would

be more useful if they were presented in 'bullet point' form and that they would be more user friendly if they were personalised, so that the definitions were in the first person rather than the third person. All of these points were recorded and noted by the project team.

Following discussions about the Senses themselves attention was turned to factors that would either facilitate or inhibit them. This too generated lively debate and provided much useful data.

We were greatly encouraged by the first two workshops, especially the enthusiastic way in which the participants contributed and 'warmed' to the Senses. This feeling was reinforced a week later when a totally unsolicited set of comments were received from the participants at one of the workshops. These are reproduced below in verbatim but anonymised form:

'A very helpful afternoon – having an insight into the Senses which will be the building blocks of our care. I was very impressed how they valued our comments.'

Staff Nurse

'Very enthusing – I wish I could have involved more of my team (not a criticism – more a 'wish list'). I will be looking at ways of incorporating the Senses and some of the issues raised into the ward. Thanks for inviting us.'

Sister

'Well presented workshop. Discussion was very useful in present climate. Found the afternoon helped us to evaluate our – the patients and their relatives' situations. Most importantly, made us feel part of a professional team. Thanks for inviting us – we would welcome any feedback.'

Staff Nurse

'A very interesting afternoon which gave a lot of insight into the understanding that exists in care of older people. Also the very valuable research that is underway, that will contribute to future improvements and future developments in giving a higher profile and awareness. An excellent presentation.'

Sister

'I was fascinated by all the research that has taken place. I am sure that it will be very valuable to the future of elderly care. I feel very privileged to have been invited to such an interesting afternoon.'

Nursing Auxiliary

'A fascinating insight into research. Very well presented. Looking forward to reading the final Senses.'

Staff Nurse

'An excellent forum for professional carers to discuss differing viewpoints. I have much to bring to the ward/staff.'

Sister

'A really good afternoon about research in this area and growing understanding – much to learn from and pass on.'

Staff Nurse

'An interesting afternoon. Looking forward to follow-up information.'

Staff Nurse

'I found the afternoon useful and was pleased that we were asked to attend. It showed that our feelings, points of view and opinions were recognised within the care of the older person.'

<div align="right">Deputy Sister</div>

Following a detailed consideration of the responses from the first two workshops amendments were made to the Senses to reflect our discussions and to provide the focus for the second round of workshops.

Up to this point the Senses Framework had been commented upon by practitioners providing care for older people with primarily physical health needs or problems. Following the first round of workshops it was felt important that the relevance of the Senses for practitioners working with older people with mental health problems were explored further. This was the focus of the next two workshops, which comprised very experienced and varied groups, involving established multi-disciplinary teams. One of these teams had been identified by students as providing an excellent learning environment, and the other had a high national profile and was widely regarded as a centre of excellence.

These two workshops followed a broadly similar format to the first pair, with the Senses being considered in small groups or pairs, with the same three questions being used to stimulate discussion:

- Do the Senses reflect important/potentially important areas of care?

- Does the definition 'grab' you, and it is written in a way that people would understand and relate to?

- Are there any major omissions, both within the Senses themselves or any broad areas that the Senses no not address?

The discussion at both events is best described as 'animated' and the Senses were seen as highly relevant to the care of older people with mental health problems, capturing important dimensions of care for all three sets of stakeholders (older people, staff and family carers). Comments such as: *'the Senses could help us to celebrate success'*; *'they can help us to define best care'*; *'they make the seemingly insignificant significant'* mirror the feelings from both workshops that the Senses provided a means of highlighting important, but often taken-for-granted, aspects of care that underpinned such notions as person-centred care. This was considered to be particularly important given the current onus on evidence-based care, which participants felt often ignored subtle and dynamic but less visible elements of care.

Both groups believed that the Senses were implicit within their existing philosophy of care but that the framework helped to make their contribution more explicit. The ways in which the Senses resonated with participants can be seen in comments such as:

'I feel a connectedness to these.'

'I can identify with this (Senses Framework) as it relates closely to my practice.'

'They highlight what gets lost in evidence-based care.'

In many respects the groups did not see the Senses as 'revolutionary' but, and perhaps more importantly, felt that they helped to highlight sometimes unspoken or poorly articulated areas of care. They were considered to raise awareness of the needs of older people with mental

health problems and their carers, and also to provide a means of identifying and potentially reconciling differing perspectives. For example, one of the groups suggested that they could form *'the bridge between health and social care'*. Significantly, much of the discussion focussed around the value of the Senses for staff themselves, with both groups believing that they could provide a means of overcoming the prevalent *'NHS blame culture'* by helping staff to *'feel good about what we do'*.

The revised definitions of the Senses attracted fewer comments, but again participants believed that they would benefit from being personalised yet further. Participants were explicitly asked if they felt that there was a need for a separate set of Senses to reflect the needs of older people with mental health problems, but this suggestion was strongly rejected.

Once again, therefore, the Senses themselves were soundly endorsed, with the latter two workshops paying rather more attention as to how they might be achieved. This was followed up in the next two workshops, one a small group comprising just 4 participants, the other with 42 individuals from the private sector. This latter workshop was especially productive, as in contrast to the earlier workshops participants were also asked to reflect upon the Senses as they relate to students. The results of this very profitable discussion gave specific attention as to how the Senses might be created in the context of continuing care environments. These discussions are captured in the following pages, which distil the various ways in which participants felt that the Senses could be facilitated or enhanced.

Factors Creating a Sense of Security

For older people

- Staff being aware of your life story so that they really know you

- Effective communication

- Introducing all staff so that you know who is who

- Encouraging visitors/people who know you really well, to be involved in your care

- Encouraging residents to bring in their own possessions – again to create a sense of familiarity

- Rearranging furniture if necessary

- Comprehensive assessment of needs on admission, including risk assessment

- Ongoing assessment and evaluation

- Allocation of key workers

NB We do not always allow individuals to take appropriate risks due to legalities and possible recrimination

For family carers

- Approachable teams/management

- Effective communication

- Feeling safe to complain without fear of recrimination

- Keeping appropriate people informed

- Advocacy

- Involving the multi-disciplinary team

- Staff being able to mediate between patients without taking sides

- Keep relatives informed of changes in care plan

For staff

- Effective teamwork and communication

- Effective leadership

- Accurate record-keeping

- Mutual respect – knowing you will be respected as an individual

- Appropriate staffing levels

- Adequate human and mechanical resources

- Training

- Open and approachable management

- Flattened management system

- Confidentiality

- Up to date records

- Compassion and understanding

For students

- Appoint a mentor

- Treat the student as an individual

- Clear aims and objectives

- Informing all staff of student's role within the home

- Comprehensive induction programme

- Allow student time to complete their own work (eg portfolio)

Factors Creating a Sense of Belonging

For older people

- Opportunities to visit the home prior to moving in

- Own room/belongings/privacy

- Wait until invited into resident's room

- Open visiting

- Own place in dining room

- Clarify expectations on admission

- Respect personal choice wherever possible

- Residents' groups with nominated chairperson

For family carers

- Make relatives feel welcome

- Encourage to take a more active part

- Ensure that staff are there for relatives and residents, physically, mentally and financially

- Encourage involvement in all aspects of care and decision-making

- Value relatives' ideas

- Use appropriate terminology – avoid jargon

- Create care partnerships

- Educate relatives in promoting independence and optimising opportunities to enhance quality of care

- Make sure that relatives are informed of all changes

- 'Be there' for relatives and encourage them to talk

- Individual service planning to create social activities and opportunities

For staff

- Responsibility based on defined roles

- Opportunity to share

- Feeling valued, trusted and competent

- Thanking staff for their contribution

- Work towards common goals to deliver high standards of care

- Having a sense of camaraderie

- Not working in isolation

- Important for care assistants to have a sense of professionalism

NB More important with big group companies

For students

- Induction programme and booklet

- Explore students' expectations and objectives (possibly using a questionnaire)

- Value their new ideas

- Encourage students to realise that nursing home staff are progressive

- Involve all grades of staff in student learning

- Mentor relationship

Factors Creating a Sense of Continuity

For older people

- Life history sheet – developed with relative if possible/appropriate

- Consistency in key worker/associate nurse/support worker

- Visit hospital prior to discharge and ensure a familiar face on admission

- Comprehensive information on discharge from hospital and admission to hospital

- Involve activity coordinator in helping resident to continue with enjoyed past-times

For family carers

- Residents/relatives meetings

- Being involved in caregiving

- Involve relatives in reviews of care plans

- Update relatives with information regularly

- Opportunities to go on outings

For staff

- Monthly newsletter

- Regular staff meetings

- Clinical supervision and appraisal

- Audit

- Quality standards

- Follow policies/procedures

For students

- Good links with university

- Training for mentors to enable links with programme content

- Student induction pack

Factors Creating a Sense of Purpose

For older people

- Create personal profiles including hobbies and interests

- Assess actual and potential abilities

- Identify targets and goals

- Residents committees

- Consider potential for discharge

For family carers

- Relatives' committee

- Involvement in care planning and delivery (based on relative/resident choice)

- Communication

For staff

- Team nursing

- Care plans

- Standing orders

- Induction and training available

- Assessments of quality of care

For students

- Team allocation

- Named resident(s)

- Involvement in decision-making

- Targets for achievement of agreed goals by end of placement

Factors Creating a Sense of Achievement

For older people

- Promoting independence (where possible) in relation to activities of daily living

- Promoting mental well being and motivation

- Setting individual goals and needs

- Recognising own capabilities

- Multi-professional approach

For family carers

- Family carer interview on admission – identify expectations

- Open visiting

- Communication from care staff

- Opportunities to assist in providing care

- Support systems for relatives

- Acknowledgement of and help to deal with guilt

- Information about services and benefits

- Addressing conflicts and concerns

For staff

- Seeing clients improving and gaining confidence in their ability to achieve goals

- Keeping knowledge updated/sharing knowledge

- Regular appraisals/constructive criticism and practice development

- Written evidence of learning/acknowledgement of achievement

- Audit/quality control

- Support of manager/back-up

For students

- Clear objectives – asking what they want to achieve

- Overview of service provided and learning opportunities

- Spending time with different members of staff

- Encourage students to use their own initiative

- Regular feedback/planned evaluation sessions

- Set objectives for placement and review

- Provide adequate support and mentorship

- Encourage decision-making

- Give feedback on developing skills

Factors Creating a Sense of Significance

For older people

- Find out how clients wish to be addressed

- Involve fully in care planning

- Individualised care planning in identifying individual needs

- One-to-one/forming relationships

- Show an interest in the individual and their family

- Social care assessment identifying family relationships

- Use of photographs

For family carers

- Opportunity for family to give positive and negative comments about the service provided

- Annual quality control (opportunity to make comments about services anonymously)

- Service user forum

- Choices about involvement in the care of a resident

- Welcoming atmosphere

For staff

- Feedback from clients and relatives (either verbally or evidence of contentment)

- Feedback from the local community – knowing you have a good reputation

- Feedback via letters and carers

- Sense of pride in the quality of care provided

- Having opportunity to feedback to education providers

For students

- Time invested in orientation and induction

- Provide student with a mentor who they will see a lot of

- Ongoing support and encouragement to apply theory to practice

- Telling the student that we can learn from them too

- Direct feedback from clients

- Encouraging students to give feedback and letting them know that their opinions matter

The above results are instructive from several perspectives. Firstly, although the factors 'creating' the Senses are obviously most relevant to continuing care settings, similar factors emerged in the other groups, particularly in relation to staff. This further reinforces the relevance of the Senses but also suggests that they may need to be 'tailored' for particular circumstances. However, it seems that the underlying philosophy transcends care settings and can be adapted without losing its essential integrity.

Secondly, the workshops demonstrated the value of the Senses for training and raising awareness of key issues. The Senses therefore provide a useful vehicle, not only for stimulating discussion, but probably more importantly for exploring and reaching consensus on fundamental but often implicit aspects of care. Moreover, although we did not attempt this in the present study, it is our belief that they would prove equally helpful in facilitating debate and moving towards consensus between differing groups, for example, staff and students or staff and family carers. The potential for this is demonstrated by the congruence between the factors seen to create the Senses for students by staff in the workshops and the experiences of students as described in the proceeding section.

In many respects this is a highly significant finding as some of the most 'impoverished environments' students described were within continuing care settings, usually nursing homes. However, these results suggest that many staff are sensitive to the needs of students (and of older people and their carers), and can readily identify how the student experience could be enhanced. Therefore, while the causes of an impoverished environment can sometimes be traced back to staff themselves and the attitudes they display, it seems highly likely that these attitudes are, at least in part, the product of an environment which fails to ensure that staff also experience the Senses. In other words, if staff themselves do not feel safe, that they belong, have a clear purpose, and that what they do 'matters', then it is highly unlikely that they will be able to create and sustain conditions in which older people, family carers and students can flourish and grow.

The final opportunity to explore the Senses provided us with access to a very varied group of participants and also marked a return to the original work resulting from the 'Dignity' Project (Davies et al 1999). As part of the feedback of these results Help the Aged organised a national conference that was attended by over 80 delegates comprising a mix of older people, family carers, and professionals from a multi-disciplinary background. One of the sessions was presented by two of the AGEIN team and was organised around the Senses with delegates being divided into smaller groups, each one of which was asked to identify the factors that they thought would facilitate the development of the Senses in an acute hospital setting. These largely reinforced the findings of the 'Dignity on the Ward' project (Davies et al 1999).

Summary

All of the workshops provided a resounding endorsement for the Senses, which were seen as highly relevant by the varied stakeholders consulted. They also proved very useful in suggesting how the Senses could be made more 'user friendly', with the latter workshops in particular highlighting a range of ways in which the Senses might be created. Some of these were eminently practical, others were less tangible.

However, in addition to elaborating upon how the Senses might be achieved the early workshops also raised a number of potential barriers of which it is very important to be aware.

The most detailed discussion of the potential barriers to realising the Senses occurred at the initial two workshops, although the conclusions were reinforced at subsequent events. Essentially

participants identified the need for action at a number of levels. Some of these related quite obviously to resourcing issues, highlighting the need for adequate staffing levels, good standards of equipment, and the time and space to engage both older people and their carers in the sort of detailed discussion needed if a shared perspective is to emerge.

The need for a basic level of resource was highlighted within the Dignity Project, as without it even the best intentioned of initiatives is likely to falter. However, the workshops were of the opinion that resources on their own were not a sufficient condition for change. This was consistent with the Dignity study which stressed the need for a positive 'culture of care'. The importance of such cultural change was endorsed by the workshop participants. The type of change envisaged ranged from macro-level changes in societal attitudes, through changes of the ways in which professionals and lay persons interact, to how work with older people is valued, especially the way in which success is defined.

Participants were of the opinion that society as a whole was largely ageist, and that this ageism was reflected in the restricted access older people have to health care. The mass media were seen to be partly responsible and participants identified the need for a more positive portrayal of older people. Some went further and advocated political solutions in the form of an Older Persons 'Act' which established the rights of all older people to a basic minimum income and standard of living. Most attention, however, was given to the way in which ageism was manifest in the structures and organisation of health care, especially in acute care settings.

Many of the participants considered that the needs of the organisation rather than the needs of the individual predominate, as evidenced, for example, in the 'discharge culture' that was seen to exist. The result was ever growing pressure to vacate beds, often before older people or their carers were ready for discharge. Participants described how cure rather than care had become increasingly valued. They considered that this further reinforced the image of gerontological nursing as 'basic', with this area of work having a low profile and status, with little recognition of the skills involved. Further evidence of this low status included poor terms and conditions of employment, low wages and limited opportunities for continuing education and professional development, especially in the private sector and continuing care settings. In many respects what was being described was an 'impoverished context' within which the 'impoverished environments' alluded to earlier were created and sustained.

Participants at the workshops saw the need for a new vision and a clearer direction for work with older people that provided a greater sense of therapeutic potential and more subtle and appropriate indicators of success. Several staff felt that they needed to be valued and supported before they were fully able to value and support older people. There was much talk of the need for strong and visionary leadership, of a supportive culture which celebrated success rather than concentrating on failure, and which recognised mistakes as learning opportunities rather than seeking to apportion blame. Several ways in which such a culture could be achieved were suggested, and the Senses were seen as a major factor. We have summarised these earlier. However, the key factors were seen to be vision and leadership, which reaffirmed the importance of an effective but clinically active ward manager (sister/charge nurse). This was one of the main findings of the Dignity Project (Davies et al 1999).

Excitingly for us, the Senses were acknowledged as providing a way of realising a 'vision' of care in which the 'fundamental' components were valued and accorded status. Furthermore,

their relevance to several stakeholder groups was endorsed, as was their interdependent nature. Therefore, having considered the Senses in relation to their own situation participants, especially staff, were better able to relate the Senses to older people and their carers. It was the perceptions of this latter group that was the focus a further final round of workshops.

Obtaining the views of family carers

In order to identify family carers who were willing to comment on the Senses the help of two voluntary organisations was enlisted. The first was the Northern England Branch of Carers UK and the other was the Sheffield Branch of Age Concern. The Carers UK put the project team in touch with an established local carers group who kindly agreed to meet for a morning with us. Age Concern were able to identify a number of carers who would also be willing to consider how the Senses might relate to them. Two groups of carers were therefore organised in appropriate venues and arrangements were made so that additional support and transport were available in order that carers could come to the meetings. A total of 16 carers attended the meetings.

Following on from the discussions at the earlier workshops the Senses were again modified slightly and an attempt was made to present them in a format that was as personalised and user friendly as possible. It was decided to use the time with family carers to focus on how the Senses related to carers, and the person they cared for. Furthermore, in order to maximise discussion at the meetings, the amended Senses, and an explanation of the aims of the meeting, were posted to the carers in advance so that they had the opportunity to consider them in detail before they arrived. A copy of a Sense of Security is reproduced below, illustrating how this was modified in light of the earlier workshops.

The meetings with family carers differed from the previous workshops, and are best considered as a focus group. However, although carers had been given prior notice of the purpose and goals of the meeting, it did not prove possible to focus the discussion solely on the Senses, as it was apparent at an early stage of the meeting that each carer wanted to 'tell their story' before it was possible to move onto other issues.

A Sense of Security – Feeling Safe

Old Definition	Modified Definition
For older people To receive competent, sensitive and consistent care in a supportive environment enabling them to feel safe and free from threat, harm, pain or discomfort To acknowledge and reduce unnecessary risk while encouraging informed risk taking	**For the person you care for** To ensure that the person you care for is safe and free from threat, harm, pain or discomfort To ensure that the person you care for receives competent, sensitive and consistent care To reduce unnecessary risk but ensure that the person you care for is able to make choices about what they do To ensure that the person you care for is clean, comfortable and well turned out
For family carers To feel able to say 'no' to care if they want to To have their own needs recognised and acknowledged To feel that they have the knowledge and skills to provide good care without detriment to their health To have appropriate, sensitive and timely support To recognise the existence of differing viewpoints within caring relationships	**For yourself** To have your own needs recognised and acknowledged To feel confident that you have the information, knowledge and skills to provide good care To have appropriate, sensitive and timely support To feel able to say 'no' to caring if you want For others to recognise that your needs, and the needs of the person you care for, may not always be the same To be able to maintain your own physical and emotional health

One thing common to the experience of all of the carers was the relative insensitivity of services to their needs, and those of the person that they cared for. Although examples of good practice were given, each carer had their own account of the general failure of services to recognise and appreciate the complexities of caring, of inappropriate services that lacked flexibility and cohesion, and of the relative lack of skill demonstrated by several paid carers.

It was in better attuning paid carers, whether professional or not, to the needs of family carers and the cared-for-person that the Senses were seen to have the greatest potential. Based on a detailed analyses of the carers' experiences, as recounted at the focus groups, together with the written comments subsequently posted by a number of attendees, the Senses were therefore again revised. These are reproduced below.

A Sense of Security – Feeling Safe

For the person you care for	For yourself
To ensure that the person you care for is safe and free from threat, harm, pain or discomfort	To have your own needs recognised and acknowledged
To ensure that the person you care for receives competent, sensitive and consistent care	To feel confident that you have the information, knowledge and skills to provide good care, when you need them
To reduce unnecessary risk but ensure that the person you care for is able to make choices about what they do	To have appropriate, sensitive and timely support
To ensure that the person you care for is clean, comfortable and well turned out	To feel able to say 'no' to caring if you want
For paid carers to respect the wishes of the person you care for	For others to recognise that your needs, and the needs of the person you care for, may not always be the same
To be confident that paid carers have the skills to provide good care for the person you care for	To be able to maintain your own physical and emotional health
	To have time for yourself without feeling guilty
	To have rapid access to support in an emergency
	To know that good support will be available if you are no longer able to care
	To feel safe to criticise services without fear that they will be discontinued, or that it will be 'taken out on' the person you care for
	To know that services will arrive on time, and as promised
	To be given an honest account of what services and options are available

A Sense of Belonging – To feel part of something, to have a place

For the person you care for	For yourself
To have opportunities to socialise and mix with others	To be able to maintain meaningful and valued relationships with the person you care for, family and friends
To be able to keep in contact with their friends	To have someone to turn to if you need to talk things over
To maintain contact with family, especially grandchildren if appropriate	To feel that you are not 'in this alone'
To maintain valued relationships with non-human companions, such as pets	To feel an active and equal partner in caregiving

A Sense of Continuity – Linking the past, present and future

For the person you care for	For yourself
For paid carers to know the person you care for as an individual, with personal likes and dislikes	To be able to maintain shared pleasures and interests with the person you care for
For one paid carer (or a limited number) to provide support for the person you care for	To be able to ensure consistent standards of care, whether given by yourself or others
For paid carers to have time to care properly, and not 'clock watch'	To be actively involved in their care if the person you care for is in hospital or a nursing home, to have your views listened to and acknowledged
	To receive help and support in a way which fits in with your routines and needs

A Sense of Purpose – A goal to aim for

For the person you care for	For yourself
To be able to do the things they enjoy	To ensure the dignity and individuality of the person you care for
To feel stimulated and challenged	To ensure that the person you are caring for receives the best possible care
To feel that they have something to offer	To be able to achieve a balance between caregiving and other important parts of your life
To be able to 'have a say', and that their opinions are listened to	To be able to work or pursue interest outside of caring
For paid carers to take full account of the person you care for's wishes when planning services	To be able to plan for the future, with general knowledge of the possible options

A Sense of Achievement – To feel you're getting somewhere

For the person you care for	For yourself
To be able to make a valued contribution, due to how they are acknowledged by others	To know that you are providing/have provided the best possible care
To maintain their independence, and sense of self	To develop new skills and abilities
To feel that they are able to grow and develop	To be able to meet competing demands successfully
To experience pleasure and happiness	To have your caregiving abilities and expertise acknowledged and valued, and to pass this on to other carers if possible
	To feel satisfied with the family and professional care that you are giving
	To feel that caregiving is appreciated by the person you care for, family, friends and others

A Sense of Significance – To matter

For the person you care for	For yourself
To be recognised and valued as a person, that their dignity is maintained	To feel that you are recognised, valued and listened to as a person
To feel that they are important	To feel that your actions and existence are important
To feel that they 'matter', that their life has value and meaning	To feel that you 'matter'

The seven workshops provided the opportunity for nearly 200 individuals to comment upon and critically appraise the Senses. As a result of this not only was their value reinforced, but detailed insights into how the Senses might be achieved were gained. These results will be reflected upon further in the discussion that follows.

WHERE TO FROM HERE? THE SENSES FRAMEWORK, RELATIONSHIP-CENTRED CARE AND FUTURE DEVELOPMENTS

One of the ENB's main goals in commissioning the AGEIN project was to see if it would be possible to identify an 'epistemology' of practice that could provide nurses working with older people with a greater sense of therapeutic direction in their day-to-day work. In reporting the results of the study we argued that the Senses Framework could achieve this for both education and practice (Nolan et al 2002). However, we also suggested that the benefits of the Senses Framework could best be realised in conjunction with a model of care based on a relationship-centred (Tresolini and the Pew Fetzer Task Force 1994) approach as opposed to person-centred one. Subsequently, we proposed that the Senses Framework and relationship-centred care could, in combination, offer a new vision for gerontological nursing (Nolan et al 2004). Here we would like to elaborate upon some of our earlier arguments and to extend that 'vision' beyond nursing, to include all areas of health and social care in which frail and vulnerable older people and their family carers receive help and support.

Early in this report we posed the question: Is there a need for a 'Framework for Practice' for those working with older people? We briefly charted the difficulties that practitioners working in the field have had in articulating appropriate goals for their care beyond cure and the restoration of functional ability, and argued that to focus only on these two goals disadvantaged large groups of older people. We also cautioned that emerging concepts in the wider gerontological literature such as 'successful ageing' were likely to further stigmatise older people who could not meet the canons of success.

Such concerns extend well beyond nursing and raise important issues for society as a whole, for as Kane (2005) advises us, long term conditions present the major future challenge to health and welfare systems globally. Responding appropriately to this challenge poses the significant intellectual task of both defining and promoting as good a quality of life as possible for older people who may have multiple health problems. Paradoxically, at such a time, health care systems are increasingly 'technologically driven' and 'outcome orientated', with their main focus remaining on the clinical and psychological manifestations of disease (Jonsdottir et al 2004). Furthermore, when cure proves elusive then there is talk of concentrating on 'restorative models' of health so that individuals can continue to function within their own homes (Baker et al 2001). Where cure and restoration are appropriate and achievable then of course these are admiral goals. However, as a consequence of the continued pursuit of such aspirations many argue that 'caring' has become 'downgraded' (Callahan 2001, Cluff and Binstock 2001) and replaced by a 'technological assembly line of care' (Stone 2001).

But technologically competent care, even if it achieves the goal of cure, does not necessarily maintain the dignity and self-esteem of older people (McCormack 2004, DoH 2006). As Marquis and Jackson (2000) note, there is a need to move beyond a managerialist approach underpinned by quantification and standardisation to a more humanistic model of care delivery that is personally validating for those **both** giving and receiving care. It is here that for us the Senses Framework and relationship-centred care can make an important contribution. In rethinking the policy futures for health care in the UK, Dargie et al (1999) argued that there is a need for a *'reorientation of policy towards the individual **and** the part played by family, friends, social networks, and the environment'* (our emphasis). It is the second element of this statement that, for us, receives insufficient attention from the present policy onus on person-

centred care (DoH 2001, and see Nolan et al 2004). We believe that a broader approach will be needed if the current drive to promote the dignity of older people is to be achieved (DoH 2006).

Expanding the vision of person-centred care

Person-centred care is an often quoted but ill-defined concept that has nevertheless exerted a considerable influence on the policy, practice and academic literatures, particularly in nursing (see McCormack 2004). 'Patient', 'client' or 'person-centred' care reflect the emergence of new approaches to work with older people in a range of care environments, including long-term care (Henderson and Vesperi 1995), rehabilitation (Nolan et al 1997), learning disability (Williams and Grant 1998), and dementia care (Kitwood 1997). Williams and Grant (1998) contend that person-centred care mandates that practitioners have to know what it is like to live 'a certain kind of life', and that this requires that they have knowledge of people as individuals. This is reflected in the vision of person-centred care promoted in the NSF for older people, where it is defined as care that *'respects others as individuals and is organised around their needs'* (DoH 2001). This focus on individuality mirrors wider trends within health and social care, which emphasise the importance of promoting the independence and autonomy of older people, which together with notions of greater user involvement, have become major policy drivers (Hanford et al 1999, Audit Commission 2004a). As McCormack (2001) notes, it is the application of consumerism to health care, and the promotion of a philosophy that treats people as individuals that has resulted in the emergence of the *'contemporary speak'* of person-centred care.

Such trends were becoming increasingly evident as the AGEIN project started and, in considering the literature, we were struck by the arguments advanced by Mulrooney (1997), who suggested that the promotion of a person **and** relationship-centred model of care had three essential prerequisites:

■ Investing in caring as a choice

■ Respecting personhood

■ Valuing interdependence

With regard to the AGEIN project one of our major goals was to explore why student nurses did **NOT** invest in work with older people as a choice. As we have demonstrated earlier, a complex set of factors influence students' decisions to potentially work with older people, but the major determinant is the nature of their placement/work experience, rather than their views of older people themselves. When students are exposed to 'enriched' as opposed to 'impoverished' environments of care and feel that they can 'make a difference' to the lives of older people, then their perceptions of: work with older people generally; the likelihood that they will choose to work with older people; and their views of the potential impact of work with older people and their carers on their careers are far more positive. Working closely with students over an extended period of time, and collecting data from both longitudinal focus groups and visits to 33 practice placements we were able to describe the nature of enriched environments of care in terms of the Senses Framework, and also to identify several of the factors that help to shape the nature of positive and potentially 'transformative' learning experiences for students. Furthermore, it was apparent that the individual Senses

were more or less important at differing points in both the students training and their placements. Therefore it became evident that the 'focus' of a student's efforts varied as follows:

- Self as focus

- Course as focus

- Professional care as focus

- Patient as focus

- Person as focus

The extent to which students were able to move along this continuum was dependent on several factors within each placement. Further work on these 'foci' was completed outside of the AGEIN project and has been reported more fully elsewhere (see Brown 2006). Here, the main characteristics of an enriched environment, as opposed to an impoverished one, and the factors helping to shape each, are summarised in Table 9, together with relevant supporting literature.

Promoting an enriched environment is essential, for the conclusions of one of the few, other albeit much smaller longitudinal studies of student nurses (Fagerberg 1998) resonate closely with ours. Fagerberg (1998) found that whilst students had 'warm feelings' towards older people themselves, few wanted to work with them, most preferring areas such as accident and emergency and surgery. For her cohort, their experiences during training tended to reinforce their ambivalence towards work with older people, as the majority of clinical placements were negative. Fagerberg (1998) called for well planned clinical placements with a supportive mentor and concluded that we need a far greater understanding of the factors promoting a good learning experience. We believe that the work reported here has made substantial progress in this regard, as the suggestions in Table 9 illustrate.

Addressing such factors will help to ensure that students are exposed to 'enriched' environments of learning, and that their placement experiences with older people are positive. This has the potential to 'transform' their views and perceptions of gerontological nursing thereby increasing the chances that they will 'invest' in this area of practice as a choice.

Attention is now briefly turned to the second of Mulrooney's prerequisites for person and relationship focused care; respect for personhood. While we have argued elsewhere that a vision of person-centred care which privileges individual need alone is inadequate (Nolan et al 2004), we agree that respect for personhood is nevertheless essential. Much depends here on how we view what it means to be a person. Kitwood (1997) defines personhood as the *'standing or status bestowed upon one human being by **others** in the context of a **relationship**'* (our emphasis). Building on such a premise from an ethical standpoint, MacDonald (2002) argues that we need to develop a relational, as opposed to an individual view of autonomy which sees human beings as belonging to a network of social relationships within which they are *'deeply interconnected and interdependent'.*

Table 9: The characteristics and facilitators of the Senses in enriched care environments compared with impoverished care environments (Adapted from Brown 2006)

Enriched environments: Creating a Sense of Security for Students		Impoverished environments	
Characteristics	**Facilitators**		
Students feel well prepared	Having clear, discrete and appropriate theoretical content relating to older people	**Students feel unprepared**	Theoretical content relating to older people hidden or absent from the curriculum (Recchia-Jeffers and Campbell 2005)
	Feeling that you are sufficiently prepared in clinical skills to contribute to practice (Greenwood and Winifreyda 1995)		Feeling you lack the clinical skills for practice
Students feel supported	Having a mentor who works with you and/or is available to support you throughout the placement. This helps students to feel safe to learn and practice (Gray and Smith 2000)	**Students feel unsupported**	Having no mentor or lack of support from mentor due to holidays or sickness for example. This can make students feel scared and alone
	Having a named mentor who is interested in teaching and student learning and understands the requirements of your course and placement documentation (Price 2005, Rawcliffe 2005)		Mentor not showing any interest in teaching or student learning or not knowing about the requirements of the course especially in relation to placement documentation (Gray and Smith 2000)
	Positive leadership from the mentor, with boundaries clearly defined		Having little direction or guidance from the mentor – being unclear about your role
Students have help to 'talk things through'	Being able to raise concerns without fear of censure	**Students are isolated with no one to turn to**	Student concerns being cast aside or disparaged (Edwards 1991)
	Staff being approachable (Rawcliffe 2005)		Staff being unapproachable
Students feel staff are highly skilled and knowledgeable	Staff consistently deliver a high standard of individualised care to older people, explain what they are doing to the student and the older person (Orton et al 1993, Davies et al 1994)	**Students feel staff lack the requisite skills and knowledge**	Staff demonstrating poor care leaving students feeling shocked and frightened

Characteristics	Facilitators	Impoverished environments
Students are made to feel welcome	Being expected on the placement – having a welcome letter Having a mentor to 'broker' their relationships with other members of the team – being welcomed by older people and their carers (Gray and Smith 2000) Mentors waiting to go on duty with students Going on 'breaks' with your 'team'	**Students do not feel welcome on the ward** Not being expected, eg no one is expecting you when you ring for details of your first shift Having to introduce and explain yourself to staff and patients Being sent out of 'hand-over' because the room is too small (Davies et al 1994)
Students feel like part of the team	Being asked to return to work on the ward again Joining a placement with a good team spirit – staff appear to be happy and work well together Taking some responsibility for sustaining the positive atmosphere by showing a willingness to learn and being flexible to the needs of the clinical setting (Gray and Smith 2000)	**Students feel like a stranger** Students feel they do not fit into the team they become isolated, and staff seem distant and aloof (Davies et al 1994) Back biting and gossip between placement staff Avoiding a negative atmosphere by 'keeping your head down'
Staff appreciate the importance of learning opportunities for students	Being brought away from the 'work' to take advantage of a learning opportunity	**Students are being treated like a pair of hands** Students feel accepted only when 'filling in the gaps' in staff provision or when they contributed to ward routine and helped to ensure that things got done on time (Gray and Smith 2000)
Students are able to identify with older people	Students recognising the 'person' in older people and acknowledging their biography	**Students are unable to identify with older people** Staff fail to identify with older people and treat them as 'other' so students find it difficult to relate older people to themselves or their own situation
Students feel they belong to their cohort and the wider student body	Students identify strongly with their cohort and especially with their branch. The university accords student nurses equal status to other students when planning Timetabling takes into account the needs of nursing students to participate in university activities	**Students do not feel part of the wider student body** Reduced library and canteen facilities during 'university' vacations when student nurses were still attending university Being denied the opportunity to participate in normal student activities such as 'Freshers' week

Enriched environments: Creating a Sense of Continuity

Characteristics	Facilitators	Impoverished environments
A clear and effective relationship between placement and the university	Practitioners come into school to teach Staff frequently have recent experience of education and value learning Mentors have a clear understanding of course requirements and documentation (Darling 1984) Link tutors are known and evident on the placement Theory relating to the placement is delivered directly prior to the placement (Corlett 2000) Rationale given for practice helps to relate it to theory (Burkitt et al 2000) Theory about older people discrete, well defined and delivered close to an appropriate placement High quality communication between school and placement makes students feel they are in accord	**A poor relationship between university and placement** Programme of training being disjointed Staff do not value theory or education (Andrews et al 2005) Mentors do not understand course requirements and rely on students to understand the documentation Placements are unsure who the link tutor is or how to contact them. The students does not see the link tutor during their placement Theory and practice not timed to coincide leaving students feeling disconnected (Corlett 2000) Little connection between nursing as taught and nursing as witnessed (Andrews et al 2005) Theory about older people too well hidden in the course to be relevant to students (Earthy 1993, Andrews et al 2005) Lack of communication between placements and school leave students acting as go between (Burkitt et al 2000)
Exposure to a clear philosophy of care	Students see and are aware of a living working philosophy of care which is enacted and discussed rather than looking good on paper	**Little evidence of a philosophy of care** Students and staff are unable to articulate a coherent philosophy of care and placements lack vision beyond day to day tasks
Consistent relationships	Mentor is key in making the links and connections Directional leadership (Gray and Smith 2000)	**Lack of consistent relationships** Mentors changing due to holidays and sickness Students left to their own devices

Enriched environments: Creating a Sense of Purpose

Characteristics	Facilitators
Students feel they have something to aim for	Having an agreed set of goals for older people and students
	Understanding their role on placement
	Having an effective mentor to assist in identifying and maintaining their Sense of Purpose by facilitating learning opportunities and having a 'feel' for the amount of input needed by individual students (Gray and Smith 2000)
	Placement outcomes set by school that clearly relate to the placement (Burkitt et al 2000)
	Feeling able to challenge practice without censure
Students actively manage the placement	Trying to fit in to a good team
	Getting to know how to approach staff to achieve their goals (Gray and Smith 2000)
	Using humour to challenge practice

Impoverished environments

Characteristics	Facilitators
Students feel unclear about the purpose of a placement	Having no clear goals – feeling frustrated, annoyed, and exploited – that they are wasting their time (Mackay 1989)
	Finding it difficult to maintain motivation where the student role is unclear
	Having limited/no mentor contact leaves students 'in the wilderness'
	Not being able to see the relevance of placement outcomes set by school
	Becoming socialised into the culture which made them assume there was not point in questioning things as they were impossible to change (Pursey and Luke 1995)
Students are confused and frustrated by the placement	Refusing to return to a placement/going off sick
	Feeling alienated from staff and isolated (Davies et al 1994)
	Fitting in with practice they do not agree with in order to pass the placement

Enriched environments: Creating a Sense of Achievement

Characteristics	Facilitators
Students find placements inspiring	Staff deliver high standards of care
	Older patients are a priority
	Person-centred care is the practiced philosophy
	Staff involved in learning themselves
	Staff fully aware of the learning opportunities available to students and ensure they get the opportunity to take advantage of these
	Staff are skilled and knowledgeable
	Staff gain a Sense of Achievement from their work which they communicate to students
	Senior nurses are approachable
	High quality mentoring facilitating learning (Darling 1984)
Seamless links between university and placements	Course work relates closely to placements focus (Burkitt et al 2000, Corlett 2000)
	Theory about older people, well defined and delivered close to an appropriate placement helps to focus students on what is possible to achieve (Earthy 1993)
	Placement staff aware of what is required of the student in course work and able to offer support and suggestions
	Mentor and placement leader having a good working relationship with link tutor (Corlett 2000)

Impoverished environments

Students find placements uninspiring	Observation of poor standards of care (Pursey and Luke 1995)
	Older people not seen as important
	Systems that operate for the benefit of the institutions rather than the patient (Pursey and Luke 1995)
	No culture of learning for qualified staff or others on the placement
	Staff unaware of what students learned or how they could help
	Staff lack essential skills and knowledge to care for older people
	Staff unhappy and dissatisfied with their work and advise students to work elsewhere (Pursey and Luke 1995)
	Senior staff not evident on the placement – seem aloof
	Mentoring is not valued by senior nurses – lack of investment in mentor training
Disconnection between university and placements	Endless demands of academic work seem to be unrelated to the placement making students feel stressed (Burkitt et al 2000)
	Poor balance in the curriculum which eroded students' sense of being able to make a difference
	Placement staff unaware of and disinterested in student's course work
	Mentor and placement leader have little time for the link tutor

Enriched environments: Creating a Sense of Achievement continued		Impoverished environments
Characteristics	**Facilitators**	**Students experience a lack of personal achievement**
Students experience personal achievement	Passing the course, the placement or an assignment	Struggling to get placement documentation completed by mentor
	Making a difference to older people (Pursey and Luke 1995, Ironside et al 2005)	Feeling unable to change things or make a difference to an individual older person (Pursey and Luke 1995)
	Students begin to develop their own standards of care (Pursey and Luke 1995)	Students adopt the poor standards they see around them (Gray and Smith 2000)
	Students' challenge to poor practice is welcomed by senior nurses	Students wanting to distance themselves from poor leads to them disengaging from the placement (Pursey and Luke 1995)
	The presence of students perceived by staff to maintain standards	Demonstrating good practice can make you a threat to staff on the placement
	Able to bring new insights to the ward	Feeling you have little to learn on the ward
	Students have their contribution to care recognised by staff, patients and carers	Students feel that no matter how hard they work no one notices

Enriched environments: Creating a Sense of Significance

Impoverished environments

Characteristics	Facilitators	Characteristics	Facilitators
Students feel that they matter	Not being treated like a pair of hands (Davies et al 1994, Gray and Smith 2000) Feeling you have a valued contribution to make to patient care and to the ward Feeling what you do 'makes a difference' (Gray and Smith 2000) Feeling staff are interested in you (Gray and Smith 2000) Feeling cared for and about (Gray and Smith 2000) Feeling noticed by relatives	**Students do not feel that they matter**	Being made to feel you are a drain on ward resources Being used to undertake tasks with little rationale Your efforts are not appreciated and make no difference to patients (Hirvonen et al 2004) People showing no interest in you accept as another pair of hands Being told that your training is not valued Relatives unsure of your purpose or role
Students feel that working with older people matters	Older people being given prominence in university teaching University and placement staff showing passion for their work with older people Older people given equal access to resources as other patients	**Students feel that working with older people does not matter**	The study of older people 'tagged on' to other sessions (Earthy 1993) University and placement staff demonstrating ageist attitudes and discriminatory language Lack of resources for caring for older people

Clark (2002) similarly contends that, if we are to provide meaningful care and services to older people, we need to 'situate' an older person's individual needs within a rich matrix of relationships and socio-cultural beliefs. In promoting a new approach to the nursing care of older people McCormack (2001) advocates a comparable stance, believing that there is a need to replace an individualistic view of autonomy with one based on *'interconnectedness and partnership'* that recognises the uniqueness of each individual, but also the interdependence that shapes our lives.

Paying greater attention to interdependence is the last of Mulrooney's (1997) prerequisites for excellent care and is reflected in recent writings in the wider literature. For example, Jonsdottir et al (2004) argue that nurses must view patients as co-participants in creating and seeking meaning for themselves as individuals, their families and the wider community when facing ill health. In doing so they contend that interdependence is the key to managing health care challenges. Others, whilst acknowledging the potential of person-centred care, also call for more attention to be paid to interdependence (Kelly et al 2005). Increasingly, therefore, the reciprocity inherent in interpersonal relationships is seen as key to the maintenance of self-esteem and well being in older people irrespective of the health challenges they face (Grasser and Croft 2000, Audit Commission 2004a, c).

This represents a paradox for the caring professions, for whilst the importance of the relational dimensions of care are increasingly promoted in the theoretical and empirical literature, service systems retain a technological focus (Callahan 2001, Stone 2001, Jonsdottir et al 2004). However, the interpersonal aspects of care are essential to enhancing the 'little things' that elevate acceptable care to good or excellent care (Davies et al 1999, Tutton and Seers 2004), and these 'caring processes' need to be articulated more clearly if progress is to be made (Watson 2004). We believe that the Senses Framework has the potential to more fully articulate the conditions necessary to create and sustain 'enriched environments' of care. However, they need to be cast in a wider context than person-centred care and, as we have argued elsewhere, relationship-centred care provides a more appropriate philosophy to underpin future developments (Nolan et al 2002, 2004).

Relationship-centred care

The term relationship-centred care (RCC) was first coined by Tresolini and the Pew-Fetzer Task Force (1994) following an extensive review of the adequacy of modern day health care systems (in the US) to respond to the future health care challenges posed by the growing numbers of people with chronic illness. The authors of this report argued, as several writers have since, that modern day health care is:

> *'Based on an individual, disease-orientated, subspecialty model that has led to a focus on cure at all costs, resulting in care that is fragmented, episodic and often unsatisfactory for both patients and practitioners.'*

As we have noted at several points in this report, such a system is not appropriate to the needs of most older people. In order to promote a more holistic vision of health care the Task Force focussed both on the social, economic, environmental, cultural and political contexts of care, and on the subjective and inter-subjective experience of illness, and the relationships that unfold between practitioners, patients, families and the wider community. They argued that these interactions lie at the heart of relationship-centred care and are the 'foundations'

of any therapeutic or healing activity. However, the reward mechanisms operating in current health care systems, and the educational preparation of practitioners from all disciplines, fail to acknowledge the importance of relationships and remain focussed on an *'inadequate scientific paradigm'*, which does not fully capture several major dimensions of the illness experience (Tresolini and the Pew-Fetzer Task Force 1994). Their report concluded that there was a need for *'a transformed approach to health care that has at its centre the relationships within and among persons within which truly comprehensive and contemporary care can occur'*.

As the Task Force noted, every participant in a health care encounter *'interprets and constructs a subjective world, and these worlds are modified by the dialogue between them. Both are changed in the process… (and) form an inseparable unit of interdependent subjects'.* We would suggest that such a vision of health care is likely to prove far more useful than one based on notions of person-centred care.

The Task Force went on to outline the basic elements of an educational system that would promote relationship-centred care but recognised that the concept itself was still emerging, and that further work was needed to *'explicate the dimensions of a relationship-centred approach to care'.* In particular such work should ensure that the appropriate balance between the needs of all involved in health care relationships is achieved. It is such a balance that we feel is currently missing in person-centred care. However, we believe that the Senses Framework explicates several of the dimensions of relationship-centred care and ensures balance between the needs of all participants.

But, as Dewing (2004) notes, buzzwords such as person-centred care (or for that matter, relationship-centred care) are a mixed blessing, for whilst they have intuitive appeal, they are particularly difficult to achieve in a 'performance driven' health care system. However, the recent renewed focus on 'dignity' in the care of older people (DoH 2006) may well provide the impetus for the changes that are needed. Consequently, it is essential that 'performance' is no longer determined almost exclusively by 'quantitative statistical expression' (Feinstein 2001). Rather judgements about quality of care will require more sensitive and finely attuned indicators that reflect the appropriate 'milieu' of care (Pryor 2000), or identify the *'supportive social conditions'* needed to promote and achieve a relational view of autonomy (McDonald 2002). We believe that a combination of relationship-centred care and the Senses Framework does this. In capturing the dimensions of an enriched care environment they highlight the *'supportive social conditions'* needed, not simply to *'create the right environment for others to grow'* (Kitson 1987), but rather to create the right environment for **everyone** to grow.

For us, therefore, the Senses Framework captures the important dimensions of interdependent relationships necessary to create and sustain an enriched environment of care in which the needs of all participants are acknowledged and addressed. This lies at the heart of our vision of relationship-centred care and illustrates the delicate interactions necessary to achieve truly collaborative care.

These interactions can be considered in the form of a matrix comprising the Senses along one axis, and the major stakeholders in health/social care encounters along the other. For a genuinely enriched environment of care to exist the Senses need to be created for **each** stakeholder. Such a matrix would look as follows:

Stakeholder / Senses	Older person	Staff	Family carers	Students
Security				
Belonging				
Continuity				
Purpose				
Achievement				
Significance				

Of course the relative meaning of each Sense, and the factors needed to create them, will vary depending upon the caring context. So, for example, factors creating a Sense of Belonging would differ in acute care settings, as opposed to community settings, and so on. However, our work to date has been able to demonstrate the relevance of the Senses for all the above groups in a range of settings including: acute care (Davies et al 1999); community settings (Nolan et al 2002); services for people with dementia and their carers; (Ryan et al 2002, 2004); continuing care/care homes (Faulkner et al in press); and student nurses (Nolan et al 2002, Brown 2006). We have not, as yet, identified all the relevant factors, and there are several areas for development, including the further application of the Senses to the support of people with dementia, and their use with a more diverse group of practitioners. We will consider developments in these areas shortly. But despite the need for further work, we believe that the Senses and relationship-centred care meet the canons of a 'good' framework for education and practice in relation to work with older people and will now consider whether the Senses do indeed 'measure up'.

Do the Senses and relationship-centred care measure up?

In taking stock of the discipline of gerontology across the board it has recently been argued that the field is rather like a ship without a rudder, lacking a larger intellectual census to provide a clear direction (Bass 2006). There is a need, Bass (2006) contends, for a conceptual framework within which to locate current thinking and chart the future direction for gerontology. Such arguments closely mirror our own aims at the start of the AGEIN project where the goal was to identify, in the ENB's words, an *'epistemology of practice'* to guide the education of nurses, and the care they provide to older people. In reporting our results to the Board we preferred the term Framework to epistemology, and suggested that the Senses Framework had the potential to provide the sense of direction that was needed (Nolan et at 2002). Furthermore, although the ENB as commissioners of the study were most interested in nursing, they also recognised the importance of considering a wider multidisciplinary and multi-agency context. As the AGEIN project progressed, it became increasingly clear to us that the arguments we were advancing were equally relevant to other health and social care disciplines.

The recent literature has reinforced the need for a framework that might unite several disciplines providing care for older people and others with long term conditions, with, for example, various authors: lamenting the limited attention given to caring within medicine (Cluff and Binstock 2001, Stone 2001); calling for a shared vision of what the social work role with older people might be (Gonyea 2004); and highlighting the fact that virtually all disciplines in the field of health and social care lack frameworks for practice that promote a positive therapeutic role with older people (Lee et al 2003, Askham 2005). This problem is particularly acute in nursing where caring is often portrayed as the professions' 'raison d'être'. Despite this, a recent analysis of 17 models of nursing concluded that none provided an adequate basis for working positively with older people (Wadensten and Carlsson 2003). These authors, along with several others (Whall 1999, McCormack 2004, Kelly et al 2005) have called for the development of a new approach that provides a sense of direction for gerontological nursing. The potential benefits of this are significant and are seen to include:

- Providing greater status and recognition of gerontological nursing as a field of practice

- Inspiring more practitioners to work in the field

- Combating ageism in health and social care

- Enabling older people to have greater confidence in the care they receive

- Promoting the positive value of gerontological nursing amongst policy makers

(Kelly et al 2005)

We would endorse the above but at the same time reiterate our assertion that any framework for practice has to extend beyond a particular discipline and be of relevance to a wide range of both qualified and unqualified practitioners and, importantly, to older people and their family carers. We believe that the Senses Framework, if applied within the context of a relationship-centred approach, does this. The key question therefore is, against what type of criteria do you 'measure' the value or potential value of such a framework?

Our own work was underpinned by the premises suggested by Nolan (1996), who argued that a relevant knowledge base for practice must:

- begin from the perspectives of older people themselves;

- abandon the search for highly abstract 'grand theory' and instead develop less abstract and more practical approaches that 'speak' to practitioners and users in a language they understood;

- reject the call to build a unique body of nursing knowledge and instead value relevant knowledge whatever its source.

Subsequently, several other authors from a range of perspectives have voiced similar sentiments, highlighting the difficulties of translating abstract concepts into practice (Liaschenko and Fisher 1999, Dewing 2004, McCormack 2004), and calling for approaches that avoid the *'disembodied slipperiness'* of existing abstract models (Clark 2002).

What is required is a simplified approach that has greater utility than *'dense and theoretical frameworks'* and avoids the tendency for the concepts used within gerontology to be *'confusing, poorly defined and bandied around such that they became more rhetoric'*

(Kelly et al 2005). On the basis of the extensive work described in this report, we believe that the Senses Framework meets the above criteria. For as Dewing (2004) acknowledges, it has been subject to the most extensive empirical testing of any recently published approaches to working with older people, and its practical utility in placing nursing within a wider social context is high. Whilst agreeing with Dewing (2004), we feel that the Senses have relevance far beyond nursing.

The extensive literature synthesis completed during the conceptual phase of the AGEIN project helped to establish the 'analytic' generalisability (Redfern 1999) of the concepts underpinning the Senses Framework in the light of the wider theoretical and empirical literature on working with older people and their family carers.

Subsequently the perceived relevance, applicability, comprehensiveness and comprehensibility of the Senses were explored in detail with student nurses, qualified practitioners, family carers and older people themselves. The Senses as presented in this report are a product of this process and were strongly endorsed by all the above groups. There is of course the need for further work, with a more multidisciplinary group of students and practitioners. For while other disciplines, including medicine, therapists and social workers were involved in our workshops, such individuals were in the minority. There is also the need to explore in more detail what the Senses might mean and how they can be achieved when working with people with cognitive difficulties. Some work in this area has already been completed (Ryan et al 2000, 2004), but more is needed and is planned.

On the basis of the above we would argue that the Senses can be seen to 'measure up' to the criteria for a 'good' practice framework.

However, other 'tests' can also be applied, and one such has been suggested recently (Bass 2006). In calling for the development of a conceptual framework for the discipline of gerontology as a whole, Bass (2006) argues that any such framework should have the following key attributes:

- It should integrate individual experience within the wider environmental context: the Senses and relationship-centre care do this by extending their focus beyond the individual and considering the creation of an 'enriched' environment of care.

- It should be iterative and recognise that the interactions between individuals, groups and their contexts are dynamic, each influencing the other in a cycle of mutual dependency. Such ideas are fundamental to the Senses and relationship-centred care.

- It must embrace the complexities of ageing and the very differing ways in which ageing is experienced. While the Senses and relationship-centred care do not claim to reflect the entire experience of ageing, they do address the experiences of giving and receiving care within a wide range of contexts.

- It should be sufficiently flexible to accommodate changing circumstances. To date the Senses have demonstrated such flexibility.

Recently several authors have reflected upon the potential usefulness of either the Senses or relationship-centred care, or both and, whilst broadly supportive, have identified what they see as limitations or areas for further work. We welcome this constructively critical comment and also the opportunity to respond briefly.

McCormack (2004) for instance notes that the notion of person-centred care is a 'recurring' theme in the gerontological nursing literature and suggests that if Kitwood's (1997) definition is applied then person-centred care can be seen to comprise four dimensions. He terms these:

- Being in relation – a person exists in relationships with others

- Being in a social world – persons are social beings with biographies and life plans

- Being in place – context is essential to the way that personhood is understood

- Being with self – to feel recognised, respected and trusted are essential to a person's view of self

He is critical of relationship-centred care saying that it only deals with the first of these dimensions, being in relation. However, if the concept of relationship-centred care is considered together with the Senses, then we believe that all four of the above dimensions are addressed. So, for example, biography and life plans are inextricably linked to a Sense of Belonging and Continuity, and also to how Purpose and Achievement are defined. Furthermore, as we have illustrated at several points in this report, the way in which the Senses are defined and achieved is influenced greatly by the context in which people find themselves, 'Being in place' is therefore integral to the Senses. Finally, a person's Sense of Significance hinges primarily on the extent to which they feel recognised, respected and valued as a person of worth; someone who matters.

McCormack's (2004) critique of relationship-centred care divorces it from the Senses and, we believe that if they are considered together then his concerns are addressed.

Dewing (2004), whilst endorsing some of the elements of relationship-centred care suggests that it is too limited, focusing, as she sees it, only on an 'enriched environment'. She argues that there is a need to broaden the focus beyond that of the 'environment'. However, we would counter that the concept of environment as reflected in an 'enriched' or 'impoverished' environment is intended to capture a myriad of influences to which older people, family carers, staff and students are exposed within a given context of care. So, for example, as we have demonstrated in earlier sections, students were exposed to and aware of the existence of ageism at several levels, including within society as a whole, the health care system generally, and the particular practice placements that they experienced. Whilst the latter is the most concrete manifestation of ageism, students noted that this cannot be divorced from wider professional, institutional and societal contexts in which care in a given unit, ward or setting is delivered. The notion of an 'enriched' environment is intended to reflect this complexity.

In addition to the Senses and relationship-centred care, Dewing also considers a number of other recent practice frameworks for gerontological nursing including: authentic consciousness; skilled companionship; positive person work, and the Burford model. She suggests that while their focus on the interpersonal aspects of care is to be generally welcomed, this may be at the expense of intra-personal and intra-psychic dimensions. However, we do not feel that this is the case with the Senses and relationship-centred care. Therefore, whilst interpersonal elements are obviously essential, these are not the exclusive focus. For example, a Sense of Security does not just relate to interpersonal safety but would also includes physical safety or security and at an intra-psychic level the threats to 'existential'

security (Who am I?) that chronic illnesses pose (see Minkler 1996, Phillipson and Biggs 1998). Similarly the relationships inherent in relationship-centred care do not just refer to interpersonal relationships, but also the relationships individuals have with, for example, their physical or institutional environment and the impact that limited physical access, or restrictive health and safety regulations have on an a older person's Sense of Purpose and Achievement.

More recently Askham (2005) has considered the issue of how dignified care for older people can be promoted in professional education, arguing that whilst the concept appears frequently in professional ethical codes and standards, it is rarely explicitly taught in programmes of professional education. She suggests that education must help practitioners to:

- learn about older people, their preferences and how to deal with them;

- learn an attitude set in which dignity is respected;

- learn how to practice in a way that does not impede an older person's dignity;

- learn how to involve users in decisions and respect their preferences;

- learn how professionals can change the environment so that it does not threaten older peoples' dignity.

She suggests that the Senses Framework offers a potentially useful model but notes that it is in its early stages of development and that at present there is no clear guidance as to how it can be taught. We hope that the content of this report addresses some of these concerns and provides a further indication of how the Senses and relationship-centred care can be applied, particularly in respect of creating an environment in which older people's dignity is not threatened.

Where to from here?

The overall aim of this report has been to provide a detailed account of the AGEIN project and related work and thereby to demonstrate how the Senses Framework has been developed and elaborated upon over an extended period of time using both a detailed literature synthesis and extensive empirical work. We have suggested that the Senses Framework, when applied in the context of relationship-centred care, might prove useful as an organising framework informing important aspects of care for older people and their family carers, and the education and training of practitioners. This is increasingly relevant in the light of recent calls to ensure that older people receive dignified care (DoH 2006).

However, whilst we have considered the perspectives of several stakeholder groups (older people, staff and family carers) in this report, at the heart of the AGEIN project was the desire better to understand how to encourage students and qualified nurses to 'invest in' gerontoloigical nursing as a positive choice. This is now an issue of global significance (AGE 2006, WHO 2006) and, to the best of our knowledge, the work reported here is the most detailed yet undertaken. The dimensions of an enriched environment, as captured by the Senses, and the various 'foci' that students adopt, provide important new insights into how best to ensure that students' practice placements with older people are positive. This is a major factor in determining their future career choices (Fagerberg 1998, Askham 2005). One of the main aims of the GRIP reports is to present research in an accessible form and to

highlight the potential practical application of research findings. We hope that this report, and the suggestions given in Table 9, meet these aims.

Furthermore, additional development work in applying the Senses and relationship-centred care to education and practice is underway. An interactive video-CD Rom package aimed at students in training will be available shortly (Brown et al 2006), and the CARE (Combined Assessment of Residential Environments) profiles (Faulkner et al in press) have been developed to help staff, residents and families in care homes work together to improve standards in residential settings. An educational audit tool for student placements is also in the early stages of development, as is an interactive learning package applying the Senses and relationship-centred care to work with people with dementia.

Importantly, as Bass (2006) suggests, any framework for gerontology needs to be flexible and able to accommodate future changes. Practice frameworks in particular need to consider the needs of various groups of older people, including those with cognitive frailty (Dewing 2004), and from differing ethnic groups (Dewing 2004). These are areas in which further work is required.

Final thoughts

Although based primarily on the results of the AGEIN project, this report is the product of over a decade of work. The Senses Framework, which lies at its heart, were first presented publically in 1997 (Nolan 1997) but the thinking that informed the Framework's development can be traced back further (see for example Nolan and Grant 1993). Furthermore, other important studies, such as the Dignity on the Ward project (Davies et al 1999), have made a major contribution to empirically testing and further refining the Senses. Moreover, whilst AGEIN itself was first reported in 2002 (Nolan et al 2002) the results are, if anything, even more relevant and significant today than they were then (see AGE 2006, DoH 2006, WHO 2006).

In tendering for the AGEIN project we argued, just as Barker et al (1997) had done of psychiatric nursing, that gerontological nursing had yet to find its 'proper focus'. However, as the project progressed, it became clear that to develop a focus for nursing alone would be inadequate and would do older people and their family carers a disservice. Rather, as the literature was consulted, it became increasingly apparent that all disciplines lack an appropriate framework for working positively and proactively **with** older people and their family carers, especially outside of an acute care context. Our goal was ambitious, to see if, in conjunction with practitioners, students, older people and family carers, it were possible to develop such a framework that would 'speak' to diverse groups in a language that they could understand and which was seen as relevant to their circumstances. The extensive affirmatory 'dialogue' we had with all of the above groups gave us confidence that the Senses Framework 'fits the bill' in this regard. Indeed, since AGEIN, the Senses have been further used to inform the development of practice relevant materials in a range of settings for use with students, services for people with dementia and staff, older people and relatives in care homes. On this basis we believe that the Senses Framework has demonstrated its widespread utility and that this will only improve with further application and refinement.

However, to realise its full potential the Framework needs to be considered alongside a relationship-centred, as opposed to a person-centred approach. We are conscious that in

promoting this view there may be some who will see this as playing semantics, using words to 'split hairs'. Such individuals might argue that expanded definitions of person-centred care, such as Kitwood's (1997), which sees personhood as being achieved in the context of relationships, implicitly reflects the sentiments of relationship-centred care. We would not necessarily disagree, and in suggesting an alternative we do not in any way seek to minimise the seminal contribution that Kitwood's work has made. But we feel that relationship-centred care, in conjunction with the Senses Framework, makes **explicit** the importance of acknowledging and seeking to address everyone's needs in a way that person-centred care does not. The work we have completed to date also provides some very practical indications as to how relationship-centred care might be achieved.

As Kelly et al (2005) contend, if services for older people and their carers are to improve, then, amongst other things, there has to be a commitment to interdisciplinary working underpinned by an explicit and shared set of values. This is essential if the recently articulated 'New Ambition for Old Age' (DoH 2006) is to be realised. Motivating this ambition is the desire to address some of the *'key challenges for the future'*, by ensuring that *'older people should be treated with respect for their dignity and human rights in all care settings, whether at home, in hospital, or in a care home'* (Byrne 2006). However, if the dignity of older people is to be assured then so too must that of practitioners, students and family carers. The Senses Framework and relationship-centred care point the way towards creating an 'enriched' environment of care that meets this wider more inclusive vision.

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APPENDIX 1

Conceptual Phase: Search and Synthesis Strategy

The conceptual phase of AGEIN explored the literature and existing empirical work on the care of older people and their families in six areas:

■ Acute/rehabilitative care

■ Primary care

■ Continuing care

■ Older people with mental health problems

■ Older people with learning disabilities

■ Palliative care and older people

The intention of the review was to identify areas of commonality and contrast in the above topics that might begin to form the basis for an epistemology of practice with older people. The identification of literature sources was rigorous and the guiding principle behind the mechanics of the review was that it should be systematic, explicit and reproducible (see Nolan et al 1997). In order to produce a synthesis of knowledge across six distinct areas of practice with older people, it was important that the review was carried out in a consistent manner across these boundaries. The databases searched are indicated in Table A1.

Table A1: Bibliographic sources consulted for the review

Cinahl	– the Cumulative Index to Nursing and Allied Health Literature provides coverage of the literature related to nursing and allied health.
Medline	– encompasses information from Index Medicus, Index to Dental Literature and International Nursing as well as other sources of coverage.
Psychlit	– covers international literature on psychology and related fields.
Bids	– ISI service provides access to four bibliographic databases supplied by the Institute for Scientific Information, covering scientific and technical information, social science, arts and humanities; we searched to social science database.
AgeInfo	– the database from the Centre for Policy on Ageing.
HMIC	– the Health Management Information Consortium brings together three complete bibliographic databases covering UK and overseas health management and related topics; the three databases included are the Department of Health Library, the Nuffield Institute for Health database, and the King's Fund database.

Search terms were identified by lead reviewers for each of the discrete areas. When these were collated, it became apparent that many of the themes and concepts were common to all

six areas and these became core terms which were relevant across the entire review. Search terms specific to each field of practice were also subsequently identified.

This approach initially identified in excess of 22,000 references. The majority of these items were academic papers in peer reviewed journals, with books and reports contributing approximately 5% of the total. The abstract for each item was scrutinised and key themes and concepts identified. Material that was obviously not relevant to the focus of the review was eliminated at this stage. Following this initial classification, each abstract was examined a second time and an attempt was made to prioritise references in order to produce a more manageable volume of literature for retrieval and closer scrutiny. For example, those that appeared to represent service user views and professional views and those representing rigorous reviews of the literature, or which claimed to provide new theoretical insights, were given a higher priority. This process resulted in the identification of approximately 200 to 300 items for each field. These items were then retrieved, reviewed and grouped thematically to provide a structure for each area.

In reviewing each reference a broad 3 stage iterative process was followed. Initially each reference was read independently and a set of notes made identifying and summarising key themes. Subsequently, the notes from this first order analysis were scrutinised in detail so as to distil the core attributes of the key themes. Finally, comparisons were made within and between themes to explore the conceptual links and achieve an element of synthesis. For a detailed account of the principles underpinning both the relevance of literature and the subsequent analyses see Nolan et al (1997).

This report distils the key messages emerging from the reviews across the board.

APPENDIX 2

Survey Method and Copy of Perceptions Questionnaire

The survey of students' perceptions of working with older people, and the focus groups/observation visits (see Appendix 3) were undertaken in four Schools of Nursing in England. These were purposively sampled so as to vary in their geographical location, type of programme offered, and course philosophy (see Nolan et al 2002, Brown 2006 for a more detailed account). Approval to proceed was obtained from the relevant head of the organisation and no formal ethics procedure was required. However, all students who took part in the study were fully informed, and the relevant consents obtained. The questionnaire survey was completed with two cohorts of students in each school at differing points in the course trajectory. One cohort was sampled at the start of their 3 year training, the other at the point of transfer from their initial 18 month 'common foundation programme' (CFP) to their chosen branch of nursing (Adult, Mental Health, Learning Disability or Children). Due to the requirements of the data protection act, the difficulty of mailing questionnaires to large numbers of students, and the desire to maximise response rates, questionnaires were distributed to pre-identified groups of students whilst attending lectures at the University. The purpose of the study was explained and completion of the questionnaire taken to imply consent. In this way 718 questionnaires were returned. In addition to demographic data the questionnaire comprised two instruments specifically designed for the project, a 'quiz' on students' knowledge about older people, and an instrument asking for their perceptions about working with older people (see Nolan et al 2002 for a copy of the first of these questionnaires, and details of their development). Other items asked students if they had previously worked, or currently worked, with older people, and space was provided for the addition of qualitative comments. As noted in the main text, the newly designed 'perceptions questionnaire' was based on early focus group data and developed in close collaboration with students attending these groups. A copy of the perceptions questionnaire follows.

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The AGEIN Project
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Prifysgol Cymru · University of Wales
BANGOR

THE AGEIN PROJECT
(Advancing Gerontological Education in Nursing)

A Longitudinal Study of the Effectiveness of Educational Preparation to Meet the Needs of Older People and Carers

Please read the statements below and indicate how much you agree with each by circling the number that best reflects your opinion:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagress
Nursing older people is mainly about basic care - it does not require much skill	5	4	3	2	1
I would definitely consider working with older people when I qualify	5	4	3	2	1
Work with older people is a dead-end job	5	4	3	2	1
I am really looking forward/I really looked forward to my first placement with older people	5	4	3	2	1
Nursing older people is challenging and stimulating	5	4	3	2	1
Nurses work with older people because they cannot cope with hi-tech care	5	4	3	2	1
Working with older people has a high status	5	4	3	2	1
Once you work with older people it is difficult to get a job elsewhere	5	4	3	2	1
The older you are the easier it is to have a good rapport with older people	5	4	3	2	1
I am really anxious/I was really anxious about my first placement with older people	5	4	3	2	1
Working with older people does not appeal to me at all	5	4	3	2	1
Nursing older people is a highly skilled job	5	4	3	2	1
Nursing older people provides little satisfaction as they rarely get better	5	4	3	2	1
Working with older people is not a good career move	5	4	3	2	1
I think older people are really interesting to nurse	5	4	3	2	1

Below are some questions about working with older people. Please respond by ticking the appropriate box or writing your answer in the space provided:

1.   Did you work with older people before starting your training?

No   ☐ (please go to question 2)

Yes   ☐

Please briefly describe the work that you did: ....

....

....

....

Did you find working with older people:

A very positive experience   ☐   Quite a negative experience   ☐

Quite a positive experience   ☐   A very negative experience   ☐

2.   Do you currently work with older people outside of your training programme (eg as a care assistant)?

No   ☐ (please go to question 3)

Yes   ☐

Please briefly describe the work that you do: ....

....

....

....

Would you say that your current work provides:

A very positive experience   ☐   Quite a negative experience   ☐

Quite a positive experience   ☐   A very negative experience   ☐

3.   Please add any further thoughts about working with older people?:

....

....

....

....

Finally, some questions about yourself. Please tick the appropriate boxes:

Are you: Female   ☐   Male   ☐

Are you: 17-19 ☐   30-34 ☐   45-49 ☐

                      20-24 ☐   35-39 ☐   50-54 ☐

                      25-29 ☐   40-44 ☐   55+   ☐

Before starting your nursing course, what was your experience of older people? (tick all that apply):

Caring for older family members   ☐   Working in people's own homes   ☐

Working in a residential or nursing home ☐   School work experience   ☐

Voluntary work   ☐   Visiting grandparents   ☐

Working in a hospital   ☐   Working in a day care centre   ☐

Working as a support worker   ☐   I have no experience of older people ☐

Working with older people in any   ☐
other specific capacity (please specify)

....

What is your highest level of qualification?:

'O' Levels/GCSE   ☐   City and Guilds   ☐

'A' Levels   ☐   Higher National Certificate ☐

Diploma   ☐   NVQ Level   ☐

Degree   ☐   Access Course   ☐

Higher Degree   ☐

Other (please specify): ....

Which branch of nursing are you studying?:

Adult   ☐   Children   ☐   Learning Disability   ☐   Mental Health   ☐

Which intake did you commence your studies and in what group? (eg September 2000, Group B):

Intake: .... Group: ....

Which of the following best describes your ethnic or cultural origin?:

White   ☐   Black (other)   ☐   Pakistani   ☐

Black (African)   ☐   Bangladeshi   ☐   Asian (other)   ☐

Black (Caribbean)   ☐   Indian   ☐   Chinese   ☐

Other (please specify): ....

APPENDIX 3

Focus Groups and Observational Visits

In order to elaborate upon the results of the perceptions survey and to further explore the potential relevance of the Senses in understanding an 'enriched' environment of care extensive data were collected from both longitudinal focus groups and detailed observational visits. Several cohorts of students took part in focus groups over a 3 year period. In total 67 focus groups were held, involving several hundred students. These are summarised in Table A2.

Students were also asked to identify placement areas where they considered that they had 'positive' learning experiences. Thirty-three of these were selected for either half/one day visits, or longer visits of up to a week. Formal ethical approval from the relevant committee was obtained before the data collection began. During this time key staff were interviewed and student/staff views on the learning environment gained (see Nolan et al 2002 for a detailed account). The results from these visits were also fed back at the focus group discussions for further analysis and refinement, ensuring that students were closely involved at all stages of data analysis.

Table A3: Overview of focus groups and the point on the course (in months) when they occurred

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