School of Nursing and Midwifery

An exploration of the professional status and recognition of nursing older people: A grounded theory study

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This thesis is presented for the Degree of

Doctor of Philosophy

of

Curtin University

July 2014

DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university

Signed Deirdre Rostron

Date 7/7/14

ABSTRACT

Within the nursing profession there are clinical settings where nurses are eager to work and in contrast areas that are less popular. Nursing older people has been a specialist area in which many are reluctant to work, with those who do work there being viewed anecdotally as less able than their colleagues in other clinical settings. The focus of this grounded theory study was to explore how nurses who care for older people feel they are perceived by others. The study involved twenty three participants who were purposefully selected from public and private settings in both metropolitan and regional areas in the South West and Wheatbelt areas of Western Australia where older people receive nursing care. Participants were interviewed and the data analysed using the constant comparative method (Glaser & Strauss, 1967).

The data revealed the basic social psychological problem described by the participants as *feeling under siege* with two conditional categories related to this problem, *feeling under attack* and *feeling trapped.* The participants navigated a process, revealed in the data as *being resilient*, to be able to *survive* in this clinical setting and ultimately, being able to *advocate.*

This thesis presents a substantive theory of *advocacy* as an outcome of *resilience* and *survival* in aged care as it relates to nursing older people. It explains how the participants not only developed *resilience* and *survived* in difficult personal and professional situations within the clinical setting, but also developed *advocacy* skills. The construct of *advocacy* that emerged in this study had three elements, *advocating* for the older person, the profession, and self. For the participants in this study the concept of *advocacy* was crucial to their role and *survival* as registered nurses caring for older people.

This study unveiled a number of implications for practice, policy, and the profession. It highlighted the manner by which research participants recognised they were not considered to be as skilled or knowledgeable as their colleagues in other clinical settings. They developed strategies to manage this disadvantage. If employers are aware of this perceived disadvantage and the strategies required to continue their work with older people they will ensure the nurses have the skills to *survive.*

ACKNOWLEDGEMENTS

I would like to thank the following people:

1. The participants who contributed to this study. They gave freely of their time and experience in order to assist me in understanding the reality of their work.

2. My principal supervisor Professor Barbara Horner who provided me with the enthusiasm to complete the research. Her guidance, knowledge, and insight on the care of older people were of great value.

3. My associate supervisor Dr Beverley Scott for her knowledge and guidance on the use of Grounded Theory and her on-going patience with my punctuation and grammatical errors. I appreciated her reassurance that my experiences of the research journey were quite normal.

4. My friend Dr Caroline Vafeas who originally encouraged me to undertake my doctorate, as she wanted a study buddy whilst she did her research. She was there to offer support and listen to me as required.

5. My work colleagues who offered support and encouragement.

6. Dr John Hall for proof reading my thesis.

7. My family: to my husband David who was patient with me whilst I spent time on my research. He offered continuous support over the years. He provided me with assistance as required navigating the computer. To my children, David and Catherine, who encouraged me to “do my homework” and tried not to offer too many distractions. Thank you to them all for their love, support, and belief in my ability to complete this research study.

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CHAPTER 1

INTRODUCTION

1.1 OVERVIEW

Within the nursing profession there are clinical settings where nurses are eager to work and, in contrast, areas that are less popular. Nursing older people is a specialist area in which many are reluctant to work, with those who do work there being viewed anecdotally as less able than their colleagues in other clinical settings. The purpose of this grounded theory study was to explore how nurses who care for older people feel they are perceived by others.

This chapter begins with the impetus, followed by the significance, and purpose and objectives of this study, including the demographics of an ageing population, community attitudes towards older people, care provision, and workforce issues and their impact on health care. This information is intended to provide an introduction to how nurses' attitudes towards caring for older people have developed on individual and professional levels. The concerns regarding nurse recruitment and retention in clinical areas, where the care of older people is prevalent, are then discussed, including the projected impact of an ageing population. This provides an overview of the environment in which the participants were working, in order to provide information on the context of this study. A list of abbreviations and definitions of terminology used throughout the thesis is then provided. The chapter concludes with an outline of the organisation of the thesis.

1.2 IMPETUS FOR THE STUDY

Longevity is now something most individuals are likely to experience, but it has been viewed by some as an impending catastrophe, being referred to as a 'silver tsunami' (Wright, 2010). While nursing and aged care may be considered widely researched topics, there are several unanswered questions pertaining to problems associated with recruitment and retention of registered nurses in the care of older people. Repeated Government inquiries (Australian Government, 2010; Health Workforce Australia, 2013; Productivity Commission, 2011) have not resulted in any changes or

improvements in Australian registered nurse recruitment or retention in aged care settings. After more than 20 years of formal inquiries, arguably the relevant questions have not yet been asked, or perhaps not asked of the right people, such as the registered nurses who care for older people. The image of nursing is a concern for those within the profession, but very few researchers have explored the image of nursing as perceived by nurses (Emeghebo, 2012).

Longevity has implications on the demand for nurses to provide care (Grealish et al 2013; Health Workforce Australia, 2013; Koh, 2012). The nursing profession must, therefore, develop strategies to manage the increasing care needs associated with an ageing population. However, the recruitment of nurses to care for older people is hampered by nurses' reluctance to work in this area (Koh, 2012; Koskinen, Hupli, Katajisto, & Salminen, 2012). This reluctance raises several questions, including: Why is it more difficult to recruit and retain nurses in environments where the care of older people is prominent? Why are new graduates reluctant to choose nursing older people as a viable long term career option?

The researcher has had experience working as a registered nurse in a variety of settings, including working with older people as a member of an Aged Care Assessment Team. Aged Care Assessment Teams comprise health care professionals who assess the needs of older people, and facilitate access to government home care packages, respite, and permanent residential care. Within this role, the researcher became aware of anecdotal evidence, further supported by literature, that registered nurses in general were not eager to work with older people. As noted above, what appeared to be lacking in the literature were the views of those who nursed older people. The researcher's interest was then aroused to explore the manner in which this lack of enthusiasm within the nursing profession was experienced by registered nurses who had elected to care for older people: how they coped with the attitudes of their colleagues and an understanding of why they continued to work with older people.

1.3 SIGNIFICANCE OF THE STUDY

Within the nursing profession there are specialist areas in which nurses are eager to work, such as intensive care and the emergency department. In contrast, there are areas in which nurses are generally reluctant to work, such as disability services, mental health, and aged care (Clark & Diack, 2007; Happell, Welch, Moxham, & Byrne, 2013; Health Workforce Australia, 2013). In this study the researcher focuses on nurses who care for older people and how they feel they are perceived by those not working in this setting. This research is of particular significance due to the concerns regarding an ageing population and nurses' reluctance to work within clinical settings where older people receive care.

Although several researchers have explored the impending nurse shortage in aged care (Richardson & Martin 2004; Fussell, McInerney, & Patterson, 2009), there is an absence of studies about the manner in which registered nurses working with older people feel they are perceived by others. The substantive theory emerging from this study is expected to contribute to a better understanding of the consequences of registered nurses' thoughts and feelings about how they are perceived when they care for older adults and, more importantly, the reasons for their continuing to work in areas where older people are nursed. Then strategies can be developed to encourage others to consider nursing older people as a viable career option.

1.4 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of this study was to explore the professional status and recognition of nursing older people in Western Australia. There were three objectives:

1. Explore the speciality of working with older people as perceived by registered nurses who work with them;
2. Describe the factors that nurses who work with older people feel have an impact on both their status and professional recognition;
3. Develop a substantive theory that explains how registered nurses working with older people manage their professional role.

1.5 BACKGROUND / CONTEXT

A number of issues had an impact on the participants in this study as they worked with older people. These include demographics of the ageing population within Western Australia, community perceptions of older people, the politics of aged care, the provision of care for older people, the nursing workforce, the impact of an ageing population on the health care system, and the need to plan future healthcare for the older person. An elaboration of each of these issues follows.

1.5.1 Demographics of an ageing population

The ageing population is not just a local phenomenon that can be directly related to this study; it is also a national and international issue, with the literature projecting an ageing population worldwide (Productivity Commission, 2011; Singh & Hubbard, 2011; World Health Organisation, 2008). In the developed world the over 60 age group is growing at a higher rate than any other age group; the reasons include an increase in life expectancy and a decline in fertility rates (Browski & McDonald, 2007; World Health Organisation, 2011). However, it is undeniable that general improvements in public health over recent decades have also had an impact on longevity (Swerissen, 2010). In addition to the overall increase in the ageing population it is predicted there will be an even greater increase in the number of those aged 80 years or over, a group often referred to as the "oldest old" or "very old" (Swerissen, 2010).

Reflecting the international trend, Australia's population is ageing (Australian Bureau of Statistics, 2012; Australian Government, 2010; Productivity Commission, 2011), with a quarter of Australia's population predicted to be aged 65 years or over by 2057 (Australian Bureau of Statistics, 2008). The increase in life expectancy is predicted to continue (Australian Bureau of Statistics, 2012; Australian Government, 2010; Productivity Commission, 2011; Wells, Foreman, & Ryburn, 2010), with it being estimated that life expectancy for men will increase by 7.6 years and for women 6.1 years between 2010 and 2050 (Australian Government, 2010), with the number of Australians aged over 85 set to quadruple (Productivity Commission, 2011). The increase in centenarians has already been documented, with the

Australian Bureau of Statistics (2010) reporting an 18.2% increase between 2009 and 2010. It is estimated that by 2055 there will be 78,000 people in Australia aged 100 or more (Department of Health and Ageing, 2006).

In comparison with other countries the population of Australia is relatively young or middle aged (The House of Representatives Standing Committee on Health and Ageing, 2005). This has been attributed to the high rate of immigration to Australia, with 89 percent of migrants being aged less than 40 years (Australian Government, 2010). Although migrants have assisted in 'moderating' Australia's ageing demographics, suggestions are that the number of younger migrants would have to increase markedly in order to have a continuing effect on the ageing profile (Productivity Commission, 2011).

Another factor in Australia's relatively young profile is that the population profile of Aboriginal and Torres Islanders is younger than that of the non-indigenous population and their life expectancy is significantly lower (Productivity Commission, 2011). Although the number of older indigenous people is low compared to non-indigenous Australians, it is significant because as a group they are likely to access aged care support at a younger age (Australian Institute of Health and Welfare, 2013). Age related disabilities for indigenous people are higher than that of non-indigenous people and occur at a younger age (Productivity Commission, 2011).

Because this study was conducted in Western Australia, the researcher deemed it necessary to examine the demographics of ageing relevant to this state. The population of Western Australians aged over 65 increased by 5.9% during the years 2009 – 2010 (Australian Bureau of Statistics, 2010). Although these figures suggest a rise in the population aged over 65 years, what is probably of greater significance is that the percentage of those aged over 80 years is also increasing, with projections that this age group will increase from 1.6% of the population in 2007 to between 4.9 and 7.3% of the population by 2056 (Australian Bureau of Statistics, 2012). One advantage Western Australia has compared with the remainder of Australia is a slightly younger aged profile to the national average.

1.5.2 Community perceptions of older people

The community's perception of older people has an impact on those caring for them, so was also deemed significant to this study. The age at which people are considered to become a burden was 65 years old, probably due to the link to retirement age (Brown, 2010). Other researchers have found that once people reach a certain age they are no longer considered to be useful to society, resulting in a negative attitude towards older people (Carigan & Szmiginm, 2003; Hatcher, 2010). This negativity has often focused on the fact that older people were considered a burden (Hughes & Heycox, 2010) with becoming 'dependent' playing a pivotal role in how older people were perceived (Schermer & Pinxten, 2013). Society itself may be to blame for older people being labelled as a burden, because society 'forces' older people into retirement, resulting in them having to spend their assets, thus they become more reliant upon others for financial support (Harvey & Thurnwald, 2009). Hughes and Heycox (2010) contend this view has the potential to change, with some older people now continuing to work either in paid employment or by undertaking voluntary work and with the projected rise in the pension age from 65 to 67 years old between 2017-2023.

Generally speaking Western society is negative towards older people (Hunter, 2012; Palmore, 2001) because older people are viewed in terms of their health and care needs, which increase with age (Productivity Commission, 2011; Swerissen, 2010). Thus the general perception of ageing is negative, with older people often stereotyped as more likely to be ill, tired, lonely, have memory loss, be defensive, be unhappy and withdrawn, and with these beliefs being reflected within health care environments (Harvey & Thurnwald, 2009; Minichiello & Coulson, 2005). Di Marzio (1999) listed four specific examples of how older people are perceived by their communities and some years later they were considered still pertinent:

> 1. The public perception of older people is fairly negative;
> 2. Older people by and large are felt to lack value and potential;
> 3. Media portrayal is often unfair and unkind to older people; and
> 4. The expectations of the future for older people are relatively bleak and pessimistic.
>
> (The House of Representatives Standing Committee on Health and Ageing, 2005, p.30)

According to The House of Representatives Standing Committee on Health and Ageing (2005) continuance of negative attitudes about older people has the potential risk of them being treated as "2nd class citizens". Battersby (1998, p.6-7) reported that: "the young have entrenched negative views about ageing", seeing themselves as young and seemingly oblivious to the fact that eventually they will age. The negative attitudes towards older people are possibly a result of people's lack of understanding and fear of ageing (House of Representatives' Standing Committee on Ageing, 2005).

Previously in certain cultures longevity brought power, wealth, prestige, and importance within both the family and society (Achenbaum, 2005; Hunter, 2012; Ron, 2007). The decline in prestige associated with ageing has been attributed by some to the industrial revolution because families had to move to seek employment, and with the introduction of the printing press to record historical events older people were no longer revered as historians (Nelson, 2005). It has been suggested that, when the number of older people was low, society viewed them with esteem but as their number increased they were seen as a burden on society (Hendricks, 2005; Ron, 2007). Some believe this negative view will change within the 21st Century due to the increased number of older people, and society becoming 'aged friendly' (Minichiello, Somerville, McConaghy, McPanlane & Scott, 2005).

'Baby Boomers' (those born between 1946 and 1964) are accustomed to subsidised health care. Most have been active contributors to society and thus have high expectations they will receive adequate service provision. This leads to an increase in consumer expectations for a high quality service with options available to meet individual care needs (Productivity Commission, 2011). A significant number of this group are likely to be experiencing the impact of elderly parents: any problems that are encountered they will want rectified especially since they too are ageing. Older people today are also more affluent than their predecessors and thereby expect a high standard of service provision. One consolation for those concerned about this group's impact on health care demand is that these Baby Boomers will 'age healthily' (Australian Institute of Health and Welfare, 2013); as they are more aware of the effect lifestyle choices have on health. The majority of older people live active lives in the community with no or minimal services.

1.5.3 Care provision for older people in Australia

Historically, in Australia the welfare of an individual was primarily the responsibility of the family and the community and not the state (Boxall & Gillespie, 2013). If the family did not provide care, the individual in question became destitute. The aged pension was introduced in Australia in 1909, providing a 'safety net' for older people who could not provide for themselves financially (Tirrito, 2003). However the aged pension is means tested, with Australians now expected to contribute towards funding themselves following retirement by making compulsory superannuation contributions while engaged in work (Hughes & Heycox, 2010); the latter only works if the individual has been in employment long enough to have accumulated sufficient funds.

In Australia in recent decades there has been a move away from institutional / custodial care for older people (Fine & Stevens, 1998; Hughes & Heycox, 2010). With this move older people are encouraged to remain in their own homes with support from community service providers. The Coleman Report (1975) played an important role in changes to care provision for older people, noting there was likely to be an excess of nursing home beds provided for their care: this resulted in recommendations being made in relation to hostel and community care services. There were concerns regarding inappropriate admission of older people to nursing homes, leading to the creation of Aged Care Assessment Teams to assess an older person's care needs and the introduction of Home and Community Care programs.

Government spending on aged care is projected to increase from 0.8% of Australia's gross domestic product in 2009-2010 to 1.8% by the financial year 2049-2050 (Australian Government, 2010). Of concern to what might be termed Western countries is the impact of the "Baby Boomer" generation which is due to reach retirement age between 2011 and 2021 (Cangelosi, 2011; Humpel, O'Loghlin, Wells, & Kendig, 2010). The Australian Government has become apprehensive at the prediction that Australia's spending on health, aged care, and aged pensions will increase, from being currently a quarter of Australia's spending to be a half by 2049-2050. The Government contends this would be exacerbated by the decreasing ratio of working people to older people. In 2010 there were five working people to every person aged 65 or above: this is considered likely to decrease to 2.7 people of

working age per one person aged 65 years or over by 2050 (Australian Government, 2010).

There has been an increase in home services for older people requiring additional support and care, which evolved following the introduction by the Hawke Government of the Home and Community Care (HACC) program in 1985-1986 (Productivity Commission, 2011). This form of aid sought to prevent older people being inappropriately admitted to residential care. Community care continues with the HACC program, Community Aged Care Packages, Extended Aged Care at Home (Hughes & Heycox, 2010) and more recently Home Care Packages (Department of Health and Ageing, 2012). The majority of older people want to live at home (Brown, 2010) and although many wished to live near their adult children, they were reluctant to live with them (Tirrito, 2003). This may result in a future shift towards even more resources being allocated to community care. In contrast to this Nay (2004) predicts a shift to residential care because the community cost will be unsustainable, resulting in the cost of community care being further escalated if, as predicted, family/carer support was reduced.

At the time of this study if an older person required residential care there were two levels of care offered. Low-care facilities (previously known as hostels) provide accommodation, personal care, and allied health support services. High-care facilities (previously known as nursing homes) provided accommodation, assistance to those who needed help with most activities of daily living and 24 hour nursing care (Department of Health and Ageing, 2013). The distinction between low and high level care was removed in July 2014 (Department of Social Services, 2014), with ‘ageing in place’ becoming common practice. Ageing in place means older people requiring residential care remain within the same residential care facility as their care needs increased.

Nurses provide care for older people in a variety of settings (Sayers & Cotton, 2013). These include residential aged care facilities, community settings, acute wards, sub-acute wards, rehabilitation units, geriatric evaluation and management units.

1.5.4 The impact of an ageing population on the healthcare system

The Australian health care system has been described as a "blend" of both public and private health care provision (Boxall & Gillespie, 2013; McCormack, 2002). The public system is funded by the Federal Government's Medicare, a compulsory health insurance scheme for Australians (Willis, 2009). Willis discussed the variety of providers offering private health insurance, with access for members to public and private hospitals, plus various health care extras, such as, physiotherapy and dental treatment. In addition to these health care options, provision for ex-military personnel through the Department of Veterans' Affairs is also available.

The Australian health system could be seen as a victim of its own success because the increase in the number of older people in the population is a result of the advances in health care provision (Davies, 2011). This could include new developments for the treatment and management of diseases, advances in health care technologies, easier accessibility, and the increased importance placed on health promotion/health education (World Health Organisation, 2008; Swerissen, 2010). As well as the advances in health care there have also been improvements in living conditions with people choosing to adopt healthier lifestyles. However, instead of these advances being embraced as leading to longevity they are often viewed as a problem because older people are perceived to be a major contributor to the health care crisis (McCormack, 2002).

Older people occupy more than half the beds in acute care hospitals and are more likely to stay longer in hospital than younger people (Australian Institute of Health and Welfare, 2012; Daly, Jackson, & Nay, 2014). However, the majority of older people have their health care needs met within the community, with only the most acute cases being admitted to hospital (Koch, Hunter, & Nair, 2010). Hospitalisation has a detrimental effect on the older person's independence because they are at risk of deconditioning (Koch et al, 2010). Even when an older person's health issue has been addressed, it can take some time to plan that person's discharge to their home or other location. As a result of this delay, older people are often seen as "blocking" acute care beds while awaiting placement in a residential aged care facility, with the term "bed blocker" suggesting that they are in some way to blame for the situation they are in (Neuberger, 2008).

People aged over 65 years use four times more health resources than those aged under 65 years (Johnstone & Kanitsaki, 2009; Swerissen, 2010). This increases further for those aged over 80, reaching a peak for those aged between 80 and 90 years old. According to Swerissen, the demand then declines, probably a reflection of the lower number of people aged over 90 years. The number of hospital bed days for those aged over 65 years will continue to rise, with predictions that this will increase from 47% in 2005 to 67% by 2050 (Harvey & Thurnwald 2009).

A number of the participants in this study had worked or were working in rural and regional towns. Particular concerns tend to be expressed regarding the consequences of an ageing population within rural towns due to the movement of younger people away from rural communities and the impact of domestic migration on older people (Browski & McDonald, 2007; Kalache, 2013). Within smaller towns, the resources to support older people with specific care requirements may be limited. An additional concern is that retired people who seek a 'sea change' are moving to smaller coastal or rural towns, where resources may be limited for meeting their needs as they age. Therefore, the ageing population in rural and remote areas of Australia could be more manifest than in the urban areas, with 30% of small to medium rural or remote towns' population being aged 60 or over (Lavender & Keleher, 2004). The concern about the impact of the increasing elderly population in many rural and remote areas is accompanied by concern about recruiting and retaining suitably qualified staff (Blake, 2010).

Care for the older person within the health care setting transcends many clinical settings (Department of Health and Ageing, 2008). A high percentage of patients admitted to general acute wards are now older (Edvardsson & Nay, 2008; Hindle & Coates, 2011). Caring for a young or middle aged patient on an acute ward is now uncommon (Street, 2004). People aged over 65 years use approximately four times the amount of health resources used by younger people (Nay & Garratt, 2004), including more frequent and longer admissions to hospital. They reported another health cost to be the expense of medications for the over 65s, which was calculated to be 2.5 times greater than other age groups.

Harvey and Thurnwald (2009) were cautious about this prediction resulting purely because of an ageing population because there is also the need to consider the

increase in treatment and management of older people in the community. The National Health and Hospital Reform Commission (2009) suggested that 20% of older people in acute hospital care would be more appropriately cared for in other settings, for example rehabilitation and convalescence units.

Kane and Kane (2005) acknowledged that many journalists and health care policy makers refer to the high health expenditure on older people. The situation could be far worse if it was not for the number of unpaid carers providing support to dependent older people in the community, with an estimated 50% of carers spending 20 hours or more weekly providing unpaid care (Willis, Reynolds, & Keleher, 2009).

In contrast to the view that older people are a burden on the economy, the Aged Care Workforce Committee (2005) stated that aged care played a significant part in the Australian economy due to its contribution as an employer. This Committee added that the aged care industry employed 1.3% of the total Australian workforce in the year 2000, ranking it as the 9th highest employer in Australia. This report, however, focused on the 'aged care industry' and excluded care of older people in other areas. If the aged population continues to increase then the number of workers employed to care for them will have to increase commensurately.

However, the future increase in health expenditure should not be blamed solely on an increased ageing population. Other non-demographic growth must be considered, for example new medications and advances in health technology (Schofield & Rothman, 2007). Schofield and Rothman (2007) acknowledged that the ageing population will place pressure on Australia's finances as a whole, but considered Australia to be well placed to address this outcome and recommended forward planning as being crucial. Borrowski, Engel, and Ozanne (2007) cited a British economist, Phil Mullan, as believing that the majority of industrialised countries will be able to support an ageing population, especially since the majority of older people are able bodied and do not require care (Nay, 2004). Indeed in 2012 12 percent of those aged 65 and over remained employed in the labour force (Australian Institute of Health and Welfare, 2013).

Many older people reside independently and contribute positively to the communities in which they live (Australian Institute of Health and Welfare, 2013) with the majority of older people not considered sick or in need of support. Although co-

morbidities increase with age, data suggest that life expectancy free of disease was increasing at the same rate as total life expectancy (Gjonca & Marmot, 2005). If this is true then the impact of the ageing population may not be as great as many predict (Johnson & Yong, 2006).

1.5.5 The nursing workforce

The predictions of an increasing number of older people requiring care needs to be considered by health care providers as it will have an impact on nursing care provision over the coming decades (Productivity Commission, 2011). Concerns have been expressed about recruiting and retaining nurses within the health care system, particularly in areas involving the care of older people, and at a time when this age group is increasing (Fussell, McInerney, & Patterson, 2009). This concern is escalating due to the ageing of the current workforce and the planned retirement of large numbers of nurses in the next decade. This is such a major issue that aged and dementia care has been referred to as the "greatest crisis" to affect the Australian nursing workforce (Chenoweth, Jeon, Merlyn, & Brodaty, 2010), with predictions being made that the aged care workforce will have to quadruple by 2050 to meet the demand for care (Productivity Commission, 2011).

It is well recognised there are global problems of recruiting and retaining nurses in the profession (Abbey, 2006; Blake, 2010; Parish, 2006; O'Brien-Pallas, 2006). Recruiting registered nurses to care for older people and retaining them in these roles are recognised as complex problems. It is predicted that in Australia there will be workforce shortages in aged care and especially a shortfall of nursing staff (Health Workforce Australia, 2012; Mesken, 2013; The House of Representatives Standing Committee on Health and Ageing, 2005). Reports have tended to focus on recruitment and retention of staff in relation to residential care facilities (Commonwealth Department of Health and Aged Care, 2002), but care of older people is provided in many different care settings including acute care, rehabilitation, and the community (Marshall, 2010). As mentioned above, rural and regional areas within Australia experience even greater problems with matters related to the recruitment and retention of all health care professionals (Crombie, Disler & Threlkeld, 2010; Department of Health and Ageing, 2008). Many rural hospitals in

Western Australia provide multi-purpose services providing care for older people within a variety of settings. Since nurses account for the greatest number of health professionals, there is a particular need to encourage nurses to these areas.

Recruiting registered nurses to provide nursing services for older people must overcome many challenges, as it is extremely difficult to change attitudes and beliefs that have been commonplace for decades. This is reflected by Gerontology being nearly the last specialist area in which people choose to work (Stevens, 2011).

There are a number of reasons for nurses leaving the aged care field (Department of Health and Ageing, 2012), these include:

1. wage discrepancies;

2. staffing levels;

3. negative image of aged care; and

4. skill mix.

Working with older people is considered to be of low status thus a "cultural change" must occur in order to attract would-be employees, in particular younger people to the industry (Hugo, 2007). This negative image towards older people, and the limited education provided about caring for them, has resulted in it being an unpopular career choice with health care workers (Reyna, Goodwin, and Ferrari, 2007).

As the population is ageing the workforce is also ageing, with the workforce caring for older people considered to be on par with that of the general Australian workforce (Martin & King, 2008). So the number of older people increasing and potentially requiring more nursing care will coincide with a time when there are fewer people of working age available to provide care (Hallam, 2002). A study undertaken by KPMG and Ipsos, predicted a nurse shortage in the next decade (Anonymous, 2010). They described how Australia had benefitted from the Baby Boomers being in the workforce over recent decades, but now these workers would be retiring. According to their study, 35% of nurses were aged over 50 years and were planning to retire in the next 10 years.

During 2001–2002 the average age of nurses was 41.8 years, which increased to 43.4 years between 2007–2008 (Workforce profile, 2011). The House of Representatives Standing Committee on Health and Ageing (2005) recorded the average age of registered nurses working in the public sector to be 44 years, but for those working specifically in aged care it was 54 years. The Committee received some reports of nurses aged over 75 working within the aged care sector. It is not only the increasing number of nurses retiring that is of concern to employers, but also the number of those who, as they age choose to reduce the hours they work (Workforce Profile, 2011), adding additional stress on an already depleted workforce.

One way the nursing profession has attempted to address the workforce deficit has been to encourage migrants to join the workforce. The success of this approach is already evident within the nursing profession because they are now a significant proportion of staff; this is especially noticeable in residential aged care settings (Blake, 2010; Fine & Mitchell, 2007; Health Workforce Australia, 2012). However, this cannot be seen as a guaranteed solution to meeting the shortfall in recruitment because other countries are attempting to recruit staff from abroad (Buchan, 2002; Fine & Mitchell, 2007). Therefore, health care providers will be competing with other local employers to recruit nurses and with international employers.

The major concern in relation to the future care of older people is the shortage of the required healthcare workers, more specifically nurses (Commonwealth of Australia, 2010; Flackman, Sorlie & Kihlgren, 2008). With the older population growing at a faster rate than the younger generation, this may not be sustainable. The changing role of what constitutes a family, and the contribution of family members to care provision, then becomes a challenging issue, for example, the changing role of women within society, working mothers, women wishing to pursue careers, and their decision to have children at a later stage in their lives (Productivity Committee, 2011). These advances which should be applauded may prove detrimental in regard to their traditional role as family carers being eroded.

The Australian Health Minister's Advisory Council (2005) recommended all health service providers should be striving to raise awareness of the needs of older people amongst staff because there has been, and will continue to be, an increase in the number of older people presenting with complex medical and psycho-social needs .

The public health care system has finite resources and therefore needs to identify its priorities (Levine, 2009). This prioritising is likely to impact upon the care of older people and all other members of society as each specialist area strives to ensure its needs are being met. Therefore, older people will be competing against people from other age groups to obtain the required resources. Williamson and Christie (2009) maintain there is little evidence to support the perception that older people are taking away resources from more needy groups or society. Their rationale for this contention is that today's older people are generally more educated, more able to manage their finances, and more willing to take unpaid work. Tirrito (2003, p.223) stated that the "health care system probably can expect the greatest impact from the longevity explosion". This highlights the need for contingency plans and policies to be put in place to ensure that older Australians' health care needs continue to be met, with registered nurses playing a pivotal role.

1.5.6 The registered nurse role

The role of the registered nurse caring for older people can be both complex and diverse (Hunter & Levett-Jones, 2010; Manchester, 2013), regardless of the clinical setting in which they practice. The care needs of the elderly can be so complex that nurses working in residential aged care facilities have made reference to it being comparable to working in "mini hospitals" (Furaker & Agneta, 2013). An explanation for this complexity is that a variety of nursing care once undertaken in hospitals is now provided in the home or community settings (Carlson & Bengtsson, 2014). As older peoples' care needs are more acute, potentially requiring nursing care across all clinical areas, then the registered nurse requires more skills and knowledge (Hunter & Levett-Jones, 2010). Registered nurses caring for older people not only require specialist knowledge of aged care, but also a broad knowledge of multiple health issues (Furaker & Agnetta, 2013; Hunter & Levett-Jones. 2010).

All registered nurses have to be proficient in the aspects of the nursing process, these being, assessment, analysis, planning, implementing, and evaluating. The registered nurse in aged care has to possess very high assessment skills because clinical changes in the older person may not be as obvious as in a younger person (Manchester, 2013). They also have to be able to distinguish between what is normal

and abnormal ageing (Forster, 2003), which can be more difficult if the older person has cognitive impairment and has difficulty communicating their needs.

The nurse's role may not always focus on an acute care episode experienced by the older person but on maintaining their independence (Hickman, Davidson, Chang, & Chenoweth, 2011). With this there has been a shift away from the medical model of care towards the inclusion of health promotion and healthy ageing in the nurse's role (Hunter, 2012). The registered nurse not only has to have clinical expertise but also has to be a confident teacher, supervisor, and manager (Furaker & Agneta, 2013).

The registered nurse caring for older people has to be autonomous especially if working in the residential or community care environments because they do not have as easy access to doctors as nurses in the acute care settings (Furaker & Agneta, 2013; Manchester, 2013).

Nursing the elderly, like any other clinical environment needs skilled and well educated nurses (Carryer, Hansen, & Blakey, 2010). With this there is a growing need for specialist nurses in aged care due to the ageing population. Since the 1990s some organisations in Australia have made attempts to increase nursing knowledge and evidence-based practice in aged care (Hunter, 2012). There has also been an increase in specialist nursing roles (Campbell-Detrixhe, Grassley, & Zeigler, 2013; Hunter, 2012), such as clinical nurse specialists and nurse practitioners within aged care, reflecting the expertise required to nurse older people.

In summary, the population of Australia has an increasingly ageing population with complex needs requiring care. Registered nurses are suitably skilled to address these complex needs, but aged care is an environment where nurses are reluctant to practice (Blomberg, James, & Kihlgren, 2013). This research is important because there is a need to understand how this situation can be improved.

1.6 DEFINITIONS AND NOMENCLATLURE

ACAT	Aged Care Assessment Team. These are teams of health care professionals who assess the needs of older people needing assistance to live at home. They also assess and approve

	people for entry to government subsidised aged care services (Department of Health and Ageing, 2011).
Acute care	Health care for severely injured or sick individuals. Care is usually intensive and of short duration.
Baby Boomers	Those born between 1946-1964.
Bed blockers	Patients who are in hospital, but no longer require acute medical / nursing care. They would be suitable for discharge to be cared for elsewhere (for example, rehabilitation or residential care), if a place was available
CACPs	Community aged care packages. Provision of low level care within the home / community setting
Carers	The term carers may refer to both unpaid and paid care staff. If carers are employed, they may also be referred to as care workers, personal care assistants, and assistants in nursing.
CAP	Care awaiting placement. These people have been assessed as suitable for residential care but have not found suitable placement. As they require care, they often remain in a hospital setting until they move to residential care.
Enrolled nurses	In Western Australia enrolled nurses work under the supervision and direction of the registered nurse (Nurses and midwives board of Western Australia, 2010).
EACH	Extended aged care at home. High level nursing and personal care provided in the home / community setting.
EACH (D)	As EACH but specifically tailored towards care of people with dementia.
HACC	Home and community care. Care provision for older people in the home. Includes care such as domestic assistance, social support, and personal care.

High-level care	Previously called nursing homes. The older person requires a large amount of care and supervision. In addition specific nursing care is often required. Care is provided over a 24 hour period.
Low-level care	Previously referred to as “hostel” care. The older person is relatively independent but benefits from the supervision and support of a residential care facility.
MPS	Multi-purpose services. These are found in rural and remote communities, where care is provided to suit the need of the individual. This can be care within either the community or residential care setting, usually at the local hospital.
Older person	For this study it was a person aged over seventy or fifty years if Aboriginal / Torres Strait Islander (Department of rehabilitation, aged and continuing care, 2004). However, much of the literature uses the definition of retirement age.
Registered nurses	Registered nurses are competent in providing nursing care, provide evidence-based practice in a variety of settings, and are responsible for their actions and delegation of care to other junior staff (Nurses and midwives board of Western Australia, 2010).
Residential care	Accommodation where support is provided to those unable to continue living at home. This could be either low-care or high-care as noted above.
Respite care	This is provided to support the carers of older people. Care can be provided in the home, in the community, or in residential care facilities, to allow the carer a break from their caring role.

Throughout this thesis the older person is referred to in a variety of ways, reflecting the involvement of the participants in their care. These terms included client, the elderly, consumer, resident, and patient.

Both the participants and the literature used various terminology for residential aged care facilities. These included residential care, nursing homes, hostels, high-level care, and low-level care. The terminology used was reflective of the time that the texts were written and what was colloquially acceptable to the study participants.

1.7 ORGANISATION OF THE REST OF THE THESIS

Chapter 2 explores the origins and development of Grounded Theory. The application of Grounded Theory methodology, including the sample population, data collection, data analysis, and ethical considerations are described.

Chapter 3 outlines the basic social psychological problem of conceptually *feeling under siege*, as experienced by the participants of the study. The concepts and categories including feeling under attack and feeling trapped are explained and illustrated by the data obtained from participant interviews.

Chapter 4 discusses how the participants managed the problem identified in Chapter 3. The basic social psychological process of developing *resilience* in order to *survive* is explained. The concepts derived from the data, active and passive strategies, recruiting to the cause, recognising victories, and developing resilience will be explicated and excerpts from the data are used to support them.

Chapter 5 will explain the substantive theory of *advocacy*, which represents how the participants advocate for the older person, the profession, and self. The researcher compares and contrasts the substantive theory with existing theory and appropriate literature.

Chapter 6 concludes this study. The implications of the study for clinical practice are discussed and recommendations made in order to address issues raised by this study. The researcher also provides details on the possible limitations of the study.

CHAPTER 2

METHODOLOGY

2.1 OVERVIEW

This Chapter will describe how grounded theory was used to explore how nurses caring for older people felt they were perceived by others. The chapter begins with a brief overview of qualitative research, followed by an explanation of the researcher's rationale for choosing grounded theory for this study. The origin and development of grounded theory are then described, including the underpinning principle of symbolic interactionism and the differing views of Glaser and Strauss on how grounded theory can be applied. The grounded theory method is discussed next, followed by its application in this research. The latter includes how grounded theory was applied in relation to the research setting, the research sample, data collection, and data analysis using the constant comparative method. Finally, the ethical considerations necessary for this study are discussed, including details on ethical approval, obtaining informed consent from participants, and issues of confidentiality for both the participants and the organisations for which they worked.

2.2 QUALITATIVE RESEARCH

Qualitative research is grounded within the area of social science, its strength being that it involves the study of issues relating to human values, relationships, and culture. This study involves all these interpersonal aspects of human experience, thus a qualitative approach was considered most appropriate. Strauss and Corbin (1990) described qualitative research as dealing with peoples' lives, their stories and their behaviour. This opinion is further supported by Morse and Field (1996) who described qualitative research as enabling researchers to understand the reality of the participants' social world, and from that understanding and analysis, models and theories can be developed. Qualitative research has the additional advantage of researching things in their natural settings (Denzin & Lincoln, 2000). Qualitative researchers believe that an important aspect of data gathering is to capture the

participants description of their situation using their own words (Holloway & Wheeler, 2010).

Recognising there is a place for both qualitative and quantitative methodologies, Morse & Field (1996) suggested the major reason for choosing to undertake qualitative research is when little is known about an event or phenomenon and it is suspected that present knowledge or theories may be biased or incomplete. Macnee (2004 p.189) further expanded on this major reason by describing three basic functions of qualitative research. These are to:

1. increase understanding
2. promote participation/immersion
3. link ideas and concepts

Qualitative research is an approach that has developed significantly over recent years, becoming increasingly popular within the nursing profession (McGhee, Marland, & Atkinson, 2007; Streubert &Carpenter, 2011). Clifford (1997) provided a rationale for this development, stating qualitative research is a more holistic approach than quantitative research. Abdellah and Levine (1994) attributed the increasing popularity of qualitative approaches to four developments in nursing:

1. An increase in the number of nurses being educated in the social and behavioural sciences
2. The increasing development of nursing models and theories
3. An increase in literature on nursing research
4. An increasing reliance on qualitative data

In contrast, Peck and Secker (1999) contended that qualitative research was not always as effective as quantitative methods in the health care sector. Their explanation for this was that qualitative research was often time-consuming and thus not resting easily with the fast-paced environment of health care in which managers and policy makers had short-term deadlines to meet. Even with these potential problems associated with its use, qualitative research has become popular within the health/nursing profession. In clinical practice qualitative approaches play an

important role, as noted by Macnee (2004 p.189): “The goal of qualitative research is to gain knowledge that informs our practice broadly and holistically.” Because nursing is an applied health science, it is quite feasible that qualitative research methods should abound in this area. For this study grounded theory was deemed the most appropriate qualitative approach.

2.3 THE ORIGIN AND DEVELOPMENT OF GROUNDED THEORY

Grounded theory is a qualitative research method which is rooted in sociology (Glaser, 1998). It originated within the field of social sciences during the 1960s, with work undertaken by American sociologists Glaser and Strauss (1965) when they explored issues surrounding death. Strauss, who had a background in symbolic interaction, was from the University of Chicago, a University at the time already renowned for qualitative research. Glaser, with a background in quantitative methods, was trained in qualitative research methodology at Columbia University (Bryant & Charmaz, 2007; Glaser, 1992; Strauss & Corbin, 1990). From their original research, ‘Awareness of dying’ Glaser and Strauss went on to write and publish information on the methodology they used in their book *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). In their original work Glaser and Strauss made a significant shift in the field of research by moving from testing theory to the development of theory; they defined grounded theory as “the discovery of theory from data systematically obtained from social research” (p.2). More recently grounded theory has been defined as: “An approach to collecting and analysing qualitative data that aims to develop theories grounded in real world observation” (Polit & Beck, 2010, p.556). Norwood (2010, p.52) provided a rationale as to why grounded theory is “grounded” by describing how it develops from “social reality rather than from theoretical speculation.” In summary, grounded theory is an approach that concentrates on generating theory rather than verifying already existing theory (Glaser & Strauss, 1967; Kennedy & Lingard, 2006; McGhee et al, 2007). Grounded Theory is a qualitative research method in which the researcher begins with no preconceived ideas about the outcome and allows the research to develop with the collection and analysis of data (Glaser, 1992; Welford, Murphy, & Casey, 2012); this enables the researcher to develop a theory “from the ground up”

(Skeat, 2010, p.107). Grounded theory differs from other qualitative research methods because it goes beyond description to developing concepts that explain social processes (Skeat, 2010), thereby building theory (Holloway & Todnes, 2006). Walls, Parhoo, and Fleming (2010, p.8) described grounded theory as simply "ending with a theory rather than beginning with a hypothesis".

Grounded theory can generate two types of middle range theories, these being substantive theory and formal theory (Glaser & Strauss, 1967). Substantive theory is developed from a narrow area of study, whereas formal theory is more generalised, covering a broad range of other substantive areas (Glaser, 1978). In this study the researcher aimed to generate a substantive theory because the area of research was narrow, focusing on registered nurses who cared for older people.

2.3.1 Symbolic interactionism

Grounded theory developed from the earlier school of thought of symbolic interactionism (Bluff, 2005; Chenitz & Swanson, 1986; Holloway & Todnes, 2006; Milliken & Schreiber, 2001; Richards & Morse, 2007). Symbolic interactionism concentrates on the interaction between individuals (Porter, 1998). It is a theory that is associated with the study of human groups, similarities within groups, and their actions (Blumer, 1969). Chenitz and Swanson (1986, p.4) described symbolic interaction as "a theory about human behaviour. In addition, it is an approach to the study of human conduct and human group life. Symbolic interaction focuses on the meaning of events to people in natural or everyday settings". It describes how people's behaviour changes and develops through their interaction with others (Morse & Field, 1996; Hesse-Biber & Leavy, 2011). Symbolic interactionism takes the view that people's behaviour and the way they interact depend upon how they interpret various symbols (Hutchinson, 1996). Symbols can include language, garments, and equipment, with the meanings of these symbols being shared by people within a particular culture (Bluff, 2005).

Although work on symbolic interactionism was originally associated with the anthropologist Herbert Mead, it was Blumer (1969) who made noticeable advancements in this field. Heath & Cowley (2004) acknowledged that Blumer

coined the term ‘symbolic interactionism’, noting that symbolic interactionism has three major beliefs:

> 1. Human beings act toward things on the basis of the meanings that the things have for them.
>
> 2. That the meaning of such things is derived from, or arises out of social interaction that one has with one’s fellows.
>
> 3. These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters.
>
> (Blumer, 1969, p.2)

Grounded theory applies the principles of symbolic interactionism in assuming that people act both as individuals and collectively as members of groups (Bryant & Charmaz, 2007). Glaser was critical of symbolic interactionism being compared to grounded theory, stating that symbolic interactionism was overused by social scientists and resulted in purely “descriptive study”. Symbolic interactionism is not essential to grounded theory but has been described as more of a “backdrop” (Stern, 2007, p.120-121). According to Bryant and Charmaz, (2007, p.21), grounded theory took symbolic interactionism from the “what is happening?” mode to interpreting what is occurring and generating meaning from actions.

2.3.2 Theoretical sensitivity

Theoretical sensitivity is so significant within grounded theory that Glaser wrote a book on this one aspect (Glaser, 1978). Theoretical sensitivity means that the researcher is aware of possible bias that may impact on data analysis (Schneiber & Stern, 2001). It is the researcher “having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn’t” (Strauss & Corbin, 1990, p42). Strauss and Corbin suggested that the researcher brings theoretical sensitivity to the research study from information obtained from literature, personal experience, and professional experience. This means that the researcher needs to acknowledge his/her potential biases in order to prevent these impacting on data analysis. Thus the researcher checks that the findings are grounded in the theory and not a mirror of their own beliefs (Lempert, 2007;

Schneiber & Stern, 2001), so ensuring an open mind and not focusing on a preconceived theory (Glaser & Strauss, 2009).

2.3.3 Development of grounded theory since "Discovery"

Glaser found that following his original writing of the book *Discovery of Grounded Theory* with Strauss (Glaser & Strauss, 1967), there were issues requiring explanation. Questions raised during his subsequent work with doctoral students led him to clarifying certain aspects of the methodology in his book *Theoretical Sensitivity* (Glaser, 1978). In the book Glaser described in detail how the researcher should undertake theoretical coding and theoretical sorting, highlighting the importance of the 6 Cs: causes, contexts, contingencies, consequences, co-variances, and conditions, as the baseline for theoretical coding in sociological research. There was some criticism that Glaser's attempt at simplifying grounded theory in *Theoretical Sensitivity* was not successful (Charmaz, 2000). What began as an attempt to simplify grounded theory progressed to the stage when Glaser and Strauss differed in their application of grounded theory. This led to Strauss providing further explanation on grounded theory in his book *Qualitative analysis for social sciences* (Strauss, 1987). These differing opinions were very publicly debated following the publication of the Strauss and Corbin's (1990) version on how grounded theory should be undertaken. Glaser's (1992) book *Basics of Grounded Theory Analysis* was a response to this literature, with him being critical of Strauss for not remaining true to what he believed were the underpinning principles of grounded theory. Glaser was of the opinion that Strauss and Corbin were not actually describing grounded theory, but a new approach which Glaser referred to as full conceptual description.

The major difference between Glaser and Strauss involved how data analysis was undertaken (Cutcliffe, 2005; Walker & Myrick, 2006). Glaser's approach to grounded theory followed qualitative approaches, trusting that the participants' stories would naturally emerge, as would the research problem during data collection and analysis. Strauss, on the other hand, focused more towards a quantitative approach which required the research to have replicability, verification and generalisability (Babchuck, 1997). Glaser encouraged the researcher to trust grounded theory to be functional, embracing its flexibility, whereas Strauss

proceeded to provide clear guidelines on how to implement grounded theory. The differences between the two approaches have been described as: “Glaser focuses his attention on the data to allow the data to tell their own story” and the stance of Strauss who asks “what if” and developed more “abstract concepts” (Richards & Morse, 2007, p.63). Glaser continued to define grounded theory as being a method of discovery, whereas Strauss developed grounded theory in relation to how data collection and analysis could be structured and verified (Charmaz, 2006; Evans, 2013). These differences led to most grounded theory researchers following either the Glaserian or the Straussian approach (Dey, 1999; Walker & Myrick, 2006). Although these approaches went in different directions, the underlying principles of grounded theory remain true (Charmaz, 2000). Originally Glaser and Strauss wished to develop a research method that would transcend all academic disciplines, and in this, according to Clarke (2005), they were successful.

2.4 RATIONALE FOR USING GROUNDED THEORY

The research paradigm chosen for this study was constructivism because it a paradigm that addresses research questions relating to how people construct reality in certain settings (Welford, Murphy & Casey, 2012). It is a paradigm that also enables the consequences of the participants’ reality to be explored (Welford et al, 2012), and promotes studying people in their natural settings (Charmaz, 2003). Ontologically this paradigm suggests reality as having numerous constructions, being both local and specific (Hall, Griffiths & McKenna, 2013; Welford, Murphy, & Casey, 2012). The subjectivist epistemology suggests that the researcher and participant are linked and this results in a “mutual creation of knowledge” (Charmaz, 2003, p250). This leads to the belief that people do not discover but rather create knowledge (Hall, Griffiths, & McKenna, 2013). It is therefore a paradigm that lends itself well to grounded theory.

Grounded theory is an approach that has been used by nursing researchers since 1970 (Backman & Kyngas, 1999; Dey, 1999), with an estimated two out of three qualitative research papers published during the 1990s claiming to have used grounded theory (Bryant & Charmaz, 2007). It continues to be one of the most popular methodologies used by nurse researchers (Ellis, 2010). A major reason for

grounded theory's popularity in nursing is attributed to the fact that the health care environment was the setting in which the original work by Glaser and Strauss (1965) was applied and that many of Glaser's early graduate students were nurses. Grounded theory is considered an important method in nursing research due to the richness and diversity of topics it can investigate (Streubert & Carpenter, 2011). There is a suggestion that, as nursing is a complex profession, it requires the ongoing development of theories relevant to clinical practice, making grounded theory a popular method (Chen & Boore, 2009).

Grounded theory was the chosen methodology for this study because it lends itself well to making sense of complex social situations such as the experiences of registered nurses working with older people. The method has been noted as particularly useful when researching areas neglected or relatively unexplored by other researchers, or when adequate theories on the topic are lacking (Holloway & Todnes, 2006; Hutchinson, 1986; Moghaddam, 2006; Morse & Field, 1996). Previous researchers have related nursing image to perceptions of aged care nursing but little has been written about how this relationship impacts upon the nurses who work with older people. Grounded theory is also appropriately employed when there is a need to answer difficult questions (Dixon-Woods et al, 2001; Moghaddam, 2006). In this study these questions were asked:

1. How do registered nurses who work with older people feel they are perceived?

2. What impacts upon their status and professional recognition?

3. How do they perceive and manage their professional status?

Morse (1994, p.223) commented that, "if the question concerns an experience and the phenomenon in question is a process, the method of choice for addressing the question is grounded theory". In this study the researcher explored the problems registered nurses encounter in relation to their professional status when nursing older people and how registered nurses attempted to resolve these problems. Although the researcher was aware of anecdotal beliefs surrounding the nursing of older people, she decided that only registered nurses who worked with them could describe the problems encountered and what strategies were employed in an attempt to manage them. This research study enabled the registered nurse participants who cared for

older people to tell their stories, including how they felt their professional status was perceived by others. Grounded theory enabled the researcher to explore the particular social processes that were experienced by the participants, including the problems they experienced and how they resolved these. Grounded theory was the method chosen for this research because there has been a lack of understanding of aged care nurses' perceptions of their professional status. It was deemed by the researcher that the theory generated from this study would provide some insight into how nurses could be recruited and retained in settings where care of older people is prominent. The application of grounded theory to this study generally followed the Glaser principles in relation to data collection and analysis in order for a substantive theory to emerge.

2.5 GROUNDED THEORY PROCESS

The following section provides an overview of how grounded theory is undertaken. It will describe sampling, data collection, and data analysis, and explain how rigour can be maintained.

2.5.1 Sampling in grounded theory

In grounded theory purposeful and theoretical sampling are "pivotal" (Coyne, 1997, p.626) because researchers employing this approach "need to locate excellent participants to obtain excellent data" (Morse 2000, p.231). The study population within grounded theory is selected initially by purposeful sampling (Bluff, 2005) because participants are chosen due to their knowledge and experiences of the topic being researched and the questions being asked (Hesse-Biber & Leavy, 2011; Morse, 2010; Norwood, 2010; Streubert & Carpenter, 2011). As the analysis of data takes place purposeful sampling evolves into theoretical sampling (Charmaz, 2006), with the researcher deciding when this change is appropriate (Draucker, Mantolf, Ross & Rusk, 2007). Although some authors have suggested that theoretical sampling is a type of purposeful sampling to inform the theory that is emerging (Draucker et al, 2007), theoretical sampling is driven by the emerging theory (Glaser & Strauss, 1967). Grounded theory cannot begin with theoretical sampling because the

researcher is unable to predict accurately who would be suitable participants at the commencement of the study (Glaser, 1978); thus the emergence of the theory cannot be initially determined (Tan, 2010). Theoretical sampling is used to collect more data to examine categories and their relationships and to be sure the categories exist (Chenitz & Swanson, 1986).

2.5.2 Data collection in grounded theory

Grounded theory enables the researcher to use a variety of data collection methods such as observation, interviews, diaries and letters. Whichever data collection method is used the gathering of 'rich data' is paramount (Charmaz, 2006). The phrase rich data refers to the meaningful description of the phenomenon being investigated (Streubert & Carpenter, 2011), with Charmaz (2006, p.14) insisting these data need to be "detailed, focused and full" because through these the participants' thoughts, feelings, and actions are revealed.

Interviews are often used for data collection in grounded theory. Denzin and Lincoln (2008) supported the notion that interviews are widely accepted as a means of collecting data, but also acknowledged that the interviewer must possess a high level of skill in both questioning and listening to develop an atmosphere of trust with the participant. Although frequently used in data collection, interviews carry an element of risk in qualitative research because the interview is controlled by the participant and not the interviewer (Morse, et al., 2009).

In this study other data sources in the form of documents were collected as coding was undertaken and categories began to emerge. This reflects Glaser's suggestion that researchers:

> Do not do a literature review in the substantive area and related areas where the research is to be done, and b) when the grounded theory is nearly completed during sorting and writing up, then the literature search in the substantive area can be accomplished and woven into the theory as more data for constant comparison.
>
> (Glaser, 1998, p.67)

Glaser (2003) is of the opinion that "all is data" within grounded theory. Leaving the literature review until data analysis is almost complete reduces the possibility of contaminating the data, resulting in the developing theory not being truly grounded in the data collected (Charmaz 2007; Glaser, 1992; Langdridge, 2004). However, delaying the literature review may not prevent pre conceived ideas having been or being formed, especially if the researcher was exploring a problem in their own practice setting; some presuppositions are required in order to support the original rationale for the study. Therefore, it is unrealistic for any researcher to claim they approached a piece of research totally unaffected by past experiences and knowledge (Bluff, 2005; Heath & Cowley 2004; Suddaby, 2006).

Hutchinson (1993) suggested that a literature review prior to data collection and analysis actually assists in identifying gaps in knowledge, therefore providing the researcher with a clear rationale for the study. It was deemed necessary by the researcher to undertake a preliminary review of the literature prior to commencing this study in order to prepare the proposal for candidacy.

2.5.3 Analysing data in grounded theory

Grounded theory is characterised by concurrent data collection and analysis, known as constant comparative analysis (Charmaz, 2006; Langdridge, 2004; Suddaby, 2006). Data collection and analysis continues until "saturation" is reached, with this being achieved more swiftly with the use of theoretical sampling (Morse, 1995; Thomson, 2004). Saturation is described as:

> …the completeness of all level of codes when no new conceptual information is available to indicate new codes or the expansion of existing ones. The researcher, by repeatedly checking and asking questions of the data, ultimately achieves a sense of closure.
>
> (Hutchinson, 1986, p.125)

Data saturation is the point when the researcher sees the same or similar issues being raised, with no new categories emerging (Dey, 1999; Glaser & Strauss, 1967; Skeat, 2010).

Grounded theory analysis begins as soon as data have been produced (Clarke, 2005). During analysis the researcher needs to peel back the layers of data descriptions, in order to find the true meaning of the topic being explored (Langdridge, 2004). Although, as outlined above, Glaser and Strauss took different approaches to how grounded theory should be implemented, they did agree on the importance of coding the data (Kendall, 1999). Coding was defined by Charmaz (2006, p.43) as "naming segments of data with a label that simultaneously categorises, summarises, and accounts for each piece of data". Further, Charmaz explained that coding is the initial analytical phase in grounded theory, whereas Walter and Myrick (2006) contended it takes the researchers from their data transcripts to the theory. Thus a major component of grounded theory analysis is the use of the constant comparative method.

2.5.3.1 *Constant comparative method*

As indicated above, grounded theory analysis involves the constant comparative method (Hunter, Murphy, Grealish, Casey, & Keady, 2011; Welford, Murphy, & Casey, 2012) first described by Glaser and Strauss (1967). This method "is the key process in grounded theory" (Langdridge, 2004 p. 300). Streubert and Carpenter (2009, p104), defined the constant comparative method as combining "an analytic procedure of constant comparison with an explicit coding procedure for generating data". Dey, (1999, p.7) cited the "four stages" that Glaser and Strauss (1967) followed when using the constant comparative method were: "(1) generating and (2) integrating categories and their properties, before (3) delimiting and then (4) writing the emerging theory".

2.5.3.2 *Coding*

Charmaz (2006) stressed the importance of coding as the framework for data analysis when employing grounded theory because it provides the link between the data collected and theory emerging. Hutchinson (1986, p.122) summarised the aim of coding as answering certain questions, these being:

1. What is going on in the data?

2. What are these data a study of?

3. What is the basic social psychological problem with which these people must deal?

4. What basic psychological process helps them cope with the problem?

Three steps or levels of coding have been described when analysing data using grounded theory (Schreiber & Stern, 2001; Streubert & Carpenter, 1999). Level 1 coding occurs when the data is initially analysed word by word, and then line by line, to allow codes to develop. The researcher writes the code words in the margins of the transcripts and field notes as detailed analysis proceeds. The exact words used by individual participants are highlighted in this level of coding to ensure their voices are heard (Hutchinson, 1986; Stern, 1980). According to Walker & Myrick (2006) the researcher is encouraged at this stage to code the data in as many ways possible and write memos as ideas emerge, a process that Glaser (1978, p.56) referred to as "running the data open".

Level 2 coding is the process of the researcher moving from "running the data" to comparing data collected and clustering them together in order to develop categories (Hutchinson, 1986; Schreiber & Stern, 2001). This involves comparing the level 1 codes identified and grouping them together with similar codes. Level 2 coding also requires the researcher to check that each category identified is "mutually exclusive" (Speziale & Carpenter, 2003).

Level 3 coding involves the development of higher level concepts, enabling the researcher to move from being purely descriptive to a theoretical level (Speziale & Carpenter, 2011; Stern, 2001). Having identified level 1 and 2 codes and clustered them into categories, the researcher now explores relationships between the

categories (Schreiber & Stern, 2001).Through the third level of coding the researcher identifies a core category, this being a concept that occurs frequently and links all of the categories together (Gerrish, 2011; Schreiber, 2001).

2.5.3.3 *Memos*

Memos are used in grounded theory as a method of recording ideas on the connections between the data collected (Hutchinson, 1986). This stage has been described as the intermediate phase between coding and the first analytical draft (Charmaz, 1994). This is a crucial stage in the generation of theory, and if this stage in data analysis is omitted then the researcher has not fully implemented grounded theory (Glaser, 1978). In addition, Glaser (1992) described memos as the writing up of ideas during the time the researcher is coding for categories, and as the "key" to enabling the researcher to convey the research findings to others in writing. Charmaz (2006) supported this by emphasising the importance of memo writing during the early stages of the research study. Lempert (2007, p.247) described the writing of memos as "the narrated records of a theorist's personal, analytical conversations, stressing the importance of theoretical memos to the analysis." To researchers, the writing of memos can prove "liberating" because it allows them to write down all their thoughts and ideas about the emerging data (Hunter et al, 2011).

Below is a short exert from a memo written during the early stage of data collection in this study:

> *There was reference made to value and valuing – code emerging? The participants need to feel valued as a professional within the profession. They do feel valued by clients/patients – for some this is not enough. I need to use more probing questions in order to get more data and a better understanding of what the nurses are experiencing. There seems to be a problem for these participants in their ability to articulate what their role actually involves.*

This memo, along with others, was used during data analysis. It supported emerging categories such as the devalued role of the registered nurse in aged care and also the participants' problems in communicating their role to others. Another advantage of this memo was that it aided the process of participant selection.

2.6 RIGOUR

Rigour in research is of great importance because it provides information on the strength of the research design (Gerrish & Lacey, 2006; Rolfe, 2004). Glaser (1998, p.17) discussed "proof of product" in relation to grounded theory, stating that the following criteria need to be addressed:

- Does the theory work to explain relevant behaviour in the substantive area of research?
- Does it have relevance to the people in the substantive field?
- Does the theory fit the substantive area?
- Is it readily modifiable as new data emerge?

Elsewhere Glaser (1992) abbreviated these four criteria to work, relevance, fit, and modifiability, which are discussed below.

"Work" explains how the participants vary their behaviour in respect of the issues raised in an attempt to address them (Glaser, 1998). Participants go through this process in order to address the issues raised.

"Relevance" is achieved if the two previous criteria are met (Glaser, 1998). It relates to how the emerging concepts reflect the true issues of participants who together with those working in a similar care setting, identify with the researcher's constructs (Hutchinson, 1986). This is when the researcher has accurately described what is happening in the participants' world and others recognise this (Hunter et al, 2011), and respond with "wow that's it" (Hutchinson, 1986, p.127).

"Fit" refers to validity. Validity is defined as, "how accurately a measure actually yields information about the true or real variable being studied" (Macnee & McCabe, 2008, p.424). Pyett (2003, p.1170) stated that qualitative researchers are able to validate their research by asking the question, "How can we have confidence that our account is an accurate representation?" For this to occur, individuals must reflect their belief in what is occurring in their everyday life and the role of the researcher is to "unearth the truth in the situation" (Chenitz 1986, p.87). Fit represents the

categories that emerge from the data in relation to the participants' reality. The use of constant comparison assists with this as the issues important to participants can be trusted. The emerging codes should "fit" the data and readers of grounded theory would sense when the data "fits" the practice area (Hutchinson, 1986).

"Modifiability" recognises that the theory can be modified as new data are collected and as new concepts emerge during use of the constant comparative method. As the world in which people live is constantly changing, there is a need to modify the theory to reflect this (Hunter et al, 2011; Hutchinson, 1986).

Glaser (1998) allocated a chapter on "trusting grounded theory" in an attempt to allay potential concerns relating to its rigour. Glaser summarised that in grounded theory, rigour is achieved through the process of the constant comparative method. It is through this that data analysis and modification lead to development of theory relevant to the participants. Thus grounded theory by its very design is a self-regulating method due to its rigorous method of generating theory (Glaser, 1998; 2003).

2.7 THE APPLICATION OF GROUNDED THEORY IN THIS STUDY

This section describes how the principles of grounded theory were applied to this study in relation to the research setting, participants, data collection and analysis, and ethical considerations.

2.7.1 The research setting

This research was undertaken in a variety of public and private nursing care settings in both the metropolitan and regional areas in the South West and Wheatbelt areas of Western Australia where older people were receiving nursing care. The settings included residential aged care facilities, the acute wards of hospitals, rehabilitation units, and community care settings. Older people are cared for in a variety of locations with only a minority actually residing in residential care facilities, thus accessing residential care settings alone would provide only a narrow picture of the issue being researched. Initially the researcher envisaged that the research setting

would be within public hospitals, but as the study progressed residential care facilities and the other care settings were included.

2.7.2 Participants

The participants were selected by a process of purposeful sampling, as described in the following section. Two criteria were initially required for participation, namely: 1) that the participants were registered nurses 2) predominantly cared for older people. The research sample comprised 23 participants, who worked in a variety of health care settings where patients or clients were elderly. Of the 23 participants, 22 were registered nurses. As the research progressed, theoretical sampling led to an allied health professional who worked with older people and a registered nurse from a different specialist area also being interviewed. As data and analysis progressed, theoretical sampling was used in order for the researcher to explore emerging concepts. Ethical considerations in relation to sampling will be discussed later in this Chapter.

At first the participants were recruited by the researcher sending an advertisement (Appendix A) to a number of residential aged care facilities and hospitals caring for older people. This approach was not always successful in recruiting participants. Although people contacted were willing to place the advertisement on staff noticeboards most responses came from organisations where a person in authority thought the research would be valuable. These managers encouraged and supported registered nurses to participate. As the research progressed, the participants were often able to provide the researcher with names of potential participants. Thus some of the recruiting of participants was done by “snowballing”, whereby the researcher encouraged participants to contact and recruit other participants (Macnee & McCabe, 2008). However, snowballing was used to recruit only four participants because the researcher wanted to ensure the theoretical sample was maintained. The researcher was concerned that if snowballing had been used for recruiting most participants the findings may not have truly represented registered nurses who cared for older people.

The purposeful sampling continued during the data collection process, thereby reflecting grounded theory methodology (Holloway & Wheeler, 1996). For example,

the first three participants worked in public hospitals, describing how lower pay was a deterrent to registered nurses choosing to work with older people in the private sector. To explore this matter further, theoretical sampling was undertaken by the researcher interviewing a number of registered nurses who worked within private aged care facilities. Theoretical sampling was also used to explore whether the registered nurses who worked with older people were justified in their perceptions of what others thought of them. This was undertaken by interviewing two nurses who did not work primarily with older people and an allied health professional.

The participants' ages ranged between early 20s to mid-60s. Their professional experience also covered a wide range, from one participant who was undertaking a graduate nursing program in her first year post-registration to another registered nurse who had been qualified for over 40 years. The majority of participants worked within a clinical setting, although two managers were interviewed. 22 of the participants were female and one participant was male. Although the distribution of the sample was skewed towards females, it reflects the study population, which is female dominated. For the majority of the participants, working with older people was not their initial choice of specialist area. Table 1 summarises the demographic details of the participants.

Table 1: Participant information

Employment level	Registered nurse	Clinical nurse	Manager	Other nurse	Allied health professional
	9	9	2	2	1
Years qualified	0-5	6-10	11-15	16-20	20+
	7	8	3	2	3
Years in present role	0-5	6-10	11-15	16-20	20+
	11	8	3	1	0

As outlined above 20 of the participants nursed older people in several settings, including residential aged care facilities, public and private hospitals, community settings, and rehabilitation units. Eight participants nursed in public hospitals, two in

private hospitals, five in residential care facilities, and two in the community. The remaining three participants nursed in more than one clinical setting, for example, in a residential aged care facility and an acute hospital setting.

2.7.3 Data collection

For this study data were sourced from interviews, field notes, research journals, and supporting documents. The primary data were collected from interviews because it was a method with which the researcher was familiar. Having worked within health care for over twenty years, the researcher had developed skills by interviewing patients, clients, and family members during health assessments. Interviews had also been used by the researcher as a method of data collection in previous studies; therefore, it was a method in which the researcher had both confidence and competence. Interviews enabled a conversational exchange in which participants could relate their story of nursing older people.

2.7.3.1 *Interviews*

The interviews were conducted between July 2007 and December 2009, varying in length between thirty and ninety minutes. This study was carried out on a part-time basis. The length of time between data collection and theory preparation was considered in relation to continuity of the information. As there were no significant regulatory, structural, or social changes in the participants' working environments, the analysis and interpretation of the data continued to be valid. Prior to commencing the interviews, the researcher conducted two pilot interviews with work colleagues in order to check the appropriateness of the interview questions and to improve interview techniques. The data from these two pilot interviews were not included in the study.

The interviews occurred in settings chosen by the participants. These settings included the participant's home or work environment, and neutral areas such as a cafe or an unused consulting room. Three interviews were undertaken by telephone due to the travel time and distances for the individual participants. The researcher's

work environment was not used as an interview venue to avoid influencing participants' responses. However, interviewing at the participant's workplace led to some difficulties. For example, although participants had allotted a time slot for their interviews, on several occasions these were interrupted by people with queries that needed to be addressed by the particular participant. On one occasion the participant shared an office with another person but insisted on proceeding even when another venue was suggested by the interviewer for the sake of privacy. Some participants wished to be interviewed in their workplace because this was the "real world" to them. For those participants verbal consent had to be obtained from their managers for the interviews to be undertaken in that environment.

In-depth, face-to-face interviews were conducted with 20 participants, with the other three participants interviewed by telephone. The face-to-face interviews began with the researcher reiterating the study focus and seeking confirmation of the participants' willingness to be interviewed. They were then asked to sign the consent form and any questions they had relating to the study were answered. At this stage the researcher also collected demographic data from them, this having the dual purposes of obtaining background information about them and enabling the development of a rapport prior to the interview commencing. The telephone interviews followed a similar format, with the exception that the consent form had been signed prior to the call. A drawback of telephone interviewing was that the interviewer could not observe for non-verbal cues; however, some guidance from voice tone and phrasing of responses was possible.

An aide memoir (Appendix B) was used during the interviews. These questions were used to assist the flow of ideas during the interviews if necessary, with care being taken to avoid "leading" the participant. Bell (1993) supported this approach for skilled interviewers. The researcher's reliance on the aide memoir decreased as the interviews progressed, and the interviewer became more proficient with the technique of interviewing and more confident in the participants' ability to describe their experiences. As data collection and analysis progressed, the questions were amended to explore the emerging categories further.

Interviews would often commence with a general question, such as, Can you tell me about your experience nursing older people? This was used as a means of gathering

additional demographic information about the participant, while putting them at ease. The research question was never asked directly, to help prevent forcing of the data (Glaser, 1992).

After the first four interviews it became apparent to the interviewer that the participants would state they had nothing more to add before being thanked for their participation and the digital recorder stopped. However, participants often continued talking and during this time some useful insights were provided. This additional information was recorded in the field notes. On subsequent interviews, the researcher left the recorder operating following the interview in order to capture this data. Then the participants' consent was obtained to include this additional and very useful data within the study. The fact that the participants continued to provide meaningful data following interview has been observed by Morse and Field (1996, p.68) who stated, "Data collection does not stop when the tape recorder is turned off."

With the consent of participants, the interviews were recorded onto a digital recorder, which was placed in close proximity to both the researcher and interviewee to ensure clear and accurate recording. On two occasions there were interruptions during the interview, which the researcher verbalised and after pausing resumed the interview. The recording of interviews adds rigour to the data as a record that can be preserved and data analysis checked (Hammersley, 2010). The interviews were downloaded from the digital recorder on to the researcher's personal computer and were stored in a password protected folder.

The use of the digital recorder enabled concentration on the interview with the participants' responses flowing easily, being unhindered by the researcher's need to make accurate written notes. The use of recording devices during interviews is a technique about which Glaser was extremely critical as he was of the view that the interviewer would remember all important information (Glaser, 2003; Stern, 2007). However, others support the use of recorded interviews because they could be accurately transcribed (Strauss & Corbin, 1990). Strauss and Corbin maintained that this is especially useful for the novice researcher who may not be aware initially of what is important. Transcription then becomes an invaluable source of accurate data, enabling the researcher to replay the interviews repeatedly throughout data analysis.

The recorded interviews were transcribed by the researcher and any identifying characteristics relating to individuals or organisations were disguised or removed. The use of clerical support in transcribing the interviews was considered at the beginning of the research process but the researcher decided to transcribe the interviews personally to facilitate data analysis. Although time consuming, the transcribing enabled interviews and the descriptive context of the data collected to be revisited. It is recommended the researcher does the transcription as this enables greater insight (Patton, 2002), analysis to commence (Langdridge, 2004), and aid immersion in the data. Once each interview was transcribed, the transcripts were randomly coded to prevent participants being identified. A file of the codes allocated to each participant was kept in a file accessed only by the researcher who held the password. It was necessary for confidentiality to be maintained in the interests of privacy and the researcher's need to contact a participant to clarify any issues that arose.

2.7.3.2 *Field notes*

As indicated above, field notes were used as part of the data. Morse and Field (1996) suggested these be audio taped, but during this study they were hand written. The researcher found the writing of field notes to be an extremely useful process because it provided documentary evidence of decisions made throughout the research process, thereby providing an audit trail that made the study more rigorous (Rodgers & Cowles, 1993). For example, the field notes created a record of the researcher's initial thoughts following the completion of an interview, thus facilitating the noting of thoughts on the environment in which the interviews took place and of observations made on the non-verbal communication of the participants. These notes were written as soon as possible after the interviews when relevant events and observations were fresh. Morse (1996) commented that field notes are important because they provide the researcher with a record of ideas and relationships that are developing between the data, therefore playing an important part in data analysis.

2.7.3.3 *Supporting documents*

In the course of the researcher's professional work as a member of an Aged Care Assessment Team, she regularly accessed general literature related to caring for older people and government documents pertinent to this area of practice. So before commencing this study, the researcher had broad background knowledge on the care of older people, but had not accessed large quantities of documents specifically relating to this research topic prior to commencing this study. The researcher also had to access literature pertaining to the chosen methodology of grounded theory, and information to support the application for ethical approval and candidacy for the Doctoral program.

Once data had been analysed the literature was searched to find whether the findings were reflected in existing literature. This was undertaken by using databases such as CINAHL and ProQuest. Key words and phrases that had been identified during data analysis, such as *surviving*, *resilience*, and *advocacy*, were typed into the databases and the search narrowed if required in relation to healthcare, nursing, and employment.

2.7.4 Data analysis

As outlined above, the data for this study were analysed using the constant comparative method (Glaser & Strauss, 1967). Each interview was analysed and codes and categories that emerged from it were constantly compared with data from other interviews, with similarities and differences being noted. These notations of categories and their properties became data for further analysis and comparison. This process is considered fundamental to grounded theory analysis (Hutchinson, 1986; Moghaddam, 2006).

The use of computer software programs to aid data analysis was considered, appearing to have some advantages in relation to sorting the data into categories. However, Glaser (2003) claimed that the use of computers in analysis resulted in the researcher spending time away from grounded theory to develop the skills and knowledge in using the computer program. In addition to this, Glaser observed computer programs to be unable to manage the complexities of grounded theory.

Therefore, the researcher decided to undertake the coding manually in order to focus on the emerging conceptual ideas (Holton, 2007). Thus the researcher wanted to remain true to the underlying principle of being immersed in the data.

2.7.4.1 *Coding*

Once the raw data from the interviews had been transcribed, each transcript was analysed word by word and notations were written in the margins. These notations were key words and phrases found in each transcript. An example of this was one participant's description of the response of a Director of Nursing: "how very disappointing that one of our finest students should go in to aged care." From this response the researcher identified the code 'disappointment' which had also emerged from the data in other interviews. For example, another participant's parents said, in response to her decision to nurse older people "… such a good education and you are going to throw it all away." A third participant said that her parents expressed a preference for the nursing speciality of midwifery. These data all had a sense of other people being disappointed in the participant's choice of nursing speciality.

During level 2 coding the researcher cut and pasted the interview transcripts on to large sheets of card according to themes that were emerging within the codes. This provided a large amount of data because it was very visual, but it enabled emerging concepts and categories to be identified. For example, the code 'disappointment' led to the emergence of one of the concepts that was called "*being judged*" for the participants' decision to work in aged care. The two dimensions of that concept were *being judged* by peers and *being judged* by family because of the way the participants felt about the judgement.

Level 3 coding arose from the constant comparison of the categories, with links between categories being identified (Schreiber & Stern, 2001) and evolving into conceptual categories. Conceptual categories enabled the researcher to move away from the words used by the participants to use words developed through the process of analysis (Hutchinson, 1986). An example of this was during data analysis categories labelled justifying, stigma, and being judged emerged from the participants' descriptions. These categories were linked because they had the

similarity that they were often critical and came from sources the participants thought would be supportive of them. Due to this, the judgements made by peers and family members became the conceptual category *friendly fire*. This also made the participants feel that they were *under attack* because of the criticism they received.

The above example related to the participants on a personal level; and on a professional level the participants' descriptions, when analysed, developed into categories relating to the devalued role of the registered nurse in aged care settings. This led to the development of another conceptual category *feeling trapped*.

Links continued to be explored between all codes and categories, and eventually the basic social psychological problem of *feeling under siege* emerged as a conceptual category. This was the category that in the words of Glaser and Holton (2004, p.15) appeared "to account for most of the variation around the problem or concern that is the focus of the study". For the participants in this study the lack of personal and professional recognition was a constant problem, giving them the sense of *feeling under siege*. In grounded theory "a process of behaviour" (Glaser, 1978, p.97) develops in response to the problem the participants encounter and this process is referred to as the social psychological process. Data analysis clearly identified there to be a process the participants followed to address the identified problem of *feeling under siege*, which was their being *resilient* in order to *survive*, and ultimately resulting in the emergence of the theory relating to *advocacy*.

Useful tools when analysing data in grounded theory are memos and diagrams. In this study all levels of coding were aided by the researcher using memos and diagramming, as described below.

2.7.4.2 *Memoing*

Memos were written by the researcher throughout this study. These were very useful for documenting thoughts and aided in identifying areas requiring further investigation as codes and categories developed. As data analysis progressed, memos were used as part of the data, reflecting the recommendations of Glaser and Strauss (1967). Another important aspect of using theoretical memos was to keep track of ideas, thoughts, and feelings as they occurred (Glaser, 1978, Richards and

Morse, 2007). As with the above extract, the memoing began at the onset, and continued throughout the research study (Stern 2007). Stern derived the analogy of data being the building blocks of the developing theory and memos being the mortar that pieced the blocks together. Richards (1998) stated that the researcher's involvement and interpretation of the data changes during the research process and these changes also become data. This may not be immediately obvious to the researcher, but if memos are kept changes will be identified when the entries are reviewed.

The data were analysed throughout the process of constant comparison until data saturation was reached. In this research data saturation occurred after twenty one interviews although the researcher completed a further two interviews to verify this conclusion. The additional two interviews did not provide any new concepts, but added richness to the data already collected.

2.7.4.3 *Diagramming*

The researcher noted that analysis of the data could be improved by using a series of diagrams, also referred to as schemas or concept maps. Dey (1993) supported the use of diagramming as a means for considering the complexities and relationships between categories. Diagramming is a process that needs to be repeated throughout the data analysis phase in order to "capture" the developing theory (Kane & Trochim, 2009). Diagramming played an important part in this research study because it enabled the researcher to cluster the data into key categories. The diagramming was undertaken by writing codes/categories on A4 sheets of paper and then making additions and links as further data were collected. The diagraming began as a mind map with a large number of codes, but as data analysis continued these developed becoming more focused on particular categories. Thus diagramming was used to link the emerging categories and concepts as they developed. As data analysis progressed, the researcher found it difficult to achieve these outcomes using diagrams on A4 sheets of paper, so she switched to A3 sheets of card pinned to a wall for increased visibility; in this fashion relationships between categories were more easily analysed.

2.7.4.4 *Verification of analysis*

Dey (1999) suggested that researchers using grounded theory "verify as they go" rather than "verify later". Use of the constant comparative method of analysis and reaching data saturation assisted the researcher in verifying data analysis in this study.

When analysing early interview data, the researcher received the assistance of an acquaintance who had completed a Doctor of Philosophy in the field of nursing, but not aged care. This acquaintance was provided with a transcript of an interview to analyse and her results were then compared with those of the researcher to ensure appropriate interpretation of the data collected. Once data collection was completed one of the researcher's supervisors was provided with a randomly selected interview transcript for an independent analysis of the data and then compared with the researcher's interpretation for verification.

Schneider et al (2007) described several ways in which analysis can be verified. For the purpose of this study three of the suggested criteria were used, these being:

- development of an audit trail;
- checking with participants that the researcher's interpretations were correct; and
- data analysis being accepted by peers.

A very clear audit trail was maintained for the analysis, the raw data from the interviews being transcribed and each analytical step being recorded in the form of diagramming or as memos. As there was no response from the participants to view their transcripts, having them check the researcher's interpretations was more difficult. However, as the major categories began to emerge, one of the participants was enlisted to discuss the primary findings. This respondent verified that the categories emerging were appropriately reflecting what had been said during her interview. Acceptance of data analysis by peers was achieved by informal discussions with work colleagues on the research findings. They acknowledged the analysis to be a true depiction of the way matters occurred in the clinical practice environment.

2.7.5 Ethical considerations

Ethical approval for the study was obtained from the Human Research Ethics Committee at Curtin University of Technology prior to commencing data collection and required renewal on an annual basis. Because the researcher was a registered nurse, the code of ethics for nurses in Australia was also followed (Australian Nursing Midwifery Council, Royal College of Nursing Australia & Australian Nursing Federation, 2008).

Prospective participants were provided with a letter containing written details of the study (Appendix C) prior to the interviews being undertaken. This letter gave an overview of the study and provided an explanation on the voluntary nature of participation and confidentiality, the latter assured by the use of codes being assigned to the data collected. The letter also explained that the interviews would be recorded and that the data collected would be stored in a secure place. The participants were also informed that they could withdraw from the study at any time without prejudice. A written consent form was signed by the participants prior to their interviews (Appendix D). The participants' understanding of the nature of the study, and their ongoing consent to participate was also obtained verbally prior to the interviews commencing. The consent form was sent to the participants who were interviewed by telephone, and the interview was not undertaken until the participant had signed and returned the consent form.

The participants were assured that privacy would be maintained. This was aided by the fact that interviews were undertaken on an individual basis, with the exception of the interview undertaken in the shared office as described above. The interviews were undertaken at a mutually agreed time and location so as not to compromise client care. The locations therefore varied, including the participant's home, their place of work, a café, and the researcher's place of work. When the researcher's place of work was the chosen a neutral part of the building that was not the researcher's office was used.

Three registered nurses who participated via telephone interview did so because of logistical reasons for they worked in various locations throughout Western Australia. Participant consent forms and personal details were kept separately in a locked filing cabinet throughout the study. The data transcripts were coded so that only the

researcher was aware of the identity of the participants. Their names were not used on the transcripts or in the researcher's journal, thus ensuring anonymity. The interview data when entered on to the researcher's personal computer were kept in a password secured folder.

Direct quotes from the participants were used to support the researcher's interpretation of the findings. The participants are identified using the letter "P" followed by a number, for example participant 3 is referred to as P3. The numbers used to identify the participants were randomly selected in order to maintain anonymity.

2.8 SUMMARY

This chapter has provided an overview of grounded theory including a rationale for choosing this method, with discussion of its suitability to address the research question. The origins of grounded theory and its development were discussed, including the divergence of the original method by its "discoverers". The application of grounded theory to explore and describe the manner in which registered nurses working with older people felt they were perceived was explained, and the full range of associated data analysis was discussed. Finally, the researcher discussed the ethical implications of this study, and how these ethical issues were addressed in order to minimise privacy risk to the participants. The following three chapters will provide details of the data analysis, including the basic social psychological problem, the social psychological process, and the emergence of a substantive theory.

CHAPTER 3

THE BASIC SOCIAL PSYCHOLOGICAL PROBLEM: FEELING UNDER SIEGE

3.1 OVERVIEW

This chapter will define and explain what emerged as the basic social psychological problem encountered by the participants, who perceived they were *feeling under siege.* The participants did not use the words '*feeling under siege'* but it emerged as a conceptual category. A siege is defined as "any prolonged or persistent effort to overcome resistance; a prolonged period of trouble or annoyances besetting a person or group" (Dictionary.com, 2009). This basic psychological problem was embedded within an environment of stereotypical images of ageing, which was experienced by the participants on both a personal and professional level. This chapter will explain how this environment influenced the problem presented.

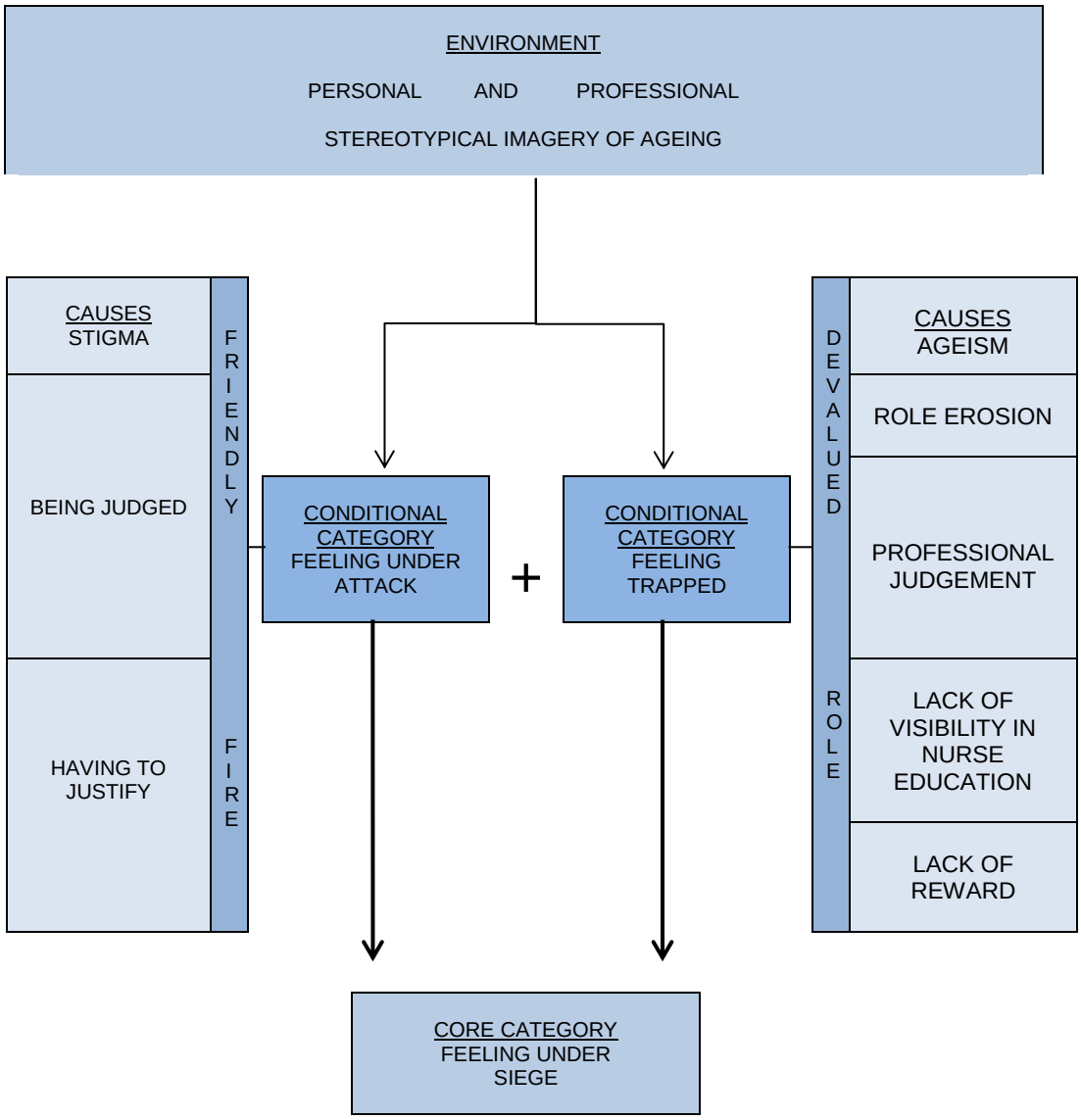
There are two conditional categories related to this problem; *feeling under attack* and *feeling trapped,* illustrating the problem of *feeling under siege*. Feeling *under attack* and *feeling trapped* were not isolated incidents; the participants described how they had experienced these feelings over many years.

On a personal level, the conditional category *feeling under attack* describes how the participants felt they were *being judged* by others because of their decision to nurse older people. Furthermore, the participants experienced *stigma* associated with working with older people who were themselves stigmatised, *being judged* for their decision to work in aged care, and having to justify that decision.

At the professional level, the conditional category *feeling trapped* describes how the participants felt professionally *trapped* in settings where older people were nursed, believing their employment opportunities in other sectors were limited. The manner in which the participants felt they were professionally perceived was from their perspective a result of their role being devalued due to ageism, role erosion, professional judgement, lack of visibility in nurse education, and lack of rewards.

Diagram1 illustrates the basic psychological problem of *feeling under siege* within the environment of *stereotypical imagery of aged care*. Each component of this problem will be discussed in detail and diagrams will be used to show how each component combines to illustrate the basic social psychological problem *feeling under siege.*

Diagram 1: Feeling under siege



3.2 AN ENVIRONMENT OF STEREOTYPICAL IMAGES OF AGEING

During data analysis it became clear the participants considered they worked in an environment surrounded by external stereotypical images of ageing. All of the participants mentioned at length these images for both older people and those who nursed them, and how these images impacted on them personally and professionally. They believed that the stereotypical images of ageing were largely a consequence of media portrayal, which conveyed negative beliefs about how older people were regarded by society. Participants described the negative images associated with older people through the following stereotypical phrases used by others to describe frail elderly people:

- *"Nothing can be done for them"* (P4)
- *"The end of the road"* (P2, P6, P16)
- *"Nursing home material"* (P9)
- *"Bed blockers"* (term used for those in hospital no longer requiring treatment, but waiting for residential placement) (P10)
- *"CAP" (Care Awaiting Placement)* (P10)
- *"Incontinent and gaga"* (P1)

These phrases were mentioned by participants throughout the interviews and reflected how they thought older people were perceived by others. The phrases were generally negative in connotation such *as "Nothing can be done for them"* (P10), *and "The end of the road"* (P6). The consensus of participants was the general public believed that nurses care for people so they (the patients) can resume normal daily activities. But this was not always possible when caring for older people, as one participant stated *"People do not always get better, they are one step away from God"* (P1). Another participant described that often relatives believed better care was provided in a hospital setting than in a residential care facility. However, the participant had some reservations, *"The nursing home has sent them into hospital, and then they think they will get better care in the hospital. I think no, because nursing homes have really good facilities"* (P20).This participant was of the opinion there was a focus on the medical model of care, with a high expectation of the

medical profession from family members. This view reflected a medical approach to the care of older people as it signifies people getting well physically and medically rather than considering how care by nurses can improve psychological, social and spiritual well-being. The participants explained that the stereotypical imagery resulted from people's lack of understanding of the registered nurses' role in caring for older people, *"They don't understand what my role involves,"* (P9) and, they think *"aged care nurses are there to baby-sit"* (P1).

The *phrase "nursing home material"* was used by several participants. They explained how the general public believed older people would require placement in residential facilities. One participant made a statement that reflected her belief to mirror many peoples' perception of nursing homes, *"What are nursing homes for? Isn't that the last stage?"* (P20), and another stated, *"... the public sees you're old, you go into a nursing home"* (P6). The participants also described how they perceived residential care as viewed by others, *"...horrible places, I think that is a society and community view of residential care"* (P18). When they were asked about the potential source of the stereotypical images, participants responded saying it was *"Coming from society"* (P8, P13, P18) and, *"There are negative myths and stereotypes* [within society] (P13).

Participants were quite critical of this attitude, pointing out that in reality the majority of older people were living in their own homes independently, or with assistance from family and/or home support services. One participant described how her views on older people differed from the negative stereotypical views:

> *There are wonderful people, living wonderful lives out there that you don't even hear about, and that's when working with the elderly becomes a pleasure… It's only when they reach the stage where they can't manage without assistance in the home that they go into hostels and nursing homes - and that's what the public sees – you're old, you go into a nursing home* (P6).

This participant's view was reflective of the area in which the participant worked, as a nurse in a community care role which focused on enabling older people to stay at home whenever possible.

Another participant believed that the breakdown in what was seen as "the family" was partially to blame for the negative attitudes towards older people. This respondent felt that younger people did not have any day-to-day contact with older

people, *"They have not got grandparents; they have not got that old age range"* (P8). This indicated that many people took note of the negative portrayals of older people without ever interacting with older people and experiencing the positives. The changes within families and the lack of day-to-day contact with the elderly were therefore perceived as fundamental issues about how society viewed older people. These negative stereotypical images were familiar to the participants, however they hoped that older people would be viewed in a more positive light, *"They are not an alien species. They are just a bit older and a lot of them don't feel any different than us"* (P7). All participants were very positive about the people they cared for, regardless of the environment in which they practiced.

As stated above, several participants noted that many of the stereotypical images associated with both older people and the nursing of older people were generated by how the media portray the elderly. These participants were clearly aware that media provided negative coverage rather than positive stories of ageing, nursing older people, and residential care facilities. One participant commented, *"It can be negatively portrayed with the headlines, you know, about aged care and the quality of care and all that kind of stuff"* (P16).

When talking about nurses portrayed on television, one participant stated. *"The public get the view that a real nurse works in a high powered place"* (P6). The participants provided examples of how this has been demonstrated in many popular medical dramas, for example ER and All Saints, where the stories are based on highly technological and fast-paced clinical environments. More recently there have been documentaries and "fly on the wall" programs in which the participants acknowledged were based on acute care. One participant suggested that, *"Stereotypical nurses are those ones that are in the action, a lot going on, and it's quite exciting, and you see people coming in[to hospital] and getting better"* (P19). As if this focus on the acute care setting was not enough, the associated stigma for aged care was further fuelled by negative media portrayal of what happens in the care of older people, *"You hear some horrendous stories [in the media] about aged care; that doesn't help"* (P1). A consequence of this negative media portrayal is that nurses in aged care were portrayed as being not as skilled or empathic as other nurses. This then impacts upon how nurses caring for older people are perceived, *"I*

think there is a perception within the community that aged care is wiping bottoms and more custodial care" (P16).

The participants identified another problem with the negative media portrayal: it was an avenue used to recruit nurses but even this had limitations in recruiting nurses to care for older people*, "…You always hear about how (pause), how exciting or how needed ICU nurses are, but you just never hear about how valuable aged care people [nurses] are"* (P4). They recognised that the media were useful in highlighting nursing as a profession and a viable career option, but it did not focus on the availability of employment within aged care, rather the emphasis being on the acute care setting.

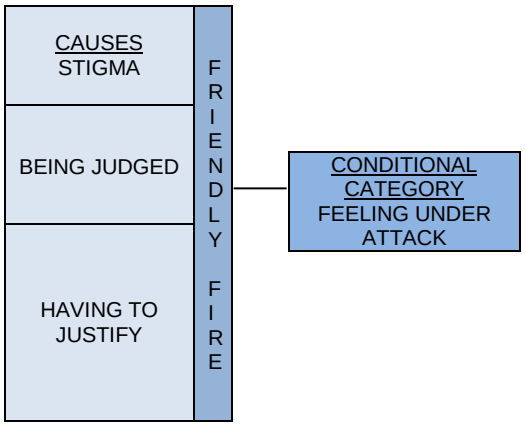
The participants were aware of the strong influence that the media played in the formulation of community opinions about older people, nursing them, and the aged care sector as a whole. As the media portrayal was often negative the participants believed this caused the community to develop stereotypical imagery of aged care and those who work in the industry.

The stereotypical images of ageing impacted upon the participants both personally and professionally. This was the foundation to the problems encountered by the participants culminating in them *feeling under siege.*

3.3 FEELING UNDER ATTACK

The first conditional category of *feeling under siege* was *feeling under attack*, with the latter being experienced by the participants on a personal level. *Feeling under attack* was the result of *friendly fire* which was a consequence of them *being judged*, having experienced *stigma,* and having to *justify* working in aged care. The *attacks* were often verbal, with the participants relaying negative comments made to them as individuals from a variety of sources. There was some dismay amongst the participants that they were *under attack* from people who lacked understanding of their role in nursing older people. Feeling *under attack* was a consequence of the participants experiencing *stigma, being judged,* and *having to justify* working with older people as depicted in Diagram 1a.

Diagram 1a: Feeling under attack



3.3.1 Friendly fire

Some of the participants described how their personal experiences made them *feel under attack* and came from unexpected sources. This theoretical category was called *friendly fire*, a term used in a military context to describe "fire that injures or kills an ally" (Dictionary.com 2009). Many of the study participants felt hurt by the negative judgements associated with their nursing older people, especially when the judgements came from sources they felt should be supportive of them, these being peers and family.

Friendly fire from peers

Participants had expected to have support from nurse colleagues, but this was not always received. This was summarised by a participant who *stated "Nurses working with older people feel devalued by their peers"* (P1). Another example of this attitude was the following comment made to a participant by a senior nurse, when the participants informed the nurse that she planned to work with older people, *"How very disappointing, you were one of our finest students, and we had higher things in mind for you, like nursing administration or education"* (P13).This response implied that only the less able nurse graduates would work with older people; the higher achievers and more highly skilled nurses would avoid choosing to nurse older people.

The participants provided numerous examples of the negative responses from peers to the participants' chosen field of nursing, with comments such as, *"people were shocked", "some peers more my age* [in their early twenties], *had a stigma about it"* [nursing older people] (P14) and*, "I think the perception then was you're wasting your nursing degree"* (P16). This is a view evident among recent graduates, with one registered nurse who had recently qualified and been appointed to an aged care ward being pitied by peers because they believed that nurses would not choose to work in aged care, for example*, "they were, 'oh poor you'"* (P20) and*, "they were a bit sorry for me"* (P20). This was a perception that continued throughout the participants' careers. A more experienced participant described how her peers, who were considered to be friends, also portrayed a negative attitude:

> *I had about three or four friends who were all working in the public hospitals and still do. They have to a certain extent wiped me off as a true nurse for working in gerontology. I don't feel I am given the credibility they still have (P21).*

A participant relayed that peers had little understanding of what caring for older people involved, with the peers saying to her*, "Wouldn't you want more variety? Don't you want something more exciting?"* (P17). The participants believed that their peers perceived nursing older people to be rather mundane, which was something they disagreed with.

This attitude was not restricted to the nursing profession; as an allied health professional who was interviewed gave a similar response when describing how peers reacted to her going to work with older people:

> *I didn't get an enthusiastic response. You know people didn't think oh wow, well done for getting a job with aged care, that's really, really great, where people who got jobs in a private practice or paeds [paediatrics], and even private practice rehab [rehabilitation], those avenues were things to be a lot more respected. There's certainly prestige attached to certain areas"* (P11).

The participants believed *friendly fire* from other nurses and health care professionals came as a lack of recognition that working with older people was a specialist area of nursing. One participant recalled the response she received on graduating when informing colleagues she intended to specialise in aged care*, "I met with a lot of negativity [from peers) saying ' You can't say aged care is a speciality'"* (P17). The participants recalled the lack of recognition by their peers in other nursing disciplines

was a major issue, and to some extent they felt responsible for this, *"... biggest downfall is not getting through to peers"* (P13). Even after their attempts to educate their peers on what their role involved they still experienced *friendly fire*.

The participants' experiences of *friendly fire* from peers varied depending upon the area in which they were employed. Those who worked within the hospital setting experienced *friendly fire* frequently and therefore *felt under attack* more often. In contrast, those who worked within the residential care setting did not experience *friendly fire* on a daily basis because the peers with whom they regularly worked all had experience in aged care and therefore had an understanding of the registered nurse role. It was not until these participants came in contact with their peers from other clinical environments that the *friendly fire* became evident. The participants who worked in residential care facilities explained how their experiences of *friendly fire* from peers usually occurred at conferences or during study days where nurses from other clinical areas were present.

Friendly fire from family

Another source of *friendly fire* was from family members, and this had a great impact upon the participants, who had anticipated their family would be supportive of their chosen career. One participant who had worked extensively over many years with older people noted a comment made by her mother when she informed her of her decision to work with older people, *"I cannot believe your father and I have given you such a good education and you are going to throw it all away"* (P13). The parents of this participant had decided which career path they thought would be suitable, *"they wanted me to do midwifery"* (P13). This was not an isolated view. Another participant commented:

> *My family have said 'Why you don't get a real job? Why don't you go back to the Hospital?' That's where I trained. Or 'Why don't you get a job in a public hospital instead of working in aged care?'* (P21).

These comments reflected a particular participant's family's views of caring for older people as not reflecting their children's abilities and skills as a nurse. These participants had become highly skilled in nursing older people and were respected at work for their abilities and knowledge within that arena. These participants did not specify whether the family members were guilty of associated stigma and felt

embarrassed, or were aware such a phenomenon existed and their comments actually were an effort to protect their child from the associated stigma they anticipated. The participants considered family members possessed the same negative stereotypical images associated with aged care that were prevalent within the community.

Family members that some of the participants could usually rely upon and, in a number of cases had supported them as undergraduates, were critical of the decision to work in aged care. This had a greater impact on them than the criticism they received from peers because the attacks felt more personal. Participants could shrug off the opinions of their peers if they had the support and reassurance from family members. To some of them this meant they had to come to terms with not only the negative opinions of society and the nursing profession but also of family members. The participants' perception of *friendly fire* was caused by them experiencing stigma, being judged, and their having to justify working in aged care.

3.3.1.1 *Stigma*

Stigma was something all the participants experienced. They recognised that the stigma was attached to the older people for whom they were caring and transferred to the individuals who nursed them. When describing the reason they felt stigmatised, participants were very clear that it was because they worked in aged care*, "… it's because you work with the elderly,"* (P3) and, *"they [nurses] don't want older people, so they don't want the nurses that work with them either"* (P9). The word stigma was used by the participants in relation to caring for older people*, "I think there is a lot of stigma involved with working with older people"* (P8), specifically in the residential care environment, for example*; "I think there is a lot of stigma attached to nursing homes and staff that work in nursing homes"* (P7).

Two nurses who did not work primarily with older people were included in this study in order to assess whether those nurses working with older people were justified in feeling stigmatised. One of the two described how nurses in other specialist areas perceived that*, "… nurses who opted to work in aged care were not interested in learning anything new"* (P9), suggesting that aged care nurses were considered as not wanting to progress professionally.

The stigma associated with nursing older people was acknowledged by all of the participants. One interviewee summarised this by stating *"I think it is going to be a hard fight to get rid of the stigmas that have stuck to aged care over the years"* (P7). The participants agreed that stigma was something they experienced from many sources and was an issue that they frequently had to address.

3.3.1.2 *Being judged*

The participants related the manner in which they were personally judged for working with older people*, "People tell us what they think about working in aged care, but most of them have never even been there"* (P17). It was difficult for participants to accept they were being judged by people who lacked the experience and understanding of what was involved in caring for older people, even if this judgement was in some ways positive*, "… they say that they admire me for working in aged care."* The participants could not stipulate where the negative responses came from, but just made general statements relating to the stereotypical images associated with ageing and those who nursed older people.

Being judged was something the participants experienced from other nurses, a different concept than being professionally judged, as the nurses making these judgements often had experienced nursing older people. Participants described their feelings about most people within the nursing profession, judging them negatively because of the clinical setting in which they worked. One interviewee attempted an explanation for this attitude, saying*, "… they had bad experiences in aged care and think it is all like that"* (P19). It was interesting to note negative judgements often changed following a positive experience, with a participant relaying a comment made by a student nurse who had spent some time in a rehabilitation unit where a large number of patients were elderly*, "why don't the ward staff spend time here? They would see what good work can be done for these [older] people"* (P3).

3.3.1.3 *Having to justify working in aged care*

A problem that the participants frequently encountered was the need to *justify* their decision to nurse older people. This meant having to *justify* their career choice frequently to others and, in the early stages of their careers, having to *justify* it to themselves.

Justifying to others

Many participants stated that working with older people was not their initial choice but they had entered this field of nursing because they needed employment. Issues cited included: availability of work, the hours suiting their family life, and the proximity of the workplace to their home. One participant summarised the reasons verbalised by many as personal or logistical for working with older people:

> *…then a baby came along and aged care was convenient because I could get the shifts I wanted. Acute care had gone across to everyone having rostered shifts at that time. With having my children, I could say, I would do three nights a week and get a regular three nights and still have my family and everything… I don't think there was any section of my actually choosing aged care: it was just where I am* (P23).

Other participants had worked in residential aged care facilities prior to undertaking their nursing degree and their rationale for returning to work with older people on graduating was to improve clinical practice. For example, there were statements such as: *"that I actually worked in a sad place and thought aged care has to be better than this"* (P17). This appeared to be a common feeling amongst the younger or newly graduated nurses who began their career with enthusiasm and aspirations to improve patient care. A more mature participant recalled feelings from earlier in her career and described how, when she was younger and newly qualified, she felt she could achieve anything and make changes to clinical practice*, "I was going to conquer the world"* (P5). In general more mature participants recalled with ease examples of other people's negative attitudes towards caring for the elderly, and having to *justify* their career choice to others.

Participants recognised the need to justify their decision was often ongoing, one saying*, "I am always trying to justify why I work in aged care"* (P18). In contrast, some of them justified their current role by relating their previous experiences in acute care with comments such as, *"I'd already been there, done that, I'd proved I*

can do other things" (P5). The participants recognised the higher status associated with working in the acute care sector and, having previously worked in the acute care setting, felt comfortable working with older people because of their proven career record. They believed they had demonstrated their ability to nurse in the environment of their choice and were not nursing older people because their skills were inferior.

Justifying to self

To some extent, the participants were not only justifying their choice of clinical area to others but also to themselves. For example, they noted how they had to justify their decision to work with older people to themselves when questioned about how people reacted to their career choice, *"…only to myself occasionally in my younger days"* (P23). The *statement "in my younger days,"* suggested that this participant had successfully developed strategies which enabled her to be comfortable in her role. Although she recognised the need to justify her decision, she no longer felt threatened. This was a common feeling amongst the participants, possibly reflecting on their own perceptions of working with the elderly.

The participants also found some justification in the fact that the majority of registered nurses were caring for older people. Referring to patients in hospital, a number of participants intimated that older people were cared for by registered nurses in a variety of clinical settings, providing such illustrative statements as*, "… well it's true the people admitted here are nearly all over 65"* (P7*); "…70 to 80 % of those they are looking after are aged care"* (P8*), and "I found that a lot of people were shocked that I was going in to the nursing home industry, but based on the clientele we had at the hospital it wasn't really that different"* (P14). The participants thus had a sense of equality with other registered nurses, but also some dismay because registered nurses in other areas did not recognise, or acknowledge that their work in other areas was largely the care of older people.

One participant felt there was no need to justify the decision to work with older people*, "I didn't feel the need to justify it to anyone else. I was happy to go in that direction"* (P16). However, the majority of participants felt the need to justify their decision to work with older people to both themselves and others. This feeling of need for justification decreased with professional and personal maturity.

Only two of the participants had actually chosen to specialise in nursing older people. It was clear that those two had a more positive attitude during their initial experience than those working in this field after having had no other choice or opportunity available to them. Although other participants had been reluctant to work in aged care initially, with time and experience they had developed a passion for this type of nursing.

3.4 FEELING TRAPPED IN AGED CARE

The second conditional category for *feeling under siege* was experienced by the participants on a professional level as *feeling trapped*. Many of them described their risk of *feeling trapped* within aged care thus being affected professionally. After having decided to nurse older people, the participants felt their opportunity to work in other specialist areas was restricted. The extent to which the participants felt *trapped* had a number of dimensions, depending on whether they had chosen to work in aged care or were there by necessity, as they had no other option, but needed employment wherever they could get it. The length of time participants had spent in the aged care setting was also significant. Their feelings of being *trapped* were initially minimal, but the longer the participants worked within aged care the more difficult they felt it was to be seriously considered for employment in other specialist areas. The participants who experienced a low level of entrapment were those who were new to the aged care setting, or knew their time in that nursing environment was limited, *"I am only here for 6 months on my grad [graduate] program"* (P20). Even those who experienced low levels of *feeling trapped* were aware of the potential of this escalating the longer they worked in aged care, *"You are seen as nothing more than an aged care nurse"* (P4). The participants considered this as not being a true reflection of their skills and wanted their nursing of older people to be acknowledged as specialist nursing in accord with other clinical settings.

Some participants acknowledged *feeling trapped*, but seemed unperturbed and accepted their lot. They were happy practising in the aged care setting and had no intention of nursing elsewhere; therefore, their experience of *feeling trapped* was minimal. For example, a respondent who had worked in residential aged care for 24 years described how previously other people had recommended she work elsewhere.

At first this did cause some concern, but now the participant did not worry about this advice, *"I'm now over it* [other peoples' opinions], *I don't worry about that any more, but previously it was a bit of a pain…I don't tend to dwell on it. It is not something that interests me anymore; you know what their impression of me is"* (P18).

Some respondents felt only partially *trapped*. These were either nurses relatively new to working in the aged care setting, or those who had kept their options open by working occasionally in other clinical areas, *"I also work at the hospital on a casual basis"* (P7). Those participants who had nursed in the same town or hospital throughout their nursing career were only partially trapped because others could recall participants' previous roles and recognised the skills they possessed, *"I have worked here for many years, so people know what I can do, they don't question my ability"* (P4). A number of participants had made the decision to work in other specialist areas on a casual or part-time basis in order to maintain their clinical skills in these areas. By clinical skills the participants were referring to 'hands on' practical skills, which involved patient care within the particular clinical setting. These skills also involved keeping up with technological advances in nursing care. A number of the participants opined this to be of major importance because it was quite easy to slip into being a specialist in one particular area of nursing, thereby losing other skills which needed to be maintained. They did recognise that the reality in nursing today is specialist nursing, with one participant who worked in a residential care facility saying: *"...I actually work casual too, up at the hospital"* (P19). Whilst justifying this decision it was evident that working at the hospital had a dual purpose: to keep in touch with the acute care sector and to appease others' perceptions of her. She continued:

> *I think there is a general consensus with people that if you go into aged care that you do lose touch with hands-on nurses you know, the acute care nursing…just to keep my hand in there, and to make sure I don't lose touch…I think it is important to keep your hand in acute as it is an area that in the future you may want to return to, otherwise I think when you have been working in aged care for several years it is difficult to return to the acute sector* (P19).

Some participants who had worked solely in aged care settings for several years described feeling totally trapped, acknowledging that being able to practise in another clinical setting was unlikely. This was particularly relevant to those who

worked within the residential care setting because the longer they were employed outside the hospital environment the more unlikely it was for them to be able to return to the hospital setting. For example, when referring to the possibility of returning to the acute care setting, one participant made the point*, "I have been written off as a real nurse"* (P18). Another respondent explained that staff in the acute care setting thought nurses working in aged care were not as knowledgeable, *"They think you haven't worked in the hospital for so long, you don't know anything"* (P6). Some believed a different specialist area chosen could have led to being viewed differently *"You are seen as having more skills if you work in ED* [emergency department] *or ICU* [intensive care unit] *... you have more career opportunities"* (P18). Even when participants had reached senior levels, this perception of them continued and they felt they were not as valued as other nurses:

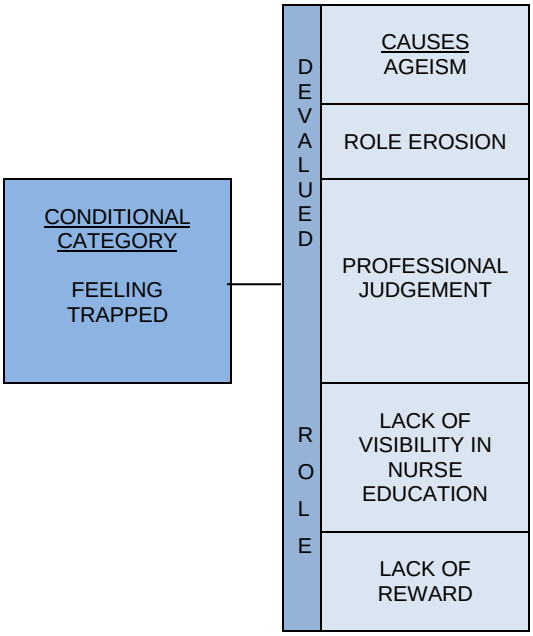
> *They would acknowledge you more if you were an ICU [Intensive Care Unit] nurse, or an emergency nurse, or something. If you said you were an aged care specialist they wouldn't consider that as anything* (P2).

Participants' comments suggested they believed nursing older people could be seen as the final role undertaken as a registered nurse, with people referring to it as the *"end of the road"* for their nursing career. It was thought to be difficult to change to another specialist area after nursing older people. Those participants who did attempt to return to the acute care sector after working with older people for a few years described being treated with extreme suspicion and caution, as participant 19 commented*, "The first few shifts they were very wary of me doing acute care nursing"* This suspicion related to the registered nurses' ability and technical skills to work in the acute care setting after working in aged care. This highlighted the difficulties of moving away from working with older people, and the potential barriers registered nurses encountered in the process. Another participant had applied for a job in management, a role undertaken prior to working in aged care, and was disappointed not to get short listed for the interview, saying: *"They said I had not got recent acute experience"* (P22). As the role was in management the participant was concerned that her management skills be recognised even though she had nursed recently in the aged care setting. She commented*, "I have the management skills"* (P22), but they were not recognised. The participants described the difficulties encountered when they chose to work within a different care setting. The participants did not acknowledge they would treat nurses new to the aged care

setting with the same caution until they were confident the new nurses possessed the skills required to be competent caring for older people. This will be further discussed in Chapter 4.

Nurses outside the aged care setting were also aware of the potential of *being trapped* in aged care, with those who worked casually or as agency staff being reluctant to work permanently in aged care. The participants considered there to be an understanding throughout the nursing profession that nurses within aged care found it difficult to secure employment in other clinical settings. This led to some new graduates employed in aged care being eager to seek employment elsewhere as soon as possible so as not to become entrenched in the aged care system and being labelled, with its negative connotations, as *an "aged care" or "geriatric"* nurse. Those within the aged care setting were very aware of the stigma choosing to work in this area could have for new graduates: *"If you went straight from training in to a nursing home, it would be very hard to return to the acute area"* (P19). This led to some of the participants advising new graduates not to work in aged care, *"We used to have students come [to the aged care facility]; I always used to advise them to go right into acute [nursing]"* (P23). They agreed that anything more than a short time spent in aged care nursing could potentially lead to registered nurses *feeling trapped* there. Although the participants spoke of feeling their career options were limited due to working in the aged care setting, none of them expressed a view that they were planning to seek alternative employment. *Feeling trapped* was a consequence of the participants recognising ageism, role erosion, professional judgements, lack of visibility in nurse education, and lack of rewards, which combined in the category *devalued role* as depicted in Diagram 1b.

Diagram 1b: Feeling trapped



3.4.1 Devalued role of the registered nurse

The participants commented that many registered nurses felt if they nursed older people they would be devalued, with this causing registered nurses to avoid employment in clinical areas where older people received care. The participants provided a number of examples with statements such as: *"Nobody wants to work in aged care"* (P8), *"The wards were mainly aged people – nobody wanted to work there"* (P12), *"Not a lot of people want to look after the aged."* (P14); *"Many don't want to nurse within aged care"* (P7), and, *"Who is going to work there [aged care ward]?"* (P20). Another respondent described how an employer was aware of registered nurses reluctance to work with older people, so would rotate new graduates through the aged care wards on a six monthly basis: *"They know people don't want to work in aged care"* (P2). Rotating staff through the aged care setting did provide the feeling of equity, with nurses all having six months working in such a setting. One participant quite simply suggested the reason nurses did not choose to work in aged care was because it was *"… unfashionable…"* (P13). This statement suggested that at some stage nursing older people would become fashionable again.

However, the data revealed nursing older people to have been unfashionable for decades with no suggestion this entrenched attitude would change in the near future.

Even the prospect of permanent employment was not enough to entice some registered nurses into aged care. A participant who worked as a manager described how she would offer casual and agency staff permanent jobs in aged care but these were frequently declined: *"They say, I'm working for the agency, and most of the time I'm working with acute care, and only when I have to I come to these [aged care] places."* (P13). This highlights some nurses' reluctance to work with older people. In this example agency and casual staff preferred not to work in such clinical settings even for a short period of time; they had a preference for the acute care setting. The respondent quoted did not acknowledge that some registered nurses chose to work with an agency or casually because it suited their lifestyle. Difficulties with recruitment to aged care settings were not unique, as another participant remarked, *"Trying to get staff is a nightmare, trying to replace nurses…the attraction [to aged care] is really, really poor. It is really hard to get registered nurses in to aged care"* (P18). Attracting new graduates into aged care was a particular problem because it was not deemed as attractive as other areas of nursing, *"To new grads it [aged care] does not have much mystique about it"* (P21). Nurses' reluctance to work in aged care was clearly evidenced by there always being vacancies for registered nurses within the aged care sector:

> *I worked in aged care when I finished my training as that was the only place I could get a job, and nobody would go and work in aged care so all the newly qualified nurses used to work there (P8).*

This statement indicated registered nurses' reluctance to work with older people, and reflected the participants' thoughts in general, namely that it is an area where there were few experienced staff, reflecting the view that anyone can care for older people. The lack of experienced nursing staff created difficulties for new graduates, because there was a lack of support from other registered nurses on the ward*: "When you are a grad [graduate] you look around and think 'oh there is only other grads on the ward, and they can't help me out with this [a clinical problem]'"* (P20). The participant described how there had been no senior staff to offer her support when she needed to reflect on her experience, or required guidance with clinical decision making. Although other new graduates were able to empathise, this participant

required the support of senior staff to mentor and guide her. New graduates did not have positive experiences so were eager to move to other clinical settings where they would be more likely to receive support and guidance from experienced staff.

The participants recognised that other registered nurses did not attempt to hide the reasons for choosing not to work in aged care*, "I still hear the nurses talk about not wanting to work with geriatrics"* (P13). This remark suggested that devaluation of nursing older people was not a new phenomenon within the nursing profession. Even with strategies in place to address them, these perceptions were embedded within the nursing culture. With the exception of those participants who specifically chose to nurse older people, the other participants expressed their own reluctance to nurse in the aged care sector, having previously possessed negative views of aged care. It was only with experience in this field and their focused professional development that these views had changed:

> *I think my attitude has changed. It changed quite a bit when I worked in the aged care setting. I was not so negative about it. I got frustrated about the inequities in the level of treatment, but I changed quite a bit then. The interesting thing was I found an essay I had written as a student, when I did my aged care rotation and I did [sic] 100% in the exam. The tutor had written, 'you have got a real flair for aged care, do you want to come and join us?' And underneath I had written 'no way!'* (P8).

Another respondent also confessed to her previous impression of nursing older people saying: *...but geriatrics it's just day-to-day nursing care, basic nursing care is what we used to think, and I'm guilty of this in the past* (P9).

One participant expressed embarrassment about her poor management style when nursing older people in the past whilst, over time, she gained insight into the importance of developing the skills required to care for older people over a period of time:

> *I approach my work very different to when I was a young twenty-two-year-old. When I look back on it now I think, 'Oh my God, how did I ever treat [older] people like that'* (P3).

Although this person was self-critical, developments in nursing practice would also have impacted on nurses' treatment of older people.

Some participants spoke of their experiences as undergraduates in which they shared the views of nurses in other specialist areas on what nursing older people involved:

> *I thought as a lot of undergrads do, you think that acute care is the almighty and very exciting…I had it in my head that acute care was the place to be* (P18).

Another described her partial resentment when she was informed on graduating that her placement would be in aged care*, "That's where they put me, on an aged care ward"* (P20). The need for a registered nurse on the aged care ward was evident but this person found the placement difficult to accept, initially blaming others for the decision.

A participant who strongly advocated for the care of older people also recognised she was initially reluctant to work with older people:

> *I must confess, there were two permanent care wings in the hospital and I didn't want to work on those levels. I worked on the other levels and I said to myself, 'No way do I want to go and work in aged care'* (P2).

These participants openly acknowledged that originally they had been reluctant to work with older people, and had negative beliefs of what nursing older people entailed. These beliefs changed with their positive experiences of working with older people and with the on-going development of skills and knowledge. Recognition of their initial beliefs of what was involved in nursing older people brought forth a certain empathy for the beliefs held by their nursing peers.

Participants suggested that nurses' reluctance to work with older people and the registered nurse role being devalued was a reflection of society's views. Their responses, when asked about the origins of this reluctance follow: *"It's something amongst the nursing group"* (P19), *and "Many of my colleagues saying, 'I never want to wash an old person, I never want to work with an old person'"* (P20). Another participant stated that, during her undergraduate course, peers were making negative comments about nursing older people in the following way*, "having people to deal with, bodies, naked bodies, and provide basic nursing care"* (P17). Such views were further supported when some respondents described their perception that other nurses thought aged care was "the end of the road" for their elderly patients, and it was frequently viewed as "the end of the road" for registered nurses:

> *Aged care nursing and particularly residential is sort of where nurses go when they are past their peak and heading towards retirement… It's pretty much the last thing they do in nursing* (P18).

An ageing workforce was also prominently discussed within the public hospitals. One participant stated: *"They are all towards the end of their careers; in a sense they are all looking towards retirement"* (P20). The ageing nursing workforce was a concern for a number of participants, who made comments such as*: "I think here at (name of facility) most of the registered nurses will be over 40, 45"* (P19). Participants expressed concern about the replacement of the ageing workforce, especially as aged care was not a popular choice for new graduates.

The data indicated five causal conditions for registered nurses being devalued within the aged care setting: ageism, role erosion, being professionally judged, lack of visibility in nurse education, and lack of rewards.

3.4.1.1 *Ageism in health care*

The participants believed ageism to be an issue within society as a whole and evident within the health care setting. Analysis of the data led to ageism being identified as a contextual condition for participants, due to feeling that their registered nurse roles were devalued. They believed that older people were often unpopular with nurses in the acute care setting, and provided accounts of their experiences of ageism within a variety of clinical settings. For example, one participant described her experience in the acute care setting where she had witnessed nursing staff responding to patients from nursing homes in a negative manner:

> *It's actually written on the handover – nursing home. It's considered quite, 'Oh what are we doing? Why are they here?' It's looked upon quite negatively. If they are from a nursing home it's seen as quite futile* (P20).

Some resentment was present about an older person being in the acute care setting because it was considered "futile." Nursing staff in the acute care setting wrote "nursing home" on the handover documentation, but this may not necessarily have been a negative response, as the participant interpreted, it may have been a means of assisting with the discharge planning for that patient.

The previous account of nurses' attitudes was not an isolated occurrence; as other participants spoke of similar experiences. A registered nurse, who worked in a

residential care facility in a country town, gave an account of taking a resident, who was receiving palliative care, to the local hospital:

> *Yesterday we took one of our residents to the hospital for a blood transfusion; he's dying. We took him there at the time we were requested and we were met with, 'Take him away; we're still feeding at the zoo'* (P3).

By the phrase *"feeding time at the zoo,"* the nurse was making reference to older people needing assistance with eating. Although the person may have used this phrase in a humorous manner, or as a means of conveying their being busy, such automatic comments reflected the low status associated with older patients, and in this case patients who were highly dependent on the care of staff. The registered nurse participant certainly did not interpret this as a humorous, off-the-cuff comment, but believed this person's comment was representative of others having the same view. This account opened up several major concerns for the participant. One was a presumption that the elderly gentleman could not hear or understand what was being said, and another concern was that such elderly people were considered as nuisances. Conversely, many of the participants who worked in residential care facilities stated that they considered residents to be extended family members, and were very protective of them. Even so, the comment made by the member of staff at the hospital was inappropriate. As a consequence of this event the participant was obviously distressed and angry, but tried to provide some justification for what was said, *"It's not her problem, it's how we treat elderly people, with 'they're nothing but a nuisance.'"* It was interesting that the participant did not challenge this behaviour at the time, almost accepting it as the norm in the treatment of the elderly, even going so far as to make excuses for the comments. This cameo highlighted the relationship between the aged care and acute care nurses as being problematic.

3.4.1.2 *Role erosion*

The participants explained how they felt professionally devalued due to changes in the registered nurse role in aged care. They felt particularly uneasy about less well-qualified care staff being employed instead of registered nurses. An area of concern for the participants was that their role as registered nurses was not always recognised or distinguishable from other health care workers in the clinical setting. One who

worked in the residential care setting commented*, "I think sometimes that they don't see the difference between nurses and carers looking after older people"* (P4).This respondent felt that both the general public and other health professionals should be able to distinguish between the different health care professionals and their specific roles. This statement was made in relation to a residential care setting, with the assumption that the different roles could be more easily distinguished within the acute care setting. Whether this lack of identity was in relation to the care provided, or the inability to distinguish different health care professionals because they all wore similar apparel, was not clear. This concern was exacerbated further by the belief that the registered nurse was often being replaced by enrolled nurses or carers. The concept of role erosion was mirrored by another participant*, "Enrolled nurses doing basically the same role as a registered nurse, so I think that brings down the professionalism throughout"* (P18). Greater concern was expressed if the tasks were being undertaken by non-registered staff*: "I think supplementing registered nurses with non-professional staff is not a good way forward for aged care"* (P18). Thus these participants viewed their professional identity as being compromised and their roles being eroded. They perceived with this came a loss of respect and status, because subordinates were undertaking tasks considered to be part of the role of the registered nurse, such as medication rounds and wound care. Concern was expressed that if the registered nurse role was eroded, it would be difficult to reinstate, impacting upon the care provided to older people. A registered nurse working in residential care made the following comment about how this could be a reason why registered nurses were reluctant to work in aged care:

> *Removing the pay issues, I think its respect and my experience on rehab [rehabilitation] wards and things like that is it is run in the majority by nursing assistants or nursing aids and enrolled nurses. There is not a huge amount of registered nurses, so I guess it doesn't pull a lot of respect with it…..I think that registered nurses make a huge difference in aged care and it just devastates me to see enrolled nurses, not so much enrolled nurses but carers and care assistant, being able to do so many of the tasks that were done by a nurse. I don't think it lowers the level of care provision but certainly registered nurses are university trained and they have more clinical skills than other staff members, so certainly things are going to be missed and not picked up by other staff members. I think supplementing non-professional staff is not a good way forward for aged care* (P18).

This participant stressed her belief that other staff played an important part in the team caring for older people, but felt the registered nurse role needed to be

maintained. Role erosion was of greater concern to the participants who worked in aged care facilities; those within acute care were more accepting of the registered nurses' changing role.

The participants believed registered nurses themselves to be partly to blame for the erosion of their role because of their reluctance to work in aged care. Since the elderly still required care, employers had to look for different means to ensure appropriate care was provided, with this often resulting in a different skill mix of care staff than that of those previously employed. They recognised that often the complex skills they possessed, such as problem solving, were invisible to others, including health care professionals and the general public. The participants were concerned their expertise and skills would not be recognised until it was too late and their role had been eroded.

3.4.1.3 *Professional judgement*

In the context of this study, the participants described how they perceived others made professional judgements about nurses who cared for older people, with this contributing to them *feeling trapped*. The following reasons were provided by the participants as to why they felt they were professionally judged:

1. Working with older people is considered professionally less demanding;
2. Fewer technical skills are required; and
3. Work is considered physically demanding and "dirty work".

<u>Professionally less demanding</u>

The participants alleged nursing specialities were hierarchical in nature, with nursing older people being considered as suitable for nurses who were not as proficient as those in other clinical settings. They were able to provide examples from their experience about how many within the profession regarded nursing older people as professionally less demanding than working in other clinical areas. A number of the respondents made reference to how older people had previously been cared for in what was referred to as C class hospitals. It appeared this label of being C class went

beyond the hospital being considered not as valuable as the tertiary hospitals to a view that the nurses who worked in them were not as capable as their colleagues working in acute care. One participant stated:

> *…people that worked in aged care were not real nurses, as in you didn't have any training and if you did have training you didn't quite make it. You weren't quite a registered nurse like the registered nurse in the hospital… They [nursing homes] used to be called C class hospitals, so that was even more degrading wasn't it? Yes, so I think peoples' perception was you didn't quite make the grade as a registered nurse* (P4).

Although this comment provided a historical context as to the reason why nurses working with older people were negatively perceived, the data suggested a consensus amongst the participants that this perception was current.

One participant explained that it was not just within the nursing profession that acute care nurses were considered superior*, "It's perhaps a society value that acute care nurses and crit [critical] care nurses are highly regarded and respected, not just among their colleagues I think but in the greater community"* (P18).This participant continued to discuss this matter later in the interview by understanding the community valuing the contribution made by registered nurses caring for older people, but valuing other registered nurses more*, "They value what you do… but I don't know whether they respect it… I don't think they put you on a pedestal as they would an emergency nurse or crit [critical] care nurse probably."* This statement reflected the differing views regarding acute and chronic care management. Acute health issues are seen as more critical because they had the potential of being life threatening and affecting all age groups within the population. In contrast, nursing older people is perceived to be more management of chronic disease and does not to have the urgency of acute care. Within the aged care setting symptoms of ageing and chronic disease management were the norm: this was possibly the reason for aged care nurses not being perceived in the same way as their colleagues in acute care.

One participant had formed the view that some nurses chose to work with older people because they believed it would be professionally less demanding:

> *There are some people that think; 'Well maybe I won't cut it in the acute so I'll do the oldies.' You know you see these people who are there for the wrong reasons* (P3).

A number of the participants described the feeling that they were not as valued as their colleagues working in other specialist areas. A number of references were made to being *"the poorer cousins of the acute nurse"* (P3), thereby implying that other nurses did not consider them as equals. One participant suggested that in the nursing hierarchy, those working with older people were*, "right down there on the bottom"* (P3). Another mused that nurses working with the elderly were*, "not always seen as a proper nurse"* (P4), and that nurses who practised their skills with older people were regarded as, *"the ones that can't hack it in the real nursing world"* (P6). Aged care was considered to be*, "somewhere that you went if you really didn't have any skills"* (P5). One respondent contended that nurses in aged care did not feel as valued, but believed they were equal, *"I was disappointed. I thought what I was doing was fairly worthwhile, you know, I didn't see myself as not being as good"* (P21). Participants also recognised that, as registered nurses working with older people, they had become a definitive group, hence losing their individuality as registered nurses and being classified as "aged care nurses". Their feelings of oppression were a consequence of being viewed by others as professionally inferior, with their clinical skills being perceived as basic rather than specialist. Individual participants considered themselves as specialist practitioners and were perturbed that others did not appreciate their specialist skills. The participants wanted nurses to care for older people, genuinely feeling that the requisite skills were not always evident. For example, a younger participant who had worked mainly with older people described a short period of time spent working in the acute care setting:

> *It was all very much, you know about outcomes. It didn't really matter about the patient, and yeah, I felt that was lacking and that was the reason I wanted to go back into aged care and why I stayed there* (P18).

Participants also provided evidence of acute care nurses being viewed much more positively. Acute care nurses were described as at: *"the pinnacle of nursing"* (P4), *"…acute care nurses and crit [critical] care nurses are highly regarded and respected,"* and possessing a degree of heroism*, "the emergency nurse was able to do everything and cope with everything"* (P3). Another participant supported the elevated stature by stating:

> *You used to have to be more high powered and more knowledgeable to be like in intensive care or whatever than aged care. Aged care they think you don't have to think too much, not like other nurses* (P6)

The participants described their feelings about a hierarchy existing in the registered nursing profession, depending upon the specialist area in which practice occurred. In their minds intensive care and emergency department nursing were considered to be the environments with the highest status, and nursing older people was seen as having low, if not the lowest, status. They recognised that in the most care settings at least some of the people being cared for were elderly: however, the ward / clinical area name made a difference to its ranking in the perceived hierarchy. For example, if a clinical area was referred to as a medical ward it was considered as a more desirable place to work than an aged care ward, even though the majority of patients on the former ward would be elderly. This was readily acknowledged by the participants with a high level of amusement, because they recognised their colleagues elsewhere nursed older people but were reluctant to accept this distinction. The settings in which their colleagues worked were not specifically dedicated to aged care even though a large proportion of the patients were elderly. This suggests that nurses may be judged in relation to the purpose of their setting and whether acute care is provided. A recent graduate spoke of an acute area in which she worked that was planning to make a move from being a general medical ward with tertiary hospital status to specialising purely in aged care, and the perceived impact on staff:

> *…make our ward just DGM (Division of Geriatric Medicine)…They are going to trial that and not have everyone else mixed in there. At the moment you are getting the odd thirty year old…it's interesting because they have people that are in conflict at the moment over what the ward is going to become. Some people are worried that it will become hard to find staff and the ward's going to be heavy. Then other people have said, 'Well it could be a good thing because you're going to have doctors that are basically those for that type of patient'* (P21).

This participant also suggested that nurses were aware of the stigma attached to caring for older people and how this impacted on the hierarchical views within the profession. However, the participant noted earlier in the interview that the ward was viewed as being "aged care" without the ward being specifically deemed as caring for older people. In contrast, another respondent described how working in certain specialist areas detracted from the fact that the majority of patients were elderly, *"… it still becomes like they are an ICU (Intensive Care Unit) nurse, and that takes over*

from the fact that they are nursing aged care. That is their validation, their justification" (P7).

Analysis of the data revealed that participants' perception of the hierarchy within the nursing profession was not limited to registered nurses' choice of specialist area but also the environment in which they chose to work. For example, nursing older people within the hospital setting was considered as having higher status than nursing older people in a community setting, with the lowest status being attributed to registered nurses working in residential aged care facilities.

Fewer technological skills

The perception amongst the participants was that other nurses believed those working in aged care did not keep up to date with advances in nursing care, especially when relating to technical advances, *"Perceptions of nurses in aged care is that they are old fashioned, they don't keep up with technology and stuff"* (P23). They believed the use of technology was often associated with clinical areas, such as intensive care and the emergency department, but was rarely required in the care of older people, *"Aged care is not high powered and does not have lots of technology"* (P1). They never doubted their abilities in providing good care for the elderly, continually updated with the latest appropriate research outcomes and technology. However, they were honest in expressing some doubts as to whether they had experienced the latest technological skills currently required in other clinical settings. For one participant this had become a major issue as she mentioned technology or technological advances a total of fifteen times in a thirty minute section of an interview. Some of the more mature participants lacked confidence in using technology: *"I did not grow up using computers"* (P23). This added to nurses working with older people having not kept up with advances in medical technology, as its use in other clinical settings was increasingly rapid. Many felt not as valued as their colleagues in other areas because the use of technology was not as visible in the care of the elderly. However, the shift was towards providing technologically based care within aged care. Participants provided examples such as the use of syringe drivers for administering medication, infusion pumps for enteral feeding, and the use of technology for direct patient care. But the participants were aware of the use of

technology in documentation, for example, progress notes and care plans being recorded electronically.

Some of those interviewed believed that technical skills seemed more valued than basic nursing skills. They thought many registered nurses no longer cared for the patient by providing basic nursing care, such as bathing. A number of them made reference to "hands on" nursing, emphasising the importance of the practical aspects of nursing to them. Participants referred often to the importance they placed on direct patient – nurse interaction. This might have been reflective of the participants' age and pre-registration experience, with many of them having experienced the hospital-based approach to nurse training and their possible lack of familiarity with technological advances. However, the need to focus on "hands on" nursing was also considered to be of major importance by the younger participants in this study who had graduated through the tertiary education system.

Dirty work

The participants suggested that working with older people was not valued because the work was viewed as being physically demanding and "dirty work", the essence being that this work was not valued, *"There is reluctance because it's hard work to work with old people because of their physical disabilities"* (P4) and *"It's dirty work"* (P9).This sentiment was echoed by another interviewee who reiterated the physical strain of working with older people by describing feelings at the end of a shift, especially as these were a frequent occurrence within the residential care setting when a nurse was the only registered professional on duty:

> *I used to walk out exhausted. I would have to wash and shower about six people. I would have to give out all the pills. I would have to do the dressings. I would have to do the doctor's round and then do all my notes and handovers. You were on the go all the time* (P5).

Working with older people was considered by the participants as physically and emotionally demanding, *"It's mentally tiring"* (P4): therefore the responsibility made the position an even less attractive option for registered nurses. One respondent explained how hard working in the aged care setting really had become:

> *I have never worked so hard in my life as I worked in residential aged care….it is a physical job. It is also a process of a lot of emotional and psychological time as well* (P17).

Although the participants recognised that working with older people was hard work they were concerned this was not acknowledged, for example: *"The acknowledgement [that] it's hard work looking after older people"* (P6). The participants did not complain about the demanding work of caring for older people, but their grievance lay with the lack of recognition of their role and that they were not considered equal to other nurses.

One of the nurses who worked with older people knew that the stigma of "dirty work" was applied and made the comment, *"Aged care nurses need to be one of the smartest nurses, not one of the dirtiest"* (P13). Regarding working with the elderly being considered demanding and heavy work of interest was that one participant, who had worked in both the residential care and the acute care settings believed it was harder work to care for older people in the acute sector than in residential care, *"I think it's harder in the hospital. I have had nurses come in to the hospital and say this is much harder than working in the nursing home"* (P20). A possible reason for this perception is the fact that in hospital an older person may be unwell and less mobile when situated in an unfamiliar environment, and the staff in hospitals may not possess the skills required for nursing older people.

3.4.1.4 *Lack of visibility in nursing education*

A number of participants explained that nursing older people had not featured prominently in their undergraduate course; they considered this omission to be a major cause of registered nurses' reluctance to work with older people. This lack of theoretical / practical units of study relating specifically to the health and care of older people made many feel that nursing this age group was not as valued as other areas of nursing. When speaking of her undergraduate course, one participant commented:

> *There weren't any theoretical units, it was actually just the placement. It had a really strong clinical focus. Anyway, there wasn't anything about aged care, it was all about developing your clinical skills, getting ready for the acute care setting* (P18).

She felt that the practical placement with older people was used as a placement in which to develop basic nursing skills before being allowed into the acute care setting,

rather than developing specific skills required for the care of older people. Participants told how it was considered acceptable within nursing to practise clinical skills on older people before being deemed competent to use them in the acute care setting. One rued the lack of focus in the educational training setting on both the theoretical knowledge, and skills required in caring for older people:

> *…generally in nursing you're taught about paeds [paediatrics], and then you are taught about the adult, then tacked on the end of it is a bit about aged care"* (P7).

This participant had been working as a registered nurse for several years, observing that undergraduate courses have changed significantly, for example, a participant who had graduated only one year previously spoke of having aged care experience in semester two, with this being supported later by two theoretical units on caring for older people. The participants' major concern was not so much the lack of content and practice in the course relating to working with older people, but rather the lack of preparation for the practical experience. One participant had worked for a number of years as a carer in a residential facility, so felt comfortable working in aged care; however, she explained that some of her student peers were not as fortunate, because they had not been prepared sufficiently for the experience of nursing older people:

> *…when I worked with the [student] group through the nursing home in the second semester it was lovely, it was a dementia specific facility, and I thought it was really lovely, but the girls were scared. They were dealing with people with dementia, which they really had not had contact with before. We hadn't done mental health or anything like that; mental health wasn't until semester 6. So these girls, they learnt to understand and got in to it after a few days. They came to understand, but at first they were really quite scared. It's quite confronting to them, to me it was like my second home, I could totally understand what was going on* (P21).

The importance of experience as an undergraduate in working with older people was highlighted, as was being familiar with what to expect within those clinical settings. The participant opined that undergraduates were not always prepared and supported through their clinical experiences; this often led to a negative experience of working with older people. This matter was very difficult to rectify and, in extreme cases, it resulted in nurses leaving the profession

It was not only undergraduate nurses who experienced problems with education; some participants had experienced difficulties with postgraduate courses. They

described being met with some hostility from other nurses when considering or undertaking postgraduate study in aged care, *"When I was talking to people at work they just think I am mad, 'Why would you be doing postgrad [graduate] studies in aged care?'"* (P7). An additional problem of accessing postgraduate courses in care of the elderly also existed due to low applicant numbers, *"They didn't get enough [applicants] to run the course"* (P7). The participants explained that many of their peers working in other specialist areas did not consider working with older people as a specialist area, with this view being reflected throughout academia.

3.4.1.5 *Lack of rewards*

The participants believed that one of the reasons nurses chose to avoid nursing older people was the perceived lack of rewards. There was a belief amongst many of them that nurses in other clinical settings felt that caring for older people took a large amount of time and often resulted in less positive outcomes. One participant commented, *"There is no credit for the hard work"* (P1). To some, the reward was monetary with participants, both from the public and private sectors, citing pay as a major issue for nurses working with older people feeling devalued, *"In the private sector there could be low pay – they feel worth less than other nurses"* (P1). Issues relating to pay were raised by a number of participants as a deterrent to people considering working with older people. This belief did not take into account the reluctance of registered nurses in the public sector, where pay scales would be the same across specialist areas, to work with older people. A number of the participants were questioned on whether they felt addressing the pay issue would solve the problem with recruitment and retention rates. They thought that if the pay issue was addressed, it would certainly assist in recruitment, especially to the private sector, but that the wider stigma of nursing older people would remain a major problem. The participants who cited low pay as a problem believed low pay reflected low status as a professional, and that monetary remuneration would earn them respect.

One participant expressed the opinion that others felt nursing older people to be unrewarding:

> *The thing about aged care is its Alzheimer's, dementia care… it's very unrewarding in the sense that the patient is unable to say thank you… It's not*

> *emotionally rewarding so you have to have a real interest in dementia to work in aged care* (P9).

Participants felt that others thought that nursing also had to be emotionally rewarding and this could not be achieved in the aged care setting. This attitude was echoed in the comments made by participants about working with older people such as, *"The end of the road",* and *"Nothing can be done for them [older people]."* Participants felt others perceived aged care facilities as sad places, where positive outcomes were rare, this attitude was a major deterrent to nursing older people. Participants also indicated that many nurses want to see their patients get well quickly and be discharged: they were generally looking for quick-fix outcomes. Because this was not always achievable in the care of older people, this became an area of nursing that was considered by many as lacking in job satisfaction.

The participants identified how many nurses considered rewards in relation to pay important, but this was not necessarily a major factor for the participants with other forms of reward being considered more important, *"I know pay wise I don't get as much as I did at the hospital. I suppose that devalues us to a certain extent, but I get the job satisfaction"* (P7). They listed numerous rewards, including positive outcomes for the patient in relation to getting well and being discharged, making a difference to the older person, enjoyment in providing care, continuity of care, and positive feedback from the older person's family.

The participants were unperturbed that those they cared for did not necessarily get well quickly, if at all, accepting that the care they provided would span a longer period of time and at a slower pace than in the acute care setting. Gratification came from other outcomes such as delivering holistic care to ensure the person they were caring for had their individual needs met. A major reward for the participants was the knowledge that they provided person-centred care for older people. This was considered more important than personal rewards, providing a high level of job satisfaction from knowing the care they provided was exceptional.

There was also recognition by the participants that nursing care often extended beyond the person for whom they cared to family members, *"…it's a much more rewarding career because you get involved with the families, so you don't just deal with the patient, make them better then send them home"* (P3). Participants offered

insights into their feelings about the better level of care necessary for older people in acute care settings, *"There was something missing in acute care. It was all very, you know, about outcomes. It didn't really matter about the patient"* (P18). This statement suggested there to be a focus on medical or nursing outcomes, with the psycho-social aspects of patient care not always being addressed. In contrast to the negative imagery of nursing older people, most participants felt amply rewarded, describing the variety of interesting and fulfilling nursing care they provide.

3.5 SUMMARY

This chapter has described the basic social psychological problem of *feeling under siege* that emerged from the data through the two conditional categories *feeling under attack* and *feeling trapped* as experienced by the participants. All of the participants experienced *feeling under attack* and *feeling trapped*, the data proving rich with participants' experiences.

The participants recognised they were experiencing an ongoing battle by acknowledging there were no easy, short-term solutions to addressing the many challenges. The perceptions surrounding nursing older people had been on-going for many years, becoming embedded within the culture of the nursing profession. The participants' descriptions suggested that they frequently experienced negative attitudes towards their choice of clinical area, thus *feeling under siege*. While the experiences of the participants revealed that others had negative views of nursing older people, they were positive about the care they provided. The following chapter will describe the process the participants adopted in response to *feeling under siege* to enable them to continue to work with older people.

CHAPTER 4

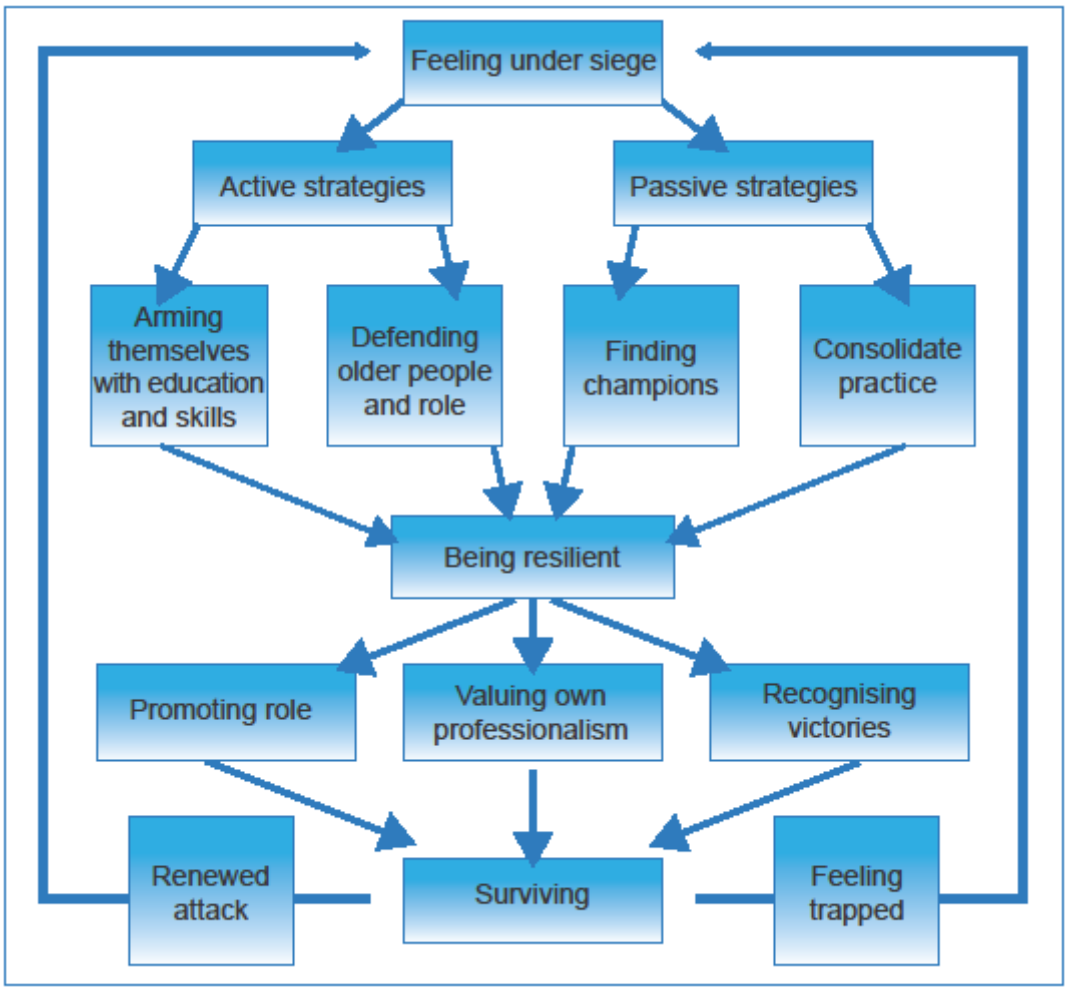
SOCIAL PSYCHOLOGICAL PROCESS: BEING RESILIENT IN ORDER TO SURVIVE

4.1 OVERVIEW

This chapter describes how the participants responded to the basic social psychological problem of *feeling under siege* as described in Chapter 3. The participants navigated a process, revealed by the data as *being resilient* in order to be able to *survive* in clinical settings, where the care of older people was prominent. The *being resilient* process involved passive and active strategies, which included arming themselves with skills and knowledge, valuing their own professionalism, taking on the role of defender, identifying champions, consolidating practice, developing resilience, and recognising victories, all of which are described below. This chapter contains a summary of the participants' descriptions of their friends, colleagues, and peers who did not *survive*, because they were not able to develop or maintain *survival* strategies whilst *feeling under siege*. These nurses became the *casualties* of the siege.

Diagram 2, depicts the participants' social psychological process of using passive and active strategies to become *resilient* that enabled them to *survive* working in this environment. This process was repeated and the diagram also shows how *being resilient* and *surviving* were not always secure, and subsequent *attacks* or feelings of *being trapped* may trigger a new process of *being resilient to survive.*

Diagram 2: Surviving by being resilient



4.2 ACTIVE STRATEGIES

The process of *being resilient* involved both active and passive strategies by the participants. Active strategies were arming themselves with education and clinical skills, defending older people, and defending the role of the registered nurse. With these responses, the participants became highly visible to others, promoting the nursing of older people in a positive manner.

4.2.1 Arming oneself with education and skills

As a result of *feeling under siege* some of the participants felt the need to increase their education and skills. For some, it was as if by arming themselves they were able to shield themselves from criticism about aspects of their professional knowledge and current skills. The lower status participants were afforded while working with older people provided them with the incentive to develop academically, *"they [nurses in other specialist areas] gave me the drive to keep studying…I by far out pass them academically"* (P21). This statement suggested a competition between the registered nurses who worked with older people and nurses in other specialities, and how a nurses' academic ability is reflected on their work environment. It was as if nurses' academic success would provide them and the place in which they worked with increased credibility and status.

All participants claimed they had continued to develop their skills in relation to caring for older people throughout their careers, combined with experience gained within the clinical setting. Many of the participants had undertaken formal postgraduate education, this being their main justification for their being on par with their colleagues in other specialist areas. Thus a certain amount of credibility was attached to undertaking a formal qualification, *"… changed their [registered nurses who work with older people] status cos they actually now have a qualification"* (P18). The participants believed that further study actually improved how they were perceived by other registered nurses, giving them tangible, certified evidence, that they were knowledgeable. Frequent mention was made of the development of nurse practitioners and clinical nurse specialists in caring for older people: *"… specialists, like you have your nurse practitioners and clinical nurses"* (P2) and, *"in 5 years I should be a nurse practitioner"* (P14). This indicated that the registered nurse participants recognised that career pathways were available to them if they wished to develop further.

Participants believed that further study impacted on how nurses who worked with older people were perceived by other nurses, and changed the perception they had of themselves, *"Nurses that have done their postgrad [postgraduate] aged care gerontology see it has changed their perceptions, and it has changed the way they*

are treated, changed their status cos they actually now have a qualification" (P6). If registered nurses working with older people undertook postgraduate study, it was expected they would be viewed by others positively: *"Those who have studied age and ageing in the academic world have been seen as somehow acceptable"* (P13).

Although many participants acknowledged further education provided them with ammunition when defending their role, they found that arming themselves with additional education did not always have the positive effect they had hoped for: *"They think your qualification is less because you have done it in aged care, but it's not easier, it's actually harder doing a course in aged care"* (P7). Perhaps the stigma associated with nursing the elderly went beyond the boundaries of the clinical practice areas: this increase in knowledge and skills was not always acknowledged by others.

Participants recognised their clinical skills had to be developed continually to ensure that high level of care is provided. These enhanced skills included the following: continence, bowel management, wound care, dementia care, chronic disease management, education on falls prevention, pain management, skin care, palliative care, multiple pathology and pharmacology. Skills related to communication and the ability to utilise non-verbal communication were also deemed important. One participant said: *"… need communication skills and observational skills especially with the increased number of people with dementia who can't always communicate verbally and say what's wrong"* (P1). In addition to these skills, the participants identified the need to follow and improve certain nursing processes such as assessing, planning, implementing and evaluating the care needed. Some of the more experienced participants added to this list the need to be able to research and solve problems.

4.2.2 Defending

Participants responded actively to feeling *under siege* by taking the role of defender. Although not verbalising the word defender, participants described their necessity to defend two separate entities: the older person and the registered nurse role.

4.2.2.1 *Defending older people*

Participants said they defended older people they were caring for from the consequences of the stigma associated with being old. A registered nurse who worked in casual roles mainly with older people, but also in a metropolitan emergency department, provided a good example. She spoke of instances in which she was perceived professionally by her colleagues and of her feeling the need to protect older people by defending them from what she believed was inferior care:

> *I normally worked in aged care at a particular hospital. They were short staffed in A&E [Accident and Emergency] and I went to help out but because I worked with older people they thought I wouldn't know what I was doing but I do have the skills… If possible I would try to care for the older people as I knew I could do a better job* (P10).

This participant explained that not all nurses possessed the skills required to nurse older people, thus contradicting the perception that anyone, such as nurses with low skills, are able to care for them. This was an interesting response because participants had previously criticised nurses in acute care for questioning their ability, but participants were now questioning their peers' expertise.

Participants indicated that older people who were in hospital awaiting admission to residential care were perceived as a problem by staff: *"With those care awaiting placement the nurses on the ward just want rid of them"* (P1). The participants attempted to address this attitude by defending their patients, thus taking on the role of advocate. The participants also made attempts to educate their colleagues on the specific needs of older people and the need to take a holistic approach to provision of care.

Concern was also expressed by many participants that nurses working in other settings did not always assess older people correctly nor did they want to identify potential problems. Participants felt a need to defend the older people against the deficiency of this practice. One participant, although being critical, tried to rationalise this attitude by referring to nurses who had not been taught the manner of caring for older people appropriately and lacked both experience and understanding, *"It's the way they [nurses] talk to them [older people] and the way they process; they just haven't got a clue. They have never been shown and they don't have the experience."* (P3) Another participant provided an example when discussing

residential respite care. Residential respite care occurs when an older person is admitted to a care facility so the regular carer can have a break from their caring role. This respite is provided in residential facilities and in some of the smaller hospitals in Western Australia:

> *They tend to be [saying] 'I'm an acute nurse and I only do this'. I can see that from people who come in for respite. They tend to be unwell at times but because they are on respite we don't do anything for respite people. He may have fallen three times but we'll ignore that.* (P 2)

An element of disappointment was expressed by the participants in that they actually had to protect older people within what is deemed to be a caring profession. Some of the comments made by the participants in relation to care provision for older people reflect the participants' specialist skills, especially when referring to older people who had to undergo medical treatment. For some participants this raised issues of advocacy, end-of-life choices, mortality, family expectations, and the rights of the older person as an individual. This was summarised by a registered nurse working in an acute care setting:

> *On the ward we are treating a 100-year-old and we are giving them all this medical management – rehydration, antibiotics and they are going for all these scans. The family are saying 'What's wrong with mother?' And you are saying 'they are 100 years old'. It seems to be that they don't understand that people get old and pass away. To me it seems a bit strange, 98 years old, 100 years old I don't know how to put it, there doesn't seem any stopping the treatment. It sounds like euthanasia but what about these people?* (P20)

This registered nurse responded actively to this attitude by questioning the treatment received by the patient and the ethics of invasive procedures, thus advocating for the older person in her care.

The participants sought to ensure that the very frail amongst the elderly were treated the same as any other age group. They spoke of their frustration at the inequalities associated with the care and health provision for older people. This can be summarised by two participants who stated, *"Everyone is given the same opportunities"* (P6), and older people *"should not be separated out"* (P5).

Participants expressed dismay that they had to defend older people both in the health care setting and in the community when under their care.

4.2.2.2 *Defending the registered nurse role*

It was not only older people who the participants defended, but also the registered nurses defending the professional role of registered nurses who care for older people. Concern was expressed regarding the reduced number of registered nurses working with older people, and the increased number of enrolled nurses and care workers. Although the participants recognised the important role that care workers and enrolled nurses played, they believed that these workers did not have the level of skills required to nurse older people with complex needs. The participants expressed the view that the registered nurse role in caring for older people was a professional issue that needed to be defended:

> *I think they need RNs (registered nurses) on the floor [providing patient care in the clinical setting]. I really believe that, you need the extra experience… I can see it happening here that enrolled nurses are in charge of the floor instead of RNs… When I did my training 22 years ago, my goodness this would never have happened.* (P19)

This respondent had adapted to many changes during her career, but she felt the need to defend the registered nurse role. The participants' eagerness to maintain experienced registered nurses in clinical practice, rather than having them move to other areas such as management and education was pronounced. This was a reflection of how the participants valued registered nurses as clinical role models and thought registered nurses should be highly visible in the care of older people.

A participant who had recently graduated and had previously worked as a carer in residential care facilities, compared her work caring for older people in the hospital setting to her previous role, *"I find it ironic that I have gone from the role of a carer in a nursing home to doing virtually the same role in the hospital"* (P 20). It is possible that this participant's views would change with more experience in the clinical setting, because more experienced participants typically had developed higher level skills and knowledge in relation to the specific needs of older people and recognised the importance of their specialist skills. Hence, experienced registered nurses determination to defend the registered nurse role.

One participant rather succinctly linked the need to defend the older person, and the role of the registered nurse caring for them, by saying: *"Aged care nursing will be the first to suffer. Replacing the qualified people with more and more carers, and*

there is then the compromise of care of the elderly." (P6) This statement reflected this participant's concern for where care of the older person would be in the future, and emphasised the widely-held opinion that the care of older people would be *"the first to suffer"*. In some cases participants had developed a contingency plan by deciding to work within other specialist areas, both acute and community based if possible. If the participants were concerned about the demise of the registered nurse role in the care of older people, by working in another specialist area they had another career pathway to follow if the need arose.

Only one participant described the registered nurse role as being more supervisory and educational, and did not feel threatened by other staff being employed in their clinical settings:

> *I see my role as ensuring that the carers give appropriate care, and supporting them when they have someone that is very terminally ill, requiring sponges in bed that they are not used to doing. Things like that, that they don't know about and need learning [sic] about.* (P23)

This participant had worked in residential care facilities since graduating so was accustomed to the contemporary skill mix.

Although most of the participants expressed their concern for the registered nurse's role in caring for older people being eroded, many described their response to the needs of their older clients as pushing their traditional role boundaries. For example, if a doctor was required for a person in the residential care setting, but was unable to assess promptly, the registered nurse would take whatever action necessary within her scope of practice until the doctor arrived.

4.3 PASSIVE STRATEGIES

As outlined above, the participants were generally active in their response to *feeling under siege*, but on occasions they employed the more passive responses of finding a champion to lead the way, and of consolidating their skills through practice. These passive responses may have occurred due to the particular personality traits of the participants. Alternatively it was used at a time when they required respite to protect themselves from *feeling under siege*, with ongoing active responses being decided as unsustainable in the long term.

4.3.1 Finding champions

The participants who responded passively relied on others to promote nursing older people, referring to these people as "champions" and "pioneers". Those identified as being "champions" fell into two categories: those who had the strength of will to speak positively at conferences and those previously observed as role models in clinical practice. A number of participants said the reason for their decision to work with older people was the inspiration of a strong and enthusiastic individual who they identified as a "champion" within the specialist area of gerontology: *"…he inspired me to work in aged care because he taught me to look at the whole person … He taught me the excitement or the depth of interest that gerontology was"* (P13), and "*There are a few people that are really passionate and they drive the others"* (P8).

As well as having had initial contact with a "champion" for the care of older people, respondents were quick to recognise that the momentum for continuing to "champion" care for older people could not remain with a few key people. Reference was also made to *"ambassadors in aged care"* and *"pioneers in aged care"*, with the participants stating that the people they deemed to be "champions" had displayed a high level of enthusiasm, energy, and were passionate about aged care. A note of advice was conveyed by one participant, *"Make clinical nurses the champions"* (P13), thereby expressing a concern that the "champions" who worked with older people often left the clinical setting for employment in management and academia. Therefore, it was recommended that the "champions" had to be clearly visible in the clinical setting where they should be role models for other staff. Several participants described the opportunities available to them clinically, specifically describing the possibility of developing the nurse practitioner role. A younger participant (P18) described being passionate about working with older people, but even with this passion she did not envisage that she could take on the role of a champion. Passive responses emphasised the need for champions who were willing to lead the way forward in aged care. However, one more experienced registered nurse was willing to embrace the concept of being a champion*, "They [undergraduate nurses] realise how much work is involved and it is a unique area….I think it will really enlighten them. They are actually quite inspired once they do realise that I finished my education quite recently"* (P17)

The “champions” with whom the participants came into contact had a great effect on how their role was viewed, *“...it’s exciting and vibrant. I am not dealing with tired people”* (P23). This highlights the major impact of positive role models or champions on new staff just beginning to care for older people. The younger participants and those more recently qualified had enthusiasm for their speciality, and were more willing to promote working with older people as a career pathway that should be considered as a serious option by all new graduates, an enthusiasm that needs to be nurtured continually.

The participants spoke about the need for individuals to be champions; however one participant suggested that the “champion” did not necessarily have to be an individual person but could be a champion unit or residential care facility where staff provided a high level of care for older people.

4.3.2 Consolidating practice

Participants identified a period of time when registered nurses new to nursing older people consolidated their practice, a key component of this being the ability to be patient. Many of the participants referred to the need to be patient as an essential requirement of their role related to the care of the elderly. Participants linked the need to be patient with the concept of their “*feeling under siege*,” because nursing older people was a long lasting endeavour for which they needed perseverance.

Twenty one of the twenty three participants interviewed listed patience as one of the core skills required to care for older people. These participants considered patience to be such an important attribute to have in the care of older people, that when asked by the researcher to describe the skills required in the care of older people; the quality of patience was listed as one of the three most important core skills. Various comments made were, *“I think patience must definitely be tops”* (P10) and *“I think patience, I think more so than anything”* (P18). Several of the participants noted that patience was not possessed by all nurses, *“A lot of people don’t have the temperament - not good at being patient”* (P15).

Being patient also referred to the participants’ ability to allow additional time for the individual care of older people. Participants acknowledged that older people require

extra time for undertaking even basic tasks and recognised that little was gained by trying to hurry older people; indeed it could prove detrimental as the older person's independence could be compromised. Examples given by the participants concerning the need for patience were, *"....very tolerant and patient and not in a hurry to do anything"* (P3), and *"... have to be patient, tolerant because you can't rush older people"* (P4). Being patient not only related to personal care of older people but also impacted on how the registered nurses actually assessed the older people, *"I guess I think a lot longer, a lot slower, I think I look in a lot more depth as what might be wrong or right"* (P8). This participant saw assessment as a continuous process.

Participants were questioned as to whether patience was an inherent personality trait or a skill that could be taught. Participants explained that not all nurses possessed the patience required to care for older people, linking this to areas of nursing seen to be "fast paced" such as in the Emergency Department, *"Nurses there wanted to deal with the young with a problem they could deal with and move on"* (P10). This statement suggests the nurses working with older people adapted their pace of work to reflect the needs of their clientele, but were aware of how time constraints may impact on the way nurses react to older people. The comment suggested that older people may have more complex needs, for example not just requiring direct medical treatment but also more complex social and psychological needs.

The participants also voiced the necessity to be patient with their nursing colleagues when handling the stigma they experienced from both inside and outside the profession. They also knew inherently to be patient with their peers' lack of understanding of the nurse's role in caring for older people. With patience, some nurses in other areas gained an understanding of what nursing older people entailed.

The participants believed that basic nursing skills were no longer valued, and that some nurses saw nursing as a step along their career path to quick promotion. One participant also noted that patience was needed in relation to career development: *"You should crawl before you walk. Sometimes they don't want to do that, and they don't know the importance of learning those skills before they reach the top"* (P3).This comment could also be related to nursing older people with registered nurses obtaining supervisory and managerial roles relatively early in their careers rather than seeking senior clinical positions within the workplace.

As the participants responded either actively or passively, the combined process resulted in a state of resilience that enabled the registered nurse to survive.

4.4 BEING RESILIENT IN ORDER TO SURVIVE

The participants had all continued to work in settings where the care of older people was the focus. To achieve this they had developed personal resilience to protect themselves from the recurring feelings of being *under attack* and being *trapped* that were associated with nursing older people. Personal resilience was deemed important in how the participants responded to *"feeling under siege".* As one participant explained: *"Nurses in aged care have an endemic inferiority complex"* (P13), that is, nurses had to develop strategies to manage this on a personal level by being personally resilient.

Although all the participants claimed they had developed resilience they recognised that not all their colleagues were successful in this. According to the participants some nurses were unable to become resilient in order to *survive* in the aged care setting, and these people became the "casualties" of *feeling under siege*. Participants felt the need to relate stories of colleagues who had not *survived*, and had been 'lost' along the way because they had been unable to be resilient. It was reported that some casualties occurred while they (the participants) were nursing students. Participants had also observed the large attrition rate of their peers who were nursing older people. The participants were not able to quantify this accurately, but estimated the proportion of resignations to be large:

> *Basically when starting my training, within three weeks we were working in aged care that was our first placement… Many dropped out at this stage, when they found out what the reality of basic nursing care was and realised that aged care was a large proportion of nursing…I can't remember the numbers now, but it was a significant number that pulled out within the first semester…I know by the time we graduated there were only half of what started out.* (P7)

The participants also knew that a number of those unable to cope with *feeling under siege* remained in the aged care sector throughout their careers. They indicated that the age and experience of the nurses had a major impact on the way they responded to *feeling under siege*. Some nurse participants had become accepting of their

situation, as placid casualties of the siege suffering from "*battle fatigue*". Although this is the terminology of those in active military combat, it could be applied to the participants in this study. Some nurses had been engaged in psychological combat with nurses in other specialist areas, and this had affected them. The participants used phrases such as "*mentally tiring*" and being "*tired of fighting*," to describe working in aged care. A recent graduate told how staff caring for older people in one care setting had become quite disillusioned:

> *If I had found a positive role model, I would probably have found it quite rewarding. I guess it's quite intense, the nurses on my ward are quite over it [nursing older people] themselves. When you do ask about a problem or ask for some help they [more senior nurses] are all a bit oh it's a bit like that. Then you start catching a bit of their negativity and they are all thinking of working somewhere else.* (P20)

This participant explained how these registered nurses had been stigmatised because of working with older people for some time and were now tired of resisting, with a number of them looking for other employment or awaiting retirement. These nurses had become casualties but were willing to continue because they knew their time there was limited.

Participants did not always consider having casualties as a major issue. Many had developed survival tactics, believing that, if a person was not happy and did not want to work with older people, they should leave. No animosity was expressed towards the people who became casualties, but rather it was accepted by the participants that everyone could not survive as aged care nurses.

A coping strategy for some participants was resigning themselves to accepting matters as they existed: *"As long as you do your job well, what more can you do?"* (P8) This participant was a registered nurse who had worked with older people since graduating and had undertaken various formal postgraduate courses; she no longer felt threatened by colleagues in other specialist areas. Additional study had enabled her to develop knowledge and skills applicable in the clinical setting.

One participant seemed somewhat disillusioned by the stigma associated with nursing older people. This person survived by not taking stigmatisation too personally, while attempting to continue fighting it: *"I do try and promote aged*

care" (P18). Other participants asserted their personality assised them to continue fighting:

> *Well actually at first I was quite disappointed with the response to what I was doing but in a sense it made me dig my heels in a bit more, made me a bit stronger in my decision, a bit more stubborn, more to show them they were wrong.* (P17)

Other participants were personally *resilient*, reflecting on the skills they believed were required to nurse older people and measuring these against those in other specialist areas. One participant spoke of undertaking further study, adding that her peers believed that working with the elderly was an easy option. She recounted how she justified the skills required to both her peers and herself:

> *Well with ageing the body impacts on every single system so you are still learning about gastroenterology, renal, cardiovascular, neurovascular and that's the way I sold it, but aged care does have a lot of variety, it can be interesting. It actually requires a lot more study than the other specialities.* (P17)

Some of the participants had developed resilience from past experience, recounting their previous experiences in other specialist areas of perceived higher status: *"I've already been there, done that; I'd proved I could do the other things"* (P5). Others had developed personal resilience by concentrating on their own development within the profession and not being concerned about what other people thought: *"It was always about myself… I don't tend to dwell on it [what others think]. It is not something that interests me anymore; you know what their impression of me is"* (P21).

One participant actually used the word resilient in relation to working with older people, but the comment was made when explaining how nurses, having been exposed to nursing older people, actually developed skills in caring for them even if the care had been given prior to their becoming a registered nurse: *"When you see the new grads [graduates] that have actually worked in nursing homes or aged care facilities to put themselves through uni [university], they are a totally different type of nurse, they are more resilient"* (P6). This participant pointed out resilience as a quality developed over a period of time, and nurses may not always possess resilience upon entering the profession.

The participants clearly recognised being resilient helped them survive the stigma associated with nursing older people. One participant summarised what many participants thought by stating*: "I know my knowledge is good and I know not to think that I don't have anything to offer"* (P11).

An experienced registered nurse participant working in a residential care facility recognised that not all staff had the ability to develop personal resilience; some were reliant on other team members to assist them: *"[you need] an ability to carry colleagues and your fellow workers along with you"* (P16). Although recognising the need to develop personal resilience, this person's statement emphasised the need for the participants to work together in order to *survive*.

Resilience empowered the participants to promote the role of the registered nurse in caring for older people, to value their own professionalism, and to recognise victories in their practice so they could *survive* in the aged care environment.

4.4.1 Promoting the role

The participants frequently expressed the need to encourage other registered nurses to work with older people, especially since many of the participants had expressed concern regarding the demise of the registered nurse role and the ageing of the workforce. The participants pointed out a number of strategies to achieve this, including the need to promote working with older people generally. For example: *"You always hear about how exciting or how needed ICU (Intensive Care Unit) nurses are, but you just never hear about how valuable aged care people are"* (P4). When this participant was questioned about how raising the status of aged care nurses could be achieved, she emphasised focusing on the positive aspects of the role: *"…emphasise the positive aspects of nursing, you know aged care"* (P4). Raising the status also involved seeing nursing older people as a realistic career pathway for new graduates, which some participants felt was lacking:

> *…they don't really target the new grads (graduates) coming out, so I think it all comes down to marketing…We could really nurture and grow some really good aged care nurses out there, if we could catch them at the right time, and I think that is the question. How do we lure them in to aged care? Let's*

> *provide them with an entering path and journey that will let them think what a wonderful and rewarding career in nursing they could have.* (P17)

A number of participants supported this view, maintaining that registered nurses would be encouraged to work with older people if a very clear career pathway was in place for them to follow. For example, one participant insisted, *"I think creating career opportunities"* (P17). Apparently creating career opportunities was something that one organisation had embraced. An interviewee told how student nurses attending for clinical placement in a residential care facility during their first year had been encouraged to consider working as carers on a casual basis. Not only did this organisation try to recruit unregistered staff, but it supported the development of existing staff: *"Some of our care staff have gone off to do their ENs [Enrolled Nurse course] and are now coming back as ENs. We are trying to develop the people we have within the organisation"* (P8).

Promoting the registered nurse role went beyond recruiting individual staff. Participants expressed that 'the mind-set' of nurses already working with older people across the different specialist areas must be changed: *"They are not prepared yet to look at different ways of working with older people in the acute care setting can make it better for the patient and themselves"* (P2). One participant stated that some employers were eager to recruit and retain staff by supporting them on a clear career pathway of carer to enrolled nurse before achieving registered nurse status in the hope these recruits would continue to work with older people.

A few participants made the point of emphasising that the political agenda required changing in order to encourage employment in the aged care sector:

> *I think it has to come from the polies (politicians). I think it's got to be programs to try and improve aged care. I think they have to lift the image to try and attract more nurses into aged care…* (P7)

Although participants made reference to the politics of nursing and the general political arena, they were reluctant to get involved politically themselves. All of the participants expressed the importance of promoting the positive role of the registered nurse in the care of older people, but in order to be successful with this they had to acknowledge their own professionalism.

4.4.2 Valuing one's own professionalism

Regardless of participants' passive or active strategies they all valued their professionalism. Participants acknowledged their role was not perceived as highly as that of their colleagues in other specialist areas, but they personally valued their role caring for older people and recognised the many skills they possessed. Whereas some interviewees said they needed to be armed with relevant education, all considered themselves as being as skilled and professional as other registered nurses and having the ability to provide far more than basic nursing care. Participants often mentioned having a broad knowledge base and good clinical skills in order to manage the complexities involved in the care of older people. One of them described some of the skills required:

> *Need to know pharmacology. The elderly have multiple pathology and you need to know the medications and how they interact. Need to know about continence, wound care, education on falls. Pain management is a big one, and skin care. Palliative care is another big one.* (P1)

Participants explained that, although appropriate education and skills were recognised as necessary by registered nurses caring for older people, it was not always easy to articulate the broad range of abilities their role demanded to other health professionals:

> *You talk about the clinical skills of nursing but really you need some artistry in pulling all those things together. I find that constantly challenging and I look at it not just as a clinical issue but there is an art to it as well which can't properly be measured. You are drawing on all those different aspects to meet all their [older person's] needs.* (P16)

As well as requiring the abilities mentioned above, some participants spoke of being able to communicate well with all the people involved in the care of older people. Due to the complexities involved in the care, they also spoke of the importance of being able to solve problems and being able to troubleshoot. Problem solving was a skill frequently used*: "On an older person you have to do a lot more investigating to actually find out why they are not travelling as well as they should be"* (P6). One participant believed the skills required to care for older people were so advanced that student nurses should not have clinical placement in areas caring specifically for older people until they were nearing completion of their course, *"Send first years to ICU [Intensive Care Unit] and third years to aged care, when they have developed*

the skills – multi-care issues" (P13). This participant articulated a range of complex skills required to care for older people and, as such, required experienced nurses.

Some participants found it difficult to verbalise the complexities of their role; for example, one participant said: *"It's just something I do"* (P21). This suggested that this participant had become an expert in clinical practice, developing skills to a level whereby she automatically provided a high level of care with ease, but was not able to communicate this to others.

4.4.3 Recognising victories

Although the participants generally felt *under siege*, there was recognition of changes occurring in the field of aged care, which were considered victories. For example, one participant stated: *"There has been a definite swing towards people not just being placed in care, but to focus on this is your home and your life, and it should be as good as possible for you"* (P2). Another described improvements within the hospital setting:

> *Even in the hospital [name of hospital] it wasn't that long ago that we had a 5 bedded unit, and that people with dementia would be in there, and the door would be shut on them and that was horrible, whereas now it doesn't happen.* (P15)

Improvements in residential care were also acknowledged, *"Back in 1987 people were just showered and fed in those days, and stuck in front of the TV. We now get people who come in from the community and their lives can actually improve"* (P14). Participants also highlighted the importance of providing undergraduates with a positive experience when working with older people. One participant who worked in a residential care facility explained:

> *A lot of the students do their prac [practice placement] and have work experience here. A lot of them are coming back as casual workers. They are enjoying the experience. They are seeing it is different, that is they [residential facilities] are not terrible places.* (P8)

One participant described experiencing some success in raising her family's valuing of work with the elderly. This was further reinforced by the fact that her sister was working in nursing academia. This participant's victory occurred when it was

recognised by a family member that the participant was skilled: *"She said, I don't know how you stand doing this…you do your job so well. You have so many skills you don't even notice"* (P3).

When questioned as to whether they had noted changes in the nursing of older people all participants acknowledged: *"The general perception has changed in the last ten years or so and (pause), things are more professional and nursing has best practice attitudes"* (P16).The participants accepted progress had been made in this field, but highlighted the necessity for the impetus to be maintained. It was important to them that they recognised and celebrated these victories in order to maintain morale and *survive* nursing older people.

4.5 SURVIVING

In this study *being resilient* was necessary for the participants to *survive* within clinical areas where nursing older people was prominent. Participants used a variety of strategies in responding to the problem of *feeling under siege*, such as arming themselves with education and becoming highly visible to others by taking on the role of defender. As mentioned several times above, the participants valued their own professionalism and wanted to defend this by speaking positively about their role. However, there were some occasions when participants were willing to ignore the stigma others had of them. Although the participants responded differently, either actively or passively, at different times, they reached the same outcome: *surviving*.

The participants also *survived* by being patient towards other registered nurses who did not appear to understand what it was like working with older people. One reason why they were able to tolerate the stigma was because many of them possessed the same prejudice when they commenced nursing: *"I thought the same [as other nurses] about aged care* (P6).

It was not only personal *survival* that was important; the ongoing *survival* of the registered nurse role in caring for older people was seen as a priority for the participants. In an attempt to achieve this, they were willing to encourage registered nurses to consider working with older people: "*I promote aged care nursing whenever I get the chance"* (P3).

There was also recognition that not everyone *survived* the aged care environment, with some nurses departing from clinical settings where the care of older people was prominent. The participants recognised that in order to *survive,* they had to choose which battles they wished to fight; otherwise they were at risk of becoming a casualty due to the relentlessness of *feeling under siege.*

4.6 SUMMARY

This chapter outlined the participants' processes of *being resilient* which was necessary to resolve the problem of *feeling under siege*, thus enabling them to *survive* in this area of practice. *Being resilient* involved both *active* and *passive* strategies, but because the *siege* was ongoing, the manner in which participants responded could fluctuate. These *active* and *passive* strategies were strivings to *survive* within environments where the care of older people was prominent. *Survival* involved arming themselves with education and skills, valuing their own professionalism, taking on the role of defender for both the older person and the nursing profession, identifying champions to lead the way and consolidating practice. Even when participants had developed strategies to *survive,* they were not immune from renewed *attacks* or *feeling trapped*, which would result in them repeating the process and reaffirming their need to be *resilient*. Those comfortable that the quality of *resilience* was theirs maintained it by recruiting others, valuing their own professionalism and recognising victories. Not all nurses who worked in aged care *survived* the experience of *feeling under siege,* finding it necessary to leave the specialist area of aged care or, in more extreme cases, leave the nursing profession. However, all the participants in this study had developed *resilience* at a personal and professional level in order to *survive* the problem of *feeling under siege*. The next chapter will describe how nurses who work with older people not only developed *resilience,* and learnt to *survive* in difficult personal and professional situations within that clinical setting, but with *survival* came the ability to *advocate* for the older person, the profession, and self.

CHAPTER 5

THE SUBSTANTIVE THEORY: ADVOCACY AS AN OUTCOME OF RESILIENCE AND SURVIVAL IN AGED CARE

5.1 OVERVIEW

This Chapter presents the substantive theory of *advocacy* as an outcome of *resilience* and *survival* in aged care as it relates to nursing older people. This theory explains how the participants not only developed *resilience* and *survived* in difficult personal and professional situations within the clinical setting practised *advocacy* skills. The construct of *advocacy* that emerged in this study had three elements of *advocating*: for the older person, for the profession, and for the self. For the participants of this study the concept of *advocacy* was a crucial aspect of their *survival* as registered nurses caring for older people. In this chapter, the theory will be discussed in relation to existing theories and literature.

5.2 ADVOCATING

The practice of *advocacy* was evident throughout participants' descriptions of their experiences in the aged care environment. Those who were novice aged care nurses had initially *survived* by developing active and passive strategies. With more experience they had developed strategies enabling them to become *resilient*. Those within this environment for a more substantial time who had become experts in aged care had moved beyond *being resilient* to *surviving* by *advocating*.

The role of nurses as advocates is not a new concept within the profession, with Florence Nightingale demonstrated patient *advocacy* during her work in the Crimean War and later she advocated when establishing the first school of nursing (Hanks, 2013; Hearrell, 2011). However, it was not until the 1970s that *advocac*y was frequently mentioned within the nursing literature (Hanks, 2013; Zomorodim & Foley, 2009) then became commonplace within the nursing profession. *Advocating* has now become an important component within the nursing profession, and is

included within professional codes of ethics and nurse education (Hanks, 2010; Jugessur & Iles, 2009).

For the participants *advocacy* comprised three elements: *advocating* for the older person, the profession, and self.

1. *Advocating* for older people involved shielding and defending them.

2. *Advocating* for the profession involved challenging the stigma associated with working in the aged care setting and promoting the role of the registered nurse.

3. *Advocating* for self was achieved by the individual participants believing, hoping and coping.

The substantive theory of *advocacy* proposes that nurses must possess the skills to balance each of the three elements (older person, profession, and self). The focus on these three areas depended on which one was perceived to be *under attack.* The nurses would prioritise whether to *advocate* for the older person, the profession, or self and ideally establish an equilibrium, whereby all three constructs were stable. If this balance could not be reached, such nurses would become a casualty of the *siege*, either moving to another specialist area or leaving the nursing profession. When participants experienced a feeling of stability it was as if an uneasy truce existed, with those *under siege* being grateful for the respite and chance to rearm whilst experienced enough to know another onslaught could be looming.

5.2.1 Advocating for the older person

Participants were conscious of the need to *advocate* for the older people for whom they cared. This took priority over *advocating* for the profession or self and reflects the opinion that nurses mainly focus on *advocating* at an individual level for their clients (O'Mahony Paquin, 2011). *Advocacy* is often associated with vulnerable individuals (Jugessur & Iles, 2009), and in this study the vulnerable were older people requiring nursing care.

Although the participants recognised there had been some progress in the status of older people, as discussed in Chapter 4, they were aware older people were still

thought of in negative stereotypic terms and provided many examples. They discussed at length the existing stereotypical images of older people, believing these to have been present for a long time in society. Although they were not able to protect every older person from the negativity in society they made efforts towards this when older people were in their care.

Several participants stated that they were embarrassed by these negative images relating to older people. Being of particular concern to participants was negative views held by members of the nursing profession. Nursing is considered to be a caring profession and to be non-judgemental. When the participants observed older people being compromised they reacted by attempting to shield and defend them. This was achieved by volunteering to care for older people as they wanted only the genuinely committed to be those providing the care.

The participants described making attempts to act as the older persons' *advocate*, making numerous references to *advocating* for the rights of the elderly to make decisions about their own care. On these occasions, participants spoke on behalf of the older person receiving care, thus ensuring their wishes were being met if the individual receiving care was unable to speak for themselves.

For nurses to be true *advocates* for those in their care, they need to know the person well, including their values and beliefs (Bu & Jezewsk, 2007; Cole, Wellard & Mummery, 2014). This closeness was described frequently by the participants as a positive aspect of aged care nursing; they felt ideally placed to accept the role of *advocate*. For example, if invasive medical procedures were proposed, and they perceived little would be gained, participants would *advocate* for the older person's wishes and dignity to be upheld. They *advocated* on behalf of the older people to peers, care providers, the older person's family, and to policy makers. This role was validated by the expectations from family or the medical profession to prolong the older person's life at all cost. Bu and Jezewsk (2007) described three attributes of nursing *advocacy*: safeguarding patient autonomy; acting on the patient's behalf; and championing social justice. Participants recounted instances of safeguarding and acting on behalf of the older person, but aspects of social *advocacy* were less frequently discussed. Social *advocacy* involves *advocating* for older people as a group rather than individuals (Hujer, 2012; O'Mahony Paquin, 2011). For the

participants, *advocacy* for the older person mainly involved shielding individuals from ageism and defending them from being considered an unpopular patient.

5.2.1.1 *Shielding the older person from ageism*

The participants described how they frequently shielded older people from the negative stereotypes associated with their age. It has been highlighted that nurses need to be cautious about the acceptance or reinforcing of the negative opinions and stereotypes of older people (Johnstone & Kanitsaki, 2009). Johnstone and Kanitsaki suggested that nurses should challenge such negatively expressed views to ensure older people receive the care they require. This had the dual purpose of both shielding the older person from such staff attitudes and raising awareness of the specific requirements when nursing older people.

Although the participants in this study did not verbalise it, the term ageism it emerged as a theoretical construct as seen by the examples participants gave to show they believed ageism existed within the nursing profession. There is a large volume of literature available on ageism in the nursing profession (Kydd & Wild, 2013; Robinson & Cubit 2005). The ways in which the participants of this study described instances of older people being treated without the respect and dignity corresponds with what has been written in the literature on ageism. The participants frequently described the stereotypical negative imagery associated with older people, these negative attitudes being known to permeate the psyche of older people resulting in ageism (Celik, Kapucu, Tuna, & Akkus 2010).

Butler (1975, p12), defined ageism as, “a process of systematic stereotyping of and discrimination against people because they are old,” with it being considered “akin to racism and sexism” (Bradley, 2007). Bradley further contended ageism that is unique because everyone in society risks experiencing it. Although ageism is a term coined by Butler in the 1960s, it is by no means a modern concept, with peoples’ ideas on ageing in Western society being attributed to the thinkers of ancient Greece and Rome (Minichiello et al, 2005). More recently, Hillier and Barrow (2007) explained how attitudes towards older people went beyond stereotyping to prejudice.

According to Hendricks (2005) these negative attitudes towards older people have increased as the proportion of older people has increased.

Many people entering the nursing profession will have experienced ageism within society and may accept this as the norm. As noted by Mead (1934), the self is influenced by the society in which it lives. Health care workers may be more at risk of developing ageist attitudes because of their high exposure to older people when they are ill. Older people are more dependent during this time, thus reinforcing the negative image held of them by some, both in the health profession and the community at large (Kearney, Miller, Paul & Smith, 2000; Nash, Stuart-Hamilton & Mayer, 2014). If this is true, serious implications for the nursing profession exist; for example, will ageism within nursing practice increase with an ageing population? Some believe nurses may be partially to blame for older people being dependent (Courtney et al., 2000), the reason being the nurse's eagerness to undertake tasks an older person may be able to complete themselves if time were allowed, thus the older person's dependency levels are increased.

Nurses' reluctance to work with older people and related ageist attitudes are not new concepts: nursing literature in the 1950s identified nurses as possessing a negative attitude towards older people (Herdman, 2002). Although many recognise ageism exists in nursing, it is thought that nurses are not aware of this phenomenon (Stevens & Herbert, 1997). Stevens and Herbert proposed that nurses and other health care professionals had reproduced ageism as the norm, stating that nursing staff appeared oblivious to ageism because they had been socialised into its acceptance, this is a result of ageism being a subtle concept (Hunter, 2012), and the least challenging form of discrimination (Nelson, 2005). Of concern was how easily ageism could be perpetuated especially during nursing handovers (Higgins, Van Der Riet, Slater, & Peek, 2007). Ageism can take place in handover, because nurses are provided with information from nurses on an earlier shift. The nurses on the previous shift have made decisions about people they are nursing and this is then passed on to the following shift, a process Higgins, Van Der Riet, Slater, and Peek (2007) refer to as 'Chinese whispers".

Nurse education in Australia has been criticised for not attempting to address the issue of ageism (De la Rue, 2003). However, over recent years theoretical and

clinical practice in caring for older people has been incorporated into undergraduate nursing courses (Kydd et al, 2014). Participants spoke of the lack of theory received on aged care nursing during their pre-registration or undergraduate courses even though a large proportion of the people they were to nurse were elderly. Zungolo (2004) insisted that nurse educators in the United States of America would not consider "sacrificing" a paediatric course for one in gerontology, even though only 10% of graduate nurses would work in paediatrics, and the other 90% would have some involvement with the care of older people. Zungolo's contentions correspond with a finding of this study: there is a hierarchy within nursing according to the clinical specialist area. This hierarchy also existed within care teams as De la Rue (2003) considered how ageism was associated with the hierarchy apparent in aged care settings with those in lower positions seemingly to be more caring towards older people than those in senior positions. The findings of this study revealed no evidence of this, the participants ranging from new graduate status to the senior levels of management and academia: all cared about the elderly. De la Rue (2003), in considering the link between ageism and professional hierarchy, may have been referring to more "hands on" and clinical based care. This was an aspect of which many participants were aware because in their career progression they expected to distance themselves from providing "hands on" care. Some participants did, however, recognise the role of the nurse practitioner and the opportunities this provided for professional development for those who wished to remain clinically active.

It was not only in undergraduate nurse education that the participants felt there was potential to reduce ageism but also in postgraduate education, although the latter could be problematic. The participants mentioned the difficulty they had accessing postgraduate courses designed specifically for nursing older people. This was not necessarily due to the number of courses on offer, but rather due to the courses being cancelled because of low student numbers, a matter somewhat expected because of the recognition that potential enrolees avoid courses related to age care (Goncalves et al., 2011; Lee et al., 2003).

The participants of this study expressed the need for education on aged care within nurse education, but there is some ambiguity in the literature as to the value of education in decreasing ageism within the nursing profession. Some authors consider

this to be a necessity, whilst others suggest the current focus on the problems associated with ageing do not assist in changing attitudes (Reyna, Goodwin, & Ferrari, 2007). Even if aged care is addressed within the classroom setting, the clinical placement also has to support the lessons taught. Student nurses have found it difficult to distance themselves from cultural beliefs that devalued older people (Henderson, Xiao, Siegloff, Kelton, & Paterson, 2008), and these students are therefore at risk of considering this the norm. However, nurses appear to be questioning the treatment of older people, with ageism being a major ethical issue for the nursing profession (Rees, King, & Schmitz, 2009).

5.2.1.2 *Defending the older person from being considered an unpopular patient*

The participants were convinced that other nurses considered older patients one of the least popular groups to nurse; therefore, the participants believed this required a more active response than the shielding of older people against ageism. Participants told how some nurses did not attempt to hide their reluctance to nurse older people, and the participants wanted to defend the older person's awareness of this.

A patient being considered unpopular is by no means a new concept in the nursing profession. Waters (2008) reported on the work of Felicity Stockwell, whose controversial article on the "unpopular patient" was published in 1972. According to Stockwell's research, certain patients were more popular with nurses than others. The most popular were those who were compliant and uncomplaining. In contrast, the unpopular patients tended to be those who were long stay patients, "difficult" patients, and those with physical defects. However, the nursing profession was reluctant to accept Stockwell's findings at the time of her publication probably because the profession was portrayed so negatively. Stockwell's ideas of unpopular patients was reflected in this study's data, as those "unpopular traits" related to older people because this group was considered difficult because of their complex needs: more likely to have physical deficits, and be more likely to remain hospitalised for longer. A particular concern of recent times has been the phenomena of older people awaiting placement in residential care, thus making them "unpopular" long-stay patients within the hospital setting. For example a study undertaken by Maben et al (2012) found that nurses caring for older people often had patients to whom they

gave preference. Waters questioned whether patients today are treated with equal dignity and noting particularly that the elderly may not be treated with the dignity shown to younger patients. The participants of this study realised nursing elderly people was not a popular choice within the nursing profession.

Participants reported that many nurses expressed personal disinterest in caring for older people; however these nurses are acknowledged as providing older people with good physical care (Gibb 1990). This was mirrored in the current study because the participants never doubted that older people received good physical care, no matter who the nurse. However, the participants expressed concern that some nurses lacked the incentive to give the necessary psychological, social and spiritual care to the elderly. This deficit implied the need to educate nurses on the complex care needs of older people.

The data from this study suggested that participants were eager to respond actively if required, moving beyond shielding to the defence of older people in their care. Often they defended the elderly from negative attitudes of health care professionals, and in some cases, family members. They did not mention any concerns related to defending the elderly's physical well-being other than recognising that patience was required in its provision. Participants spoke of their experiences as showing that all nursing staff needed to be skilled in aged care, while recognising many of their colleagues preferred to work in different fields of nursing practice. This led to the participants not only *advocating* for the older person, but also for the profession.

5.2.2 Advocating for the profession

The participants described the necessity to *advocate* for the profession by addressing the stigma associated with nursing older people and promoting the role of the registered nurse in aged care. Several participants expressed that the registered nurse's role in caring for older people was not fully understood.

Nurses who embraced the challenge that working with older people provided flourished in the clinical setting, as they were controlling the destiny of the care of the older person by taking the lead in developing practice: *"I try to teach them [other nurses]about aged care at every opportunity"* (P11). These participants had

recognised that change within the clinical setting was inevitable: *"It wasn't like this when I first started nursing…the registered nurse was very hands on"* (P8). Although participants may not have liked all the changes within clinical practice, they had managed to become *resilient*.

Some participants in this study reported that their commitment to working within aged care had been spurred on by the stigma of caring for older people. Nurses comprise the largest number of health care professionals but they are thought to lack unity within their profession (Thupayagale-Tshweneagae & Dithole, 2007). Thupayagale-Tshweneagae and Dithole reported nurses were guilty of victimising each other and not acknowledging the expertise of colleagues in other specialist areas. Thupayagale-Tshweneagae and Dithole's (p.145) study did not focus on nursing older people particularly, but it mentioned the concept of *friendly fire* within the profession by stating "the enemy of nursing is within the profession." They made a strong recommendation that nurses should respect each other's specialist skills and expertise. For many years certain specialist areas of nursing have been considered more prestigious than others; for example, "private duty nursing" was considered to be the ultimate for a trained nurse at the turn of the twentieth century (Madsen, 2007). A professional hierarchy still exists; many of the participants in this study made reference to emergency and intensive care nursing being seen as the pinnacle of nursing. People are unlikely to stay in an environment where they do not feel valued (Nay, 2004), and if there is a stigma for working with older people this would have major implications for recruitment and retention. Since change in attitudes has occurred in the past, then there is hope that positive changes may occur in the future so that nursing older people will be embraced as a valued career option.

The participants in this study felt that professional *advocacy* was required due to their choice of career speciality. They described career episodes when they had experienced stigma while nursing older people. They were also conscious that the stigma associated with the elderly appeared to be transferred to those who cared for them. As society's views about the care of older people have tended largely to be negative, this has been transferred to health care settings (Tuckett, Parker, Eley, & Hegney, 2009).

5.2.2.1 *Challenging stigma*

According to several researchers nursing older people is an area in which nurses have been, and continue to be, reluctant to specialise (Happell & Brooker, 2001; McCann, Clark & Lu, 2010; Moyle, 2003): it is also a career perceived to lack status (Abbey et al., 2006; Cornwell, 2012). One of the major challenges for the participants was coming to terms with the stigma associated with nursing older people. The word stigma is commonly used in society, originating from the Greek meaning of a brand mark placed on people denoting devotion to the temple, criminality or slaves (Saunders, 1981, Page, 1984). Stigma is defined in the Oxford Dictionary (1988, p.803) as "a mark of shame; a stain on a person's good reputation." It was used as a sign on a person's body that indicated that there was something unusual about them or indicated poor moral status; currently it is linked to some form of disgrace (Goffman, 1968). Goffman defined three types of stigma: physical, characteristic and tribal. The physical stigma related to people who had an obvious physical disability; characteristic stigma related to people who demonstrated certain behaviours perceived as "weak," such as addiction or mental health issues; and tribal stigma was used for people stigmatised because of race or religion. In the context of this research, however, it is applied to groups of people, such as older people and those caring for them. In this study participants believed nurses working with older people were stigmatised due to many of their nurse colleagues having a negative image of them.

Stigmata are generally set by society, which determines what is "the norm" and what attributes are to be discredited (Goffman, 1968).Certainly the study participants felt that the stigma associated with the nursing of older people came from society as a whole. They justified this conclusion in terms of people's stereotypical behaviour and attitudes. The participants responded to the stigma associated with nursing older people which both passive and active strategies. This ambivalence was found by Page (1984, p.18) who described stigmatised people as either "accepting or rejecting that people believe they are inferior".

Saunders (1981) contended that to understand the stigma associated with a particular profession one should investigate the history of the profession being stigmatised. The history of nursing older people in Australia originated from an inquiry in 1877

which led to a change away from older people being cared for in asylums purely on the basis of their age. At the time this change was considered as unnecessary, it being believed older people could be cared for by unqualified staff: this debate has continued (Stevens, 2003). The participants made reference to the historical antecedents of nursing older people, alluding to them previously being cared for in "C class hospitals": hence the perception of nurses who care for older people being "second class" and this being "endemic in nursing".

The participants described their feelings when other nurses regarded them as less skilled than those working in other clinical settings. The participants' experiences correspond with what Page (1984, p.39) referred to as "stigma by association", that is, nurses working with older people were not stigmatised for their individual qualities and traits, but rather because of the client group with whom they worked. If older people experienced stigma, then others associated with them, in this case the registered nurse participants, were also stigmatised. Nurses recognise those who work with the elderly are "marginalised" by their colleagues; they try to hide this recognition "…possibly talked about in tea rooms, it is an issue that is not talked about openly" (Hall, 1999, p.232). The Commonwealth Department of Health and Ageing (2002) publication noted that the image of nursing the elderly is formulated because it is one area of nursing that does not require a postgraduate qualification, thereby giving this specialist area a lower status than others. This explains why many of the participants of this study armed themselves with skills and knowledge, in order to be considered equal to other nurses. This attitude of wanting to avoid stigma is not exclusive to the nursing profession. A study undertaken by Klein and Liu (2010) described how occupational therapists perceived working with older people as less prestigious than with other client groups. Students generally have been found to recognise the lack of status associated with employment in careers related to ageing, avoiding such employment if possible (Cohen et al., 2004; McCann, Clark & Lu, 2010). In the current study an allied health professional expressed a similar negative response to her decision to work with older people. Although there have been many attempts to address the issue of the negative image of caring for older people, this appears to be an ongoing problem.

Several participants mentioned that the stigma associated with aged care environments was partly attributed to the lower pay received by those working in

residential aged care than those working in other clinical settings. However, the discrepancy in wages does not explain why nurses working in the public sector are reluctant to work with older people because here they are paid the same wage as their counterparts in other specialist areas. If the wage discrepancy is an issue within the private sector, it has been suggested that providing an increase in pay could prove cost effective as staff may then be less likely to leave and the organisation would not incur the costs associated with having to recruit new staff (Gray, Phillips & Normand, 1996). Although Gray et al. were researching the British National Health System when they reached this conclusion its findings may be replicable in Australia.

Brown, Nolan, Davies, Nolan and Keady (2007) in their study of United Kingdom nursing students found the majority of students entered nurse education without a negative perception of older people. Hallam (2000) speculated that student nurses arriving in England from overseas were of the view there would be jobs in geriatrics because nobody else wanted to work in that speciality. These negative images had the participants this study committed to continuing to work in aged care and endeavouring to make a difference.

Celik et al. (2010) in their study on student nurses attitudes towards the elderly found that half of the participants admitted having negative views about ageing. However, the majority of the participants reported being positive and sensitive in their care of the elderly. The Celik et al. study was undertaken in Turkey where the authors claimed older people were respected as having wisdom due to their life experiences. However, even there were negative views on ageing. Celik et al. (p.25) stressed the importance of student nurses having positive attitudes towards older people: "*Because today's students are tomorrow's health care professionals, the development and cultivation of positive attitudes towards ageing and older people is crucial*". Registered nurses working with older people are role models showing respectful methods of treating the elderly; and this is particularly important when students are observing them in order to learn (Eymard & Douglas, 2012; Lookinland & Anson, 1995). This suggests that students' subsequent negativism is learnt from other nurses and their peers during placement. This is contradictory to a study undertaken by Lookinland and Anson (1995) into the attitudes of registered nurses compared to health care students. Lookinland and Anson employed Kogan's (1961) Attitudes toward Older People scale to measure attitudes, finding the registered

nurses had a more favourable attitude towards caring for older people. It must be noted that the participants studied had worked with older people, the results may have been different had the research participants been sampled from other specialist areas. This research is over a decade old, so attitudes towards older people may have changed.

The stigma that many of this study's participants described was reinforced by the media's negative portrayal of the elderly. The media usually reinforces societies' views of particular groups of people (Gibb, 1990; McCann, Clark & Lu, 2010), so by providing negative imagery the media has further reinforced the stigma of caring for older people.

Participants of this study responded to the challenge of the associated stigma of caring for older people were many. An initial acceptance of the low status accorded those nursing the elderly, was tempered by the challenge of proving other people wrong. This was achieved by identifying champions to promote their cause, making a commitment to professional development, and acting as role models to others.

Given the stigma associated with aged care nursing, it could be questioned why nurses continue to work there. Stein (2002, p.7) listed the reasons why nurses continued to work in aged care: "proximity to home; relationship with residents; the team environment; continuity of care; relationships with colleagues; career prospects; and autonomy." Although the reasons related specifically to the residential aged care setting, they could also reflect other clinical care environments. Stein's seven reasons corresponded with those of the participants when justifying their decision to work with older people. They considered the availability of work close to home important, finding their relationships with clients, patients, residents, and families usually a positive experience. No doubt these perceived advantages contributed to the participants' ability to offer continuity of care over a long period of time.

Allen (2010) suggested the challenge was to accept stress as normal and embrace it as an opportunity for personal development: the participants of this study made every effort to achieve this. Although participants did not refer to being stressed in their workplace, they clearly acknowledged the impact of negative attitudes from other nurses on their choice of clinical practice area. All participants were aware of the stigma associated with working with older people, responding to the many

challenges throughout their career. The participants had moved from feeling the need to justify their choice of occupation to others to feeling competent and comfortable in their work. One of the challenges faced was to advocate for their profession: as stigmatised professionals they had learnt to live with the alleged stigma and had made personal adjustments by developing *resilience* and ultimately *surviving*. Spicker (1984, p.139) in his study related to social welfare reported that "a stigmatised person has to adjust, to learn to live with his stigma." In the current study those who had not made the adjustment and developed *survival* strategies became casualties, seeking employment away from the aged care setting.

Nurses' attitudes towards older people differ depending upon the area in which they work. Nurses who work in residential aged care were found to have slightly more positive attitudes towards older people than other nurses. However, nurses involved in teaching and rehabilitation were even more positive (Courtney, Tang, & Walsh, 2000). This contradicts the belief that nurse educators do not consider care of older people to be important. The fact that nurses working in rehabilitation had positive attitudes was because they were able to work to obtain measurable outcomes.

The participants in this study recognised there would not be a quick resolution to the problem of stigma; they explained this was why patience was an attribute the vast majority of them possessed. They believed the solution lay in changing nurses' attitudes towards older people but this could take time. Brown (2010, p.14) explained "nurses' attitudes will not change until older people are not associated with disease and there being a need to cure them". Acute care nurses are described as being focused on the medical needs of patients, something that has been referred to as the care-cure dichotomy (McKenzie & Brown, 2014). With this belief comes an attitude that, if people are medically fit, all is well. These professionals do not always recognise other problems associated with an older individual's ability to cope. A change in the totality of care needed in the overall caring for older people is necessary in the acute care setting in order to address this deficiency (Street, 2004), especially with the average age of patients increasing (Deschodt, Dierckx de Casterle, & Milisen, 2010). There are workforce issues throughout the nursing profession: however, with the perceived stigma associated with working with the elderly still strong, this area of nursing is severely disadvantaged.

5.2.2.2 *Beyond basic nursing care*

Many comments from participants related to their perception that nursing older people was considered by many of their colleagues to be basic nursing care only, requiring the minimum level of skills and understanding. Sadly this view is supported in the literature relating to gerontology (Deschodt, Dierckx de Casterle, & Milisen, 2010; Kydd & Wild, 2013). Several researchers have discussed clinical areas which depended on the ability and understanding of professionals to deploy the latest technological advances and their popularity with nurses, and as a result of this, working with older people was not as popular (Abbey et al., 2006; Happell 2002; Stevens, 2011). Student nurses recognised early in their career that higher status was attributed to those working in high-technological areas. Working with older people was not considered to be one of these environments, with people believing nurses working in these settings provided only basic nursing care (Henderson et al., 2008). The association between status and technology has been acknowledged as follows by Happell (2002, p.530), "The higher priority afforded to acute care clearly portrayed the message that the status of nursing is positively correlated to the degree of technological improvement."

Nurses were concerned that the lack of technology in aged care would prevent them keeping as up to date with their colleagues in other clinical settings (Grealish et al, 2013). Proof of this contention has been given by Abbey et al. (2006, p.16) of a shift in recent years to technical skills being viewed as "the core of modern nursing". Stevens (2011) believed it was ironic that student nurses perceived areas of high technology as having greater status, especially as these areas were medically led and nursing skills were not utilised fully. Another contention is that higher value is placed on areas of nursing where people can be cured (Hall, 1999). This is not recognised when nurses care for older people, even though some older people are able to be treated or cured of particular health issues. If the view is that cure is the ultimate outcome, why do nurses who work in palliative care not experience the same stigma as their colleagues who work with older people? An explanation for this seeming anomaly is that people requiring palliative care could be at any stage of life. If the patient is young much public sympathy is likely to be accorded both the individual and family. Staff caring for those in palliative care could be seen as noble and possessing special qualities. Although nurses working in palliative care are

perceived differently to nurses working with older people, City and Labyak (2010, p25) have stated that the same outcomes should be expected for those in care: "comfort, compassion, and dignity". McCoppin & Gardner (1994) have pointed to the nursing profession, underlining the need to make a distinction between the medical role of curing and the nurses role of caring.

The participants in this study recognised that the care they gave went beyond "basic nursing care". Several of them spoke of the "art of nursing," whereas others spoke of the "science of nursing." The debate on whether nursing is an art or science has been ongoing for many years (Castledine, 2010). Those who invoked the art of nursing described such skills as patience, empathy, problem solving, and communication; whereas those who referred to the science of nursing mentioned the increase in pharmacology and technology within the clinical setting. Eydenberg (2008), in support, acknowledged nursing to be a science due to the technical skill and the knowledge base required, but this becomes art when care, compassion and empathy are present. Castledine offered a word of caution to all nurses who focused on the science of nursing rather than the art, pointing out that if the art of nursing is lost nurses will become medical assistants or technicians, another "artist" undertaking the role they vacated. This concern was reflective of the participants of this study highlighting other health care workers undertaking tasks previously their responsibility. The question could be asked: Is this a sign of the demise of the role of nursing? Castledine offers a resolution to this dilemma, stating that in England there is a move away from target-driven care to "patient centeredness.'" If this is so, then the art of nursing will flourish. Well qualified nurses maintain the balance between the art and science of the profession, with each having to work in harmony for a desirable outcome. Findings of his study attest to nursing older people being the ultimate in nursing, a view that other nurses should aim to emulate.

Nursing older people has been identified as an unpopular career option (Kydd et al., 2014). Nay (2004) claimed many people believe nursing older people is easy and any woman experienced in mothering would be able to cope with it. This reflects a view of older people as childlike and requiring mothering. This attitude does not acknowledge the role of male nurses in the care of older people. Happell (2002) told of the opinion held by a group of nursing students who thought caring for older people was basic care without the need for formal qualification. Many elements of

basic nursing care align closely to aspects of Maslow's hierarchy of needs (1943), and go back to the beginnings of the history of nursing as an organised occupation. The British Medical Association (2009, p.119), when discussing ethical issues relating to nursing older people described "essential nursing care". The adoption of "essential" instead of "basic", which suggests an elementary level of care, would be more acceptable and reflective of the care provided to older people. A word of caution has been offered by van Achterberg (2014, p.1) that basic care is not "mistaken for simple care". Many participants in this study believed colleagues in other specialist areas thought nursing older people involved mainly basic nursing care in an area where new nurses are taught before they progress to more complex tasks. It is also suggested, cynically, that if something is repeated often enough it is believed (Gordon, 2006); something the participants of this study felt was true.

Ramdhanie (2001) argued that nursing staff are so skilled in what they do that the job appears easy, giving observers the impression of care for this client group being simple. As matters stand, the registered nurse must be multi-skilled, especially as other health professionals are reluctant to work with older people (Stevens, 2011).

5.2.2.3 *Challenging the image of dirty and heavy work*

Respondents discussed the manner in which other nurses often viewed nursing older people not only as basic nursing care, but as dirty and heavy work. Nursing literature has supported the view that some nurses believed nursing older people was heavy work, monotonous, and a waste of time (Alabaster, 2007). Rothman (1987, p.228) claimed that 'dirty work' was work that "must be done but…does not earn social rewards because it is unpleasant, physically disgusting, or associated with things that are symbolically unclean". In this study participants complained of a lack of recognition and reward for their professional endeavours. Smith (1992) described how student nurses found caring for older women particularly unpopular, this often being related to "heavy work", especially assistance required for toileting.

Even within groups of first year nursing students, negative attitudes towards working with older people had clearly become entrenched. Henderson et al (2008, p.34) opined, "…students viewed working with older people as boring and frustrating,

depressing, and lacking diversity". Henderson et al explained student nurses considered working in this area of nursing as being physically demanding. The student nurses also made reference to the "smell": this was not expanded upon but it was obvious that the smell they associated with working in a clinical setting for older people in care was offensive. Robinson and Cubit (2005) found that preceptors of nursing students identified the students' reluctance to touch older people as being fearful of touching "an old naked body". As many of the participants of the Robinson and Cubit study had practical placements where care of older people was prominent early in their course, they could have been fearful of touching a naked body regardless of the age of the person. They could also have been fearful if they had been told that older people are frail and vulnerable. Participants of the current study spoke of the high attrition rate of undergraduates during their aged care clinical placements.

Working with older people being seen as heavy or dirty work did not always relate to the older person per se, but to professional expectations. Nursing care is now often driven by clinical outcomes that are easily identified within the acute care setting. A patient is admitted with an acute health issue, and in most cases treated and discharged within a short period of time. The care provided in the acute care setting is often predictable. With older people this is not the case. The nurse has to manage more complex needs over a longer period of time and this long-term involvement may not appeal to many nurses. A feeling was expressed by the participants that many registered nurses wanted to nurse using a medical model: they wanted to deal with the medical issue and discharge the patient as soon as possible. A number of them provided examples of colleagues wanting to treat the older person's medical condition and discharge them without considering the wider issues of aged patient's psycho-social needs.

Jervis (2001) reported on a United States study which described nursing home aids (care staff), who had worked in residential care for a long period of time as being willing to describe in detail "dirty work" they had undertaken, and were proud of their "battle scars". This was described as "survivors' pride" by Wolin and Wolin (1994): a sense of pride an individual has as a result of being able to cope in an environment where they may have experienced hardship or adversity. Interviewees in this research expressed a sense of pride in relation to the level of care they were

providing to the elderly, and also that they had "survived" in an area of nursing where others had not. They spoke about the challenge of communicating to others what nursing older people involved, that it was more than dirty work, contrary to the view of others in the profession. As the participants described how others thought aged care to be basic, dirty, and hard work, they believed they were considered professionally inferior.

5.2.2.4 *Being considered professionally inferior*

Several researchers have found that nurses working with older people were devalued by people within their community, other health professionals, and their nursing colleagues from other specialist areas (Eymard & Douglas, 2012; Wells, Foreman, Gething, and Petralia, 2004). Nay (2004, P.61) mused, "If nursing is the poor cousin of the health professions, gerontic nursing has been seen as the untouchable illegitimate of nursing".

It has been suggested that nurses are reluctant to work with older people, recognising it not to be as prestigious as nursing in other clinical settings (Moyle et al., 2003; Stevens, 2011).This attitude is so prevalent that working on aged care wards has sometimes been used as a punishment for nurses whose ability in the provision of nursing care was deemed deficient (Nay, 2004), thus highlighting the low status associated with nursing the elderly and nurses' reluctance to work in this specialist area. There is an opinion that virtually anyone can nurse older people because no specialist skills are required (Firth-Cozens & Cornwell, 2009). This attitude exists even though such nursing is recognised as complex, diverse, and requiring high level skills (Eymard & Douglas, 2012; Pearson, Fitzgerald, & Walsh, 2000). The opinion that nursing older people requires minimal levels of competence has been long held, with researchers in the 1950s having identified this phenomenon (Stevens & Crouch, 1995). In order to make changes within the clinical setting, the participants had to overcome the hurdle of being considered professionally inferior. This had the potential for them to feel oppressed as a group, an occurrence when a more powerful group exploits a less powerful group (Woelfle & McCaffney, 2007). Some believe that nurses in general have been considered an oppressed group (Bogossian, Winters-Chang & Tuckett, 2014; Etienne, 2014). The participants in the current study

described there being at risk of feeling professionally inferior to a greater degree than their nurse colleagues solely because they worked in aged care; indeed they contended all aged care nurses were a subgroup of oppressed professionals. However, several participants said they planned to continue in aged care after developing a strategy to cope with the ongoing associated judgement and stigma: this led to them becoming more confident in their role. Roberts (2000) argued that oppressed groups remain so if they are not empowered, stating that empowerment is not possible if the group has low self-esteem or a lack of identity. The research participants had become empowered by developing strategies to survive the negativity associated with nursing older people.

If one group is considered inferior and another superior, with this interpretation continuing over a period of time, both these groups believe the relationship (Freire, 1971). Although relevant a number of decades ago this interpretation was reflected in the current study, participants being considered inferior by their colleagues in other specialist areas. In contrast, nurses who work in the emergency department or intensive care units may believe they are superior due to their high status. The higher status these nurses receive may be as a result of the images that have been assigned to those working in emergency and intensive care settings (Moyle et al., 2003). Interestingly, nurses in intensive care units were more positive about caring for older people than their colleagues working in general medicine and surgery environments (Courtney, Tong, & Walsh, 2000). This was justified in that patients in intensive care units are of high dependency regardless of their age, so the age factor does not become relevant.

The participants in this study described the problem associated with stereotypical imagery and associated inferiority was the result of media portrayal. Many of the medical and hospital television dramas focus on acute care settings, for example, ER, Casualty, and All Saints. Even with reality programs the focus is on the emergency and acute care settings. If older people are portrayed in the media it is not usually as independent and healthy (Neville, Dickie & Goetz, 2014). Interestingly, participants spoke of media in relation to television programs and newspaper articles. Beal (2012) found that similar concerns have been expressed on the internet and social media sites.

All the participants described their experiences of stigma and being considered professionally inferior. This resulted in them advocating by promoting the registered nurse role. Hujer (2012) recognised that advocacy can be used to promote the nurse's role in aged care.

5.2.2.5 *Promoting the registered nurse role*

The registered nurses who participated in this study described the need to advocate their professional role of caring specifically for older people. Ramdhanie (2001) complained that registered nurses caring for older people, especially in residential care, were considered to be a luxury. Of concern too was the increase, specifically within residential care facilities, in the number of employed care workers and personal carers (Eager et al, 2010). It is probably no coincidence that this change in the workforce mix has coincided with an increase in the dependency of older people needing care (Productivity Commission, 2011).

Courtney, Abbey, and Abbey (2004) described the very vague statement in the Aged Care Standards legislation (Aged Care Act, 1997), requiring that care facilities should have an adequate number of suitably skilled staff to meet the needs of the older people. They believed the statement allows aged care service managers to opt for lesser qualified and therefore less expensive workers, thereby leading to the deskilling of care providers.

This is not new to the nursing profession, as Stevens (2003) pointed out, the first reference to the specific needs of older people and the need for nurses trained with specific skills was made during a 1877 inquiry. This suggestion resulted in a division of opinion, with some believing that untrained staff would suffice; the divide has continued for over a century. The need for staff with an increased level of competence is readily demonstrated by environments employing a higher proportion of skilled nurses having a higher standard of patient care, reduced morbidity, and mortality (Aitken & Patrician, 2000; Gould & Fontenia, 2006). The respondents described how they perceived others viewed them, but did not see themselves or their professional image in the same way. There was a marked contrast between the reported negative views of others and the positive views of the participants.

The challenge of promoting the registered nurses' role was acknowledged by the participants as being imperative for those caring for older people. The decreased number of registered nurses working in aged care was of concern to the participants, and this was mentioned in a report for the Department of Health and Ageing (2002), which showed a decrease in the number of qualified staff being appointed and a consequent increase in the number of non-qualified workers. King and Martin (2008) also noted that in residential homes, personal carers were the largest group of employees, accounting for two thirds of the workforce. The importance of the registered nurses' role to help address the stigma was emphasised by participants.

Registered nurse participants spoke of their autonomy when working in aged care. Because they were often the most senior person on duty, they had the autonomy to make important decisions relating to care. Relationships with colleagues and the team environment varied amongst the participants. Those working in residential care facilities claimed their colleagues were generally supportive. In contrast, those working with older people within the acute care environment experienced less support and more negativity, especially from nurses working in other specialist areas.

Some participants were willing to push the boundaries of their role, recognising that, in order to ensure the elderly received the care to which they were entitled, the participants needed to transgress into roles considered as the domain of other health professionals. Examples included knowing what personal aids the person may require, pre-empting what the doctor would suggest, and making recommendations about the care required for older persons.

The participants were committed to their career and actively promoted their role as a viable career option, even though at times the stigma associated with their choice of specialisation was stressful. Several participants stated they were committed to continuing to nurse older people: *"I can't imagine working anywhere else"* (P10), and *"I am very happy here"* (P13). Some felt so committed to aged care that they would actively promote aged care as a viable career to others: *"I would definitely recommend it to new grads [graduate nurses]* (P11). Participants with this level of commitment were somewhat frustrated that others could not understand their reasons for working with older people, such as finding the work exciting, challenging, and rewarding. Participants believed that little would be achieved by departing from their

chosen work settings; therefore, they sought to get involved in making necessary changes wherever possible, and however small.

Participants were critical of people's ignorance of the role of the registered nurse in aged care. Thus another challenge was created, that of communicating to others what their role involved.

5.2.2.6 *Communicating the role of the registered nurse caring for older people*

The participant *advocated* by attempting to communicate what was involved in their role. One reason for registered nurses working with older people not being considered equivalent with other specialist areas of nursing is that the duties performed by the registered nurses are not easily communicated to others both in the nursing profession and in society. Indeed the experienced nurse may find it difficult to communicate the scope of their work to the novice nurse or others within the profession. In order to make changes and influence outcomes registered nurses working with older people need to communicate what their role entails to others.

Buresh and Gordon (2006) described the following difficulties nurses have had in communicating the actual requirements of their position to the general public:

1. Not enough nurses were willing to talk about their work;
2. They tended to talk about virtues rather than knowledge; and
3. They devalued basic nursing care, placing greater value on 'elite' nurses.

The above and other points raised had relevance to how the respondents and their colleagues must communicate the nature of their duties to their peers in other specialist areas. Buresh and Gordon (p.42) described nurses as "missing in action" and urged them to become more visible with regard to their knowledge and skills, they suggest nurses' risk being "unseen and unknown". Further they stated that nurses have the option to "highlight their clinical knowledge and competence, or they can conceal it". This can be applied to this study's participants who seemed unable to portray the skills and knowledge they possessed to others, reflecting how nurses find it difficult to describe what they do in clinical practice (Ford & McCormack, 2000)

as they possess knowledge that is often hidden, difficult to identify, and difficult to teach (Hall, 2005). In addition many nurses believe that showing people how knowledgeable they are is not acceptable (Gordon, 2006). Ford and Mc Cormack outlined the manner in which aged care nurses "fight" for their skills to be recognised. The participants of this study, who were fighting for their skills to be recognised, ran the risk of being perceived as 'difficult', causing them to be ostracised further.

It has been claimed that there is a reluctance to work with older people due to the lack of challenge and rewards (Cohen et al, 2004; Hogan, 2004). However, this reluctance was not evident with the participants in this study; they described many challenges inherent to working with older people and their families. Concern was expressed by some of them as to whether nursing older people was rewarding. This was divided between those who found the work rewarding and those who wanted their work further recognised by monetary means: this would make them feel valued through adequate financial reward.

The clinical setting in which the participants worked affected their manner of communicating their role to others. Nurses providing aged care in an acute care setting were described by participants as more visible than those in the residential care setting. One reason for nursing older people in the residential or long-term care setting being less visible is that these settings are made to look and feel homely (Abbey et al., 2006), this being a major shift from the image of clinical areas many people possess. The clinical care provided is "hidden" within the homelike environment; it is not always visible to the untrained eye. This could explain why the participants considered their work not to be always recognised by others. Another possibility is that the general public can no longer distinguish different members of staff in the clinical settings, with staff wearing the same uniform, as noted by Summers and Summers (2009).

Some participants claimed communicating the role of the registered nurse in aged care should not be restricted to the general public. Of greater concern is that the registered nurses communicate their role to junior members of staff to encourage these people to work in aged care settings. Happell and Brooker (2001) contended that student nurses, when asked to rank nine of their nursing options, ranked geriatric

nursing as their final option. A reason suggested for this state of affairs was that nursing students shunned working with older people, specifically within residential care settings because they did not see the role of the registered nurses (Abbey et al, 2006; Nevillle, Dickie & Goetz, 2014). Many student nurses, whilst on clinical experience in residential care did not practice alongside a registered nurse, but were often teamed with other care staff. This would explain why some of the participants in this study could not initially identify the difference between working as a carer and as a registered nurse in a residential care setting. Uhlmann, Brescoll, and Paluck (2003) described that individuals are "passively conditioned" by their culture to have certain beliefs or judgements. This view is supported by Woelfe and McCaffrey (2007, p.128), who are adamant student nurses experience "professional socialization", and adapt the "norms, values, and rules" that characterise the group as a whole. Thus, the cycle of beliefs about nursing older people continues. Study participants frequently explained that the negative beliefs about nurses who work with the elderly were long standing within the nursing profession. A number of the participants contradicted the negative views by reporting their strength as skilled problem solvers. This capacity is more likely to be evident in experienced nurses rather than recent graduates as observed by Taylor (1997) who noted the ability to problem solve was important in care provision. The interviewees spoke of this quality frequently when referring to the complexities of providing care to older people and the necessity for the participants to communicate this to others effectively.

5.2.2.7 *Recognising professional identity and status*

The manner in which the participants advocated for their professional status was to be comfortable with their professional identity. Madsen (2007) stated the concept of the "professional nurse" had been controversial for more than a century and acknowledged that the following efforts have been made to increase the professional status of nursing: changes to nursing unions who promote the importance of the nurses' role and seek appropriate pay awards; and the shift of nurse education to the university setting, thus bringing their academic training in line with that of other health professionals. Nay & Garratt (2004) contend that professional status is often

measured in relation to academic achievement; however, the tertiary education entry score for nursing tends to be lower than other health-related courses, resulting in nurse graduates having lower status. They also warn, however, that this is not a true indicator, because the tertiary entry score also reflects the popularity and availability of courses.

The participants in this study had to *advocate* for their professionalism to be recognised. They expressed concern regarding the difficulty of moving away from nursing older people if they wished to gain experience in another specialist area and this was expressed as them *feeling trapped*. As noted byThupayagale-Tschweneagae and Dithole, (2007), the greatest enemy to nursing hides within the profession itself, with power struggles being evident between different factions. There is a lack of understanding of the work undertaken by nurses by their colleagues in different clinical settings (Emeghebo, 2012). From comments made by the participants it can be assumed that nurses must be encouraged to accept and respect the different specialist areas, and acknowledge the high level of expertise nurses possess in the different areas.

The participants did, however, suggest a number of ways their image could be improved through an increased focus on caring for older people in undergraduate education. Their ideas mirror the following recommendations made in the National Aged Care Workforce Strategy (Aged Care Workforce Committee, 2005):

- Incorporate aged care principles into undergraduate nursing courses and other undergraduate health care/allied health courses
- Integrate aged care into suitable curriculums
- Make residential aged care a training option in undergraduate courses
- Market aged care as a career option to year 11 and 12 students
- Promote the aged care sector as professional and valuable to improve the image

One participant, who had recently graduated, described the pity she experienced from peers. Nay (2004) referred to this view, asserting that new graduates who went to work in aged care experienced pity. This was because of the low status accorded to

and the shunning of those in aged care. However, if the Aged Care Workforce Committee's (2005) strategies were embraced, this perception would be altered.

The participants' choice of their nursing speciality was not always viewed positively, nor was it always recognised as a genuine choice of professional specialty by other registered nurses, but they had the self-confidence to be aware of their professional skills. Registered nurses in other specialist areas did not recognise the skills and knowledge required to care for older people, however several concepts emerged from the data to explain why care of the elderly is not recognised as a specialisation. Participants recognised their professional identity, expertise, and ability; and they understood there was an art to nursing older people that went far beyond the boundaries of what was considered basic nursing care. Having achieved this understanding, the next challenge was for them to communicate this hidden revelation to others.

In summary, the participants' views on caring for older people as a career choice were an ongoing challenge for them because of the negative opinions of others within the profession. Challenges they encountered included dealing with stigma by association and promoting the registered nurses role in aged care. They attributed this attitude to people's lack of understanding of the importance of the registered nurse's role in aged care. In recent years some aged care organisations have negotiated with the acute care sector for their nursing staff to have some experience in that sector in order for them to develop their clinical skills (Australian Nursing Federation, 2011). Although this is a positive step, it needs to be reciprocated, with acute care nurses having experience in the aged care setting. Only then will a clear understanding of the differing roles be understood and appreciated. The myths and stereotypes associated with older people and those nursing them are often based on lack of knowledge (Hunter, 2012); it is only by increasing other nurses' awareness of the positive aspects of caring for older people that the situation can be improved.

5.2.3 Advocating for self

The participants needed not only to *advocate* for the older people for whom they cared and the status of the profession but they also need to *advocate* for themselves

by highlighting their professionalism. Indeed, it stands to reason that nurses must have a positive self-image in order to improve their professional image (Summers & Summers, 2009). For the novice nurse in the aged care environment, self-preservation was reported as a major priority, with them having to develop techniques to achieve this (Skogstad, 2000). However, in this study, some of the participants seemed to thrive on and value the close contact they had with older people, describing the relationships they forged with them as being a positive experience.

Participants reported using several personal strategies to assist them in *advocating*. A major attribute of this was believing they were making a difference: *"I am really good at what I do"* (P8), and: *"I know that the residents and their families appreciate what we do"* (P6). They explained that the positive feedback received from the people they nursed and their families outweighed the negativity experienced from other sources. Participants were also confident in their clinical expertise and theoretical knowledge, and although recognising that others may consider them not as skilled as other nurses they possessed a strong belief in their own abilities. To many of the participants, being able to problem solve was considered a major attribute which bolstered self-integrity. They were proud of the fact they could find solutions to complex problems related to nursing older people in the clinical setting. These participants were optimistic, describing major changes in aged care which had already occurred: *"Things have definitely improved"* (P2), and*, "I went back to aged care because I wanted to make a difference"* (P12). This optimism resulted in them hoping they could make a difference to aged care. Several participants explained how change within the aged care environment was relatively slow, but they were grateful of improvements already made.

Those who care for the elderly were found by Richter, Astrom, & Isaksson (2012, p. 98) to possess certain personality traits including being, "slower tempered, more stoic and reflective, tolerant to monotony, and more systematic" This description was partially reflected by the participants of this study as they spoke of the need for patience. However, participants did not believe nursing older people was mundane.

Arthur (1992) developed a "professional self-concept of nurses' instrument", a tool that could be used to measure how individual nurses viewed themselves as

professionals. In a later study Arthur claimed that self-concept is a transient quality and not until an individual matures does self-concept stabilise (Arthur & Randle, 2007). Participants in this study described their becoming resilient, which corresponds with the three attitudes defined by Gillespie et al., (2007, p128): self-efficacy, hope, and coping.

5.3.3.1 Self-believing

As outlined above in order to *advocate* for themselves, the participants in this study had to believe in themselves. Self-belief was certainly evident in responses by the participants. Gillespie et al., (2007) used the terminology self-efficacy in relation to an individual's confidence in their ability to perform a particular task. Self-efficacy is believed to be a coping mechanism because it demonstrates an individual's belief that a desired outcome can be achieved. According to Gillespie et al., the greater the self-efficacy, the more likely an individual is to persevere. Belief in self was demonstrated by participants when they described themselves as confident and skilled practitioners, and content with their work setting.

Advocacy for self was required as the participants intimated that nurses in other clinical areas were critical of, and stigmatised the skills nurses in aged care displayed. They spoke of how they were personally stigmatised by nurse colleagues using a form of horizontal violence. Leiper (2005) and Corney (2005) reported horizontal violence coming from peers was more disturbing than if it came from outside the peer group, reflecting what was conceptualised as *friendly fire* in the findings of this study. In current instances of *friendly fire* new staff and undergraduates were advised not to become involved in this friction. However, if this strategy could not be activated the younger nurses were being "eaten alive" or older nurses were metaphorically "eating their young" (Meirer, 1999; Sheridan-Leos, 2008), this suggested younger and less experienced nurses were more likely to be targeted (Woelfle and McCaffrey, 2007). This study found the more mature and experienced participants were less threatened by others. If they experienced stigma, frequently from nursing colleagues, then it is justifiable to conclude they were experiencing horizontal violence.

Rayner and Hoel (1997) listed five types of bullying, one of which related to the threat on professional status, which would occur if an individual's professional status was belittled as a group or as an individual. When nurses from other specialist areas criticise nurses who work with older people is this a form of bullying? The respondents recognised that other nurses were critical of their professional ability but did not make reference to bullying. Thupayagale–Tschweneagae and Dithole (2007) noted a similar phenomenon in the nursing profession which had been divided for many years, with different cliques or sub-groups developing. Elaborating on this, they made the point that diversity within the nursing profession had not strengthened the profession, as had been hoped, but divided it, with nurses being critical of other nurses' expertise. Participants in this study bemoaned being looked down upon and having to continually strive to be recognised as skilled practitioners.

Horizontal violence has been recognised, albeit under different guises, and improvements should be made but these have not occurred (Eley et al., 2007). Corney (2008, p.171) in her research on aggression in the workplace spoke of "enculturalisation of behaviours" that are passed on over many years, these generally pass from senior staff to their juniors, thereby making the behaviours acceptable. This study found the views on nursing older people to have been negative in the nursing profession for a long time. The finding highlights the need for senior staff to take a leading role in the implementation of a change in attitude towards older people and those who nurse them.

Although all of the participants in this study had experienced "*friendly fire*" in one form or another, they found it particularly hurtful when the criticism of their decision to work with older people came from those they expected to be supportive. This however, could be interpreted as the families and peers attempting to protect the registered nurses who chose to work with older people because they were aware of the stigma associated with this area of nursing.

5.3.3.2 *Hoping*

The participants portrayed hope through their belief that attitudes would improve over time, for both themselves and older people. Hope was key to the participants'

survival because optimism has been recognised as a major factor in *resilience* (Charney, 2004), which is particularly necessary when caring for older people (Richter, Astrom, & Isaksson, 2012). The more experienced practitioners recalled how care for older people had improved throughout their careers. They provided examples they had witnessed of older people being treated poorly in the past, and how this was improving. The physical needs of the elderly were met in the past, but little consideration had been given to their spiritual and psycho-social wellbeing. However, concern was expressed that this holistic approach was still lacking when the older person was unnecessarily moved from one setting to another. Jones (2005, p4) referred to this activity as being "moved from one clinical silo to the next". The participants hoped this could be addressed but were realistic about the pace at which any substantial changes are made. The less experienced participants practised dutifully, hoping they would be able to make a significant difference to the care provided to older people. They recognised that they had limited experience in aged care but this deficiency was enhanced by their enthusiasm for care improvement. No matter how much experience the participants had in caring for the elderly, they intended their contribution to make a difference and to promote positive attitudes in others in this regard.

5.3.3.3 *Coping by being resilient*

As described in Chapter 4, the participants of this study survived the ongoing stigma and stereotypical imagery by developing strategies for survival and being resilient. The participants developed *coping* strategies to protect themselves from the negativity associated with working in the aged care environment. One *coping* strategy was to surround themselves with like-minded people: *"I mix with other professionals who work in aged care so I don't experience criticism"* (P10). They also learnt not to take the stigma and stereotypical imagery personally, recognising that this often came from people who lacked understanding of what was involved in nursing older people.

Coping forms the foundation of resilience development (Deveson, 2003), and involves the ability to cope within the clinical setting. Participants became *resilient* by developing strategies to *survive feeling under siege*. Corney (2008, p.173)

commented on workplace aggression in nursing: “The notion of survival keeps on rising from the depths like some subterranean monster, a deplorable metaphor to be able to legitimately apply to a group of professionals whose business is caring.” Resilience is defined as “the capacity to cope with or adapt to significant risk and adversity and to recover quickly from stressful change or misfortune” (Campbell, Campbell, & Ness, 2008, p. 61). Its origins are from the Latin “resilire,” meaning to spring back or rebound (Dictionary. com 2013), an admirable coping quality possessed by participants.

Much literature relates to resilience, much of which has been generated over the last two decades (Windle, 2011). A variety of views have been expressed on what makes a person resilient, with some believing it is a personality trait and others a dynamic process (Cameron & Brownie, 2010; Campbell, Campbell, & Ness, 2008; Castro, Kelly, & Shih, 2010; Grafton, Gillespie & Henderson, 2010). Various authors and researchers have explored resilience in relation to traumatic health, trauma, bereavement, significant life events, organisations, and the military setting. The literature is divided over whether resilience is a personality trait, develops from environmental factors, or is a combination of both (McEwan, 2011). More recently, genetics has become part of the argument (Lemery-Chalfant, 2010). However, the literature has lacked studies into the resilience of people working within particular environments where stigma and negative attitudes were extant. The literature within nursing has predominantly related to mental health settings (Cleary, Jackson & Hungerford, 2014). Among the few studies on nursing, one undertaken in Canada involved black nurses who were “surviving on the margins of a profession” (Etowa, Sethi, & Thompson-Isherwood, 2009). This to an extent corresponded with this study’s participants who were *surviving* on the margins of the nursing profession.

The claim that resilience develops is supported by Gillespie, Chaboyer, and Wallis (2007) who argue its development could occur at any time during one’s life. If this is so the participants may not have initially had resilience oriented personality traits but had developed them through their careers.

Boss (2006, p55) believed that prejudice and stigma “erode resilience”. This would explain why participants related having seen nurses quit the aged care settings. It could also mean that nurses remaining in aged care were at high risk of having their

resilience “eroded”, especially if they were *feeling under siege*. Boss also explained that negative attitudes towards individuals or groups could result in resilience being reduced for a number of generations. The participants reflected the Boss conclusion when they spoke of negative images of aged care nursing being long standing within the nursing profession.

The belief that resilience can be taught has led to a number of texts being written in relation to the pedagogy of developing resilience within children and adolescents (Allen, Murray, & Simmons, 2005; Healey, 2007; Windle, 2011). Some interviewees hoped that, if resilience is taught at an early stage, nursing students would have the necessary resilience for their careers. Due to the changes in the nursing workplace, it is important that nurses develop resilience in order to *survive* at work. McDonald (2010) proposed that an education program on resilience in the workplace would improve resilience for nurses. Although there are numerous articles and texts on resilience, studies on nurses’ resilience are lacking (Matos et al., 2010).

The research by Cameron and Brownie (2010) identified how experienced registered nurses, who worked in the aged care setting, developed the resilience to manage stressors associated with their work. They outlined eight common themes underpinning the attainment of resilience:

1. the result of experience, complex skills and knowledge required to manage time, crisis situations prioritise tasks and staff;
2. fostered by the degree of satisfaction achieved in being able to provide holistic skilful care;
3. enhanced by having a positive attitude, making a difference or a sense of faith enhances resilience in the workplace;
4. reinforced by the notion of making a difference and the close intimate relationships and sharing of experiences with residents;
5. promoted at work by using strategies such as debriefing, validating and self-reflection;
6. support from colleagues, mentors and team camaraderie;
7. when individuals have insight into their ability to recognise stressors and put strategies in place such as humour to minimise the effects; and

> 8. ensuring exercise, rest, social support and interests are maintained to maximise work-life balance.
>
> (Cameron & Brownie, 2010, p.68)

Several of these themes were mentioned in the participants' interviews. For example, the nurses with more experience appeared to have more resilience. Cameron and Brownie (2010) found that nurses, who have clinical expertise, were more resilient due to confidence held in their own ability. Respondents in this study argued the need to "arm themselves with education and skills," resulting in an increased confidence and increased ability to *survive feeling under siege*. Some participants described making a difference to patients or clients also had a positive impact. The only reference made to work-life balance was made in relation to the participants justifying their decision to work with the elderly. Tusaie and Dyer (2004) explained that all people have the ability to become resilient, and described how other factors are an influence, such as the workplace environment, and the social support available. These authors stressed that resilience is an important attribute for nurses to possess in order to cope, which corresponded with Hodges, Keeley, and Grier (2005, p548) who wrote that resilience can be learnt and is, "an essential element for practice in a chaotic practice world".

It has already been mentioned that everyone has the ability to develop *resilience*, but an important additional determinant is the environment (Tusaie & Dyer, 2004). Resilience is something that must be fostered because the attrition rate for nurses during the 21st Century is increasing; the average career-life in nursing is down to five years or less (Hodges et al., 2005). Because this statistic refers to the nursing profession as a whole, arguably resilience is something needing development as a matter of urgency, particularly for those working with older people. It is assumed that those who do not develop resilience leave the profession (Cameron & Brownie, 2010). McEwan (2011) contended that people who are resilient in the workplace ignore the small things and focus on over-arching areas where they can make a difference. As outlined in Chapter 4, the participants fluctuated in their use of active and passive strategies to *feeling under siege*, thus choosing where to focus their energies. They had developed resilience in order to *survive* within the aged care setting, although previously little was known about the factors adding to registered

nurse resilience in aged care (Cameron & Brownie, 2010). Those who work in difficult situations develop a range of coping mechanisms (Garcia & Calvo, 2011): the participants in this study had certainly practiced with difficulty at times, and had developed a range of strategies ensuring the resilience necessary to cope. Resilient nurses have been described as those who are able to "transform a disastrous day into a growth experience and then move forward in practice rather than seek a new career" (Hodges et al, 2005, p 550). There is a belief that nurses are generally resilient due to the events they encounter during their clinical practice, but some nurses are more resilient than others (Jackson, Firtko, & Edenborough, 2007). The participants in this study were successful in their endeavour to be resilient.

This study is not unique in identifying that nurses feel *under siege.* Other researchers have described nurses as being *under siege* in the workplace due to staff shortages, bullying, and organisational reconstruction (Jackson, Firtko, & Edenborough, 2007). *Feeling under siege* was prominent in this study due to the participants' choice of specialist area, and the stigma this attracted on personal and professional levels, resulting in them having to become *advocates* for themselves.

5.4 SUMMARY

This chapter has reiterated the substantive theory of *advocacy* an outcome of *resilience* and *survival*, including its underlying components and related theory to existing theories and literature. There is a significant body of literature about stigma associated with working with older people, but this research has found that the participants required something more: resilience that enabled them to survive so that they could *advocate* for the older person, profession, and the self. Nurses who care for older people were not "ones that could not make it in acute care" or "second class" as a number of participants described they were perceived by their peers in other specialty areas, they were indeed strong because they *survived feeling under siege*. In fact the participants had gone beyond *surviving* and were able to flourish, grow, and *advocate*.

This study also proposes that nurses caring for older people are not basic practitioners but advanced specialists. If this was acknowledged, those who nurse the

elderly would attain the professional recognition they deserve, there would be enhancement of the registered nurse role, and maintenance of the self-esteem of those already nursing older people.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 OVERVIEW

This thesis has outlined a substantive grounded theory of *advocacy* as an outcome of resilience and survival in the care of older people. It tells of the participants' development in addressing the problem of *feeling under siege*, by *being resilient* in order to *survive*. The participants went beyond *surviving* to *advocating* for the older person, the profession, and self. This was possible due to their ability to develop strategies in order to become *resilient*. The participants were able to take on the role of *advocate* once they had become *resilient* and recognised they were skilled practitioners in nursing older people.

This chapter comprises the conclusions arising out of this study and the limitations of the study. The major findings of the research are restated, along with suggestions on how the findings of this study could influence clinical practice. Finally, recommendations for both clinical practice and further research are presented.

6.2 IMPLICATIONS FOR PRACTICE

The findings of this study have implications for practice, policy, and the profession. The study described the manner by which research participants recognised they were not considered to be as skilled or knowledgeable as their colleagues in other clinical settings. They developed strategies to manage this disadvantage. If employers are aware of this perceived disadvantage and the strategies required to continue working with older people, they will ensure the nurses have the skills to survive. The implications for practice are addressed under the *advocacy* categories relating to older people, profession, and self.

6.2.1 Move towards positive ageing

This study identified the need to change the image ageing evokes from a negative to a positive one. The more experienced participants in this study realised that improvements had been made during their careers, with a more positive approach to ageing being promoted. “Positive” and “active” ageing are familiar phrases to health professionals who have cared for older people over the past couple of decades. The Australian Government in the year 2000 emphasised the need for a positive image of older people to be promoted (Department of Health and Ageing, 2006). Although stereotypical views on ageing are currently more positive than they were some decades ago, society still needs to change and be encouraged to see ageing as positive, and to recognise older people as being valuable (Hillier & Barrow, 2007).

McCallum and Geiselhart (1996, p.66) commented on the necessity for the health care system to shift its focus from ‘high tech medical services’ to what they term ‘geriatically sensitive medicine’ concentrating more on the patients’ and families’ needs. The community needs to shift its opinion of older people to the view that “ageing is not an illness, and disabling disease is not inevitable in old age” (Andrew & Carr, 1990, p.111), as disability free years increases with age (Productivity Commission, 2011). The participants of this study reflected this as they spoke of normalising and promoting the positive aspects of ageing.

Battersby (1998, p.5) believed four fundamental issues underpin successful ageing:

- Understanding ageing and its biological and social processes
- Ageing in a community context
- Care and housing for older people
- Issues concerning quality of life

Some years later Kalache, Barreto, & Keller (2005, p.42) took a more individual approach, listing six determinants affecting active ageing:

1. Behavioural (whether individuals adopt healthy / active lifestyles);
2. Physical environment (safe or unsafe environments / risk of isolation);

3. Social environment (social support available);

4. Economic (income and security);

5. Health and social services (for example, community based care); and

6. Personal determinants.

Bradley (2007) referred to the terminology “ageing well” as meaning being able to convey to people a positive rather than a negative image of ageing. Positive ageing must go beyond the remit of the individual person and health care setting to communities that facilitate older people to be active members of those in which they live (The House of Representatives Standing Committee on Ageing, 2005).

An area of health care that has had a significant impact across all age groups has been the advancement in health promotion. In the past it has been rarely considered in relation to older people but is currently a developing area. Health promoters have to adapt the way they deliver the information so as to reflect the needs of their older clientele, for example, using larger fonts on written information (Hussain & Marino, 2005). The elderly tend to consult their doctors when a particular health issue arises rather than consulting on preventative management: however they would pursue a preventative approach if it was recommended by the doctor (Chenoweth & Sheriff, 2003). Holstein and Minkler (2003) used the terminology “new gerontology” to describe the shift of focus away from disease and disability to preventative measures to avoid or delay physical and mental losses.

6.2.2 Change attitudes, education, and career development

Three areas of the nursing profession were identified by the participants as requiring change: attitudes, education, and career development.

6.2.2.1 *Nurses' attitudes*

As the ageing population continues to increase it is imperative that care be provided to support this age group, with the registered nurse playing a pivotal role (Stevens, 2011). Of particular concern to the participants in this study was their need to promote the role of the registered nurse in the care of older people. As previously discussed, nursing students and new graduates seem reluctant to practice with older people when they qualify, this being an area requiring investigation. A change in nursing culture is necessary in order for older people and those who care for them to be better valued. This will not be an easy task because cultural change is slow and responses are needed to accepted new solutions and procedure. However, the participants identified that positive changes are being made and this momentum needs to be maintained.

The participants in this study perceived societal attitudes towards older people were, to some extent, responsible for the attitude of nurses towards them. The negative attitudes towards older people within society as a whole were transferred to the nursing profession. They believed that if the same impetus had been given to promoting a positive view of older people, the nursing profession would be attuned better to the needs of this increasingly large group of people.

Palmore (2001) described a tool for use in collecting data on perceptions as to whether older people were experiencing ageism. The rationale for the development of the tool was that people were aware that ageism exists in society, but its extent is unknown. The tool had twenty statements for the respondent group to respond to about their experience of ageism. Examples of these statements included: treated with less dignity and respect, and denied medical treatment. The tool was designed for implementation in a sample of the community, but it could be adapted for employment with sub-groups such as health care settings. Health care providers could evaluate whether health care staff demonstrated ageism.

6.2.2.2 *Education*

All registered nurses graduate at the same level, and are professionally recognised as such, but equality of status alters as soon as the new graduate makes a career choice:

they find the care of the elderly is less appreciated than other sectors such as intensive care units and accident and emergency. This early career positioning led participants to feel the need to arm themselves with additional skills and knowledge in order to compete with their colleagues for equal recognition. This highlights a need for continuing education for nurses who care for older people. This may be easier to achieve now that registered nurses must demonstrate they have maintained competence to practice prior to renewing registration. As with other aspects of caring for older people the education of staff needs to be equivalent to that provided to nurses in other specialist areas. The Commonwealth Department of Health and Aged Care (2002) described the training for nurses working in aged care to be both limited and costly. It continued by offering a number of solutions to this including onsite training and the use of other media to deliver information: telephone, video conferencing, and such like. Another suggestion was sponsoring trainees with the proviso they would work in aged care settings on completion of their studies. Some employers have already used this strategy, offering sponsorship assistance with course fees in return for the student nurse agreeing to be bonded for a set period of time upon graduation. Other employers also offer a program of training for the new graduate (Jones, 2011).

Another option for nurses who wish to upgrade their qualifications is enrolment in distance education courses. This may be an overwhelming option for those who are not competent in or comfortable with the use of information technology. Indeed the potential student may require orientation to the technology before they commence learning in this way (Mueller & Billings, 2006). This method of study may further isolate and make invisible those nurses working with older people so that they are less able to advocate for older people or their professional role in face-to-face conversations. Professional education should never be underestimated as education leads to growth, power, and respect (Koop & Quirke, 2003).

Although the participants spoke of the need for postgraduate training and education, they intimated how pre-registration courses should include more emphasis on nursing older people. Nursing students in previous studies have described the dearth of theoretical components on the care of older people when compared to the large component of clinical time focused on nursing in acute care environments (Davies, Gell, Tetley, & Aveyard, 2002; Fagerberg, Winbald, & Ekman, 2000). The

community and health care professionals also need increased education on ageing, aged care, and the role of the registered nurse in such care.

6.2.2.3 *Career Pathways*

The participants spoke of career pathways being limited, especially if they wished to be directly involved in patient/client care. They recognised nurse practitioner numbers are increasing and were positive towards this. Some diversity of opinion occurred between respondents as to whether nursing older people should be a specialist area. Some believed the specialist skills and knowledge required to care for older people made it so. In contrast, others believed all nurses should possess the skills required to care for older people as most nurses would provide care to older people in the future. Nurses caring for older people need to feel they are valued, as this quality is important in the recruitment process (Chenoweth et al, 2010).

It is not only nursing within residential care facilities that are unpopular but also nursing older people within the acute care setting. Miller (2004) suggested that having nurses with expertise in aged care within the acute care setting would be advantageous. This would support nursing staff that are unfamiliar with the specific needs of older people. Cautionary advice was given that such breadth of qualification might lead to the expectation that the aged care specialist nurse would care for all the older people. However, this role if adopted would provide those who wish to work in aged care with another career pathway.

Participants showed their awareness that the nursing workforce is ageing, so adding additional pressure to specialist areas that are deemed unpopular. This will lead to an increased competitiveness amongst health care providers to recruit available staff (Cohen, 2006). Therefore they contend the focus will shift from recruiting new staff to retaining existing staff. Organisations which develop a culture wherein staff feel valued are more likely to retain staff. This can also encourage older nurses to continue in the workforce. Employers' recognition of the expertise, knowledge, and vast experience older nurses provide will more likely encourage them to remain gainfully employed (Cohen, 2006).

6.2.2.4 *Recognising nursing older people as an equal speciality*

Nursing older people is definitely recognised by participants as a specialist area of employment. The specialist skills and knowledge have been recognised by "nurse champions" being identified in some clinical areas. Examples can be found in Canada, where emergency nurses specialising in the care of older people have been appointed (Baumbusch, 2011), and in New South Wales with the Aged Care Emergency Team Program (Shanley, Sutherland, Tumeth, Stott, & Whitmore, 2009). Participants realised examples such as these showed one way forward for the profession, but thought about how this type of intervention may affect the role of champion. Its purpose is not to off load care of the elderly to "the champion", but rather that the champion is a resource, facilitator, role model, and educator in methods appropriate to the nursing of older people.

The participants noted, as Baumbusch (2011) did that acute care environments and fast paced areas such as the emergency department may not be conducive to the needs of older people, hence giving rise to status and stigma issues. Edvardsson and Nay (2008, p.67) used the term "culture clash" when describing the interface between acute care and the care of older people where person centred care was required. The clash was related to the speed at which outcomes were to be achieved. These authors acknowledged the expertise and care provided in acute care settings, but suggested that some nursing procedures may not be 'fit for purpose' in responding to the care needs of older people. In Australia policies such as the Australian National Action Plan for improving the care of older people across the acute-aged care continuum have been formulated (Australian Health Ministers' Advisory Council, 2010), and age-friendly principles and practices developed (Australian Health Ministers' Advisory Council, 2005), that recognise the specialist care required by the elderly. Although programs have been implemented as a result of these policies nursing older people continues to lack the status attached to other areas of nursing. Participants believe that alternatives must be considered in order to address this need more fully, whether it is adjusting the practices of existing staff or employing new members of staff with specific roles in this specialist field. Caution must be exercised when making changes so that older people do not become further ostracised, segregated, or stigmatised.

6.2.3 Advocating for self

Participants of this study have developed a variety of strategies in order to advocate for themselves. These strategies need to be shared with other nurses and those involved in recruitment and retention so that nurses do not leave the profession. Nursing students should undertake some form of psychological testing prior to commencing the course to assess this important suitability aspect of the profession. A number of participants, who had undertaken hospital-based training, spoke of attending an interview prior to being selected as a suitable candidate for nursing. With the shift towards tertiary based education this has been lost, the focus now being on tertiary entry suitability according to grades. Psychological screening would enable those recruiting to explore whether potential students had the aptitude for *surviving* the clinical experiences of nursing as well as possessing the intellect for the theoretical component.

The new graduates beginning their career pathways should be mentored by those identified as possessing high levels of *resilience* and *advocacy*. All novice nurses should have access to this exemplification of *survival*, ensuring the provision of a positive role model both professionally and personally. Davies et al (2002), reminded us of its importance if the novice is learning to practice in the private sector or residential aged care facilities where nurses are at risk of experiencing isolation.

6.2.3.1 *Rewarding nurses who care for older people*

Participants spoke of the rewards received from nursing older people. This aspect focused on the personal belief that a high level of care was provided to the elderly. They were supported in this belief by the feedback they received from the elderly and their families. A number of the participants discussed the need for registered nurses working with older people in the private sector being rewarded in monetary terms, as generally pay was lower than in the public sector. Previously working with older people in some countries was rewarded financially, for example, during the 1980s nurses caring for older people in the United Kingdom's public sector for more than six months received additional pay and referred to as geriatric lead.

The nurses did not necessarily need to be rewarded, being considered equal to skill and worth with their counterparts in other specialist areas. Participants felt strongly that being valued would improve individual's self-integrity. If the issues surrounding the integrity of both the elderly and of those registered nurses caring for them are addressed, then self-integrity would gradually follow.

6.3 RECOMMENDATIONS

The outcomes of this study and the substantive theory *advocacy* as an outcome of *resilience* and *survival* imply a series of recommendations for the profession, policy makers, and the wider community.

1. Nurses working with older people need to develop skills that enable them to *survive* in aged care settings. A key ingredient for *survival* is *resilience*, which starts by acquiring practical strategies during formal education, and through a mentorship program.

2. *Advocacy* should be promoted as a fundamental role of the registered nurse. It should continue to be taught in nursing education and clearly identified in codes of professional conduct.

3. Negative attitudes towards older people need to be changed. The seed for this change is positive portrayal of older people in the media. Opportunities for children to have positive interactions with older people from a young age would aid in the change process.

4. Working with older people should be promoted as a viable career option for both student and graduate nurses. Nurses who have been successful in working with older people could be role models and teachers, providing details of the opportunities available in this area of nursing to students and new graduates.

5. Theoretical and practical units which relate specifically to the care of older people should be included in undergraduate nursing courses. This teaching would then need to be followed by and integrated into clinical practice. Student nurses should have practical experiences in aged care areas where

there is an enthusiasm about the care of older people. There needs to be a continued shift from focusing on illness, disease, disability, and dependency of older people to a wellness model.

6. Practical placement for student nurses should include mentoring by a registered nurse who is well versed in the complex nature of nursing older people.

7. Graduate nurse pathways in the care of older people should be developed so new graduates experience and develop the specialist skills required. Clinical supervision and support by experienced nurses would provide opportunities to discuss and reflect upon the novice nurse's practice.

8. Registered nurses need to embrace the expertise of all nurses, no matter what sector of nursing they choose for specialisation.

9. Prepare registered nurses for the potential negativity they may encounter when nursing older people. This means incorporating skills in all training and education to help them *survive* and not to become casualties and leave the profession.

The participants in this research indicated that attempts have been made to address some of these recommendations. However, to date the success of interventions have been limited. Therefore perseverance is required, because it is unlikely that a culture, entrenched and rampant for decades will change quickly.

6.4 LIMITATIONS

This study has several limitations. To start with, the sample was small and from only one state. Furthermore, the participants were all Australians who may not reflect the beliefs of nurses from other cultural backgrounds. The participants worked in metropolitan, regional, and rural areas of Western Australia, but were all from the south-western part of the state, so may not reflect the views of nurses working in other parts of the state. There were no restrictions made by the researcher on the length of service of the participants. Another limitation was that the registered nurses from a wide variety of clinical settings were not included in this study. Finally, only

one of the participants was male, this proportion is reflective of the nursing profession as a female-dominated profession.

6.5 CONCLUDING STATEMENT

This study revealed that the registered nurse participants caring for older people experienced *feeling under siege* and *under attack* from other members of their profession as well as from society, their families, and the health care system in general. However, this study also revealed that registered nurses working in this sector have been willing to fight for both the older person's rights and their own professional status through a process that has enabled them to *survive* and subsequently become *advocates*. The participants were passionate about and skilled in their nursing of older people, but felt inhibited by the negativity and judgement that surrounded their practice. They have become positive role models to others who work with older people.

Indeed, the participants in this study were not the 'poor cousins' of the nursing profession, but were the 'champions', bringing to the profession and those they cared for a wealth of expertise, skills, and compassion. It is time that the nursing profession and the wider community recognise aged care nurses for their strength and *resilience*, and rewarded them for their decision to care for the most vulnerable people in society.

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APPENDIX A

An exploration of the professional status and recognition of nursing older people: A Grounded Theory study

As a Doctor of Philosophy student at the School of Nursing and Midwifery, Curtin University of Technology I am undertaking a research study. I wish to explore the professional status of Registered Nurses who work with older people.

I am looking for Registered Nurse volunteers who work with older people to participate. Participation will involve a taped interview lasting no longer than one hour.

Should you wish to participate or discuss further please contact Deirdre Rostron on (08)96412379 or email demaro@westnet.com.au

APPENDIX B

Aide memoir for in depth interviews

Tell me about your experience working with older people

Tell me about your choice of specialisation

What changes have you seen in nurses' attitudes to nursing older people?

What do you think contributes to this?

Can you make any suggestions on how the image of working with older people can be improved?

As a specialist area what are the skills you think nurses who work with older people have?

APPENDIX C

Curtin University of Technology

Dear Nurse,

As a Doctor of Philosophy student at the School of Nursing and Midwifery, Curtin University of Technology I am undertaking a research study. I am interested in exploring the professional status and recognition of nursing older people. For the purpose of this study I have defined "older people" as those over the age of seventy years. This is particularly relevant as the number of older people increases and these people may require nursing care. This study should benefit the nursing profession by identifying issues important to nurses caring for older people.

I am looking for Registered Nurse volunteers who work with older people in any health care setting. Participation will involve a taped interview lasting no longer than one hour that will be conducted at a mutually convenient time and venue. If I need to clarify any issues raised following the interview I may have to contact you again for a short discussion. If not logistically possible to conduct the interview face to face a telephone interview will be undertaken.

Once the interview is complete I will store the data in a secure place. Codes will be used so as not to identify individual participants – I will be the only person who knows your identity. If at any stage you wish to withdraw from the project you will be able to do so.

As with any research the findings will be shared possibly in academic publications or presented to interested parties. At no stage will the identity of individuals or organisations be made available.

This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR 24/2007). If needed verification of approval can be obtained either by writing to the Curtin University Human Research Ethics

Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 92662784 or by emailing hrec@curtin.edu.au.

Should you wish to participate or discuss further please contact me on [contact details provided].Alternatively you may wish to contact one of my supervisors – Associate Professor Dr Barbara Horner on 92667993 email b.j.horner@curtin.edu.au or Dr Beverley Scott on [contact details provided]

Deirdre Rostron

APPENDIX D

CONSENT FORM

An exploration of the professional status and recognition of nursing older people: A grounded theory study

I …….. acknowledge that I have read and understood the information provided to me in the information sheet and consent to participate in the study.

I am aware that by providing this consent I am agreeing to:

- Be interviewed by Deirdre Rostron
- For the interview to be taped and transcribed
- Clarify any issues if required at a later date
- The dissemination of the results of the study

I am aware that my identity will be protected and I can withdraw from the study at any stage.

Signed …… (participant) Date……..

Signed……. (researcher) Date……..