Attitudes towards caring for older people: literature review and methodology

In the first of two articles, Angela Kydd and Deidre Wild discuss how the specialty could be made a more desirable career choice.

Abstract

Care of older people is often referred to as a ‘Cinderella’ service and is not seen as an attractive career option in health care, but with the global population continuing to age, caring for this group will become increasingly important.

This article outlines the literature that formed the basis for two studies investigating the attitudes of healthcare staff towards working with older people, including respondents’ perceptions of other healthcare professionals’ attitudes toward this important area of work.

The Multifactorial Attitudes Questionnaire was designed to examine five major themes identified from the literature: ageism; learning environment; working environment; professional esteem; and specialist status.

This study is presented in two parts: this article discusses the literature and the design of the questionnaire. The second article, to be published in a subsequent issue of the journal, presents the results from two studies done in Scotland, the first in 1999, with a replication study in 2009.

Keywords

Attitudes to older people, gerontology, professional esteem, specialist status

Projected needs

Advanced age has been identified as a risk factor associated with frailty (Cornwell 2012). Although life expectancy is increasing in developed countries, older people’s quality of life can be reduced by debilitating and disabling conditions, such as arthritis, stroke or dementia. Services that address quality of life can help older people with long-term conditions to live at home for longer (Kydd 2008), therefore delaying the need for admission to long-term care with onsite nursing (nursing home) or without onsite nursing (residential home).

As a result, older people who are admitted to nursing or residential homes have high dependency and more complex healthcare needs.

In Scotland, there are 920 residential and nursing homes caring for 33,645 older people (Information Services Division 2012), which constitutes 8.4 per cent of the 400,000 people aged 65 and over who live in nursing and residential homes in the UK (British Geriatrics Society (BGS) 2011).

The BGS (2011) highlighted that the healthcare needs of older people in nursing and residential homes in the UK are not met sufficiently by the NHS. The BGS identified that as this area of care has been taken over by the independent sector, NHS facilities have been withdrawn. As a result, many care home residents are denied equitable access to NHS services and many frail older residents are inappropriately admitted to hospital (BGS 2011).
Older people are the main users of hospital services, for despite efforts to reduce inpatient care in NHS hospitals, this group of patients are reported as using 68 per cent of hospital emergency bed days (Imison et al 2012). Obesity and lifestyle-related related disease such as type 2 diabetes, coronary heart disease, cancer and chronic obstructive pulmonary disease can compound existing conditions (Humphries et al 2010) and increase the dependency of older people. From population projection figures alone, care of the frail older population, now and in the future, cannot be ignored. However, nursing older people is not seen as an attractive career choice and many articles have sought to explore the possible reasons for this.

The study
The aim of this study was to use the available literature to identify and update knowledge of the multiple factors affecting health professionals’ attitudes towards nursing older people and towards people who work in this field. A Multifactorial Attitudes Questionnaire (MAQ) was developed (Kydd et al 1999), and was presented at several conferences. The MAQ was used to assess the attitude of healthcare professionals working with older people in Scotland in 1999, and again in 2009.

This article, the first of two, discusses how people can be encouraged to enter a career in caring for older people, including suggestions on how to improve the status of nurses, allied health professionals (AHPs), and health and social care staff who work with older people.

Literature review
The literature review ranged from 1980-1997 for the 1999 study and from 1998-2012 for the 2009 study. From these, five themes were generated as the framework for the study. These themes were also central to the process of designing the original MAQ (Kydd et al 1999) and in refining the tool for use in Scotland in 2009 and internationally in 2010.

Ageism
There is a long history in the literature of the negative attitudes of healthcare professionals, including nurses, towards working with older people. Kane (1999) found that ageist attitudes exist when healthcare professionals perceive that clinical interventions are not worthwhile for older people. Negative attitudes to older people occur in acute healthcare settings when healthcare professionals perceive these individuals to be in the wrong place (Latimer 2000, Hochschild 2012, White et al 2012). In healthcare systems the emphasis is on accountability and results rather than care of vulnerable individuals (Tadd et al 2011, Ceci et al 2012).

This organisational stigmatisation of older people can be seen throughout European healthcare systems (Latimer 2011) and can affect working attitudes (Hillman et al 2010).

Several authors have suggested that, in general, nurses’ attitudes towards working with older people are negative (Courtney et al 2000, McLafferty and Morrison 2004). However, stereotyping is more likely to be orientated towards the working environment rather than to working with older people (Brown et al 2008).

The negative attitudes of some nurses working with older people may be a response to patients’ reciprocal negativity towards healthcare professionals and the treatment they receive. Older people’s perceptions of good care were determined by the positive attitudes of staff and staff’s sensitive interactions with them and their families, and not from the actual treatment of their condition (Gray 2009, Kydd 2009). A further finding by Kydd (2009) showed that older people’s expectations of good care were low and the hope they had was for kindness.

In the late 1980s and early 1990s, authors such as Hope (1994) found that nurses working in acute care specifically for older people had a more positive attitude than nurses working in a general acute setting. Reasons for this could be that nurses with positive attitudes tend to work with older people through choice, or that exposure to gerontological nursing care positively affects nurses’ attitudes towards older people. This supports the work of Zebrowitz (2003) who hypothesised that someone who has experience and knowledge of a specific group of people is less likely to attribute stereotypes to that group.

Learning environment
Health and social care roles have undergone change in many developed countries across the time span of 1999 to 2009 between the present studies. Nursing has changed from being a vocational profession to a university-based diploma or undergraduate degree course. Tasks that were once the preserve of doctors, such as cannulation and administration of intravenous drugs, are now routinely done by nurses.

Older people’s perceptions of good care were determined by the positive attitudes of staff, not the actual treatment of their condition.
The role of the healthcare assistant (HCA) in hospitals and care homes, once generally called an auxiliary, has also evolved to include the monitoring skills of taking temperature, pulse and blood pressure, in addition to offering personal care. These fundamental tasks, once called 'basic care', have been relabelled as 'essential care', no less because they provide vital information from which nurses can assess appropriate intervention and care planning. Yet, in hospitals (Francis 2013) and community care homes (Wild et al 2010), education for this support role in health care is still limited and its quality variable. Thus, the importance of clinical information may not be fully appreciated and could impede timely intervention.

This can compromise a proactive approach that aims to prevent ill health and maintain good health by providing timely and appropriate treatment for older patients. The lack of training for HCAs and the lack of nurses' personal involvement in patient care can demoralise staff and lead to a poor caring ethic and a feeling of failure: these factors may contribute to problems with recruiting staff into the care home sector (Cornwell 2012).

Several authors contend that education can influence attitudes by improving knowledge and challenging beliefs (Edelmann 2000, Mellor et al 2007). Attitudes towards a specialty can influence career choice (Happell and Brooker 2001, Marsland and Hickey 2003, Rognstad et al 2004, Aud et al 2006, Alabaster 2007) and affect the quality of care provided (Gallagher et al 2006, Ellis et al 2011). It is not only classroom education that is important for nursing students, but also clinical placements, post-registration education (Aoki and Davies 2002) and exposure to best practice (Kydd 2002).

There is evidence that good practice in gerontological education can positively influence the attitudes of nursing students towards the specialism; examples include teaching gerontology as part of the nursing curriculum (Jansen and Morse 2004), developing specialist nurses in gerontology (Reed et al 2007), and training and practice to promote the development of competent and caring gerontology practitioners (Cornwell 2012).

Working environment The working environment is seldom viewed as a contributory factor affecting the attitude of healthcare professionals to gerontological care. Attitudinal scales tend to exclude the working environment (Dickens et al 2005). However, early work by Pursey and Luker (1995) found that negative attitudes towards working with older people centred on an unwillingness to work in an environment where the work is routine, busy and demoralising.

Similarly, Keighley (1997) suggested development opportunities and a working environment that supports, encourages and values the work being done is required to attract staff into a career in gerontology.

Care of older people is often referred to as a ‘Cinderella’ service because of resource discrimination, which has led to impoverishment of older people’s care environments (Nolan et al 2002). Cornwell (2012) reported that care home staff were often poorly paid and worked in understaffed conditions. In addition to the impoverished environment, the nature of working with older people is seen as ‘basic’, with the implication that no knowledge or skill is required (Firth-Cozens and Cornwell 2009).

Professional esteem Long-term care nursing is plagued by a negative image from in and outside the profession. Several authors have noted a paucity of research into what constitutes a specialist nurse in gerontology, which has hindered the profile of professionals working with older people (Wade 1999, Reed et al 2007). In a study of nursing students, Henderson et al (2008) found that the reasons given for a lack of interest in working with older people included: poor experiences of providing care for older people; an inability to relate to or communicate with older people; and a perception that the work is depressing and boring.

Negative stereotyping of working with older people is highlighted by Cornwell (2012), who states that caring for older people does not have a high social status and is not generally considered an attractive option for healthcare professionals.

Specialist status Given that many frail older people with severe dementia and those with increasingly complex needs are in care homes, there is a need to promote specialist staff in this area. A recent report by the National Longevity Centre–UK (Mason 2012) concluded that care homes are struggling to employ nursing and care staff and more effort is needed to promote a career in care home nursing.

Strategic policy documents acknowledge that age-related changes in health status require specialist knowledge to enable older adults to reach their full potential (Department of Health 2001, 2006, Scottish Executive 2007, Welsh Assembly
Government 2008) and has been reiterated by other authors (Wild et al 2012). Such enablement requires practitioners who know what an individual is capable of to help them retain their strengths and abilities, rather than disable them further by performing tasks for them, that with time and encouragement, they could do themselves.

Aim
The aim of the 1999 study and its replication in 2009 was to investigate the attitudes of healthcare professionals towards working with older people, including their perception of how other professionals perceived their work in gerontology.

Method
Influences and adaptation A thematic approach was adopted to explore staff attitudes and the perceived attitudes of others about working with older people. The five themes, although not mutually exclusive, formed an important part of the framework within which the attitudes of those responsible for the quality of care provided to older people and their concepts of professional esteem could be investigated.

This article describes the design of a 20-item questionnaire (Box 1) – the MAQ – that was used in two studies in Scotland, the original study in 1999 and a replication study in 2009. The literature review was updated to reflect changes in policy as well as adding relevant research findings from other studies on attitudes towards working with older people. The 2009 study was the forerunner to an international study, which was undertaken over a two-year period. The results of this international study are still undergoing analysis and are not presented in this article.

Questionnaire review Minor amendments were made to the MAQ used in the 1999 study for use in the 2009 study (Box 1). For example, the word ‘elderly’ was changed to ‘older people’. The overall meaning of the items (given as statements) remained unchanged. The format of the five-point ordinal Likert responses to each item was consistent so that comparisons could be made between studies.

The five-point Likert values were: 1 = strongly agree; 2 = agree; 3 = unsure; 4 = disagree; 5 = strongly disagree. The ‘unsure’ response was added, as advocated by Courtenay and Weidemann (1985), to increase accuracy by permitting respondents to recognise their lack of knowledge (Palmore 1998). The data collected included respondents’ profession, whether they were working with older people, and if so, how long they had worked in the area, their job title and grade, and their place of work.

The use of psychometric tests to measure attitudes towards older people was considered. However, the Attitudes to Older People Scale by Kogan (1961) was thought to be outdated and a new validated instrument to measure medical students’ attitudes to older people, the Carolina Options on Care of Older Adults, was not available.

Box 1 The Multifactorial Attitudes Questionnaire, a 20-item questionnaire designed to determine attitudes towards the care of older people

<table>
<thead>
<tr>
<th>Ageism</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Older people should have access, if appropriate, to medical and surgical procedures regardless of their age.</td>
</tr>
<tr>
<td>2. On the whole, communicating with older people can be very frustrating.</td>
</tr>
<tr>
<td>3. The thought of being old worries me.</td>
</tr>
<tr>
<td>4. As older people become increasingly old they become more irritable, touchy and unpleasant.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Working with older people can be very depressing.</td>
</tr>
<tr>
<td>6. Care of older people should be taught by specialists.</td>
</tr>
<tr>
<td>7. Working in care of older people could be described as both challenging and stimulating.</td>
</tr>
<tr>
<td>8. Care of older people as a specialist subject should be given more curriculum time in the training of healthcare professionals.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Working environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. In general, working conditions in care of older people are not conducive to recruiting and retaining staff.</td>
</tr>
<tr>
<td>10. I feel that older people are cared for in inadequate and depressing settings.</td>
</tr>
<tr>
<td>11. If care of older people wards had better resources it would be easier to attract staff.</td>
</tr>
<tr>
<td>12. There are too many routine tasks in care of older people.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional esteem</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. People working in care of older people are deemed to have a lower professional status than those who work in high technology areas.</td>
</tr>
<tr>
<td>14. On the whole, there is a lack of career advancement in care of the older person.</td>
</tr>
<tr>
<td>15. I feel the less experienced and most out-of-date doctors and nurses seem to work in care of older people.</td>
</tr>
<tr>
<td>16. I have chosen to/would consider a career in geriatric medicine/nursing.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist status</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. A qualified nurse/doctor does not need to have specialist training to deliver excellent care for older people.</td>
</tr>
<tr>
<td>18. On the whole, people who work in care of the older person are enthusiastic about their work.</td>
</tr>
<tr>
<td>19. Working with older people is more demoralising than working in high technology areas.</td>
</tr>
<tr>
<td>20. Other healthcare professionals do not seem to appreciate that care of the older person is a highly skilled specialty.</td>
</tr>
</tbody>
</table>

(Kydd et al 1999)
at the time of the study (Hollar et al. 2011). The words ‘older people’ and ‘old’ have been used to identify the target population. However, there is a wide diversity of possible interpretation of these words. This is more than a question of semantics, it is the identification of meaning that can be subscribed to by anyone responding to an attitudinal questionnaire on older people.

**Distribution of the questionnaire** In the first study in 1999, 800 questionnaires were distributed by post and hand to health and social care facilities in the west of Scotland and of these, 376 (47 per cent) were returned. Of those who responded, 204 (54 per cent) were nurses, 117 (31 per cent) were HCA, 11 (3 per cent) were nursing students, and 35 (9 per cent) were AHPs. The remaining nine respondents comprised six (2 per cent) in other roles and three (1 per cent) who did not identify their roles. In the 2009 study, there were 546 respondents. However, on this occasion the questionnaires were sent via email to multiple email addresses, some of which were also forwarded on request to other addresses, in addition to post and hand delivery. This email distribution made it impossible either to calculate the response rate or calculate if the larger number of respondents to the second study represented a percentage increase in the return rate. Of the 546 respondents, 169 (31 per cent) were nurses, 140 (26 per cent) were HCA, 154 (28 per cent) were nursing students, 29 (5 per cent) were AHPs and 52 (10 per cent) were classified as others. Two respondents (0.4 per cent) did not identify their roles.

**Ethical considerations** After informal consultation with the University of the West of Scotland ethics committee, formal approvals were not required. As participation in the study was voluntary and anonymous, and by staff and not patients, there was no potentially harmful intervention, and the questionnaire’s content was not regarded as sensitive.

---

**References**


Study limitations The use of questionnaires does have limitations, which have been described by Oppenheim (1992) as:

- Restriction of the amount and quality of data that can be obtained.
- Inability of the researcher to influence completion and return of questionnaires.
- Variability between respondents in their comprehension of questions.
- Format for responses.
- Fatigue, boredom and consequential inaccuracy if the questionnaire is too long.

In light of these limitations, the results may not be generalisable to the wider population. The absence of research funding for these studies restricted the choice of method and materials to those of best fit for the purpose in available resources.

Conclusion

The literature review highlighted some important issues that are relevant to researching the attitudes of healthcare professionals to the care of older people. The literature search proved particularly informative, and the initial study, in 1999, generated interest and commitment from other researchers in the field.

One important issue, which was not explored, however, is the need to define ‘old age’. In future studies using the MAQ, the addition of a question addressing what respondents would classify as ‘old’, in conjunction with what attributes they associate with the definition, could prove meaningful.

The organisational culture of care, working conditions and their related opportunities and threats are important issues that should be addressed through further research if students are to be inspired to pursue a career in gerontology. Interest in, and contribution to, the studies from staff in gerontology is indicative of a wider academic and professional interest.

This interest is timely, given that the care of older people is hampered by the problem of resources keeping pace with demand.


