

EVALUATION OF A TEACHING PROGRAM
FOR
NURSING STAFF IN GERIATRIC CARE FACILITIES

by

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EVALUATION OF A TEACHING PROGRAM
FOR
NURSING STAFF IN GERIATRIC CARE FACILITIES
WHICH USES EXPERIENTIAL LEARNING AND A GROUP DYNAMICS APPROACH

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AGE - v.t. & i. (part. -ING or AGING
(Cause or allow to) grow old or mature
or show effects of passage of time:
begin to appear older

THE CONCISE OXFORD DICTIONARY
OF CURRENT ENGLISH - 6th Ed.

EVALUATION OF A TEACHING PROGRAM
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WHICH USES ENCOUNTER SESSIONS AND A GROUP DYNAMICS APPROACH

The Purpose of the Study

Awareness of the basic concerns of institutional living for the elderly is essential for the caregiver. Most institutions (Personal Care Homes, Long Term Care facilities) which house a majority of our sick elderly are staffed by untrained personnel who have had little or no formal training in Gerontology. Neither the financial means nor the teaching programs are available to practising staff or their employers to learn the skills required to provide the therapeutic environment reported in the literature as necessary for the mental health of the geriatric patient.

The author has developed a series of encounter sessions for nursing home personnel that are intended to promote greater sensitivity for the basic needs of the institutionalized elderly. This full day workshop can be used for all levels of nursing home staff and depends upon the participant exploring the source of his own attitudes about ageing, his current values and lifestyle and the effect of his ageing process on the eventual outcome of his life. The objective of the workshop is to develop more positive attitudes in the participants toward their patients.

Initial evaluations which have been collected through written, anecdotal reports indicate that the process is effective, at least in the short

term (See Appendix III). It is the author's intention to formally evaluate the process in three stages. First, a theoretical framework will be established which will provide measurable items which will indicate whether participants in the workshop experienced change as a result of the material and the method of presentation. Evaluation tools will be selected or developed to provide these measurements. Secondly, a pilot project will be described in which the evaluation tools will be validated. This project will be referred to as the Lions Gate Study. Thirdly, the evaluation will be applied under more controlled circumstances using the validated instruments and the outcome of that study will be described. This project will be referred to as the Fairfield Study.

The author will begin by describing the problem of institutionalization for the elderly and will explain some of the difficulties encountered in providing adequately trained staff. The workshop sessions will be described in detail with the objectives and the rationale for each exercise explained. The method for evaluating the workshop will be detailed and the outcome of the study discussed with special concern for the value of such encounter sessions on the long term effect on attitude of the participants.

SOME FACTS ABOUT AGEING IN CANADA

"The kind of life older people in our society can live is the kind of life we will live. For this reason alone, aging ought to be of concern to us all".

Victor W. Marshall - 1980

The past seventy-five years has produced substantial increases in the relative size of the ageing population in Canada and it is projected that this increase will continue and be especially pronounced in the first few decades of the next century. Although the crisis situation predicted by some experts is not anticipated there is a projected decrease in the relative size of the youth population which will coincide with an increase in the relative size of the elderly component. (Denton & Spencer, 1980)

Table I summarizes some projected population figures which will inevitably involve us all. These figures have obvious implications for public and private pension funds and their ability to meet future obligations for a growing elderly population whose support from the labor force has been reduced. The greatest impact however will be on health care services and the size of future health budgets. As people age they need more medical services and health care supports and since most of these are now subsidized by the provincial and federal governments, we can expect to see major increases in the cost of health care premiums in the next few decades. (Marshall, 1980)

There is another concern demonstrated by these projections and that is the dilemma facing older women. Even today women over the age of 65 outnumber men and the gap widens with the advancement of age. By the time women are 80, they will outnumber men almost two to one. Elderly women in Canada are very likely to be poor. (Ross, 1975) (Delude, 1978, p.38) Most elderly women have never worked and have depended upon a spouse to provide for them. But pensions with no survivor benefits

*PROJECTIONS OF POPULATION IN CANADA BY SEX & AGE 1981-2021

SEX	1981		1991		2001		2021	
	Thousands	% of Pop.	Thousands	% of Pop.	Thousands	% of Pop.	Thousands	% of Pop.
MALES								
0 - 19	4,087	16.6	4,389	15.6	4,701	15.2	4,986	13.8
20 - 64	7,126	29.0	8,290	29.5	9,151	29.6	10,490	29.0
65 - 69	380	1.5	453	1.6	470	1.5	837	2.3
70 - 74	274	1.1	320	1.1	378	1.2	612	1.7
75 - 79	176	0.7	226	0.8	271	0.9	366	1.0
80+	154	0.6	207	0.7	260	0.8	338	0.9
FEMALES								
0 - 19	3,891	15.8	9,160	19.8	4,450	14.3	4,715	13.0
20 - 64	7,146	29.1	8,249	29.4	9,102	29.4	10,386	28.7
65 - 69	445	1.8	568	2.0	568	1.8	1,045	2.9
70 - 74	349	1.4	450	1.6	526	1.7	875	2.4
75 - 79	249	1.0	357	1.3	466	1.5	624	1.7
80+	284	1.2	430	1.5	624	2.0	888	2.5
TOTAL	24,561	100.0	28,099	100.0	30,966	100.0	36,162	100.0

*Denton, Frank T., Spencer, G. "Canada's Population & Labour Force Past, Present and Future" Aging In Canada, Fitzhenry & Whiteside Ltd. p. 14 - 1980

TABLE I

PREVALENCE OF WIDOWS AND WIDOWERS, 65 YEARS AND OVER, CANADA

	1961	1971	Percentage Change 1961 - 1971
WIDOWERS	137,277	130,235	-9.5
WIDOWS	346,903	475,635	+37.1

Reported in the 1971 Census of Canada - No. 99-725 - Table 26

TABLE II

leaves one-third of Canadian widows with no personal income except for their old-age security. Some women, widowed before the age of 64 have no income at all. (Dulude, 1978, p.40) The rate at which women are widowed is rapidly increasing while the proportion of men widowed is declining so that in 1971, for all ages, widows outnumbered widowers by nearly four to one in Canada and that gap had widened to five to one a decade later. (Mathews, 1983) (Table II illustrates this phenomenon) Factors which influence *this difference* are related to life expectancy and the social norm of women marrying men older than themselves. From 1961 to 1971, the life expectancy of men increased by one year from 68.4 years to 69.4 years. In the same period the life expectancy of women increased by 2.3 years from 74.2 years to 76.5 years. The years that a widow can expect to live alone has increased with these changes. Half of the women widowed at age 65 will live for fifteen or more years and one-third can expect twenty more years. (Riley & Foner, 1968) The lives of these women can be drastically different in those later years as they face the world alone.

AGEING AND ILLNESS

Not all old people are sick. Those who have studied ageing have come to refer to the 'young' elderly and the 'old' elderly. Usually, the distinction is made between those who are under 75 years of age and those who are over the age of 75 although the distinction may vary from study to study. (Havighurst, 1968; Freiderian, 1974) In the Manitoba studies on Ageing, Havens questioned the designated age for categorizing the

elderly according to a needs assessment completed in that province in 1971. Analysing the data to differentiate unmet needs by age/sex cohort, Havens found the appropriate age designation for females to be under or over 85 and for males under or over 80. (Havens, 1971) She questions the use of such age distinctions in measuring the needs of the elderly and suggests a more useful designation is 'young' elderly, 'middle' elderly and 'old' elderly - 'young' being from 65-79 years, 'middle' from 80-94 years, and 'old' from age 95. These findings are consistent with other studies (Schrieber, 1972; and Powers, 1972) and indicate that there are many 'young' elderly who are living healthy, active lives. Debility and dependency becomes more prevalent with advanced age but some of our elderly citizens in Canada are living to 'old' age with surprisingly few needs for support.

AGEING AND INSTITUTIONALIZATION

Much work has been done in Canada in recent years to determine who lives in nursing homes. Compared with Britain and the United States, we have a poor record at maintaining our elderly at home. Extremes in climate, the geography of the country and distance between rural dwellings and much needed support services and the mobility of our population all contribute to making life very difficult for the dependent elderly citizen. In a Canadian study of bed use in institutions in Canada in 1976, it is reported that on any given day of that year, 5.8 percent of the population of Canada over 65 were housed in some special care facility. A further 2.3 percent of the population over 65 were hospitalized while 0.4 percent

were housed in mental health facilities. This means that a total of 8.4 percent of the aged population, 65 and over, were ill or dependent. At the same time in Great Britain, only 5.1 percent of their population 65 and over were housed in institutional care and, more comparitively, in the U.S., 6.3 percent of their elderly population were in institutions. (Schwenger/Gross, 1980) (This information excludes institutional facilities in the Yukon and the Northwest Territories and special care facilities in Quebec.) When the information is further broken down, Alberta holds first place with a rate of 9.4 percent (a figure which excludes more than 4000 residents in Alberta's 'lodges' which are described as semi-institutional). Next is Manitoba with 9.1 percent and Ontario with 8.9 percent. In British Columbia, a province which might be designated as Canada's retirement center, only 6.9 percent of the population over 65 are institutionalized. (See Table III for comparisons)

There are several studies which provide reasons for this increasing rate of institutional usage in Canada. This country has proportionately more persons over 65 than in the past but the numbers of 'old' old (85+) and the 'middle' old (75-84) have increased at a greater rate. (Auerbach and Gerber, 1976).

The 'middle' to 'old' age group require more institutional care. In Ontario alone, for example, over one-third of the population 85 years and over were in an institution setting on any given day in 1976. (Schwenger, 1977). This group continues to expand at a faster rate than the rest of the population in Ontario. (Denton & Spencer)

The implication of these figures for health service planning agencies

NUMBER & PERCENTAGE OF AGED PERSONS IN VARIOUS TYPES OF INSTITUTIONS
 AT ANY GIVEN TIME - CANADA & THE PROVINCES

PROVINCE	POPULATION THAT ARE 65 & OVER	% THAT ARE HOSPITALIZED	% IN SPECIAL CARE FACILITIES	% IN MENTAL HEALTH FACILITIES	TOTAL
NEWFOUNDLAND	36,535	1.4	4.1	0.1	5.6
PRINCE EDWARD ISLAND	13,245	1.5	6.4	0.1	7.9
NOVA SCOTIA	80,730	1.6	5.2	0.3	7.1
NEW BRUNSWICK	61,080	1.9	5.1	0.3	7.4
QUEBEC *	481,360	2.4	-	0.7	-
ONTARIO	738,290	2.2	6.5	0.2	8.9
MANITOBA	106,560	2.2	6.5	0.4	9.1
SASKATCHEWAN	102,175	2.2	6.3	0.2	8.7
ALBERTA	137,925	3.4	5.3	0.7	9.4
BRITISH COLUMBIA	242,055	2.1	4.2	0.6	6.9
CANADA	2,000,585	2.3**	5.8	0.4**	8.4

*No data available on Quebec Special Care Facilities

**National rates for Hospitals and Mental Health Facilities are based on Canadian population 65+ exclusive of Yukon and the North West Territories

SOURCE -GROSS & SCHWENGER 1980

TABLE III

AUTHOR'S NOTE - THE SMALL PERCENTAGE OF ELDERLY HOUSED IN MENTAL HEALTH FACILITIES COMPARED WITH THE NUMBER OF MENTALLY IMPAIRED ELDERLY IN NURSING HOMES IS INDICATIVE OF THE LIMITED ACCESS TO MENTAL HEALTH SERVICES FOR THE ELDERLY.

is obvious. The problem will continue to grow and the nursing home is going to continue to be an important part of the answer to the problem. There are many who would consider alternatives such as more home care services, day hospital and day care programs and a myriad of support services designed to maintain people at home. (Schwenger, 1974) The fact remains however that these services are costly and do not provide 24-hour supervision and support for an individual who can no longer get out of bed and to the bathroom alone.

An interesting thesis that supports the bureaucratic development of 'placement' services and the nursing home system is provided by John Myles (1980). He explores the historical sociological development of the nursing home through the workhouse, the move to social welfare and finally the 'medicalization' of the institution. He suggests that an alternative to the nursing home dilemma and the concern for 'quality of care' is to close them all down. The result obviously would not produce an improvement in 'quality of care'. He states that "Within this perspective, it is not meaningful to talk of 'good' nursing homes or 'bad' nursing homes; it is not 'quality of care' which is at issue but rather the nature of institutional life as such". (P.267) He suggests turning our attention away from blanket condemnations of these institutions and working towards eliminating the abuses which exist within these systems.

SUMMARY:

Since the system of institutionalization of our dependent elderly appears to be here to stay then we should be looking at means of making our nursing homes and nursing home personnel more responsive to residents'

needs. Demographic predictions tell us that nursing home usage will probably increase in the next few decades and that we are more likely to see residents who fall into the category of 'middle' old (80-94) and 'old' old (95+) with women outnumbering the men two to one.

GERONTOLOGICAL NURSING - THE STATE OF THE ART

Nursing homes have naturally evolved as medical facilities because the residents in them are coping with physical problems related to their medical illness and require assistance with activities usually associated with nursing care. The concern for the residential environment does not necessarily stem from the delivery of medical care however. The resident's concerns are much more involved with the manner in which that care is given or the approach used by nursing staff. (Kastenbaum, 1981)

It is necessary then, at this point, to define gerontological nursing and to consider exactly what components of that definition will be addressed in this thesis. In a study of ethical issues in relation to research in gerontology, Hirschfeld (1979) defines Nursing Gerontology as the scientific study of nursing care of the elderly as individuals, as members of families and of population groups. It is concerned with the interrelationship of physical, psychological, socioeconomic, cultural, environmental and spiritual factors as they affect the aged in health and illness. This thesis will focus on the psychological and environmental issues facing that population of elderly persons living in nursing homes in Canada.

Obviously these elements will be affected by physical, socioeconomic, cultural and spiritual factors since all are interrelated. However, it is the author's contention that if emphasis was placed upon the psychological needs of patients in a supportive environment, then those other interrelated problems would be more readily resolved.

In the same paper, Hirschfeld goes on to discuss various ethical dimensions in gerontological research. She addresses three issues and their interdependence and application in practice. The first, respect for person, demands that we identify the uniqueness of each individual. She suggests that, in a stronger sense, it calls for the enhancement of his autonomy and encouragement of his projects and purposes. The second factor she addresses is knowledge base. She states:

"The principle of respect for persons not only demands research relevant to the needs of the aged, but also relevant to the needs of those who work with those aged who fit the stereotype of ageing as physical and mental decline. In many countries this physically and emotionally difficult work is done by socially disadvantaged and poorly paid women.

(Hirschfeld, 1979)

Hirschfeld says that if we accept the principle of respect for persons, then we must develop the knowledge base that will assist us to help the elderly make the best decisions for themselves. She points out that the knowledge base for clinical decision making and provision of service does not exist or is rarely utilized and there is no theoretical framework for research or practice.

The third factor Hirschfeld discusses is the process of rethinking ethical

issues. She states that nurses are becoming more involved in social policy decisions and must be prepared to offer substantial research to support their decisions. It is true that in gerontology as in other areas of practice, nurses do have experience in what works and does not work with specific problems related to ageing. They must be prepared to make recommendations and offer alternatives if they want to see the systems change. These three principles appear to be noble concerns for the state of the discipline of nursing. Exploring them in practice provides a much more sobering picture.

Although the Canadian Nursing Association has not yet developed standards of Gerontological Nursing Practice, their neighbours in the United States completed such documentation in 1976*. Gerontological nursing is described in this document as being 'concerned with the assessment of the health needs of older adults, planning and implementing health care to meet these needs and evaluating the effectiveness of such care. This medically oriented approach reflects the way that most nurses are taught to operate within their nursing specialty and Canadian nurses are no exception. The nursing model of practice or nursing process**, as it is called, directs the nurse to confine

*STANDARDS OF GERONTOLOGICAL NURSING PRACTICE
AMERICAN NURSES ASSOCIATION 1976 (2420 Pershing Road, Kansas City, Miss.)
64108

**Nursing Process is the model of practice adopted by the Nursing Division of the World Health Organization and approved for use around the world. Nursing Process involves Assessment, Planning, Implementation and Evaluation for patient care problems.

her energy to identifying problems, formulating plans of action which are goal-oriented and evaluating their eventual outcome. Without the conceptual framework discussed by Hirschfeld, nursing cannot respond to individual psychosocial needs that have not resulted in some overt, pathological behavior. Even when the behavior is identified, it is more likely that the nursing care plan will respond to the behavior rather than attempt to determine the cause.

To further this argument about nursing adopting a task-oriented approach to patient care, it is necessary to understand the framework within which nurses do operate in long term care facilities. The assignment of nursing personnel to a given population of patients depends upon an instrument called a workload tool. Over the past ten years several of these tools have surfaced as credible measurements of staffing requirements in acute care facilities. (GRASP, MEDICUS, PRN. See bibliography of references)

The workload tool identifies a multitude of critical nursing skills that a given patient might need in a 24 hour period and these are listed on a workload indicator. The nurse or her administrator, completes an indicator for each patient and submits it to the staffing officer who feeds the information into a computerized staffing system. The result is an objective assignment of nursing personnel depending upon patient acuity. Obviously, areas with high levels of acuity will receive greater numbers of staff and the staff for those areas will be more qualified to meet the needs of those patients. Areas where acuity is low will receive lower patient/staff ratios and staff will be less

qualified to provide care. Bathing, toileting and feeding are obviously very low on the list of acute care needs and these assignments are made to aides and orderlies or licensed practical nurses.

These workload tools have since been adapted for use in long term care facilities. The principle is the same and although some efforts have been made to modify the indicators and weigh the items which are more significant for geriatric care, the focus on a medically-oriented model and the socializing of nurses in the system to consider critical needs as being of the dramatic, life-saving variety has taken its' toll. For example, in British Columbia, the most frequently used workload tool is the G.R.A.S.P. system*. Extended care facilities have taken the indicators from this system and expanded only the communication indicators to allow staff to spend more time directing activities of daily living and explaining procedures and reassuring patients. No attempt has been made to develop special aspects of care which encourage nurses to use skills developed specifically to meet the needs of the elderly. On one hand, nurses are presented with opportunities to attend workshops designed to develop communication skills related to reminiscing and spending time with elderly patients, but in practice they find the system does not support that time or even offer credibility for their new skills. The indicators are specifically defined to assure consistency in reporting and there is little room to re-interpret the intention of the identified items. (See Appendix I for

*See bibliography for reference.

workload indicators and definitions from the GRASP system.)

What we see then is nurses practising within a framework that is designed to produce efficient, essential, task-oriented, physical care. Concern for the identity of the individual has been abandoned in favor of dividing him piecemeal into required nursing procedures. Even in acute care hospitals, this process of task-oriented care has been recognized with some concern by nursing and attempts have been made to approach the problem with such nursing models as primary care*. The nursing home, however, cannot afford the luxury of such assignments. One nurse might be responsible for the overall wellbeing of some forty residents while the direct, hands-on nursing care is left to licensed practical nurses, or, most likely, nursing assistants and orderlies.

Nursing aides and orderlies do fall under the jurisdiction of nursing personnel. Their performance necessarily reflects the direction of those registered nurses supervising the over-all care and the physical environment of the institution or ward. Some nursing supervisors expect rigidly structured routines and place an emphasis on neatness and cleanliness of the facility and one has the sense that the patient is

*Primary Care is the method of assigning one nurse to a patient as the primary care giver responsible for the daily care and any changes in the nursing care plan. All other nurses providing care in a 24-hour period are expected to report and consult with the primary nurse about problems affecting her patient.

a nuisance in the order of things. Such environments demand conformity of the patients to rules and regulations and offer little opportunity for individuality. Other units are administered by sensitive, caring supervisors who allow personal interpretation of daily routine by patients and staff. The relationships between residents in various institutions that reflect these values is discussed by Bowker (1982) in a study comparing a variety of nursing homes in the United States operating under different models of care. The most successful model is described as one in which the medical needs of the residents are balanced off against their humanistic needs. This is reflected in the attitudes of the administration and the actions of staff members. Bowker reports that high levels of medical services are delivered in this facility without having the medical model dominate institutional life.

While comparisons can be made with institutional care in the United States, there is little value in researching the development of Gerontological nursing outside the North American experience. Socio-economic, cultural, environment and even spiritual considerations vary from country to country affecting the attitude of the elderly client and the caregiver in the institutional setting.

SUMMARY:

Gerontological nursing as a specialty supports the philosophy of provision of care for the patient based on individual needs and the interrelationship of physical, psychological, socio-economic, cultural, environmental and spiritual factors. Nursing, however, is caught in

a system in which the medical model dominates the provision of care and service is based primarily on physical needs. All of the supportive mechanisms in the system give credibility to procedural tasks and there is little supportive framework for nurses to model their own approach to less tangible needs. Meanwhile, research suggests that, in nursing homes, response to physical needs must be balanced with more humanistic approaches to care. This would involve focusing the attention of the caregivers away from physical needs and on to psychosocial supports.

THE DILEMMA OF BEING OLD AND DISABLED

"I don't feel any differently than I did when I was younger. I thought I would be different when I got old, but I'm not. I just feel trapped in this old body and it makes me angry".

80-year old retired teacher
Day Hospital, Victoria B.C. 1983

This woman expressed so well the feelings of many elderly people in today's society. Trapped in a biologically changed form, often treated like someone with limited intelligence and unable to express this frustration over demands for information about her physical health, she was verbalizing her need to be challenged mentally, to be given the opportunity to make decisions and to have herself, as a person, acknowledged for the contribution she could still make in today's society. The dilemma of our seniors who find themselves physically dependent on others for care is a growing concern. The health care system, oriented to medical crisis has overlooked the psychosocial needs of these elderly

clients who, once diagnosed, must live in a medically oriented institutional setting. Personal care homes, nursing homes and other long term care facilities are filled with disabled, old people who have received the assignment of a diagnosis and the resulting commitment to an institution where personal space, privacy, choice and identity are forgotten luxuries of youth.

Some patients who have the strength and inner resources, adapt to the new environment and can advocate for themselves in the system. For others, it is an assignment to a living hell. Those fragile souls who have already suffered multiple losses of friends, siblings, spouse, health and home and who have depleted those resources, are overwhelmed by the communal experience of institutional living. They cry out for help but their cries are misinterpreted, misunderstood or not heard at all by an untrained staff, overburdened by the physical needs of the patients in their care. Young people faced with the burden of such loss would have access to a multitude of psychosocial services. However, for the aged, the label of dementia and senility is easily applied to the mentally distraught and emotionally depleted. Even established psychologists have been unable to acknowledge or identify the psychosocial needs of elderly patients. Freud and Rogers both developed theories of psychotherapy based on child/parent relationships which have little content applicable to geriatrics. Erikson and Jung concentrated on developmental tasks and ignored completely the environmental differences that predispose older people to psychopathology. Lewin, White, Fromm and Maslow do describe the crises of ageing in environmental terms and

offer perspectives on how such crises lead to psychopathological thought and behavior while Adler offers the most comprehensive explanation of the role of bodily changes, attitude and will in addition to reactions to the environment. (Brink, 1979). None of these great men offer therapeutic techniques for meeting these needs and identification of the pathology of behavior of an elderly resident is no solution to the caregiver dealing with the problem. In fact, the caregiver in today's institution is neither likely to recognize these great names or identify their particular theories for practice.

Staffing for most institutions is based upon predetermined factors which are identified by the government agencies responsible for paying for the service. Patients are classified according to the needs designated by the number of physical tasks they require to be done for them and the complexity of those tasks. The number of nursing hours required for each patient each day is then computed. Workload tools, designed to measure staffing needs, were first introduced to control staffing in acute care facilities where the performance of medical tasks or procedures was critical for the maintenance of human life. The more critical the care required, the more qualified was the staff assigned to perform that function. Basic nursing requirements such as bathing, toileting and feeding were left to less skilled personnel. The application of such workload tools in a long-term care facility, where critical nursing activities are minimal, results in nursing homes being staffed by the less skilled nursing personnel. Those individuals are trained to respond to the physical care required but are quite unable to cope with the

psychosocial needs associated with change and loss.

Meanwhile, the registered nurse must confine herself to the administration of medications and the occasional dressing or treatment and so has little opportunity to test her skills and feel challenged in the traditional nursing sense. (Gillis, 1973) There is little prestige offered by a position in geriatric nursing and until recent years when Gerontology gained some attention as the last frontier in medicine, there have been few rewards in nursing for wanting to care for the elderly. The fact is, nursing homes are perceived by nurses as a safe working place for the insecure or the nurse who has allowed her practical skills to deteriorate. (Delora & Moses, 1969) There are few opportunities for her to replace those skills with others more likely to assist her in meeting the needs of her elderly patients. The turnover rate of staff in such institutions is estimated to be 60 percent according to United States' statistics from the Department of Health and Welfare. At the same time, new graduate nurses avoid working with the elderly for all of these reasons (Gunter, 1971) and so new techniques for dealing with issues in geriatric nursing are not put into practical use in the system.

Meanwhile, the number of institutionalized elderly is growing year by year and most facilities have waiting lists, some of up to two or three years in length. Acute hospital beds are 'blocked' by elderly patients awaiting 'placement' as patients are 'wait-listed' for emergency beds in the first available long term care facility that has a space. In other instances, individuals who have lived for years in one facility which cares for clients requiring minimal care and whose needs are too

excessive now for that facility, might be rooted up overnight and 're-placed' in a more appropriate institution when their names reach the top of 'the list'. The process of providing for institutionalized patient care is insensitive and inhuman and yet the fiscal realities of changing the system, especially in today's depressed economic climate, are obvious.

Trapped in this system, the patient waits for someone to acknowledge his losses, to provide him with the dignity and respect that the gerontologists would aspire to, to ask him if he would like to make some choices about his life and to recognize who he is and where he came from and what positive attributes he has to offer in his new environment. Nursing personnel as primary caregivers are in a position to respond to those needs and to create a more sensitive environment that is therapeutic for the patient. To do this, however, nurses must come to grips with their own ageing. They must recognize the negative attitudes they have toward their patients and they must be prepared to acknowledge those basic needs as having the same value as the physical care that they are required to provide.

PSYCHOSOCIAL NEEDS OF THE ELDERLY RESIDENT

The elderly nursing home resident can be assumed to have undergone some physical loss associated with deteriorating health. This debility has left him/her with an altered lifestyle because of the resulting dependency and generally produces a loss of self-esteem and often of identity with a role that he can no longer fulfill. The loss of health

might be a final blow as the most recent in a series of losses which have occurred one after another. Admission to a nursing home is reported in one study to result often in premature death and the patient submits to the final loss of independent living. (Ferrari, 1962)

Consider, for example, the plight of the widow. Death of her husband has left a void more painful than that recalled by the empty space at the table. Loss of role as a wife and loss of self-esteem is often reported by the new widow. (Blau, 1961:Evans, 1971) There are financial losses too and the reduction of income results in the need to sell the home and move to a more modest, and less spacious dwelling. Furniture that she has cared for over the years is divided and sold because it will not fit the new space. Pets must go if the move is to an apartment. Finally, removal from the old neighbourhood and community friends and supports, to a new location ends a bitter chain of events that leave the widow depressed and often angry at the turn of events and at her husband for abandoning her when she needed him most. (Caine 1974:Wylie 1977)

Stressful life events and poor health status are positively related in later years (Wan, 1982). Reduced health and crises resulting in subsequent dependency often produces withdrawal and apathy and the widow accepts the inevitable insult of institutional life and succumbs to its' depersonalization. (Dye, 1979)

Most institutionalized elderly are dealing with grief and loss of siblings and friends. Their world with all the supports that were there for them is deteriorating and the process is frightening and painful.

Often, because of their disabled condition, they are protected by well-meaning family from news of death only to discover at some later date that someone they deeply cared for is gone and so they are left to mourn alone.

ADMISSION TO AN INSTITUTION

Admission to an institution can place the patient into a state of total shock. Giving up one's home and private living space and entering a facility where communal living, shared living space and constant interruption from staff is the norm is overwhelming for the patient. Much work has been done on the total institution and its' effect on the individual (Goffman, 1961). The role of patients in the hospital or nursing home is described as parallel to that of an inmate in prison where the general milieu is one of reinforcing patient failures instead of successes (Ford, Liske and Ort, 1962). In a follow-up study of Goffman's work, admission to an institution is described as being accompanied by a series of procedures that transfer the individual's power over his own life to the institutional staff (Brady, 1973). Power in the institution becomes an issue as the patient succumbs more and more to the regulations imposed by personnel charged with his care.

Overwhelmed by this series of events, disabled and often suffering from some sensory deficits that make interpretation of the environment difficult, the patient arrives in the institution to be admitted and catalogued by nursing into a list of required daily tasks and procedures. The nurse is concerned with the business of completing forms and carrying out her responsibilities to the physician and administration. There is little

opportunity for acknowledgement of the personal grief experienced by the patient. The new environment presents an interesting and often terrifying mix of cohorts, especially to the layman unused to seeing the sick, disabled and mentally impaired. Kastenbaum explains the milieu best as he describes the scene at Cushing Hospital, site of his Holistic Therapy Project:

"The combinations of disability are sometimes especially cruel. A mentally intact octogenarian may be almost entirely immobile and dependent on others for care and stimulation, while another person of the same age retains much physical independence but wanders about in a confused, disoriented state. Additionally, the mix of residents is quite pronounced. Some people have scarcely had a sick day in their lives until a trauma (for example stroke or a fall resulting in a broken hip) disrupted their continuity. Others have lived in the community all of their lives, but eventually declined to the point where neither family (if available) nor other support systems could meet their needs. Still others have had troubled existences all along, living in and out of mental hospitals. In fact, some have been more 'in' than 'out' and have arrived finally at a geriatric hospital because their current problems were more those of a frail, vulnerable old person than of a psychiatric patient".

Kastenbaum, 1981 - p. 57-58.

Kastenbaum goes on to say that this is a collection of sick, old humanity who have been ejected from the community into collective living space for expedience and 'for their own good' in a facility that is at the bottom of every decision-makers priority list. The competition for staff is obviously with much more glamorous components of the health care delivery

system. Compliance must be maintained with every conceivable policy and regulation in the community and from provincial health administration departments and there is rarely offered either practical assistance with human problems, or appreciation for a job well done. The predictable result is misery generating misery for staff and residents.

The picture, though gloomy, has some bright spots. There are staff in these institutions who do care and who see the faults in the system. Because they receive few supports to build on their positive attributes, their efforts are not always visible. But it is through their efforts and by building on the methods that they have found that work, that we can initiate change of the institutional environment from within.

SUMMARY:

Physical needs of elderly people are adequately met in an institutional setting but their psychosocial needs are sadly neglected. Institutionalization is often the final crisis in a long series of life stresses. The milieu of the institution is often a terrible shock and the patient is left to deal with the loss of personal space, self-esteem, role and significant peers with little or no acknowledgement from staff. Even his permanence as a member of the new community of the nursing home is dependent on bureaucratic decision making and if his level of function changes he can be moved, often overnight and with minimal time to prepare for change. The system, however inhumane, is here to stay. It is the responsibility of those providing care within such facilities to

create a more sensitive and caring environment which will respond to the needs of the resident.

THE ATTITUDE AND BEHAVIOR OF NURSING PERSONNEL
TOWARD THE AGED

For the purpose of this practicum, reference to nursing personnel will include all staff providing direct patient care under the jurisdiction of nursing administration. This will include nursing assistants, licensed practical nurses and orderlies. There is no available literature from Canadian sources on attitude of nursing staff toward the elderly and the author had to depend entirely on information from the American scene.

Attitude of nursing staff toward the elderly can be characterized as negative and comparable to typical societal stereotyping. Nursing personnel generally appear to prefer young people and young patients to old people and old patients although there are some interesting variables associated with this such as nurses' age, amount of experience nursing the elderly, level of education and the agency in which the nurse is employed. The amount of stereotyping of the elderly is decreased with education however nurses report less desire to work with the elderly after receiving more information about them (Gillis, 1973; Brown, 1966). These effects will be discussed more thoroughly in Chapter II. Student nurses consider Geriatrics to be associated with students who have lower aptitude scores while obstetrics and paediatrics were the most highly favoured specialty areas

sought by more highly qualified students. Adjectives such as 'depressing', 'dull' and 'slow' were used to describe geriatric nursing. (Delora and Moses, 1969)

The turnover of staff in nursing homes is very high (one report says 60%) because there are few rewards for working in such institutions. Staff morale is usually low and there are few supports to enhance the environment and make the work experience a creative one. Nurses adopt behaviors which are patronizing and demeaning as they provide care in an environment that is sickness oriented and custodial. Patients are often restrained, labelled inappropriately as confused and given little opportunity to assert their own will. Gerontologists provide us with philosophical values that fail in practice. They fail for two reasons. They fail because the system does not support them. They fail because staff in the system do not believe the philosophy and have not been 'sold' on it. It is beyond the ability of the educator to change the system per se. What the educator can influence is a change in attitude of staff from one of resignation that nursing the elderly is dull, boring, uninteresting and no challenge, to one where they perceive the excitement of unravelling the entanglements of a life story which is close to the end and which needs to be told.

THE PROBLEM RESTATED

There is an increase in the proportion of numbers of elderly citizens in the Canadian population and these citizens are living longer and longer. One-third of these people over the age of 80 will require some kind of

supervised institutional care in the future. The nursing home is here to stay. Nursing homes are generally run on a medical model with physical needs superceding humanistic needs and this environment is not therapeutically conducive to good mental health because it does not acknowledge other traumatic incidents in the patient's life. The key to providing the right environment lies in providing what gerontologists insist are essential elements of care, respect for person and individual striving for personal goals. Nursing staff have negative attitudes about ageing however and do not support these principles of care in their daily practice. The system too appears to reinforce the nurses' role in carrying out procedures directed to physical needs and custodial care and does not provide supports for the nurse who would like to spend time just talking to her patients. Until nurses' attitudes change and nurses can function in the system in a caring way, and until they see caring for the elderly as a challenge, then the system will not change. The nurse must advocate for the patient from within the system and to do that she must believe that her patients are worthy of that effort.

The obvious question involves how the educator can provide a learning experience for nursing staff that will result in a change of attitude toward the elderly resident.

DEFINITION OF TERMS

For the purpose of this practicum, it will be necessary to clarify some of the terminology encountered thus far:

NURSING HOME/LONG TERM CARE FACILITY - a health care facility which provides extended and long term care for a predominantly elderly population, often referred to as long term or extended care facility.

RESIDENT/PATIENT - these terms are used interchangeably and refer to any individual living in a nursing home or long term care facility.

NURSING PERSONNEL - all nursing staff, aides, orderlies, licensed practical nurses and registered nurses working under the jurisdiction of nursing administration.

GERONTOLOGICAL NURSING - nursing care of the elderly which is concerned with the interrelationship of physical, psychological, socioeconomic, cultural, environmental and spiritual factors.

INTRODUCTION

The study of attitude and attitude theory has produced volumes of research and vast numbers of theoretical propositions. For the purpose of this work, the author has elected to discuss the theory proposed by one social scientist, Martin Fishbein. It is the author's view that this concept of attitude and behavior is the most definitive and the most useful in describing the complexities of attitude theory. Theory, concept and definitions will be discussed and then related to other work in the field of attitude and behavior change. The author will then present a rationale for the development of her own work with staff development for nursing home personnel and the application of theory into practice.

THE CONCEPT OF ATTITUDE AND ITS' RELATION TO BEHAVIOUR

Although many scientists have devised definitions for the word 'attitude', Fishbein (1975) prefers to consider the word as a concept involving several interrelated components. Changing attitude would involve consideration of each component. He suggests that measurement of the behavior of an individual, especially if the measurement is of a single behavior, is no measurement of the attitude of that person toward the subject. Although attitude might predispose toward behavior over time, there are many other factors in the environment that

influence behavior and the way that an individual responds initially to a subject may not reflect his internal thinking. Not until there is demonstrated consistency in the behavior can assumptions be made about attitude of the individual and even then, the assumptions must be made with care.

This idea that attitudes are predispositions which result in predictable behavior is continued by Fishbein who disputes the notion that because an individual has favourable attitudes, one can predict that he will behave in a positive way. The attitude/behavior relationship has caused much controversy and, according to Fishbein, can be traced to the investigators description of the nature of the predisposition. He provides two examples. Firstly, Sarnoff (1960) defines attitude as 'a disposition to react favourably or unfavourably to a class of objects'; and secondly, Thurstone (1931) and others have argued that attitude is an affective or evaluative predisposition. This debate about behavior and attitude has significant relevance for the educator who must decide whether attitude change should be induced through change in behavior or whether sufficient information to change the cognitive component of attitude will result in behavioral change. This argument will be pursued as this chapter unfolds.

Two other definitions of attitude are included in Fishbein's discussion and relate to predisposition. Chave (1928) defined an attitude as a 'complex of feelings, desires, fears, convictions, prejudices or other tendencies that have given a set or readiness to act to a person because of varied experiences'. This notion that personal experience affects attitude is reflected again in a definition offered by Krech and

Crutchfeld (1948) who define attitude as 'an enduring organization of motivational, emotional, perceptual and cognitive processes with respect to some aspect of the individual's world'. Since each individual has a personal set of experiences and a unique history, it would be impossible for the scientist to measure attitude using any of the above descriptions. However, producing a more scientifically measurable definition of the word involves making assumptions about components of attitude that have not been empirically supported. Fishbein offers the definition of attitude that would most satisfy investigators as a measurable concept and theory. Attitude, he says, can be described as a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object. This definition assumes the notion that attitudes are learned and that they do predispose to action and that such actions are favourable or unfavourable toward the object. How attitudes are learned appears to be the focus of the discussion.

There is general consensus among social scientists that attitudes involve three major components, affect, cognition and conation. To further understand the complexity of the concept of attitude it is necessary to define these terms and determine what distinctions are involved between them.

According to Fishbein:

Affect refers to a person's feelings toward and evaluation of some object, person, issue or event;

Cognition denotes his knowledge, opinions, beliefs and thoughts about the object;

Conation refers to his behavioral intentions and his actions with respect to or in the presence of the object.

Fishbein argues that since we are dealing with attitudes and are concerned with predispositions to behave rather than with behavior itself, it would be desirable to make a distinction between behavioral intent and actual behavior. This in turn suggests a classification consisting of four broad categories: affect (feelings, evaluations), cognition (options and beliefs), conation (behavioral intentions) and behavior (observable, overt acts). The term attitude he reserves for one of these categories, namely affect. He suggests the term belief be used for the second category of cognition and the term 'intention' for the third category, conation. He defines these terms further:

Beliefs represent the information a person has about the object and links the object to some attribute;

Behavioral intention refers to a person's intention to perform various behaviors;

Behavior refers to observable acts that are studied in their own right and not used to infer beliefs, attitudes or intentions.

CONCEPTUAL FRAMEWORK

To reiterate, Fishbein identifies the foundation for a conceptual framework as the distinction between beliefs, attitudes, intentions and behaviors. The concern for development of this framework is the relationship between these variables.

Beliefs provide the basis of the concept. Beliefs are formed by an individual from observation, information or by inferences in his environment resulting in his association of the object with various attributes. From this process of information gathering, he forms opinions about himself, other people, institutions, behaviors and events, etc.

'The totality of a person's beliefs serve as the informational base that ultimately determines his attitudes, intentions and behaviors' according to Fishbein (p. 14). The approach used then is that man is a rational organism and that he uses this information to make judgments, form evaluations and arrive at particular decisions.

The way that an individual processes information is based on his salient beliefs about that object and his attitude is a result of a positive or negative collection of beliefs rather than one particular belief. It follows that each belief or collection of beliefs results in an intention to behave in a certain way toward the object and, barring unforeseen events, a person should perform those behaviors he intends to perform. These notions are illustrated in Fig. 1:1.

The conceptual framework then involves consideration of the performance or non-performance of a specific behavior. There are several external factors which might influence a particular behavioral intention however, and knowledge of a person's attitude toward an object does not necessarily predict that performance.

We have already seen that intentions are a result of certain beliefs. Some of these beliefs however may not relate to the object but rather involve beliefs related to the outcome of performing the particular behavior. Normative beliefs of the individual's referent group affect his motivation to perform especially if his behavior is contrary to the acceptable behavior of that group. These normative pressures are collectively termed the subjective norm. Therefore, a person's

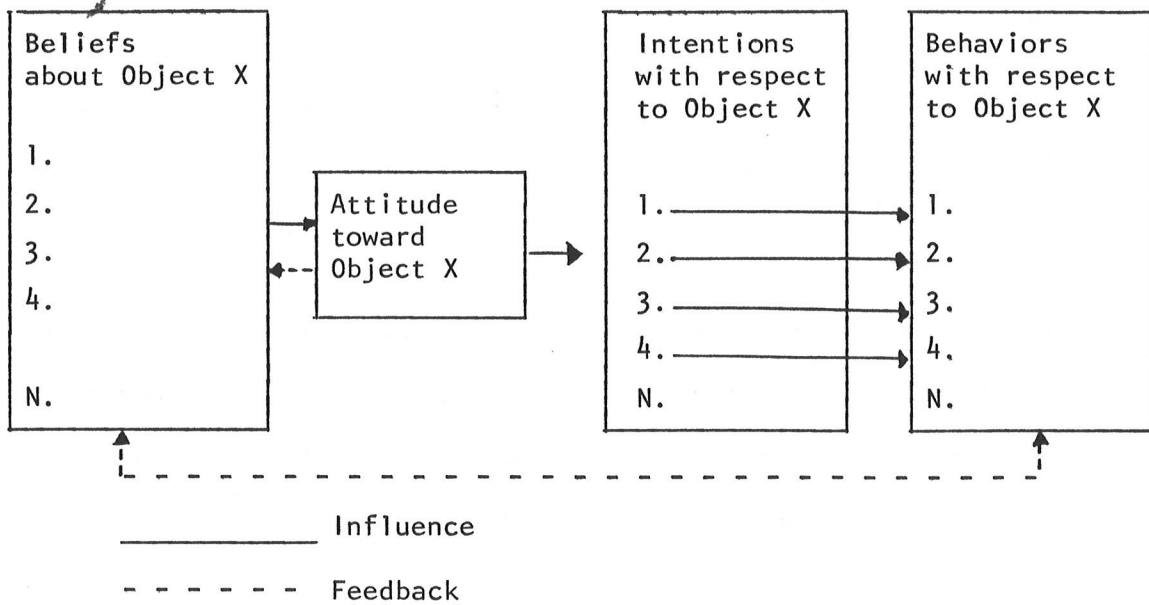


FIG. 1:1 SCHEMATIC PRESENTATION OF CONCEPTUAL FRAMEWORK RELATING TO BELIEFS, ATTITUDES, INTENTIONS AND BEHAVIORS WITH RESPECT TO A GIVEN OBJECT.

Reproduced from "Beliefs, Attitude, Intention and Behavior"
Martin Fishbein, Icek Ajzen 1975

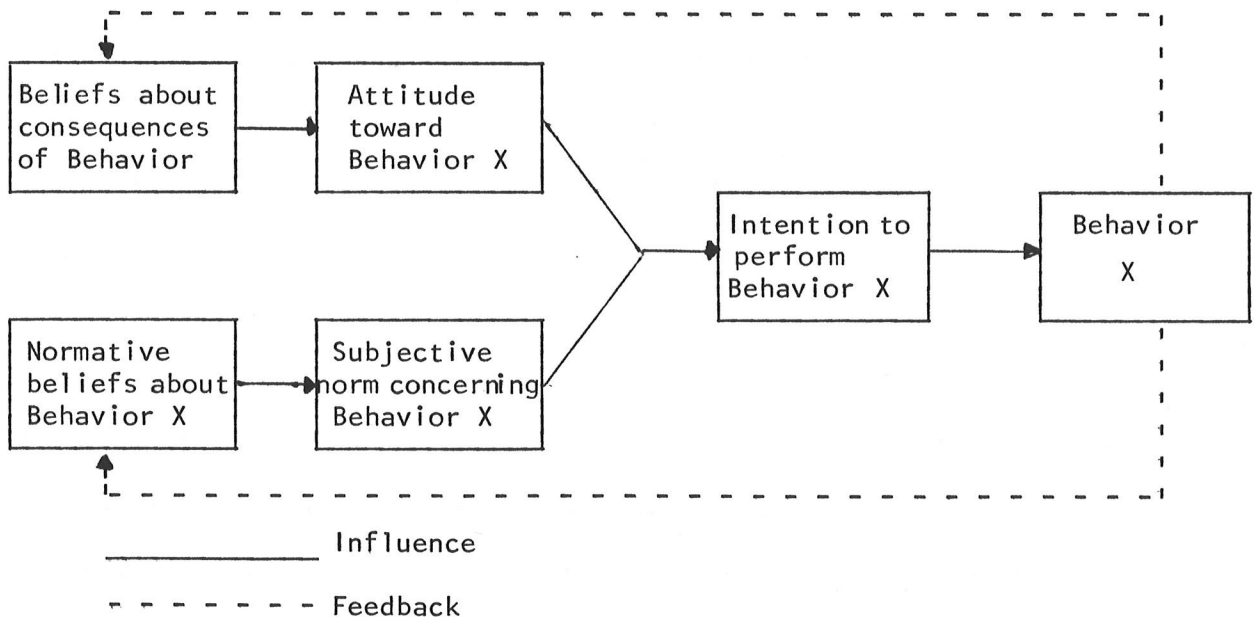


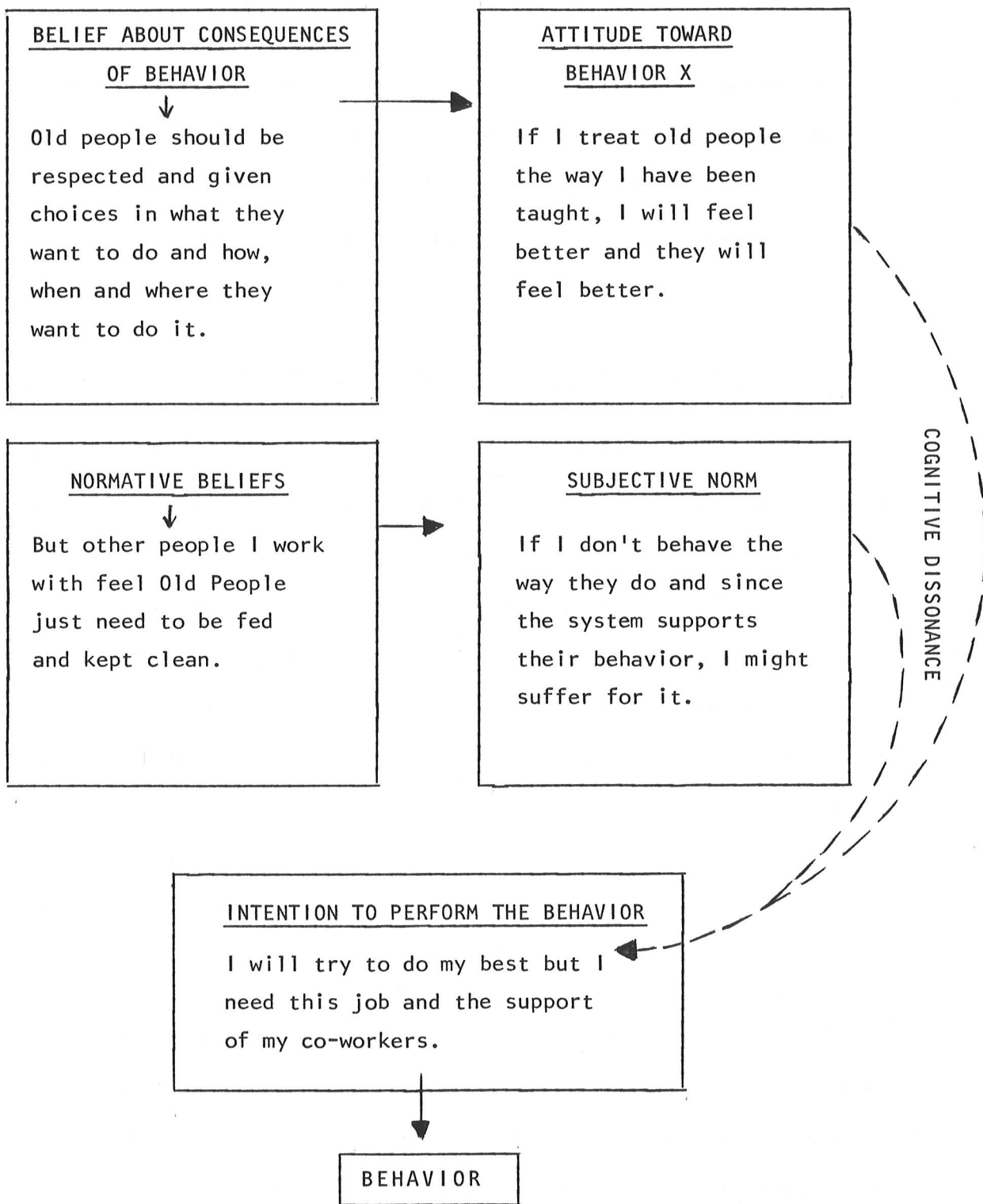
FIG. 1:2 SCHEMATIC PRESENTATION OF CONCEPTUAL FRAMEWORK FOR THE PREDICTION OF SPECIFIC INTENTIONS AND BEHAVIORS.

Reproduced from "Belief, Attitude, Intention and Behavior"
Martin Fishbein, Icek Ajzen 1975

behavioral intention is viewed as a function of two factors: his attitude toward the behavior and his subjective norm. The intention is viewed as the immediate determinant of the correspondent behavior (Fig.1:2 illustrates this concept).

Before we explore other theories or concepts about attitude and attitude change, there is need to reflect upon the initial problem identified in Chapter I and decide how this theory can be applied to the negative attitudes of nurses toward elderly patients and the behaviors which result from those attitudes.

We have learned from the literature that most nursing personnel hold negative beliefs or stereotypes about aged patients. Although these negative beliefs are dispelled with the introduction of new information (cognition - i.e. the more education the nurse receives, the less stereotypes she holds) their attitudes (affect - feelings and evaluation) toward the elderly do not change. This is consistent with Fishbein's theory since the subjective norms in the system do not support the nurses intention to perform differently. In this case, the subjective norms are the administrative framework of the environment that directs nurses to look for problem behavior and identify tasks which will direct the patient toward conformity to a strictly regulated environment (See Fig. 1:3 for application of the conceptual model to predictions of nurses' intentions and behaviors). Obviously a supportive environment designed to acknowledge desired attitude change is essential to foster the intention to perform expected behaviors.



APPLICATION OF THE CONCEPTUAL MODEL TO PREDICTIONS OF NURSES INTENTIONS AND BEHAVIORS

FIG. 1:3

OTHER WORK ABOUT ATTITUDE AND ATTITUDE CHANGE

There are several theories of attitude and behavior change which are considered credible among social scientists. All of them have emphasis on particular components which identify one from the other. The author will examine them as they relate to Fishbein's theory and model and to the specific problem at hand.

The Yale Attitude Change Approach - the Persuasive Communication

Hovland, author of this technique, defines attitude as an implicit approach or avoidance response (a favourable or unfavourable reaction) to some attitude object. The attitude is the affective or emotional reaction people have to the attitude object; it is their liking or disliking for a person, object, group of people, or symbol. Hovland believed that attitudes (the affective component) can be influenced or changed by altering the beliefs (the cognitive component) of the individual. Thus, we should be able to change attitude by changing beliefs. However, Hovland qualifies this change by suggesting that the incentives or anticipated rewards for accepting new beliefs must be substantial. (1953)

Obviously, this theoretical approach is similar to Fishbein's in that cognition alone is not seen as adequate to support change in attitude but that subjective norms concerning the behavior might detract from the perceived benefit of performing that behavior. Considering nurses attitudes, it might be easy to convince nurses that patients need them to sit down and talk to them and reminisce about the past and that this is a therapeutic exercise which helps to build self-esteem and a sense of identity.

However, if other nurses on the unit do not perceive this nursing behavior as meeting a patient's needs but rather consider the nurse who sits and talks to patients as being lazy and avoiding work, then the behavior will receive few rewards and the subjective norms opposing the behavior will prevail.

The mechanism responsible for supporting the change in belief is the persuasive communication and it is delivered through four kinds of processes. The first involves attention and depends upon innovative techniques for capturing individual interest in the message. Secondly, the message must be clearly understood and presented as a logical argument. Unless there is comprehension of the message on the part of the receiver, the effort will be lost. Thirdly, acceptance of the argument depends upon the personal rewards offered. Unless they are acceptable to the subject, the message will be discarded. Finally, retention of the communication is essential so that the information can be used to produce an appropriate response (behavior) at the right time.

Hovland goes on to describe four variables that affect the acceptance of arguments and he identifies them as the source, the characteristics of the communication, the audience and audience reactions. These variables involve credibility of the source and how the audience views the messenger's expertise and trustworthiness, style, argument development and explicitness of the message, ability of the audience to understand the message without the corruption of outside influences and the modification of the delivery of the message in response to audience reaction. (Hovland, 1953) This is useful methodology for communicating but really does little to develop a

unique model for changing attitude. Hovland's model, although much like Fishbein's, has some weaknesses in the lack of explanation about immediate environmental issues that affect behavioral outcomes.

The Group Dynamics Approach: If you can't beat 'em, join 'em

The assumption of the Group Dynamics theory is that the individual is more than an isolated person who processes information in logical combinations of arguments to produce predictable attitudes. Instead, the author, Kurt Lewin, assumes that the individual is a social being who depends on those around him for information about the world and for feedback about himself. The groups to which we belong and the people who are important to us all have a major influence on the formation of our beliefs and attitudes. The major factor which causes people to change their attitudes, beliefs and perceptions of the world around them is the discrepancy that exists between what they think and feel and the group norm. According to Lewin, when a discrepancy or inconsistency exists between one person's position and that of others, the individual moves toward the normative position. (1958) Obviously, the need for acceptance, approval and recognition of significant peers and peer groups is an important component of this theory. Leon Festinger (1954) expanded this idea into a theory of Social Comparison in which he explored the need of people to compare themselves to similar others in order to evaluate their own abilities and opinions.

Unlike the Yale approach which depends upon a simple learning process, the group dynamics approach depends upon the motivations described by Fishbein as normative beliefs and the subjective norm concerning the behavior.

Building on Lewin's Social Learning Theory (1935), group dynamics theory stresses the importance of environment and social factors within the personal environment of the individual. The implications in the design of educational strategy to change attitude implies the need to pay special attention to the supportive structure of the study group. More specifically, nurses in educational programs designed to influence their attitudes about ageing would need to have an environment that not only supported, but also encouraged them to practice new behaviors.

Theory of Cognitive Dissonance - I don't like anything that's good for me!

What is not explained by Lewin is the anguish associated with abandoning strongly held beliefs in deference to a power group. Festinger extended his Social Comparison Theory to develop the Theory of Cognitive Dissonance (1957). This theory attempts to explain the tension related to discrepancies and inconsistencies between belief and expected behavior. Festinger implies that dissonance may not necessarily occur however through social differences, but that inconsistencies can exist within the individual in attempting to explain his own behavior. The obvious example of dissonance is smoking. The individual understands that smoking is unhealthy but continues to smoke even though he may receive few social reinforcements for the behavior. The way to change dissonant cognitive elements to consonant elements is to change the behavior related to the dissonance. If the individual has no choice but to persist with the behavior while aware of the discrepancy between feelings and action, then Festinger argues that there will still be a need to reduce the resulting dissonance. There are

four methods identified by the author to reduce dissonance. These are first, to change the behavior, secondly, lower the importance of the cognition or of the behavior, thirdly, increase the cognitive overlap or find rational arguments that fall somewhere between cognition and behavior or fourth, add consonant elements which will alter the balance between cognition and behavior.

There are two types of decision making which further affect the amount of dissonance an individual might experience. If an individual is placed into a position where he is forced to perform in a manner which opposes his own beliefs, he will experience dissonance to a lesser degree than another individual who has the free choice in the process. In a force compliance situation, the magnitude of initial justification for the behavior is greater and the individual can place responsibility for the behavior on the enforcer. In a free choice situation, the responsibilities are entirely those of the individual. Once the decision is made to proceed with an action or behavior, the resulting dissonance must be modified and there is a move toward increasing the attractiveness of the chosen alternative while decreasing the attractiveness of the unchosen one. This means that the individual must change his attitudes and perceptions (internal environment). The alternative of course is to change the external environment (the source of power which is imposing the alien behavior) and maintain one's internal personal integrity.

The theory of cognitive dissonance acknowledges the need for information and learning to affect beliefs but focuses on the process of formulating behavioral intentions and explains more fully the interaction of the

individual's internal environment and his functioning in the external environment. This theory builds on Fishbein's original concept and offers more indepth explanation of the complexities of the relationship between the individual, his attitude and his choices of behavior. It is the only theory that emphasises the process of choice and the effects of the types of choices and the resulting inconsistencies on the internal environment of the individual.

Cognitive dissonance is a factor which must be given serious consideration in planning nursing education programs which place demands on individual participants to perform in a manner which the mechanics of the system do not support. For example, allowing an elderly resident of a nursing home the choice of walking alone to the bathroom rather than calling a nurse to accompany him would be difficult for the nurse who must fill out an Incident Report and take full responsibility for that resident if he falls. The nurse may well believe that allowing the choice is the most acceptable behavior. However, she needs her job and the incident report might well be placed on her file. The alternative is to restrain the resident in his chair so that he cannot get out alone, and if he does escape and fall, then the administration can be assured that the nurse took every available precaution to prevent the situation and that what resulted was an accident and the responsibility of the resident. The nurse, meanwhile, suffering from the dissonance created between what she believes to be right and what she feels compelled to do, will be faced with three choices: first, she can tie the patient into the chair and reduce the dissonance by rationalizing that it is for his own good; a fall might result in a

fracture and the resident would be worse off then before. Secondly, she might decide not to tie him up and give him the choice and take the consequences. This second choice might involve a great deal of pressure toward uniformity from her peers (Group Dynamics Theory) as she chooses to allow the patient freedom on her shift and he complains to other nurses who choose to tie him up on other shifts. Thirdly, she could decide to use her new information about giving the elderly more choices in the institution and argue with her peers and administration for a change in policy based upon the authority and the logical outcomes offered by the source of her learning (Yale approach). The motivation of the individual to pursue his own beliefs might well depend on more than Festinger suggests in that the individual's sense of control and conviction that he is right might interfere with the decision making process. Therefore, locus of control could be a significant factor in formation of attitude and behavior.

Attribution Theory - Bad guys and good guys

One theory that attempts to explain behavior in terms of an individual's personality is the Attribution Theory - originating with the work of Fritz Heider (1958). This theory attempts to explain behavior by looking at the perceived motives and intentions of the individual rather than his need to reduce dissonance or comply with pressures toward uniformity. The scientist observes a particular behavior and attributes that behavior to some quality of the individual or his environment such as ability, motivation, luck or opportunity. There are two classifications of

potential causes for an individual's actions. These are described as situational or dispositional. Situational attributions identify factors in the social and physical environment that are causing the person to act in a certain way. Dispositional attributions identify more unique properties of person or character traits which make up that individual's personality. Personality theory is, in fact, a theory of dispositional attributes.

There are several factors which are said to affect the use of dispositional rather than situational explanations for behavior. When behavior is non-normative and differs from the usual or acceptable mode, it is rarely described as situational but is usually characterized by a personality trait. The more often a person engages in the same behavior, the more likely that behavior is to be attributed to personality and if the same behavior persists in many different situations it most assuredly will be assumed to be the result of disposition. When there is no obvious cause for the behavior then the individual takes full responsibility.

This theory ignores the function of beliefs and fails to explain how attitude can be changed in relation to personality characteristics. It does however go on to explain the biases associated with the observer's perception of behavior and that is a useful concept in dealing with attitude change. It is reasonable to accept that a person's behavior is always the result of both aspects of the situation and aspects of the person. Where situational aspects are not obvious to the observer, then inferences are made about the personality of the individual and its' relationship to the behavior. This represents attributional biases

which can result in severe misunderstanding. For example, it would be easy to assume that because the nurse ties the patient into the chair that she has negative attitudes toward elderly people and feels that all old people should be tied up. If the observer does not understand that there are situational factors, (the incident report, responsibility for the fall and a punitive administration system) then the attribution to the nurse of negative attitude toward the elderly would be a false assumption.

This theory could be applied further and on behalf of the resident who may frequently call out at night for her dead husband. The nurse perceives the behavior as disruptive and unnecessary since the patient appears to be comfortable and says there is nothing wrong when the nurse approaches her. The nurse attributes the behavior to an attempt to seek attention and decides that the patient is confused. She may be totally unaware that the woman, married for some 60 years, lost her husband just days before admission to the nursing home and was unable to attend his funeral because she was in an acute care facility dealing with the disabilities of a recent stroke.

Attribution theory and especially the concept of attributional biases are most helpful in explaining the pathology of behavior. However, there is little direction for ways to intervene in the pathology and to redirect the process of attitude formation and behavioral outcomes.

Social Learning Theory

Social Learning Theory (Lewin, 1951) argues that there is a continuous reciprocal interaction among a person's behavior, his internal environment (thoughts, emotional reactions, expectations, etc.) and the environmental consequences of that behavior. The individual gets constant feedback from his environment and that feedback influences the probability of him repeating the behavior again. This feedback process is a form of learning and there are several different methods of learning which an individual will experience and these include directly experiencing the consequence of behavior, observing the behavior of others, listening and reading and the effects of emotional arousal. An individual learns to expect different consequences from specific behaviors and then discriminates among situations or stimuli to produce the behavior that is desired and that fits that set of circumstances. Anticipated consequences control the way people behave because some consequences are rewarding and others are punishing. The consequences may vary between different peer groups and so are not absolute and, as we have seen, association with a particular social group will provide pressure to perform in a particular way (Group Dynamics Theory).

There are four major factors assumed to affect a person's behavior and these are described as performance accomplishments, vicarious experience, verbal persuasion and emotional arousal. Direct reinforcement of performance accomplishment through a system of rewards is most likely to encourage positive behavior. Prevention of the desired consequences of a particular behavior is also likely to reduce the use of that behavior.

Vicarious reinforcement or vicarious extinction is a useful way of changing behavior and involves the individual seeing other people receiving reward or punishment of various positive or negative behaviors. Finally, verbal persuasion through the presentation of instructions, rules or communications which leave no doubt about the desired behavior can be used. This provides the individual with a set of persuasive messages for particular circumstances to which he must refer. This social learning theory has been applied frequently to describe the nursing environment and the affect on individual practice.

Social Learning theory expands on the theory of Group Dynamics and the need to perform in the accepted pattern of our chosen social group. It becomes the normative process and suggests a social levelling which does not allow for personality differences associated with the Attribution Theory. Although it considers all the factors addressed by Fishbein, it focuses on the influence of the environment rather than the internal direction resulting from an individual's ability to logically make decisions about behavior based on learned information. There is no acknowledgement in Social Learning Theory of the cognitive dissonance associated with the move toward the normative beliefs and resulting behavior. While social learning does much to explain how we are 'socialized' into the regulations of our chosen groups it fails to demonstrate how the interventions described would effectively change attitudes or behavior.

Social learning is an interesting explanation for the process that nurses experience in their affiliation with their professional body. Nursing has adapted a model of practice known as the Nursing Process, a problem-

solving model designed to identify problems and formulate plans of action in response to those problems. However, there is a great discrepancy between patients' needs (as identified by the patient) and nursing problems (as identified by the nurse). Nurses have been influenced by physicians to approach patients from a medical perspective rather than a holistic point of view. This process is reflected in the adaption of workload tools and problem oriented systems of recording patients' progress which depend on procedural tasks. The expectations placed on practicing nurses by the policy makers in their own profession and by the administrators of the facilities where they work has produced a social milieu that is self-perpetuating in its' distinction of functions. The nurse may wish to practice new approaches to patient care but be unable to overcome the social pressure of her own peers to perform according to policy and procedure. In other words, new beliefs become forfeit to the system.

SUMMARY

Attitudes are made up of a variety of interrelated, complex components which, collectively, represent a concept which demonstrates the influences on individual behaviors. There are several theories which attempt to explain the nature of this interaction. They involve the individual's system of beliefs, how he learns and who he learns from and the support system in his environment and personality traits which help him to respond to that environment. Attempts to change attitude must be directed toward all of these components in such a way as to influence the more vulnerable aspects of the individual's attitude formation.

Having explored the theoretical framework of the concept of attitude and various other works related to the influences that result in attitude change, the author will now discuss the nursing literature to determine what factors influence nursing attitudes and what methods have been found in nursing to bring about changes in attitude and behavior.

INFLUENCES WHICH AFFECT NURSES' ATTITUDES TOWARD ELDERLY PATIENTS

In Chapter I we have already discovered four factors which affect nurses' attitudes toward the elderly, age, level of education, years of employment working with the elderly and the place of employment. For the sake of clarity each of these factors will be discussed separately so that their relevance can be thoroughly explored.

Age: Taylor & Harned (1978) used Kogan's Scale for Assessing Attitudes Toward Old People and applied it in a quasi experimental design to participants who worked with the elderly attending six 2-day conferences held at widely separated locations in the state of Oklahoma. The completion of the Kogan Scale pre- and post conference was voluntary and nurses were asked to either use their own names or choose a pseudonym so that the results of the pre- and post tests could be matched presumably for change in attitude as a result of the workshop information. Only those nurses who used their own names and could be reached by postcard for follow-up information including age, active nursing experience and employing agency were eligible for the study. This suggested an immediate bias in reporting since those who had negative attitudes about the elderly people in their care would be most likely to use false names fearing some

retribution for their feelings. The study failed to report on the affect of the workshop information but produced some interesting information about participants who did meet eligibility criteria. This included the fact that nurses under 40 years of age had more positive attitudes than their older counterparts. All scores in this study ranged from positive to neutral and not too surprisingly, none lay in the negative attitudes area. In another study, a greater percentage of nurses under 30 years of age than those 30 years of age and over reported that they like caring for older patients and that they would like to work in areas with primarily older patients. (Hogstel, 1979) On the other hand, Gillis (1973) found no relationship between age and attitude.

Where age has been a variable in consideration of attitude of nurses toward the elderly, there is little research that provides adequate support for the assumption that the older the nurse, the more negative her attitudes. The Taylor and Harned experiment appears to be poorly designed while the Hogstel research was apparently dependent upon questionnaire feedback in one institution and at best reflected an isolated situation. The Gillis study was the most well conceived and demonstrated no relationship suggesting that, if credibility is to be given to the first two experiments, then more work needs to be done to determine the relationship of age to attitude.

Years of Employment in Geriatrics: One factor which might be considered to reflect age of the individual is the number of years in employment. Taylor and Harned's study found that nurses with fewer years experience scored more positively than their older and more experienced counterparts.

Gillis again found no relationship while a study comparing various professionals (physicians, social workers and nurses) demonstrated that length of practice for nurses appeared to be positively related to attitude (Futrell & Jones, 1977). These findings were supported by Wolk & Wolk (1971). These conflicting results provide no direction for assumptions about the relationship between number of years in employment and attitude toward the elderly and point toward the need for more consideration of this variable.

Level of Education: Where age and number of years working with the aged are poorly reported in the literature, level of education and the affect of different teaching programs has received much attention. In Gillis' study, nurses prepared at the associate degree and diploma levels were the most positive in their attitudes toward the aged and baccalaureate nurses were less positive than licensed practical nurses. The more extensive the educational background of an individual, the less likely he has been found to hold stereotypes (Campbell, 1971). However, stereotyping seems to have little effect on desire to work with the aged as nurses with few stereotypes about ageing appeared to avoid working with the elderly while nursing assistants who accepted many stereotypes were more willing to work with older people. Gunter (1971) worked with a number of students whom she found to have a considerable number of stereotypes and provided them with a course in gerontology which focused on normal development in later life. Following the course, students were found to have overcome their stereotypical feelings but as a result reported being less likely to work with the elderly than before they took the course.

The content of courses for students has been the subject of a variety of studies involving the evaluation of various approaches to sharing information about ageing. Hart et al (1976) evaluated the effect of a course in which students had a learning experience with 'ill' elderly following a structured experience with healthy elderly persons. Their attitude about the elderly remained about as positive as those students who had had only structured contact with the healthy elderly but they expressed a stronger interest in working with the aged than their counterparts who had not had the second experience. They even ranked this age group first or second in terms of preferred age group, diagnostic group and work setting. Later work supported this study and found that course work does not have to focus on the normal ageing process and healthy ageing but should involve a generous opportunity for clinical experience with the elderly and permit the development of attitude through experience with both the healthy and the ill (Robb, 1979).

Presentation of factual information about ageing is not adequate to provide a change in attitude unless the individual has the opportunity to test that information and receive personal experience and feedback as to how the information works in reality. If the hands-on experiences are guided then the teacher can provide a unique opportunity for the student to test the information and receive a positive response which will reinforce the same behavior again.

The reader can see that discussion about level of education has actually digressed into a discussion about the form that education should take. The research appears to support the fact that an increased level of

education may dispel stereotypes but it does not necessarily increase the individual's desire to work with the elderly. The types of content for courses which do involve an attitude change and increase the desire to work with the elderly, offer the opportunity for exposure to both the well elderly and the sick. (This factor has been supported by further studies by Evans, 1969; Heller & Walsh, 1976; Hart, Freil & Crowell, 1976; Chamberlain, Rawls & Powell et al, 1978; Tobiason, Knudsen, Stengel et al, 1979; Benson, 1979 and Hogstel, 1980)

Place of Employment: The place the nurse works will have an effect on her attitude toward the elderly according to the literature. In a study to investigate the nature of social organization and the interactions and expectations of the individuals within the organization, some interesting findings were made. Consistent with Lewin's Social Learning Theory, the setting in which the nurse works was assumed to vary according to the different individuals and groups that interact within each system. Controlling for the variables of age, length of time spent nursing older patients and level of education, Brower (1981) selected registered nurses and licensed practical nurses from agencies from four counties in the state of Florida. The agencies involved nursing homes, visiting nurse associations, private home health agencies and the largest teaching hospital in the South. Two instruments were used to collect the data. The first was a questionnaire to determine demographic data for the independent variables of age, amount of time spent with the elderly, educational level and organizational work setting. The dependent variable, nurses attitudes toward the elderly was measured by the Kogan Attitude to Old Persons Scale. (1961)

The results demonstrated that nurses in hospitals had more favourable attitudes toward the aged than did nurses in private home health agencies. Nurses in visiting nurses associations had more favourable attitudes than nurses in nursing homes and private home health agencies. The researchers indicate that nurses in nursing homes traditionally have been stigmatized by their professional peers and are assigned lower role status and that many nurses internalize this role expectation of them and this is reflected in their attitudes and values.

The work reported by Devine (1980) looks at another aspect of the social interaction of nurses in two institutions which utilized different approaches to care. The first institution had initiated milieu therapy, a process of giving the residents of the institution some power in the administration of their facility (Coons et al, 1973). The second institution functioned in the more standard custodial style. The assumption was that nurses would have more positive attitudes where they were fostering independence in their residents. Results indicated that there were no differences in nursing staff attitude between the two facilities. However, the second facility was about to introduce the concept of milieu therapy and so it would follow that staff would have gone through a process of adopting the principles of milieu therapy and their attitudes would have been affected already by that process. This would appear to confound the principles of the study and to obtain more accurate measurements a nursing home where milieu therapy had never been considered would have been a more appropriate comparison.

Although these papers represent two aspects of how the social work setting affects nurses' attitudes about ageing, they provide a less than adequate picture of the role of the structural setting. More information about the affect of the administrative structure and supportive system for nursing is needed to adequately evaluate its' effect on nursing attitudes toward their patients.

SUMMARY

While these variables of age, education, years working with the elderly and place of work all have been shown to affect nursing attitudes toward the elderly, it would appear that there are other factors which would influence attitude. One of these factors is the content and innovations used to expose student nurses to the elderly in the nursing curriculum. Nurses who see both healthy and ill elderly and have an opportunity to work with them appear to develop more positive attitudes about ageing. This would appear to give direction for the curriculum development in our nursing schools. The problem remains however for the educator to provide programs for nurses of all ages and all levels of education and a variety of years of experience who are in service and who are reported to have the most negative attitude about ageing if they are working in nursing homes.

COGNITIVE DISSONANCE REVISITED

Do Nurses working with the Elderly have Trouble
Resolving what they Hear with what they See ?

As health care providers, our own perceptions of and reactions to aged, infirmed people bespeak awareness of our own imminent death, fear of lingering illness and the psychological defenses we are using to protect ourselves against overwhelming anxiety: anxiety associated with threat to our inner psychic world where we are healthy and live forever. Character-armor and role-dictated behaviors fail to sufficiently insulate us from our own feelings so that our awareness of lost youth, illness and death become critical. They (patients) are us and the awareness is overwhelming.

Celeste A. Dye - 1979

In one of the few studies exploring innovative approaches to changing attitudes of staff in service, Dye explores the critical concerns associated with designing programs that will reach past the barriers created by stereotyping and find the vulnerable surfaces that can be penetrated by a variety of approaches. She argues that attitudes toward the elderly are different and more resistant than attitudes toward the mentally ill or physically handicapped and suggests that these areas of difference must be identified and dealt with. It is the author's contention that the difference is definitely associated with the fact that we do not perceive ourselves as ever being mentally ill or handicapped. We have been blessed with good mental and physical health. However, we do perceive ourselves as ageing and working with the elderly in nursing homes provides us with the most unpleasant view of ageing. Nurses who work in nursing homes rarely can balance that experience with an equal opportunity to see healthy aged people enjoying their retirement and the freedom from

social demands such as those imposed by work and family. Students who have the experience of seeing both the well and the ill elderly have more positive attitudes because they have had the opportunity to see both positive and negative features of ageing. Nurses, working in nursing homes receive information about healthy ageing through in-service programs but because they are unable to observe and explore this experience themselves and must return immediately to the environment of the sick elderly are faced with a great inner conflict between what they believe from their own experience and what they hear from others. This cognitive dissonance is reinforced by the profound fear of ageing that their negative experiences induce. This inner turmoil must be resolved within the social structure of the individual's support system so that not only he has a more objective view of ageing which can then be reflected in his behavior, but his cohorts share the same views and they can support each other in the work place and, in turn, provide a more healthy milieu for patients.

The method of providing this resolution of experience and fact is complex and would involve several factors:

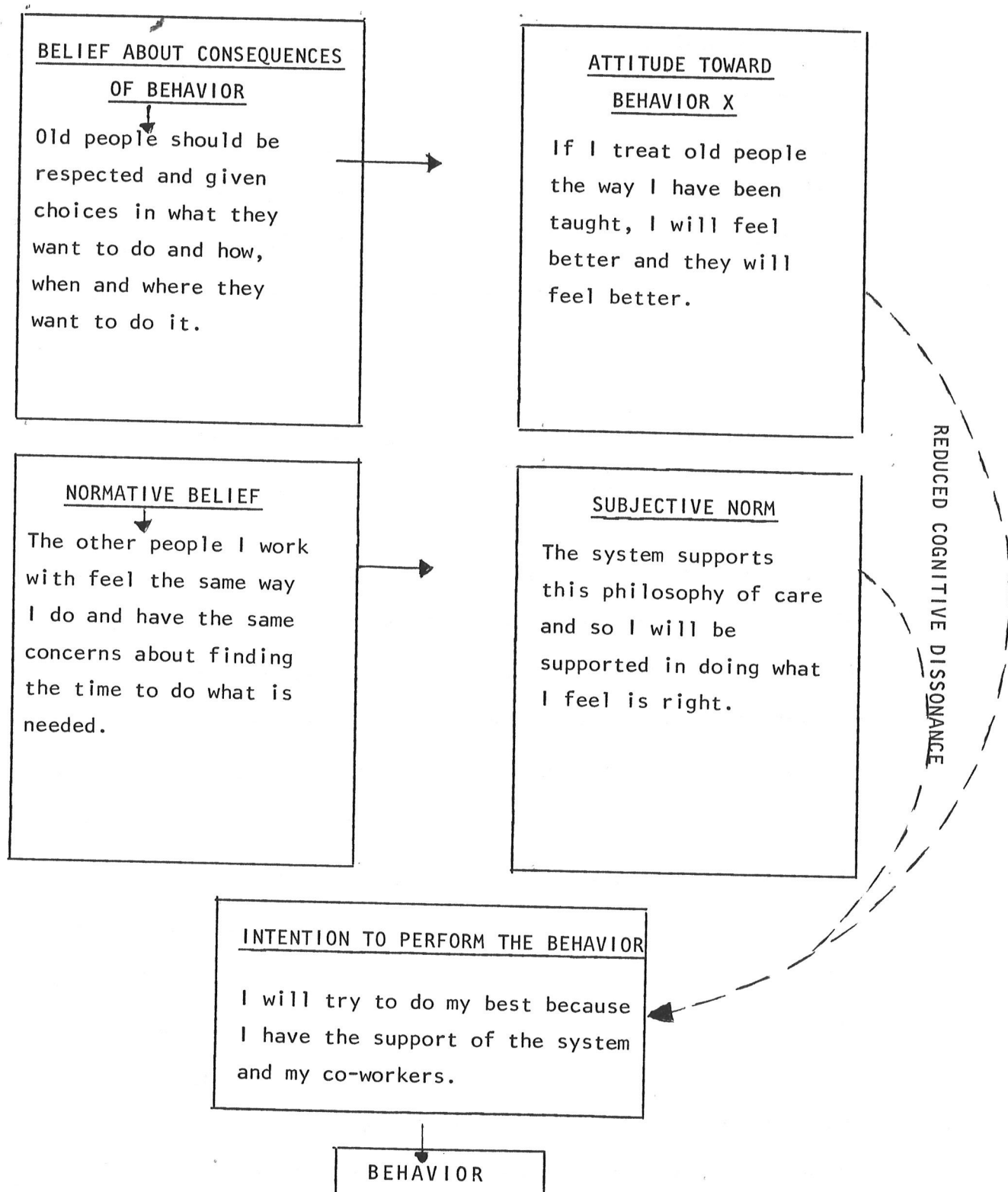
1. Provision of factual information about issues of Ageing in contemporary society;
2. Clarification of values to determine what features of living maintain an individual's self-esteem and sense of identity;
3. Exploration of feelings and thoughts (attitudes) toward Ageing and personal feelings about Ageing and Death;
4. Creative problem solving approaches to provide healthy institutional living.

Dye supports the idea of the group dynamic approach to these issues because it would build a sense of trust, acceptance and commonality with others. She reports on a study that she completed with two treatment groups of graduate nursing student volunteers and a third comparison group. The first group was subject to an attitude discussion session where presently held attitudes, the origin of such attitudes and choices in forming attitudes were discussed. The group leader introduced controversial issues about ageing, caring for the aged and stereotypes. The underlying rationale was that a careful re-examination of attitude structure would result from group-induced cognitive dissonance. The second treatment group involved re-enactment of various widely accepted scenarios where the principle player had to solve a problem in 15-20 minutes (e.g. being old and evicted; being abandoned in a nursing home). This role playing was designed with the underlying rationale that acting out a disavowed role as part of a larger predicament and being forced to resolve the dilemma creatively would require a reduction in cognitive dissonance through attitude assessment. Kogan's Attitude to Old People Scale used pre- and post session produced little reported change in attitude. The author admits that there was no attempt to discuss personal reaction to the dilemmas introduced but that participants could keep their discussion on a professional level where it was not necessary to share personal fears and reactions. This was a missed opportunity to use the dynamics of the group to resolve cognitive dissonance. Other criticisms of the study involve use of graduate student nurses who were reported to have fairly neutral attitudes toward the elderly and who were about to embark on an exciting period in their life as new nurses presumably

choosing to work in different areas of medicine and with few thoughts of ageing. The groups were also very small - Group I -6; Group II -7 and Group III - 14. If Dye had used nurses who had several years of experience working with the elderly then the results might have been more dramatic.

In another experiment to determine the effectiveness of a social simulation game designed by the author, Chaisson (1980) developed a game called Life-Cycle which exposed the participant to issues of ageing in an effort to create more empathy and understanding for elderly patients' needs. One week after playing, she used a questionnaire with open-ended questions designed to generate data about probable emotional and verbal responses to a video tape of an old man discussing his feelings of rejection and despondency at being left in a nursing home. She received significantly more positive, accepting answers from people who had participated in the game than from those who had not suggesting that this type of experience provided participants with personal insight about their own attitudes. Other similar games for exploring issues of ageing have been developed and used with some success although the reason why they are effective has not been adequately discussed in the literature.

It is the author's belief that any opportunity to place the experience of ageing on a personal level so that the learner must think about the circumstance within the context of his own life style should be seized. Once the individual has made a personal connection between the situation and his own reactions to it, he will experience the cognitive dissonance that is related to what he has felt about and how he has reacted to others (old people) in the same situation. If he can be placed in a



APPLICATION OF THE CONCEPTUAL MODEL TO PREDICTIONS OF NURSES INTENTIONS AND BEHAVIORS THROUGH USE OF SOCIAL LEARNING AND A SUPPORTIVE ENVIRONMENT TO REDUCE COGNITIVE DISSONANCE

FIG. 2:1

situation where others are experiencing similar dissonance and if the situation can be discussed openly and the fears and anxiety associated with the issue discussed, then the social dynamics of that discussion can result in a positive resolution of the issues, especially if there is an experienced group leader present who can provide objective information and offer observations about reactions to the process. (See Fig. 2:1)

RATIONALE FOR THE USE OF GROUP PROCESS AND EXPERIENTIAL
LEARNING TO RESOLVE COGNITIVE DISSONANCE

There appear to be two issues which must be addressed in developing effective teaching methods which will provide behaviours responsive to the psychosocial needs of patients. These issues involve resolving the cognitive dissonance associated with caring for the elderly, and providing learning experience for those practicing nurses who are too young to have faced their own ageing.

The author has used two methods in developing a workshop designed to provide empathy and understanding toward the elderly. The first method involves small group encounters designed to provide a forum for the exchange of information, facts and ideas, feedback and the free expression of feelings toward the elderly in an attempt to reduce that dissonance. The second method involves the use of vicarious experience and offers the opportunity to explore the effects of being old through experiential exercises.

SMALL GROUP ENCOUNTERS AND THE GROUP PROCESS

The field of modern group dynamics is most closely related to the work of Kurt Lewin (1951) who organized and developed the field theory. This theory pays special regard to the interdependence of part-whole relationships in behaviour and experience. Some of the basic field theoretical constructs involve:

1. the concept of life space as all the facts that exist for an individual or group at a particular time;
2. tension, energy, need, valence and vector as dynamic concepts essential to the analysis of behaviour;
3. processes such as perceiving, thinking, feeling, acting and remembering as the means by which tensions in a system become equalized;
4. learning defined as a variety of processes involving change, such as change in cognitive structure (new knowledge), change in motivation (learning new likes and dislikes), or change in group belongingness (as in growing into a new culture (Luft, 1970)).

Lewin (1948) found that certain methods of group discussion and decision making were superior to lecturing and individual instruction for changing ideas and social conduct. These findings were supported by a number of investigators working in diverse settings. Coch & French (1948) established that resistance to change in Virginia Textile factories was reduced when employees and management came together as a group to discuss their concerns and to plan new approaches to problem-solving. Levine & Butler (1952) supported this work in similar studies involving factory workers and their supervisors in a large manufacturing plant.

In a more recent report by McKeachie (1960) the value of group discussion and the lecture method were compared. Initial results demonstrated that in both methods, students learned about the same amount of subject matter of psychology. However, the group-centered class developed greater insight into personality dynamics than did the ordinary lecture class and they seemed better able to apply what they had learned to new problems.

In reviewing the evidence supporting group process, Luft (1970) is quick to point out that these teaching methods are not conclusive by any means and that the individual differences in the values and skills of the instructor provide important variables.

It would appear to follow that if people learn better in a group, are able to share experiences and ideas and if they are then able to use these ideas in their work, then the basic information that is necessary should be presented to them in a forum which offers the opportunity to discuss the issues. The processes identified as essential to field theory and which involve perceiving, thinking, feeling, acting and remembering should be stimulated to produce a consensus in which the group is able to equalize the tension of having different beliefs. This growing into a new culture would produce new behaviours and a sense of class identity with the group and the group norms.

The effect of member involvement and participation in the learning process is discussed by Bradford (1968) who states that:

"If the individual learner . . . and his peers could be invited to supply data from their own feelings and

learning experiences concerning the effectiveness of the procedures and activities; if they could test jointly the accuracy of their perception, could explore diagnostically the individual emotional problems affecting learning and join in experimenting with different procedures for learning, involvement would be much deeper".

(from 'Developing Potentialities through Class Group' p.43 Bradford 1968)

LEADERSHIP

The establishment of acceptable group norms depends largely however on the skills and strengths of the group leader. As Luft pointed out, the values and skills of the instructor can have an immeasurable effect on the outcome of the process. The potentiality for power in the role of the group leader has been thoroughly explored in a variety of studies over the years and involves such variables as personality and charisma, dress, entertainment-style, the audiences perception of the leader's knowledge base and experience (Williams & Ware, 1977). There are those who would consider the group process as manipulative and dangerous for society based on the persuasive powers of group leaders (Baritz 1960: Odiorne 1963). While the author wishes to acknowledge these criticisms, it is not the purpose of this paper to debate this issue, but rather to direct the reader's attention to the success or failure of the group meeting certain goals depending upon more than just the process. Having a group leader who is credible and knowledgeable is an essential element of successful group work where the learning has pre-established goals and objectives.

It is generally acknowledged that the group leader should be able to sense what is happening in the group and within himself. This cannot be measured unless one is able to observe the skill used in contributing to the task of the group and to the emotional process that is taking place (Ohlsen, 1970). It appears to be important within the framework of field theory, that the group leader be identified as that person 'whose pertinent frame of reference is one which other group members attempt to assume'. It is clear that the group leader must be credible for this to take place and must have a clear commitment to the direction which the group is to take (Hartford, 1971).

For the purpose of this study, the group leader will remain constant. However, the author acknowledges that the measurement of the outcome of the workshop is also a measurement of the competence and ability of the group leader.

The group leader's role is primarily that of a facilitator. The leader should be skilled in recognizing predominant feelings within the group and noticing when the group members seem to be particularly aroused by the subject. The leader should recognize those who are more withdrawn within the group and be prepared to draw them into the discussion. Knowing when to offer information and when to allow new ideas and discussion without interfering with the process are important aspects of this leadership role. (Klein, 1969).

WHY GROUPS WORK

All people work in groups and it is the rare person who can assume an existence independent of other living beings. Indeed, such people are considered eccentric for their reclusive behaviour. Even when working alone, one is dependent on the input of others so that work can be supplemented and the expended effort is not at cross purposes and causing duplication. Interpersonal consultation is an important aspect in balanced learning where studying alone can be enhanced by an opportunity to discuss concepts and issues with a group.

There are several variables that appear to affect the functioning of a group. These include the size of the group, the nature of the task, group membership, time, motivation (both internal and external to the group), goals (imposed and self-determined), intergroup communication, conformity pressures and morale and interpersonal influence (Luft, 1970 p.28-29). There is however no comprehensive theory which links these variables to demonstrate a definitive framework for how they relate with one another. There do appear to be some common factors which identify group process as an effective method of problem solving. These involve the facts that:

-While problems demanding a single over-all insight are usually better handled by one individual, problems requiring a wide variety of skills and information or a cross-checking of facts and ideas seem to call for a group approach. Feedback and free exchange of thinking may stimulate ideas that would not otherwise emerge.

-Shared goals produce co-operative effort.

-The smaller the size of the group, the better it will function provided that the necessary diversity of skills and group maintenance resources are present.

-A group may be a source of strong interpersonal stimulation and will generate its' own conformity pressures. These two sets of forces (stimulating and binding) should be kept in mind.

(abbreviated from Summary of Group Versus Individual Productivity (Luft 1970 -p.30)

STRUCTURE

Groups are affected by internal organization and procedures. In a study of homogeneous groups arranged on the basis of need for structure by individual members (Stock & Luft 1962), the highly structured group members proceeded in a more direct, open manner, were more task-oriented and less process-oriented and seemed to move more quickly toward surface communication and surface relationships and showed greater deference to persons of power and authority. Low-structured group members were more supportive and more interpretive of group members and feelings and took more time to reach consensus.

For the purpose of this study, the author proposes to use a highly structured process because of the restriction of time and the necessity of meeting some pre-established learning objectives. It is anticipated that, while communications and relationships are more superficial, the individual group members will experience a more personal realization of the subject and their beliefs and concerns for the elderly will move

toward those identified as acceptable by the group and the group leader.

To reduce the threat to individuals of self-disclosure in front of large numbers of people, groups should be restricted in size. The less time that is available to complete a given task, the smaller the group size so that members can get to know each other more quickly and overcome that fear of expressing an unpopular opinion or revealing an inadequacy. It is documented that individuals find it extremely difficult to sustain direct relationships with any more than 10 or 11 individuals at any one time (Somers, 1968). Group sizes of 8-10 persons appear to provide optimum levels of interaction among members.

GROUP PROCESS AND THE THEORETICAL FRAMEWORK

The theoretical framework for reducing cognitive dissonance about ageing and working with the elderly has been described and represented in Figure 2:1 (p.61). Group process will be the vehicle for creating a subjective norm for the individual which will support positive intentions to behave appropriately. The group discussion of various attitudes toward their work with the elderly and how the elderly behave will create a climate for this consensus of opinions. The normative beliefs will be explored and consensus will be reached among group members under the guidance of the group leader as to how members of the group should behave toward the elderly. It is expected that once individual group members recognize that others have the same concerns about

finding the time to do what is needed and realize that the system in which they work supports this philosophy of concern, then they will try to behave in a way that they and their co-workers decide is acceptable.

THE USE OF EXPERIENTIAL WORKSHOPS

While group dynamics might be useful to explore attitudes and determine acceptable behaviours, the instructor must have a means for tapping into those findings about the ageing process. For the younger nurse who has not had extensive experience with ageing or who has had no personal experience with the ageing process, relating to the issues is difficult and requires a direct encounter with circumstances which create difficulty for the ageing patient. Like the Life-Cycle game (Chaisson 1980) which has been discussed, some form of vicarious or experiential learning is necessary to provide that opportunity. Various other games have been developed to provide this experience and include such simulation games as Into Aging (Hoffman, T.L., Reif, S.D., 1978), Self Portrait (Monea H. 1976) and The Loss Game (Martin, Buckwalter 1984). In this recent article by Martin and Buckwalter (1984) the need to measure the effectiveness of such methods of teaching is explored. In discussing a theoretical framework for experiential learning, the authors refer to an experiential taxonomy developed by Steinaker & Bell (1979). They describe participation as "characterized by a conscious effort on the part of the learner to replicate in some way that to which the learner has been exposed"(p.26). Identification is

defined as 'a union of the learner with what is to be learned in an organizational, emotional and intellectual context'. When internalization occurs, the authors believe that an intellectual commitment and learned behaviour results.

The use of experiential workshops is becoming increasingly popular in continuing education for gerontological nursing. Martin and Buckwalter recognize the need to evaluate that effect and have developed a methodology that involves pre- and post workshop testing and the need for follow-up post tests to determine the long-term effect of such an encounter. They focus on the measurement of attitude change and do not address the issue of the resulting behaviours, or indeed, whether it would follow that behaviours would change with attitude. This author contends that they have missed a critical point in determining the effectiveness of such workshops on those who are providing direct, hands-on care to the elderly.

PURPOSE OF WORKSHOP EVALUATION

It is the author's intention to evaluate a similar workshop program which combines group process and experiential learning to determine whether the process changes not only the attitude of the participants but also whether an intention to behave differently can be demonstrated. The critical questions appear to be:

1. Can attitudes or behaviours be changed in this forum ?
2. If attitude is changed, does it necessarily follow that positive behaviours will result ?
3. If positive behaviours result, are they maintained over time ?

AGEING ! - MOI ?

This author has designed a full day workshop that is intended to use these principles of cognitive dissonance and social dynamics to teach nursing staff in service about ageing and to improve their attitudes and behaviours toward their aged residents. The workshop is a series of connected exercises that are run in sequence and are designed to explore the source of the individual's attitudes (both positive and negative), the process of ageing from the individual's perspective, current values and the reaction to grief and loss, power in the institution and its' effect on self-esteem and personal identity and the effect of meaningful communication and reminiscing. (See appendix

for workshop agenda and objectives). The content of these workshops has evolved from two years of presentations to community and nursing home staff and has involved ambulance attendants, firemen, community health workers (social workers) and nursing staff. Evaluation has involved anecdotal feedback requested at the end of each session (a sample of this is found in appendix). The sessions depend heavily on experiential feedback and discussion and the group dynamics theory. It is the author's belief that cognitive dissonance plays a great part in the reported attitude change but this is not directly measurable from the results. Such evaluation reports include comments like 'I never thought about it like that . . .' and 'You made me see things in a different way . . .' suggesting a re-orientation of the individual's belief system to provide a different perspective on all too familiar circumstances.

Using cognitive dissonance theory and principles from the theory of social dynamics as a conceptual framework, the author intends to evaluate these workshops to explore the effect of experiential learning and group dynamics on staff attitudes and reported intentions to behave positively toward the elderly.

CHAPTER III

PROPOSAL FOR EVALUATION OF THE WORKSHOP AND VALIDATION OF INSTRUMENTS

INTRODUCTION

The purpose of this evaluation process is twofold. First, the author wishes to establish the validity of the two instruments designed to measure degree of attitude change and change in intention to behave when nurses are involved in a workshop using group work and experiential learning. This will be accomplished by analysing the scores when these instruments are applied for the three variables of level of education, age and number of years working with the elderly. Comparisons of these results will be made with results of work reported in the literature and with the theoretical framework and expectations for attitude and behavioural change discussed in this paper. Consistency of scores will be considered making the following assumption:

Attitude and Behaviour are positively related and so a positive or negative change in attitude toward old people will produce a corresponding change in intention to behave.

The second purpose of this study is to evaluate the effect of a workshop which combines group process and experiential learning on nursing staff who work with the elderly. Attitude and behavioural intentions will be measured pre-workshop, post workshop and three months later to determine the effect of the workshop content on various groups of staff. The

author expects that there will be differences in reaction to the material and makes the following assumption:

When group encounters and experiential learning are combined to teach nurses about behavioural approaches to care of the elderly, there will be a positive change in attitude and reported intentions to behave and this change will be sustained over time if the environment in which the staff practice is supportive of those behaviours.

METHODOLOGY

THE SETTING

Evergreen House is a 200-bed long term care facility attached to Lions Gate Hospital in Vancouver, B.C. The director of that facility is concerned about producing change in nursing behaviours to provide an environment characterized by 'empathy and caring'. With this goal in mind a proposal was submitted to the Hospital Board for funding for an educational program for all nursing staff. This proposal involved attendance by staff at a one-day workshop (see proposal - appendix). The expected number of participants at the workshop would be 130 people. The workshop would run daily for five days with approximately 26 people attending each day.

WORKSHOP OBJECTIVES AND CONTENT

The workshop is divided into five sessions or exercises which are designed to run consecutively and take staff through a series of learning experiences (the advertising poster and workshop agenda are included in appendix).

SESSION #1 WHERE DO WE GET OUR ATTITUDES ABOUT AGEING ? 1 hour

OBJECTIVE: Each participant will recall one positive and one negative experience with an elderly person and recognize what impression that experience had on his/her attitudes about old people.

METHOD: Small group discussion (no more than 6-10). A moderator (group leader) should be assigned to make sure that no one person monopolizes the discussion and that each person has a turn. Each participant should offer one brief story of a positive and a negative experience with an old person from his past. The moderator might choose to review all negative experiences first and then all positive stories. He/she may choose to begin the session with his/her own personal story, especially if no one steps forward to begin.

Things to be aware of: Such reviews often evoke tears as old memories are revived. The group should be warned that this might happen and that accepting each others'

tears is an expectation of the process.

SUMMATION: The group leader should sum up the discussion by referring the members back to the objective of the exercise and reiterating that all of these feelings help to form our attitudes of what it must be like to be old. Examples of positive characteristics: Old people are seen to be active, productive, good teachers with time and patience, wise, influential, proud, loving and caring. Examples of negative characteristics: Old people are seen as lonely, frightened, helpless, angry, bitter, sick, confused and a burden to others.

SESSION II AGEING ! MOI ? 1½ hours

OBJECTIVE: Each participant will be able to relate the ageing process as it is viewed socially, to his own lifestyle and will recognize both positive and negative elements in that process.

METHOD: The group of 6-10 people will sit in a quiet room, away from distractive noise and interruption. The lights may be turned down and quiet music played to create a peaceful environment. The members of the group are asked to find their own space both physically and mentally and not to share information with one another.

METHOD:
cont'd.

A group leader will slowly read the instructions from Table #1 allowing adequate response time for each item. After completing the exercise in Table 1, the group should be given a few minutes to reflect on 'who they are' as an old person. Then the light can be turned up and the group can discuss the items on the list in relation to the information they have about lifestyle and how current practices will affect their ageing process (e.g. smoking, overeating, etc.) and some of the sociological realities of how they will live as they get older.

Things to be aware of: The nature of the exercise lends itself to humour and so people may not take it seriously at first. It must be stressed at the beginning of the exercise that the process is only as effective as the members of the group make it.

People who have debilitating disease processes or who have family histories which suggest early infirmity and perhaps early death will take the exercise most seriously. The positive aspects of how early screening, diet and exercise and information about good health can prevent progress of such problems should be stressed. (It is interesting to note that if an age is chosen for the exercise beyond the suggested 72 years, most smokers draw themselves in a box.)

AN AGEING FANTASY

Each group member should have paper and a pencil.

The setting should be quiet, with lights dimmed and music playing softly. The group is first directed to project themselves into the future and think about growing old. They are told to think of themselves at 72 years of age.

The leader then directs the group as follows:

1. On a piece of paper, draw a picture of yourself at 72. Include any mechanical aids you might need at that age (glasses, canes, walkers, etc.). (approx 3-5 mins.)

2. Keep this picture of yourself in mind and respond to the following questions:

- who do you live with ?
- where do you live ?
- do you have any other significant family members ?
- where do those family members live ?
- what is your income ?
- how do you spend your time ?
- are you healthy ?
- do you have any pets ?

Allow adequate response time - do not rush the group.

3. If you become disabled and you are admitted to an institution, describe what you would like the environment to be like. Consider your living space, list the things you would like to be responsible for and the control you would like to have over that space.

Allow at least 5 minutes response time.

4. Consider the staff of that institution. What would you like them to be like ?

Allow at least 3 minutes response time.

The group should then discuss the above material and make a list of environmental and attitudinal changes that staff in an institution could make without significantly changing ward routines or the physical layout of the building.

TABLE I

SESSION III

COME TO LUNCH IN THE DAY ROOM

2 hours

OBJECTIVE: To provide the members of the group with the experience of being a patient and to demonstrate power and its' use through the structured behaviour of staff in an institution.

METHOD: 6-10 people with two persons acting in the custodial role. Follow the directions in Table II.

PART I:
(1 hour)

Things to be aware of: frustration, tears, anger and 'acting out' behaviour are often expressed by the participants. Those persons whose behaviour is particularly disruptive should be 'isolated' much as we would isolate 'problem' patients.

The people who demonstrate the strongest personalities in real life are often the ones who will be the most difficult to manage in this exercise. Be aware of some of the extreme measures suggested and used to contain that behaviour. Be prepared to discuss this phenomenon during debriefing.

PART II:
(1 hour)

DEBRIEFING: DISCUSSION

Have people list the feelings that they had toward the 'caregivers' during this exercise. Discuss the feelings expressed. The list will include anger, frustration, fear, powerlessness, despair, withdrawal and even dis-

"COME TO LUNCH IN THE DAY ROOM!"

Small group 6-10 people

Two persons acting as 'staff'

Bibs, restraints, string, opaque tape, straws, 'lunch'

As the group arrive, they are individually assigned to wheel-chairs or geriatric chairs. They are provided with 'deficits' (one lens on their glasses covered for hemianopsia, center of both lenses covered for cataracts, one arm tied to the chair-arm for hemiparesis, one leg on the same side tied to the wheel-chair) are restrained, are provided with a bib and are labelled with large printed labels saying "I AM DEAF" or "I AM CONFUSED" or "I CAN'T SPEAK". Each participant is told about his label.

The participants are seated around the table and served lunch. Tea should be sipped through a straw. The 'staff' can be innovative in managing their patients, feed them, isolate them if they act out, take them to the bathroom (if they are on a 'bladder routine') and play 'nice' (loud) music for them so that they can enjoy themselves. Rubbing orange peel, strong soap or cleaner on the hands before offering fluids through a straw produces interesting reactions. The 'staff' can be as innovative as they like within reasonable and realistic terms.

After 30 minutes, 'release' the participants and discuss the feelings that resulted from this activity. Who was in control?

TABLE II

orientation. Explore why these feelings occur. Who has the power? What choices do residents have? Are they able to maintain a sense of dignity and self-worth under these circumstances? What would be the natural process of such treatment for these group members if they were unable to step out of that role? Did the caregivers feel powerful?

SUMMARY: The group should discuss these staff/patient roles and the resulting behaviour and then consider the effect of this treatment on patients who have already undergone multiple losses.

SESSION IV POWER IN THE INSTITUTION - WHO HAS IT? 3/4 hour

OBJECTIVE: Members of the group will identify nursing behaviours which affect the resident's freedom to make choices about everyday life.

METHOD: Small group 6-10 people. The group leader will introduce the topic by discussing factors in our own life which we take for granted such as: privacy in our own room and in the bathroom, the choice of clothing, the choice of when to eat, where to eat and with whom to share the meal, the choice of activities, etc. etc. Special concern should be placed on the issue of the risks involved in giving residents their freedom.

SUMMATION:

The group leader will sum up the discussion by listing the controlling behaviours and soliciting alternative approaches that nurses should use in returning power to the patient.

SESSION V

LOSSES AND WHAT THEY DO

1 hour

OBJECTIVE:

Each participant will recognize how the series of losses associated with their personal life can affect one's self-esteem and sense of identity.

METHOD:

Small group discussion 6-10 people. A moderator should be chosen who will provide the directions from Table III. After each item is removed from the list, discussion should follow about the effect of the loss of that item on the individual's sense of person and self-esteem.

Things to be aware of: This can be a most depressing exercise and some participants may become tearful as the sense of loss overwhelms them. The group should be warned of this and that accepting each others' tears is part of the process.

SUMMATION:

The group leader should relate the exercise to the experience of many people who are in a nursing home and who have suffered multiple losses of spouse, home, role, community and friends and finally, health.

LOSSES AND WHAT THEY DO

Small group - 6-10 people
Paper and pencils

The moderator will read the following directions:

Each person will list 5 things which he/she most associate with himself as a person. These may include people, places, possessions or roles.

(Allow 5 minutes response time, or until everyone appears to have finished)

1. Ask the members of the group to choose one item from the list and cross it off - Discuss.
2. Ask the members of the group to remove the item from their list which is closest to the bottom - Discuss.
3. Ask the members of the group to reach over (without reading their neighbours list) and cross off one item from the list of the person sitting to their left - Discuss.
4. Ask the members of the group to cross off the most valuable of the two items that remain - Discuss.
5. Discuss the effect of such losses if one's health and independence were also taken away.

TABLE III

FOLLOW-UP
EXERCISE

Each group member should review one history of a resident and count the losses that individual has suffered in the past ten years. A follow-up meeting of the group to share these stories of residents would provide the members with an opportunity to get to know their patients in a more personal way.

SESSION VI

REMINISCING "WHO AM I ANYWAY"

1½ hours

OBJECTIVE:

Each group member will know some personal anecdote from the past of each of the other participants and will recognize that the roles we see others in are only a small part of who they are.

METHOD:

Small group 6-10 people. A group leader should be chosen to follow the directions in Table IV.

Things to be aware of: Surprises !!!

SUMMATION:

The group leader should relate the exercise to the experience we have in taking care of residents in a sick, patient role. Sometimes we do not consider that they have another story. The therapeutic value of being able to tell that story, both to validate yourself as a person and to receive feedback from friends that you really are "O.K.!" should be discussed.

FOLLOW-UP
EXERCISE

"PEEGE" - a movie about communication and reminiscing.

REMINISCING - "WHO AM I ANYWAY"

Small group - 6-10 people

The moderator will direct the group members to take 5 minutes to think of a story from their own life which best reflects some aspect of who they are which is unrelated to their role at work as others see them. For example, someone might relate an experience that they had while living elsewhere in the country when they were involved in an art group or in making pottery. The stories should not relate to any aspect of their life as it is known now to other members of the group.

The moderator should allow each person 5 minutes to tell that story and an additional 2 or 3 minutes for other group members to ask questions and glean more details. Time should be minimized carefully.

The group should then discuss the change in perspective that they have about each other through the sharing of these brief glimpses into each others' lives. How does this exercise with each other reflect upon the impressions we have of patients in their sick role ? What stories would they tell ?

TABLE IV

These are just some of the techniques that the author has found useful in sensitizing staff to the needs of elderly residents in long term care facilities. Unlike the "Ageing Game" and other elaborate techniques to create empathy for the elderly, these exercises are simple and require few 'props' and only the concern of a small group of people to explore the process in a personal way.

The author does not intend to suggest that nurses do not already have such information and skills. These exercises combine some valuable and much touted current techniques such as Life Review, Fantasy Validation and theories about grief and loss which are well established in the field of psychology and mental health. The intention of this workshop is to draw the best from each of these techniques and theories and package them so that nurses can share them effectively and within the limits described at the beginning of this paper. More importantly, nurses who are concerned with the day to day care of patients can use them, revise them, be innovative with them and make them fit their special concerns. Hopefully they will spark further interest in some of the more formal techniques referenced in the bibliography.

THE SUBJECTIVE NORM AND THE RIGHT ENVIRONMENT

According to the theorists, learning and attitude change can only occur where the participant is supported by the environment and his peer group. The administrative body at Lions Gate Hospital (the Board) and the director of the department both have demonstrated their support for the learning experience by providing the money for workshop participation and other 'props' such as 'We Care' buttons. The director devised a list of behaviours that he would like to see staff assume as a result of the learning experience. These behaviours will be reinforced throughout the workshops (i.e. no physical restraints, knocking on doors when entering the patient's room, etc.). This represents demonstration on his part of the expectation of performance for his staff.

OPERATIONAL DEFINITIONS

The dependent variables in this study are staff attitude and behavioural intentions. The independent variables are age, length of time working with the elderly and level of education.

Attitude - a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object. (Fishbein, 1975)

Behavioural intention - refers to a person's intention to perform various behaviours. (Fishbein, 1975)

Length of Time working with the Elderly - the number of years a nurse has worked with old people.

Level of Education - the level of preparation of the nurse - Bachelor of Science in Nursing with 4 years preparation in a University setting; Diploma nurse, graduate or a 2 or 3-year program in a hospital or community college setting; Licensed Practical nurse with 1 - 2 years preparation in a hospital or community college setting; Nursing Assistant or Orderly with no formal training necessarily.

(For the purpose of this study other non-nursing personnel will be included - Social Workers with 4 years preparation at the University level, Occupational and Physiotherapy aides and Ward clerks with no necessary formal training.)

Encounter Sessions - (T-group or Sensitivity Group) are described for this study as a group of people who have been brought together to learn about a specific subject (i.e. ageing) and who are able to interact in a setting that is conducive to openness and acceptance, learning, understanding and growth. (Joseph Luft, 1970)

EXPERIMENTAL DESIGN

This evaluation will be quasi experimental with a pre-test, post test design and analysis of three instruments - one to collect demographic material, one to measure the degree of change in attitude toward old people and one to provide information about behavioural intentions. Post test will involve immediate feedback post workshop and three months after the workshop is completed.

ASSIGNMENT

Population involves the total population of nursing staff from the Evergreen House. The participants will randomly assign themselves to one of five full-day workshops to be held on five consecutive days. Each work-

shop will accommodate up to 26 participants. Once in the workshops, the participants will be asked to number off 1 to 3 and will be re-assigned to three working groups, each of which will have a group leader trained by the workshop leader. The three groups will participate in the exercises separately except for Session III (experiential lunch) and will come together for discussions and information sharing.

Before the program begins, the workshop participants will be informed that they are participating in an evaluation process to determine the value of the workshop design and that this will involve completing questionnaires pre- and post workshop and that the workshop leader will visit the hospital in three months to complete a follow-up session involving the completion of the questionnaires again.

Since the evaluations are designed to measure attitude and behavioural intentions, the participants will be assured that there are no 'right' or 'wrong' answers to the questions. The only measurement is whether there is change in how the questions are answered after the workshop and if this change is maintained over time. The individual's name will not be recorded on the evaluation so responses cannot be traced.

INSTRUMENTS

Three instruments will be used to collect the data: See Appendix VI

1. A questionnaire to determine participant's age, number of years working with the elderly and level of education will be used to collect demographic data relevant to the independent variables.

2. Modified Kogan Scale of Measurements of Attitudes toward Old People.

The original scale developed by Kogan is a Likert scale of "Old People" (O.P.) items constructed in the form of positive-negative pairs yielding two O.P. scales: a scale containing items making unfavourable references to Old People and a scale containing matched favourably worded items. While Kogan was unable to establish a clear relationship in the scale between authoritarianism and attitude toward Old People, favourable attitudes toward Old People were associated with anomie and negative dispositions toward ethnic minorities and a variety of physically disabled groups.

The Kogan Scale is composed of thirty-four items listed in pairs of positive and negative statements. These items are intended to be randomly interspersed throughout a questionnaire containing other unrelated items with the result that the instrument can contain from 50 to 100 statements requiring response. The purpose of the instrument is to measure the degree of positive or negative responses of individuals toward the subject (Old People).

This author is concerned with measuring attitude change (either positive or negative) and its' association with change in behaviour. The application of an extensive questionnaire pre- and post workshop along with two other instruments (one to collect demographic data and one to measure behavioural intention) would be too time-consuming and demanding of workshop participants. Since a simple measurement of attitude change is what is required, the author

chose to modify the Kogan Scale by taking one item from each pair and using these items in a simple questionnaire format with no attempt to disguise the questions by interspersing them with other unrelated items.

Seventeen items were selected by choosing the positive item of the first pair and the negative item of the second pair, and so on. Since both the positive and negatively-worded items are reported as having the same reliability, this appears to be acceptable. Kogan reports that correlations between positive and negative scales was found to be significant in the direction of logical consistency of response and all correlations between the positive and negative members of specific item pairs were in the logically consistent direction, the large majority significantly so. Also, a nurturance factor derived by Kogan from a brief personality inventory that was given to the subjects was significantly correlated with Old People scale scores. The more nurturant subjects were more positively disposed toward Old People. This might have significance in the consideration of age and attitude since an individual might demonstrate more nurturance tendencies because of personal life experiences.

For the purpose of this study, the seventeen items on the modified Kogan Scale are arranged for a True/False response with one point being assigned for each correct answer for a total possible 17 points. In considering degree of attitude change in analysing data, the number of points difference in scores between pre- and post workshop

will be converted to percentages. Analysis of results will depend upon a comparison of pre-workshop scores and post workshop scores, pre-workshop scores and three-month follow-up scores to determine the long term effect of the workshop and post workshop scores and three-month follow-up scores to determine the degree to which the change was maintained over time.

Since the Kogan Attitude to Old People Scale is the most frequently used instrument measuring attitude toward Old People, it will provide comparative data as reported in the literature. Consistency in findings of those using the Kogan Scale with the findings in this study will support the validity of the modified tool for measuring attitude change.

3. Workshop Evaluation to Measure Behavioural Intentions

Attitude and attitude change is to be measured in this study by application of a modified Kogan Attitude to Old People Scale. Although derived from an effective tool for determining attitude, this scale will not be effective in measuring behavioural intention or for determining whether the material in the workshop produced any intention to change behaviour. It is necessary to address this concern and to develop a tool which will provide this information.

Methodology for Establishing Questions for Workshop Evaluation to Measure Behaviour

There were two sources of information for determining the items on which it would be necessary to effect change and these were:

1. the objectives of the workshop,
2. the behavioural expectations listed by the Director of Nursing at Evergreen House

The objectives of the workshop have been described along with descriptions of the content of each session. The list of expected behaviours was very basic and included:

- staff will knock on residents' doors before entering their rooms;
- staff will allow residents to have choices about where and with whom they eat, what they wear, what activities they attend, etc.;
- staff will not use physical restraints;
- staff will allow privacy for toileting and bathing;
- staff will practice Reality Orientation and Fantasy/Validation appropriately*;
- staff will allow residents to make choices that may involve some risk if the choice improves the quality of life for that individual.

Five head nurses at Victoria General Hospital - Long Term Care Facility were asked to review the above list of behaviours and add any other behaviours. One additional item was added:

- nurses should not require patients to bathe on a routine basis but should be prepared to assist them with necessary personal hygiene while allowing them to conserve their energy for more enjoyable pursuits.

*Reality Orientation - a 24-hour program of reminding the individual of where he is, who he is and what time of day it is (the three spheres of reality).

*Fantasy/Validation - reminiscing and validating through feedback to reinforce personal identity and self-worth.

This list and the workshop objectives were compared to determine whether there was material in the objectives which was not covered in the list of expected behaviours. These remaining items were listed as:

- staff should not make assumptions about the elderly and anticipate negative behaviour because this establishes a climate where the old people produce the anticipated behaviours.
- staff must have a sense of the person (resident) within the context of his/her life story and as having the same values that he/she has always had;
- staff recognize the affect of multiple loss on the behaviour of old people.

Head nurses at Victoria General Hospital agreed to act as a committee to validate a tool designed to respond to these issues. Coincidentally, a workshop for head nurses had been organized so that they could be introduced to the content of the "Ageing! Moi?" workshops before it was used for Victoria General Hospital staff. They agreed to test the tool pre- and post workshop to determine its' relevance and validity and to assess the wording of the questions. Two head nurses and the nurse clinician worked with the author to establish the wording of the questions.

QUESTION FORMULATION

It was decided to limit the number of questions to no more than ten items since the modified Kogan Scale was a more lengthy seventeen item questionnaire. It was decided to address the broader issues from the workshop objectives first and to ask for responses on a level of agreement ranging from: "I agree - Very Much; Moderately; A Little and Not At All".

Scoring was established by assigning the most positive answer the score of 3 and the least positive answer the score of 0 for a possible total score of 30.

1. To respond to concerns that old people should not be restrained and should be allowed to have choice in what they do, the first question was worded:

In most instances, old people should be restrained to keep them out of harm's way.

Agree Very Much -0; Moderately -1; A Little -2; Not At All -3.

2. Acknowledgement of grief and loss is an important aspect of caring for the elderly and avoidance of these sensitive subjects often results in confusion and anxiety for the geriatric patient. The second question was worded:

When old people cry and express sad thoughts, it is very important to change the subject immediately and remind them of how many things they have to be cheerful about.

Agree Very Much -0; Moderately -1; A Little -2; Not At All -3.

3. Institutionalization often results in the expectation on the part of the staff that all patients are the same and there is no individualization of care. Staff anticipate the worst behaviour and even plan for it and the result is that those in their care live up to those expectations through a system of socialization. The whole issue of urinary incontinence falls into this category. The third question was worded:

Old People frequently are incontinent at night, so the staff should anticipate that and pad the bed and patient securely to keep them warm.

Agree Very Much -0; Moderately -1; A Little -2; Not At all -3.

4. The need to recognize that age is not related to the need for intimacy between members of the opposite sex and that individuals always need to feel sexually attractive is the subject of this question. It was worded:

Male and female residents in an institution who demonstrate physical and emotional attraction and attachment to each other should be separated before an embarrassing relationship develops.

Agree Very Much -0; Moderately -1; A Little -2; Not At All -3.

5. The need to recognize that old people will probably continue to have the same values that they always had and that they need the opportunity to make choices about attending activities and participating in residential programs is the issue addressed in Question #5. This question is worded:

It is good for nurses to encourage old people to do things together even though they may never have liked to join groups before.

Agree Very Much -0; Moderately -1; A Little -2; Not At All -3.

6. The choice of where to eat and who to eat with is an issue in institutions since staff to supervise the mealtime is usually limited. There was a general agreement in the past that patients should be encouraged to eat together as it met a social need (see Question #5). However, the need for privacy in the dining room is surfacing as a major issue. Question #6 tests the response to that issue and is worded:

It is good for residents to all eat together even though they might have disabilities and require assistance with feeding.

Agree Very Much -0; Moderately -1; A Little -2; Not At All -3.

7. The question of over-nurturing and the provision of an overly-protective environment is the issue in this item. Many nurses would go to the extreme of restraining patients to protect them

from falls rather than allowing them to take risks and enjoy independence. This question was worded:

Generally, old people should not be restricted from doing things which require them to take risks because they might injure themselves and cause more disability.

Agree Very Much -3; Moderately -2; A Little -1; Not At All -0.

8. The next question was re-phrased using the same rationale as Question #7 but was designed to test the perceived need to provide the protective environment regardless of the belief that old people should be allowed to take risks. It was worded:

It is the nurses' responsibility to protect residents so that they do not injure themselves.

Agree Very Much -1; Moderately -3; Very Little -2; Not At All -0.

9. Offering everyone, regardless of their mental and physical status, the opportunity for privacy was tested in Question #9. The question was worded:

Knocking on the door of a resident's room is a waste of nursing time if the resident is confused or deaf.

Agree Very Much -0; Moderately -1; Very Little -2; Not At All -3.

10. The issue of personal hygiene and the need for regular bathing versus retaining energy for other activities was addressed. The question was worded:

Every resident should have a tub or bed-bath at least three times each week because old people have poor personal hygiene.

Agree Very Much -0; Moderately -1; Very Little -2; Not At All -3.

It was agreed that these ten questions covered all items in the behavioural list and from the objectives.

Validating Responses

The head nurses completed the questionnaire pre- and post workshop. All positive items received positive responses in the 'moderately' to 'very much' range. All negative items received negative responses in the 'not at all' range. One item was directed to be changed.

Item changes:

Because of conflict nurses would feel when the words 'risk', 'injury' and 'further disability' were used together, it was suggested that Item #7 be reworded. The new wording was directed to be:

Old people have the right to take risks.

Head Nurses responded to this item on a 'very much' to 'moderately' range.

This instrument, tested by five head nurses, a nursing director and a nurse clinician, all practicing in Gerontology, was validated as mostly responsive to positive statements about beliefs and behavioural intentions for old people and totally responsive to negative statements. It appears that it will retrieve sufficient information regarding behavioural intentions for the purpose of this practicum. (See Summary of Scores, Appendix)

The instrument will be applied pre-workshop, post workshop and three months later and results compared with results from the modified Kogan Scale for consistency between attitude and behavioural change. Scores pre-workshop and post workshop will be compared for differences in

response. Pre-workshop scores will then be compared with three month follow-up scores to determine the amount of change over time and post workshop scores will be compared with three month follow-up scores to determine whether new behaviours are sustained or lost over time. Differences in scores will be converted into percentage differences for the purpose of comparison.

The workshops would be run with the help of two assistants, both trained by the workshop leader as group leaders. The assistants would also monitor workshop content from day to day to make sure that all the material was covered and the workshop objectives were met.

LIMITATIONS OF THE RESEARCH DESIGN

The population for the study involves all of the staff at Evergreen House and there is no attempt to produce random assignment of personnel from a variety of facilities. Since one of the major premises of this practicum is that participants require a consistently supportive environment and the experience of knowing that those they work with are suffering from the same cognitive dissonance, the need to operate in one facility and to provide the social dynamics of the workshop for co-workers is essential.

Consideration was given to dividing the workshops into two groups to test the effect of two types of presentation: the first involving experiential, participatory exercises; the second providing straight didactic presentations that would not require the individual to draw

upon personal experience or provide personal input. This methodology was rejected for two reasons:

1. Administrators at Evergreen House had contracted for the experiential learning workshops because of previous success with the program in another area of their facility and they did not wish the format to be changed.
2. Although there might be an immediate difference in the response of participants as reported in the Attitude to Old People Scale, that difference would be modified over time by the fact that the two groups (experiential and didactic) would infect each other thus compromising the long term feedback.

Since attitude change is of little value without change in behaviour, the author should attempt to measure actual behaviours pre- and post workshop. However, this process would be time-consuming and would require considerable effort to establish and is beyond the limits of time and funding for this evaluation. The author intends, through the results of the third instrument only to measure participants' intention to change behaviour.

SUMMARY

The Group work and Experiential Workshop design will be evaluated for its' effect on attitudes of participants toward old people and to determine the effect of the attitude change on behavioural intent of the participants.

Data from the questionnaires will also establish validity for the two instruments to measure attitude and behavioural intentions. The results of this study are expected to generate hypothesis relative to the use of a variety of innovative methods for presenting information about ageing and the effect of the working environment on those methods.

L I O N S G A T E H O S P I T A L

S T U D Y

S U M M A R Y O F R E S U L T S

LIONS GATE HOSPITAL STUDY

IMPLEMENTING THE WORKSHOP

The workshops were carried out over five days in February, 1984. Several problems developed which interfered with the initial intention of the project and they are described below. There were also several reinforcing factors that were initiated by the administrative staff at Lions Gate Hospital.

Group Assignment

The total number of participants was 128 people divided between the five days (Day I - 28; Day II - 24; Day III - 27; Day IV - 25; Day V - 24). All participants completed the pretest and one Licensed Practical Nurse failed to return in the afternoon to complete the post test due to illness (127 respondents).

The original intention was to randomly assign the participants for each day into three working groups by numbering off in "3's". Each group was to be led by a group leader directed by the author. These group leaders did not materialize because of commitments elsewhere and the entire group met together and worked together each day under the leadership of the author. While this might have provided more consistent leadership and removed an important variable in the response of group members to the process, it also interfered with the opportunity for more personal exchanges. The participants would have been more inhibited in speaking out in front of such a large group. Rather than the proposed group size of approximately

8-10 people, the groups consisted of 24-28 people compromising one of the fundamental principles of group process.

The Setting and Reinforcing Factors

The setting for the workshop was a large comfortable room with moveable chairs. The chairs were arranged in a circle so that all participants could see each other. Several techniques were used by the hospital administration to identify their support for the process. These included the request that each participant submit a list of five caring behaviours which they were to place in a raffle box. At the end of the week there was a draw and the winner received a large Care Bear. This bear sat in on each of the workshops and became a familiar 'mascot' to those who had participated. The caring behaviours on the lists were compiled and made available on each unit as reminders and reinforcers of some of the decisions made during the workshop process.

At the completion of each day, each participant received a "We Care" pin from the administrator. This simple, visible message was a powerful reinforcement from the hospital administration of the expected outcome of the workshop. Recipients made sure that they did not leave without their pins.

The agenda for the day was provided for each participant and was adhered to with some compulsion so that adequate break times were taken and people did not feel trapped or anxious about the content and length of the day.

The Instruments

Pre-test questionnaires were handed out by the workshop leader before any discussion took place about the days activities. The intention of the questionnaire was explained as being an evaluation tool to examine the type of learning that was taking place in the workshop. It was explained that there were no right or wrong answers to questions, and people were to complete them as well as they could, not add their names, and place them upside down on a table at one end of the room. Post test questionnaires were handled in the same way and a reminder was given that participants would be asked to complete a third questionnaire in approximately three months' time. At the end of three months, questionnaires were sent to Lions Gate Hospital, in care of The Administrator, with a request that he circulate them to all workshop participants. There were 65 responses to the three-month follow-up questionnaire - approximately 50% of the original population.

ANALYSIS OF RESULTS

Results of responses to the modified Kogan's Attitude to Old People Scale and the Workshop Evaluation designed to measure intention to behave positively were analysed for the three independent variables - age, number of years working with the elderly and level of education.

A total of 128 people responded to the pre-workshop questionnaire and 127 people responded to the post-workshop questionnaire. Seventy-five of the respondents were nursing assistants and orderlies and the

average age of this group was 34.78 years. Five respondents held degrees in nursing and their average age was 37 years. Thirty were registered nurses from Diploma programs with an average age of 49.93 years representing the 'oldest' age group. Seven were Licensed Practical Nurses (one did not respond to the post workshop questionnaire). The average age of this group was 31.14 years. Non-nursing personnel included seven Occupational Therapists (O.T.) and Physiotherapists (P.T.) aides and two ward clerks (W.C.) with an average age of 37 years, and two respondents were social workers with an average age of 45 years.

SUMMARY OF RESULTS

Total possible score for the Attitude Scale was 17. The mean scores for the total population of 128 participants on this modified Kogan Attitude to Old People Scale was 11.81 before the workshop and 12.55 after the workshop, a net gain of only 0.74. This would suggest only minimal positive change in attitude immediately following the workshop. There was no increase in attitude after three months with a total gain in mean score increasing to only 0.77 (0.03 points over post workshop scores).

Total possible scores for the behavioural intention questionnaire was 30. The mean scores for the workshop evaluation which measured intention to behave positively pre workshop was 16.39 while post workshop this score had increased to 19.5. This demonstrates an increase of 3.11 points in the behavioural scores immediately following the workshop. This score dropped to 1.7 (6%) over pre-workshop scores in the three month follow-up study indicating a loss of 1.41 (5%) in the total post workshop score in that time.

LIONS GATE HOSPITAL STUDY

Comparison of Mean Scores and Percentage Differences
For the Three Variables of Level of Education, Age &
Number of Years Working with the Elderly

LEVEL OF EDUCATION

	PRE-WORKSHOP			POST-WORKSHOP					3-MONTHS FOLLOW-UP						
	No.	Attitude	Behaviour	No.	Attitude	Behaviour	Mean Difference Pre-Post Workshop		No.	Attitude	Behaviour	Mean Diff. Preworkshop		Net Loss/ Gain in 3 m	
							A	B				A	B	A mths.	B
BScN. Av. Age 37.00	5	12.4	21.6	5	13.0	24.0	0.6 4%	2.4 8%	4	13.3	23.3	0.9 6%	1.7 6%	0.3 2%	(0.7) (2%)
Social Worker Av. Age 45.00	2	12.5	21.5	2	13.5	22.0	1.0 6%	0.5 2%	1	16.0	21.0	3.5 20%	(0.5) 12%	2.5 15%	(1.0) (3.0)
R.N. Av. Age 49.93	30	12.0	17.8	30	12.9	20.9	0.9 6%	3.1 11%	13	14.4	20.7	2.37 15%	2.94 10%	1.5 9%	(0.2) 1.0%
L.P.N. Av. Age 31.14	7	14.1	17.4	6	14.5	21.2	0.4 2%	3.8 13%	2	15.0	19.0	0.9 5%	1.6 5%	0.5 3%	(2.2) (7%)
WC/OT/PT Aides Av. Age 37.00	9	11.7	17.8	9	13.3	18.7	1.6 9%	0.9 3%	5	14.0	20.2	2.3 14%	2.4 8%	0.7 4%	1.5 5%
N.A. Av. Age 34.78	75	11.4	15.2	75	11.3	18.5	(.1) 1%	3.3 12%	40	11.5	17.2	0.1 1%	2.0 7%	0.1 1%	(1.3) (4%)
TOTAL POPULATION	128	11.81	16.39	127	12.55	19.5	0.74	3.11	65	12.58	18.09	0.7	1.7	0.03	1.41
AGE															
40 +	56	11.6	16.6	56	12.5	19.8	0.95 6%	3.2 11%	18	13.6	19.6	2.0 12%	3.0 10%	1.1 6%	(0.21) (1%)
30-40 years	36	11.5	16.2	36	12.4	19.4	0.9 5%	3.2 11%	17	12.7	19.5	1.2 8%	3.3 11%	0.3 3%	0.1 0
30 years ↓	31	12.1	15.4	31	12.4	18.6	0.3 2%	3.2 11%	17	12.1	17.3	0 0	1.9 7%	(0.3) (2%)	(1.3) (4%)
NUMBER OF YEARS WORKING WITH THE ELDERLY															
10 - 20 years	32	12.0	17.5	32	12.8	19.3	0.8 5%	1.8 6%	16	13.6	19.4	1.6 10%	1.9 7%	0.8 5%	(0.1) 1%
5 - 10 years	42	11.7	15.6	42	12.8	19.0	1.1 6%	3.4 11%	18	13.2	19.3	1.5 9%	3.7 12%	0.4 3%	0.3 1%
2 - 5 years	33	11.7	15.6	33	12.1	19.4	0.4 3%	3.8 13%	18	11.5	17.3	(0.2) (1%)	1.7 6%	(0.6) (4%)	(2.1) (7%)
2 years ↓	17	11.8	17.4	17	13.4	21.1	1.6 10%	3.7 12%	9	12.4	20.1	0.6 4%	2.7 9%	(1.0) (6%)	(1.0) (3%)

A summary of total scores is reported in Table I. This table also reports mean scores pre- and post workshop and for the three months follow-up for the three variables of level of education, age and number of years working with the elderly. Relationships between these variables and attitude and intention to behave are demonstrated in Figures I-VI. These data are discussed below for each variable.

Level of Education

There is a demonstrated relationship pre-workshop, between the level of education of the participants and attitude, with social workers and degree nurses scoring only slightly higher (12.5 and 12.4 respectively) than registered nurses (12.0) other non-nursing personnel (11.7) or nursing assistants (11.4). (See Figure 1) The exception is the licensed practical nurses who scored considerably higher than any other category (14.1) in attitude scores.

Behavioural intention scores do appear however to demonstrate a more positive relationship between level of education and expected behaviours, with social workers and degree nurses reporting higher scores of 21.5, registered nurses 17.8, non-nursing personnel 17.8 and licensed practical nurses 17.4. Nursing assistants scored only 15.2 on this pre-test questionnaire.

Figure 2 demonstrates the difference in mean scores between post-workshop scores and the three-month follow-up scores for the various levels of education. There is no relationship demonstrated between the level of education and the attitude change, or change in the intention to behave

over time, as a result of the workshop. In all instances attitude scores improved over time while there was some loss between three-month scores and post-workshop scores in intention to behave positively, with the exception of non-nursing personnel who made noticeable gains in this score. Registered nurses (N=13) made the most gains in attitude mean scores 2.37 (15%) and retained the greatest increase in mean score for intention to behave positively 2.94 (10%) over pre-workshop scores. The average age of this group was reported as 49.9 years and they represented the 'oldest' reporting group.

Non-nursing personnel (N=9) scored almost as well in the three-month follow-up with an increase in mean score for attitude of 2.3 (14%) over pre-workshop scores, while behavioural mean score increased by 2.4 (8%) demonstrating a consistent improvement in scores over time. Degree nurses (N=5) and LPN's (N=7) made consistent gains in attitude and behavioural scores 0.9 (6%) and 1.6 (5%) respectively for both scores, while Nursing Assistants (N=75) improved behavioural intention scores over time by 2.0 (7%) while attitude scores changed minimally by only 0.1 (1%). (Social work scores (N=2) are included on the Table but the results are not considered valid because of the small number of respondents.)

The author would conclude that while level of education has a slight positive relationship to attitude pre-workshop, it does not appear to affect the degree of improvement in attitude over time. Intention to behave positively is affected positively by level of education pre-workshop but does not affect the degree of intention to improve behaviour, although final scores continue to be positively related to level of education.

LIONS GATE HOSPITAL STUDY

COMPARISON OF MEAN SCORES PRE-WORKSHOP FOR ATTITUDE AND BEHAVIOUR WHERE LEVEL OF EDUCATION IS A FACTOR

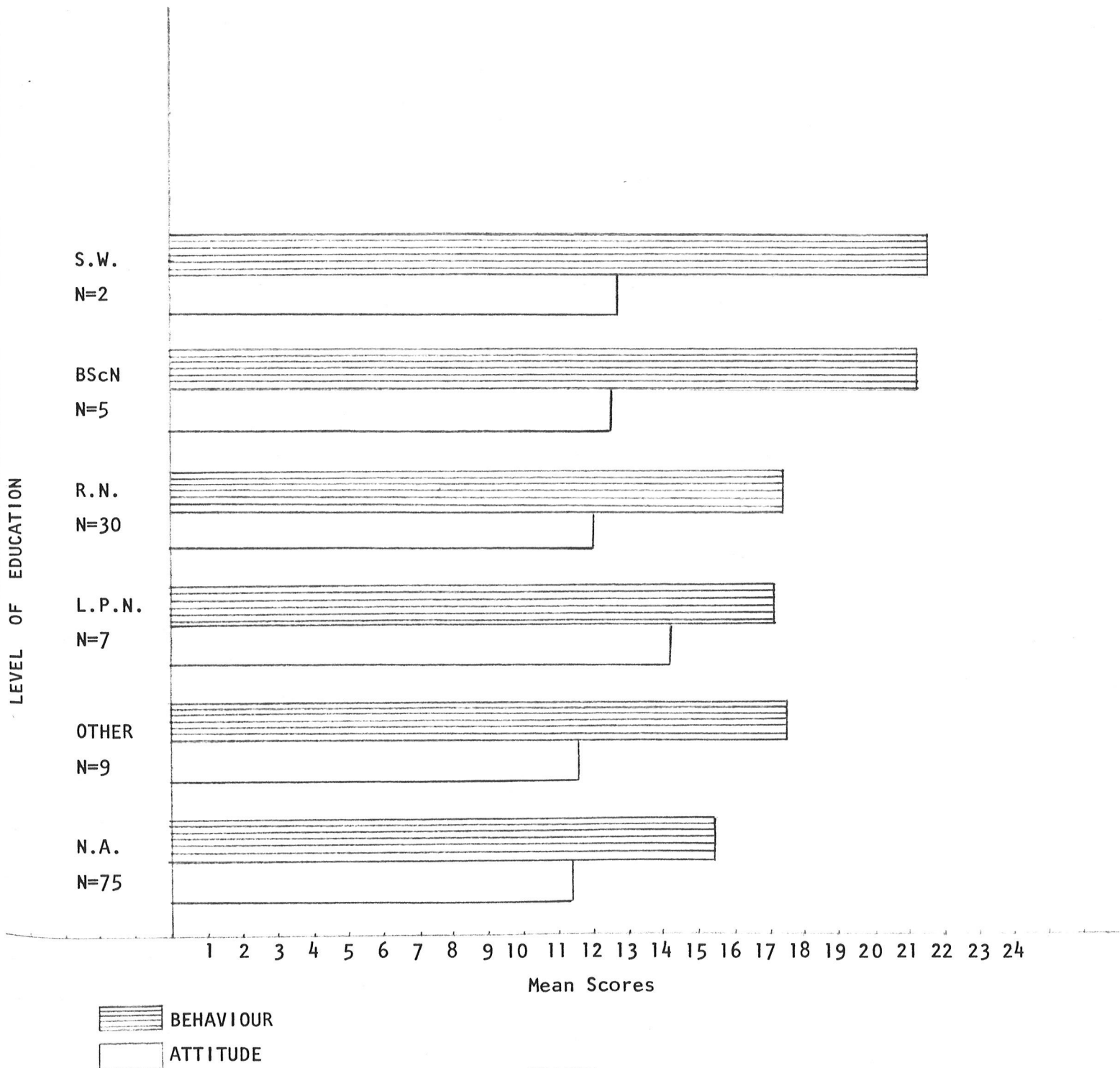


FIGURE 1

LIONS GATE HOSPITAL STUDY

COMPARISON OF DIFFERENCES IN MEAN SCORES POST WORKSHOP
AND THREE MONTHS LATER FOR ATTITUDE AND BEHAVIOUR WHERE
LEVEL OF EDUCATION IS A FACTOR

LEVEL OF EDUCATION

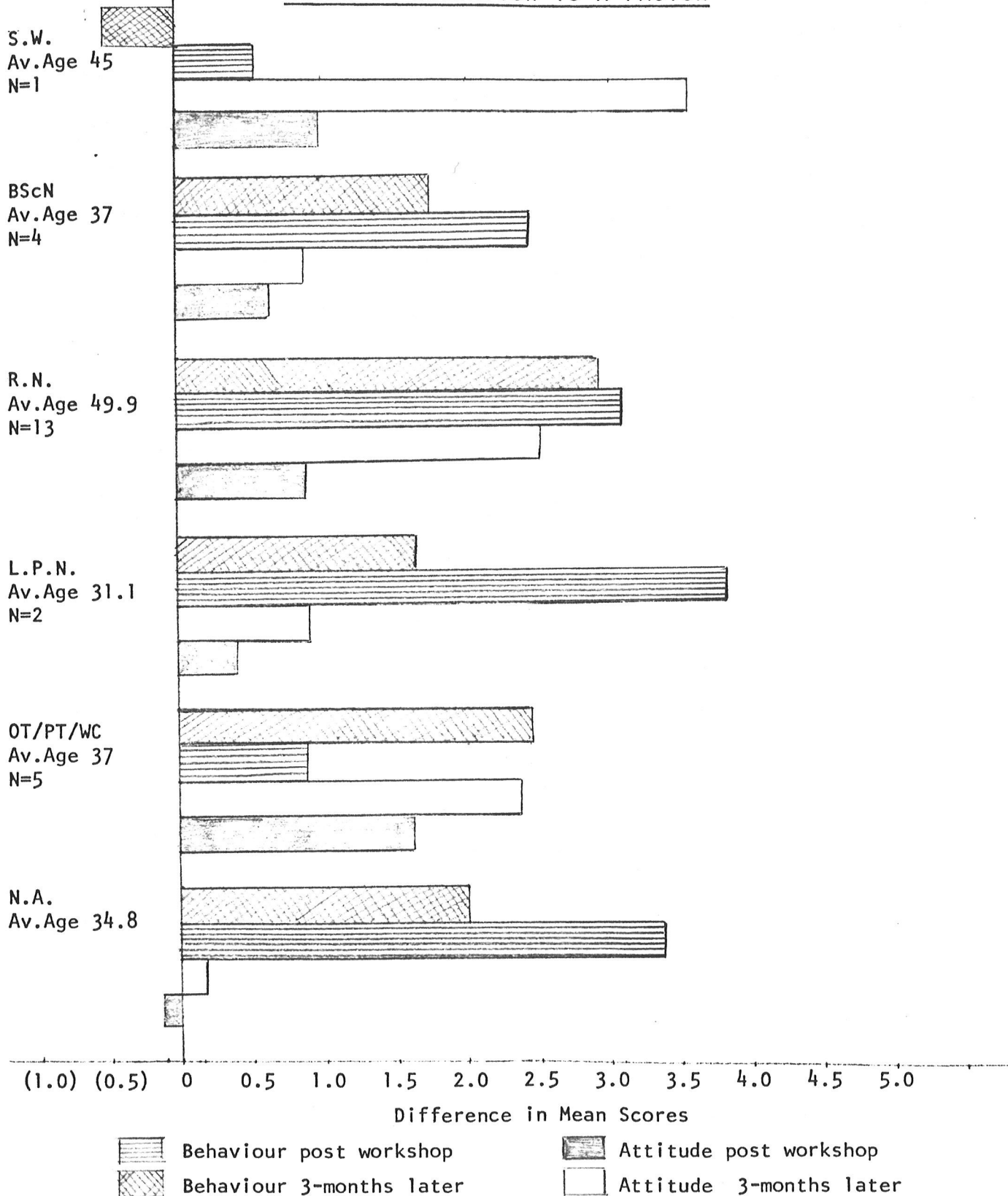


FIGURE 2

Age

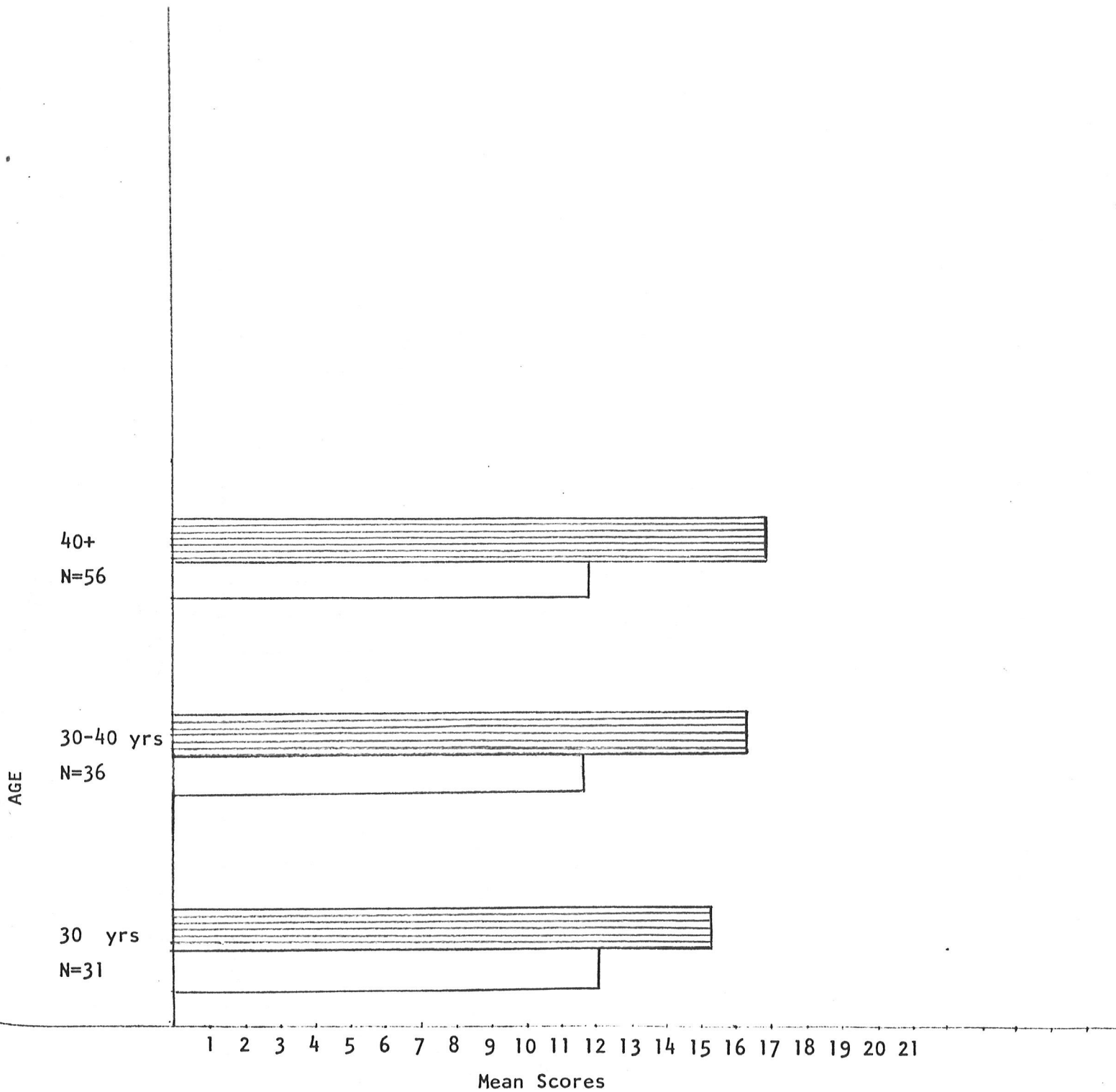
There appears to be no significant difference in the relationship between the age of the participants and their attitude pre-workshop as demonstrated by Figure 3. However, post workshop scores and three-month follow-up scores do vary considerably. (See Figure 4). Both the 40-plus age group and those 30-40 years old made some gains in attitude scores (0.95 (6%) and 0.9 (5%) respectively) post workshop, and continued to gain over time with those 40 and over obtaining a total increase in mean score of 2.0 (12%) over pre-workshop scores, and those between 30-40 years of age increasing their mean score by 1.2 (8%) in the three-month follow-up study. Those 30 and under made a small gain in mean score post workshop of only 0.3 (2%) and lost that gain over three months to return to their original pre-workshop score.

Scores for intention to behave positively were improved post workshop by both the 40 years and older and the 30-40 year age group to the same degree with an improvement of 3.2 (11%) over pre-workshop scores for both. Both maintained these scores over time with the 40 and over age group dropping only 0.2 (1%) of their post workshop gain. Those 30 and under also improved their mean score post workshop to 3.2 (11%) but were unable to maintain this increase and demonstrated a mean score of only 1.9 (7%) above their pre-workshop score in the three-month follow-up.

There is a consistently demonstrated relationship between behaviour change and the reported attitude scores over time. Where intention to behave is reported to be maintained over time as with the 40+ age group and those between 30-40 years of age, attitude scores increase during

LIONS GATE HOSPITAL STUDY

COMPARISON OF MEAN SCORES PRE-WORKSHOP FOR ATTITUDE
AND BEHAVIOUR WHEN AGE IS A FACTOR



 BEHAVIOUR
 ATTITUDE

FIGURE 3

LIONS GATE HOSPITAL STUDY

COMPARISON OF DIFFERENCES IN MEAN SCORES POST-WORKSHOP AND THREE MONTHS LATER FOR ATTITUDE AND BEHAVIOUR WHERE AGE IS A FACTOR

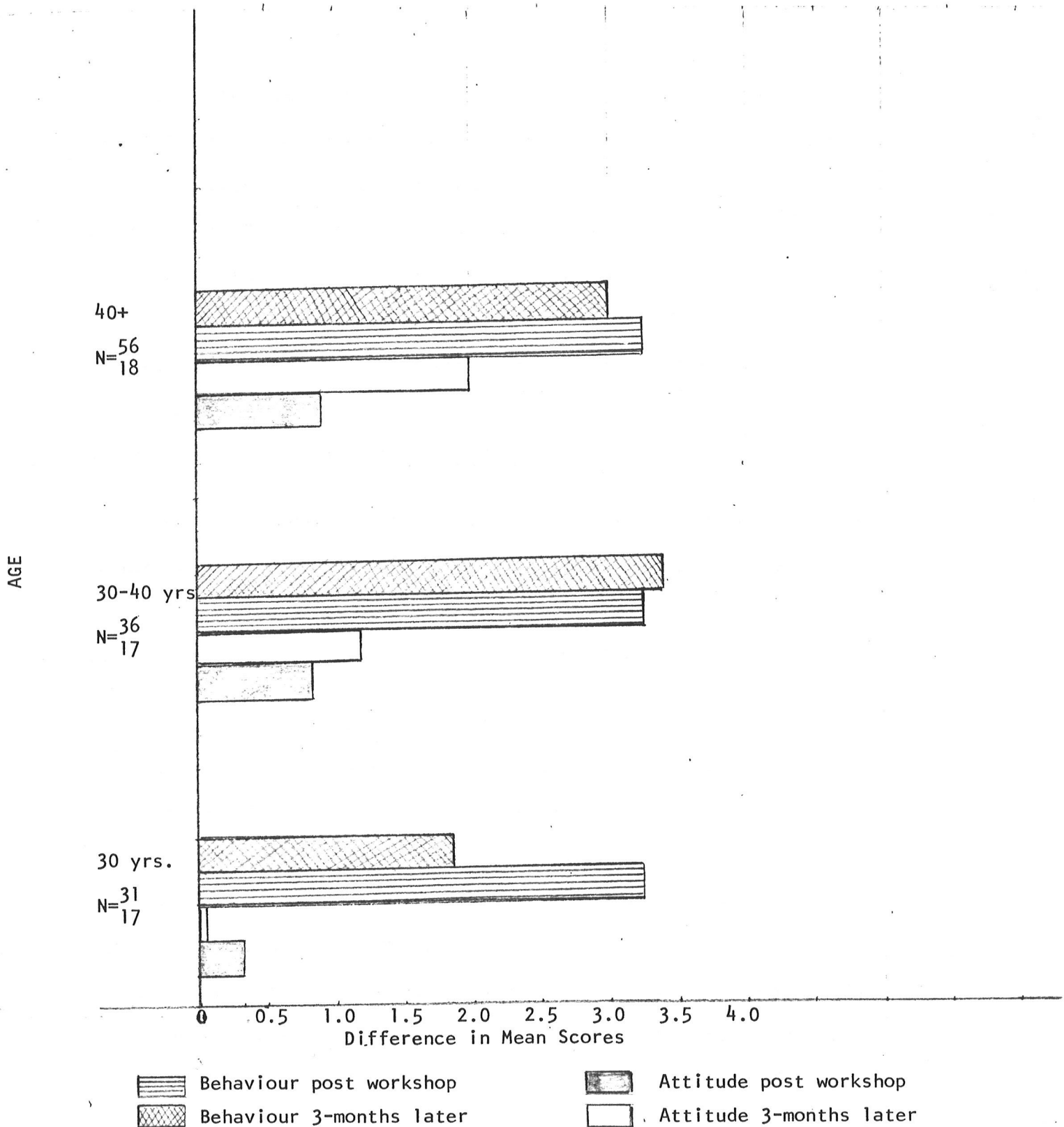


FIGURE 4

that same period. Where behaviours are not maintained to the same degree as with the 30 years and below age group, attitude scores are not maintained.

The author would conclude that there is no demonstrated relationship between age and attitude or intention to behave positively pre-workshop, however, post workshop and in the three-month following, those persons over 30 years of age retain the new behaviours and develop more positive attitudes while those under 30 years of age were not able to retain all behaviours and attitude was not affected. There also appears to be a positive relationship between behaviour and attitude over time.

Number of Years Working with the Elderly

There is no demonstrated difference in attitude scores or intention to behave positively when number of years working with the elderly is introduced as a variable. Like scores related to age, these scores are fairly consistent across all experienced groups (See Figure 5).

When post workshop and three-month follow-up scores are compared, there is some consistent relationship between longer years working with the elderly and both attitude and behavioural intention scores. Both the 5-10 years experienced group and the 10-20 year experienced group scored significantly higher on attitude testing post workshop (10-20 years - increase of 0.8 (5%); 5-10 years increase of 1.1 (6%)) and those scores increased over three months (10-20 years further increase to 1.6 (10%); 5-10 years further increase of 1.5 (9%)). Behavioural scores increased significantly also post workshop (10-20 years - 1.8 (6%) and 5-10 years

LIONS GATE HOSPITAL STUDY

COMPARISON OF MEAN SCORES PRE-WORKSHOP FOR ATTITUDE AND BEHAVIOUR WHEN NUMBER OF YEARS WORKING WITH THE ELDERLY IS A FACTOR

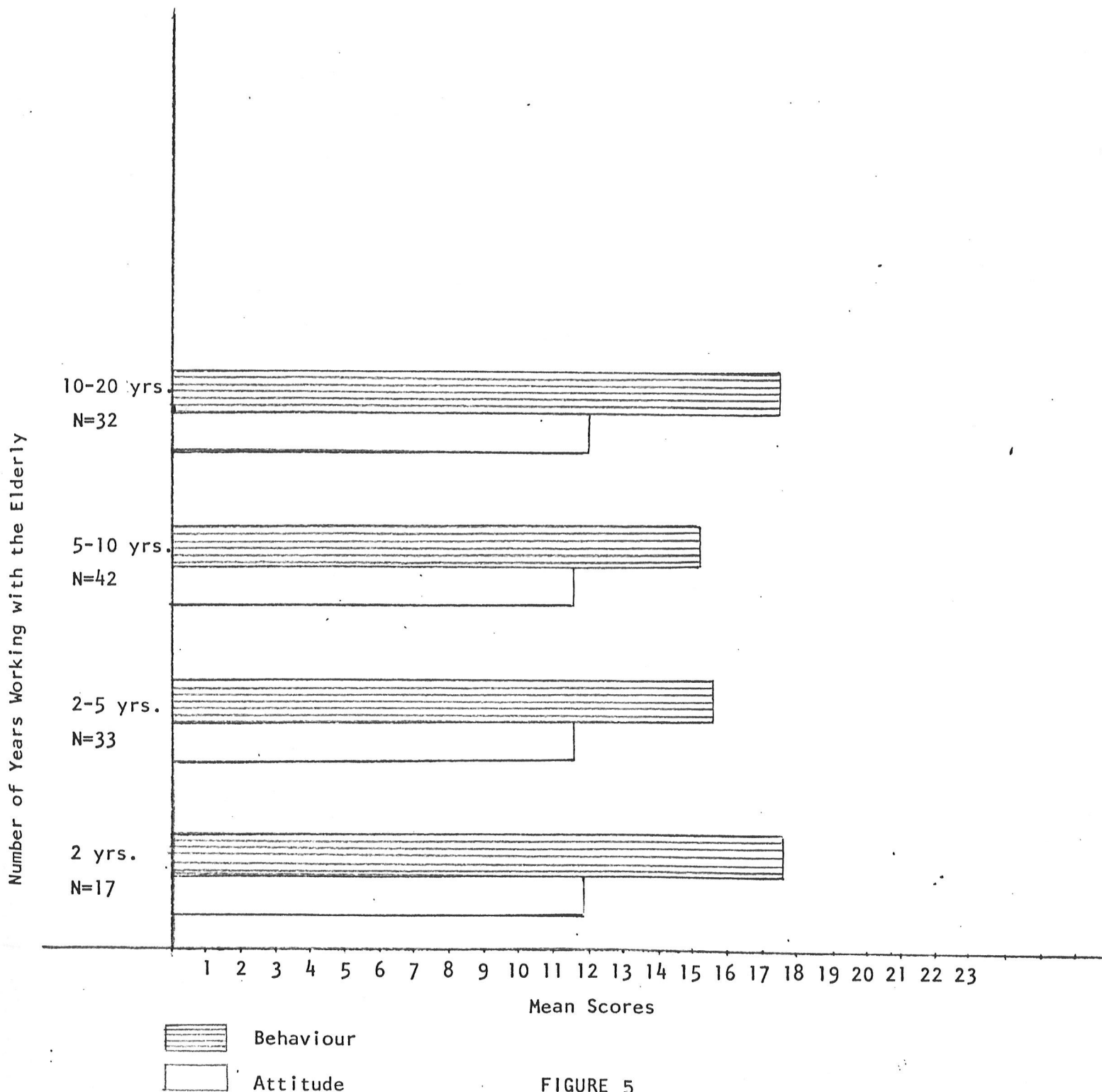


FIGURE 5

LIONS GATE HOSPITAL STUDY

COMPARISON OF DIFFERENCES IN MEAN SCORES POST-WORKSHOP AND THREE MONTHS LATER FOR ATTITUDE AND BEHAVIOUR WHERE NUMBER OF YEARS WORKING WITH THE ELDERLY IS A FACTOR

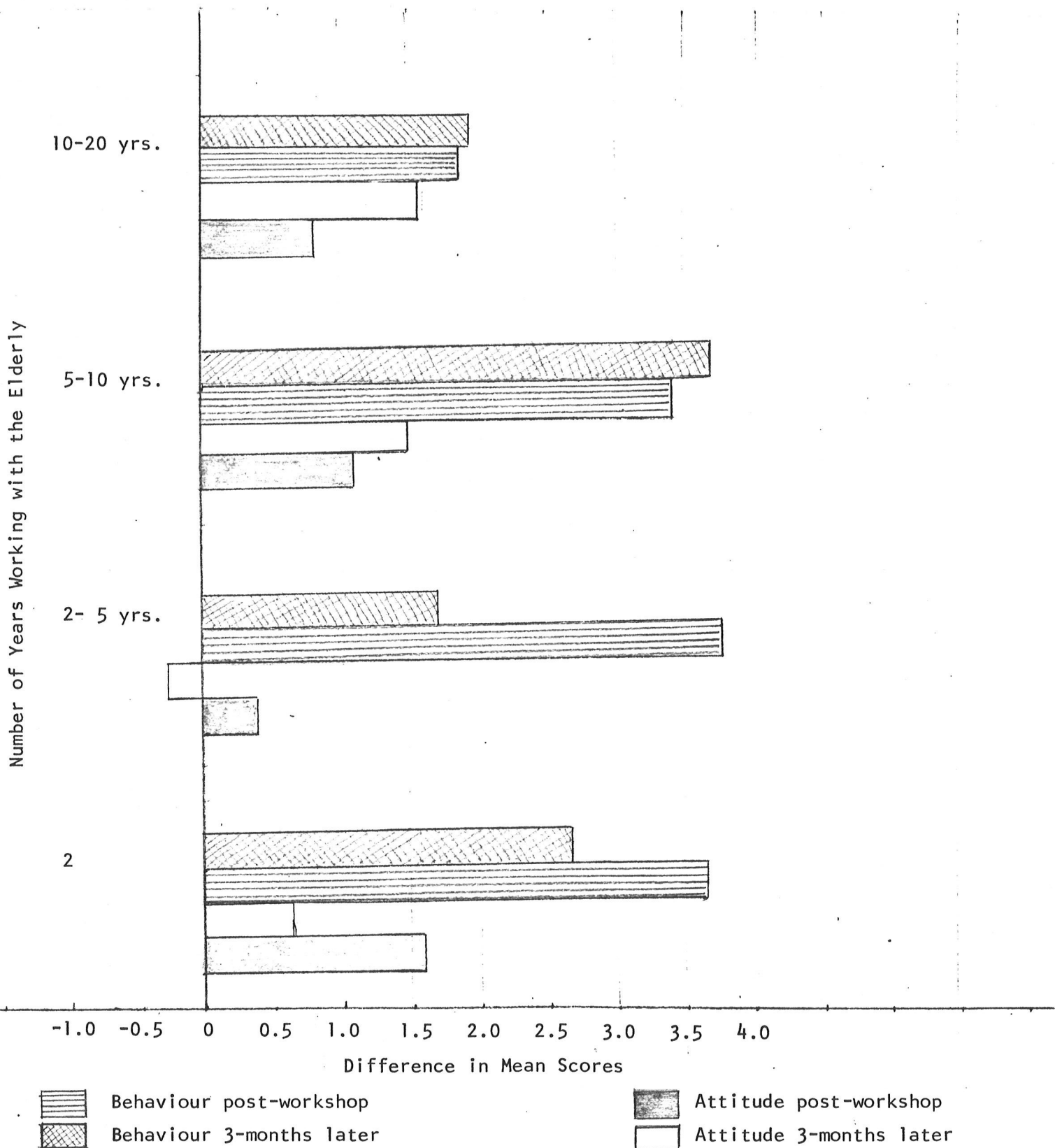


FIGURE 6

3.4 (11%)) and these increases were not only maintained but slightly better scores were obtained in the three-month follow-up (10-20 years further increase to 1.9 (7%) and 5-10 years a further increase of 3.7 or 12%). (See Fig. 6).

Those with less than five years experience working with the elderly did not fare so well. In the 2-5 years of experience group, attitude scores improved marginally post workshop (0.4 (3% gain over pre-workshop scores) and dropped to 0.6 (4%) below the pre-workshop scores three months later. Behaviour intentions scored well with a post workshop gain of 3.8 (13%) over the pre-workshop score and then lost 2.1 (or 7%) of that score in the following three months for a final mean score of 1.7 (6%) over pre-workshop scores in the three month follow-up. Those with two years or less experience did little better in attitude scores but did well with behavioural intentions. Post workshop scores for attitude made the most significant gain of all post workshop scoring, 1.6 (10%) above the pre-workshop score and then fell to only 0.6 (4%) above the pre-workshop score in the three-month follow-up, a loss of 1.0 (6%). Behavioural intentions made significant gains post workshop scoring 3.7 (12%) higher in mean score but lost 1.0 (3%) to score 2.7 (9%) above pre-workshop scores in the three-month follow-up.

Again attitude scores appear to be related positively to behavioural intention scores and where behavioural intentions were maintained or improved post workshop, so attitude improved. Conversely, where behavioural intentions were not maintained, so attitude was less positive although for the purpose of this evaluation it should be noted that intention to behave positively was increased overall post workshop and those behavioural intentions were maintained in

varing degrees and generally scores were improved for all participants.

The author would conclude that both attitude and behavioural intention are positively related to the increased experience of the participants post workshop with those who have more than five years experience responding most positively to the content of the workshop. Further, the maintenance or increase in behavioural intention scores is related positively to an increase in attitude scores.

SUMMARY OF CONCLUSIONS

From this study the author can make the following assumptions:

1. Level of education has a slight positive relationship to attitude and behavioural intention but does not predict the degree of effect of this workshop on the amount of attitude or behavioural changes experienced by participants.
2. There is no demonstrated difference in naive scores for attitude or behavioural intention where age is a factor. However, age does appear to predict the effect workshop material has on participants. Older participants are able to maintain and significantly improve their behavioural intention scores over three months and their attitude scores also improve significantly over the same period of time.
3. There is no demonstrated difference in naive scores for attitude or behavioural intentions where number of years working with the elderly is a factor. However, those with more experience working with the elderly respond positively to the content of the workshop, and maintain or significantly improve their behavioural intention scores over three months, and their attitude scores also improve significantly over the same period of time.
4. Where behaviours are maintained or improved over time, attitude is improved over the same period of time.

DISCUSSION AND ANALYSIS

The purpose of this analysis is to establish a consistent relationship between scores for the two instruments used in the methodology to measure attitude and intention to behave. (Modified Kogan Scale and Behavioural Intention Questionnaire). The outcome of the study for the three variables of level of education, age and number of years working with the elderly will be compared with other data reported in the literature and with rationale described in Chapter Two of this paper. Validity of these two instruments will depend upon the consistency of data from this study with these two authorities.

Attitude Scores Pre-Workshop

Four factors which have been identified as affecting nurses' attitudes toward the elderly are level of education, age, number of years working with the elderly and place of employment (environment). For this study, all participants were employed at the same institution (Lions Gate Hospital) and so place of employment was not a variable. The fact that the administration of Lions Gate Hospital provided many supportive activities around the workshop certainly helped to create an environment which fostered the positive behaviours which were emphasised throughout the day.

Gillis (1973) reports a positive relationship between level of education and attitude with Degree nurses having more positive attitudes than Diploma nurses, who, in turn, had more positive attitudes than Licensed Practical nurses, and so on. The Gillis study is well designed and is supported by previous findings of Campbell (1971) who discovered that the more extensive the educational background of an individual, the less

likely he/she has been found to hold stereotypes about the elderly. Both studies used the Kogan Attitude to Old People Scale and the results are similar to the findings of this study (See Table 1).

(In analysing the data from the post workshop scores, it is noted that the number of Social work respondents for the follow-up study was only one. Although the results are consistent with other findings relative to level of education, this small responding group cannot be reliable and will not be included in the discussion.)

While this study demonstrated no relationship between age and attitude toward working with the elderly in naive scores pre-workshop, other work reported in the literature is conflicting. In a study by Taylor and Harned (1978) nurses under 40 were reported as having more positive attitudes than their older counterparts. This study involved 71 registered nurses at two conferences in the State of Oklahoma who completed Kogans Attitude to Old People Scale and who identified themselves by name and reported back by mail in a follow-up study. The study was highly selective in determining who would be considered for follow-up in that the completion of the questionnaire was not anonymous and only those reporting their own name were eligible suggesting a biased population. The results conflicted with findings of the author. In a study by Futrell and Jones (1977) which also used the Kogan Attitude to Old People Scale it was found that the older the nurse, the more likely they were to have significantly more favourable or positive attitudes toward the elderly. The author did find this affect reflected in post workshop scores but it was not present in pre-workshop scores.

Taylor & Harned (1978) found in their study that nurses with fewer years of employment scored higher on the attitude to Old People Scale than their older and more experienced counterparts while Futrell and Jones (1977) and Wolk and Wolk (1971) found length of practice positively related to attitude. Gillis (1973) found no relationship between length of experience and attitude. Again the results provide a conflicting picture of how this variable affects attitudes of nurses. The results of the author's work are consistent with the findings of Gillis pre-workshop although the affect described by the others can be seen in post workshop scores. (To be discussed.)

In the study by Gillis (1973) using the same three variables of age, length of time employed with the elderly and level of education and using the Attitude to Old People Scale, there was no significant difference found between participants on the basis of age or number of years employed. However, nurses prepared at the associate degree or diploma levels were the most positive in their attitude toward the aged while baccalaureate nurses were less positive than licensed practical nurses. These findings concur most closely with the findings of the author with the exception of the Baccalaureate nurse who was found in this study to have slightly more positive attitudes although the scores were very similar for all levels of education.

In a summary study by McTavish (1971), associations of variables toward attitude were found to be small and certainly inconsistent. This would certainly support the information in the nursing literature and this paper which discusses similar use of the Attitude to Old People scale

and provides no demonstrated consistent results.

This author chose to use a modification of the Kogan Scale for the purpose of establishing whether the workshop produced any change in attitude rather than to determine whether nurses had positive or negative attitudes. Since the tool produced fairly consistent naive scores across the three variables of age, years of employment in Geriatrics and level of education, it might be argued that it was not sensitive enough to discriminate between the variables. However, the author would argue that since the work of one major study supports these findings and since the results of other studies produce conflicting scores, then the questionnaire is as reliable as the Attitude to Old People Scale as its' application is described by the author (Kogan 1961).

ATTITUDE SCORES POST WORKSHOP

Post workshop scores appear to demonstrate more sensitivity than the findings of other studies reported in the literature. While pre-workshop scores for level of education reflect a small difference in attitude positively related to higher levels of education, post workshop scores reflecting reactions to the content of the workshop demonstrate a different response.

Other nursing personnel scored best on post workshop testing and made gains over the three month period following the workshop (Figure 2). Diploma nurses were second with attitude scores post workshop and made the most gains over the three months following matching the follow-up scores for other non-nursing personnel. Degree nurses, Licensed

Practical nurses and Nursing Assistants scored significantly less in the order given. This order of scores reflects more closely the naive scores of nursing personnel represented in the Gillis study (1973).

In considering factors which affected this outcome, the average age of the respondents in each group was calculated. The diploma nurses who made the most significant gains in scores over time had the highest average age of 49.9 years. Other nursing personnel and the degree nurses had an average age of 37 years while nursing assistants had an average age of 34.8 years. (The social workers had only one respondent post workshop so is not considered to be a reliable indicator of that professional body.) Degree nurses (N=4) and Licensed Practical nurses (N=2) have small respondent groups also in the three month follow-up but are considered reliable for the purpose of this study. Age is the only consistent factor influencing the outcome of this comparison of attitude and level of education.

Age and attitude are then compared post workshop and this phenomenon is further supported. Those over 40 years of age made the most significant gains in score post workshop and doubled those gains in the three month follow-up study. Those 30-40 years of age made equal gains post workshop and less significant gains in the three month follow-up study. Those 30 years and under made small gains post workshop but lost that gain over time. All reporting groups were adequate in size and there appeared to be no other significant factor affecting these scores.

The author would argue that the older the respondent the more likely they were to have been sensitive to the workshop material because it held

a personal relevance for the over-40 year age group. While those 30 years of age and under are concerned with more practical issues of establishing themselves with a new spouse, a family, a house and a car and use their work as a means to earn enough money to survive, those 30 years and over are more established and have had enough life experience to be sensitive to loss and grieving, the need for retirement planning and some of the negative aspects of ageing. This phenomenon becomes more obvious when discussing behaviour.

Years of experience working with the elderly produced some similar results post workshop - those with 5-10 years experience scored well with the 10-20 years of experience group close behind. However, they were out-scored by those with 2 years or less experience and the 2-5 years experienced group scored the least of all four categories. This latter group made no gains in the three month follow-up scores and those with 2 years or less experience lost most of their initial gain in scores. The 5-10 year experienced group and the 10-20 years experienced group made significant gains over three months. The author would suggest from these findings that those working for less than two years are more willing to change their attitudes but that willingness does not sustain itself over time perhaps because of some disillusionment in seeing the realities of sick ageing (cognitive dissonance). The 2-5 year experienced group do appear to reflect this disillusionment or disinterest and would also represent the under 30 age groups whose concerns are outside the workplace. Those with more than 5 years experience would have overcome their disillusionment or indifference and have had more life experiences which would help them to relate to the material in the workshop. Consistent with the phenomenon

associated with age, those with 5 years or more experience would represent the older age group of respondents. These findings then would be consistent with those related to age.

Consistency in response with respect to age and number of years working with the elderly would appear to provide sufficient validation for the tool for measuring change in attitude of respondents to old people pre- and post- workshop when factors related to workshop content are considered.

VALIDITY OF THE MODIFIED KOGAN ATTITUDE SCALE

The original purpose of developing this instrument was to measure change in attitude pre- and post workshop. The Attitude to Old People Scale developed by Kogan is the most frequently used scale in nursing and health related research to measure the degree of positive or negative attitude toward old people. Because of the length of the tool and the time it would take to apply pre- and post workshop, the decision was made to use only one of the questions from each pair alternating the positive question from one pair and the negative question from the second pair, and so on, and to establish whether this modified version of the scale would be sensitive enough to discriminate between the attitude of various groups where the established variables affecting attitude were applied. (See Chapter III).

The tool was applied in this pilot study to 127 staff members working with the elderly at Lions Gate Hospital in Vancouver and was tested for

level of education, age, and number of years of experience working with the elderly. Results were then compared to similar studies using Kogan's Attitude to Old People Scale applying the same three variables.

Naive scores, pre-workshop, demonstrated no appreciable difference in attitude for age or number of years working with the elderly. There was a slight positive relationship demonstrated between level of education and attitude. These findings would concur with the similar work by Gillis, however other work in the field produced conflicting results and was not conclusive.

Post workshop scores did demonstrate that the tool was sensitive enough to discriminate for change in attitude pre-workshop, post workshop and in the follow-up study. The changes in attitude moreover were predictable when considered from the discussion related to attitude and behaviour in Chapter II. Sustained positive behavioural intentions coincided with positive attitude change supporting the argument that change in attitude can be accomplished by changing behaviour.

Moreover, scores were sensitive to life experience. Where participants had higher levels of experience working with the elderly or were older themselves, they were more able to resolve the dissonance associated with caring for the elderly and had been more able to relate to the expected behaviours and incorporate them into their practice.

Criticism of the modified scale involved the failure of the tool to provide a degree of significance which would predict a measurable affect of the change. No attempt was made to establish degree of significance

for the purpose of this study and the reader might argue that directions in change of attitude can be predicted but not measured in a way which would suggest the change was significant enough to justify the methods used.

BEHAVIOURAL INTENTION SCORES - PRE-WORKSHOP

The only study available that considered behaviour and its' relationship to the attitude of those caring for the elderly was carried out by Hatton (1977). She observed seven nurses working with the elderly and documented various aspects of their behaviour. She then scored these behaviours and compared behavioural scores with attitude scores obtained by using the Kogan scale. Hatton concluded that there was a relationship between attitude and positive interaction in five of those nurses although, as in this study, the data were not statistically significant.

Level of Education as a Factor in Behavioural Intentions

When intention to behave was measured pre-workshop by this author using the evaluation tool and then compared with level of education, those respondents (degree nurses and social workers) with higher levels of education reported the higher behavioural intention scores; diploma nurses, licensed practical nurses and other nursing personnel scored about equally and nursing assistants scored lowest. This would appear to be consistent with the expectation that those with higher education would have learned what behaviours would be expected in caring for the

elderly.

In considering naive scores related to age for behavioural intention, results are very similar although the 40 years and over age group scored slightly higher than the 30-40 years age group who in turn scored slightly higher than the 30 years and under age group. Again, this would appear to be fairly consistent considering that age would represent a cross section of all educational groups but that experience might have played some part in teaching the respondents the behaviours which would be more acceptable.

Number of years working with the elderly produced fairly consistent behavioural intention scores with those working 10-20 years and those working less than 2 years scoring only slightly higher than those working 5-10 years or those working 2-5 years. This might suggest a willingness to approach the elderly in a positive way initially and then some disillusionment as to the use of positive behaviours which is overcome as the respondents age. This is purely speculative but is consistent with those findings about attitude.

Unlike Hatton's study, this study depends on self-reporting rather than observed behaviours and, at best, can only provide information related to respondents' intention to behave in the reported manner. There is no specific statistical measurement of significance against which future changes in score can predict any appreciable change in the delivery of care to the elderly patient. At best the mean scores for the various groups will indicate only a trend in behaviour which can be compared with a change in attitude.

BEHAVIOURAL INTENTION SCORES - POST WORKSHOP

Behavioural intention scores predictably improved post workshop following the various persuasive messages related to appropriate interactions with the elderly (see Figure 2). The issue involves whether behaviours can be maintained over time and if they affect attitude.

When behavioural intention scores were considered for level of education, licensed practical nurses and nursing assistants made the most significant gain in scores followed by registered nurses, then degree nurses and other nursing personnel. (Social workers are not considered because there was only one who responded in the follow-up study providing unreliable results).

In the three-month follow-up study, the registered nurses retained most of the new intentions to behave and this corresponded with the greatest increase in attitude score. Other nursing personnel who scored poorly post workshop on behavioural intention scores made a significant gain in score and also increased their attitude score. Degree nurses retained approximately 75% of their intentions to behave positively and made small gains in attitude scores while licensed practical nurses and nursing assistants, who had initially made the greatest gains in behavioural scores, retained only one half of those intentions and made only small gains in attitude scores.

Where intentions to behave were maintained over time (and presumably practiced) attitude scores consistently improved. The higher the level of retention of intentions to behave positively, the greater the increase

in attitude score. This is consistent with the discussion reported in Chapter II and suggests that persuading a population toward positive behaviours will result in producing a more positive attitude. Scores indicate a strong relationship between attitude and behaviour with attitude as the dependent factor.

Where age is considered as a variable, all three age groups had approximately the same score post-workshop, which suggests some consistency in learned material across all age groups. However, those 40 years and over and those 30-40 years of age retained all of their intentions to behave while the 30 years and under age group lost almost 50% of their intentions. The 40 years and up age group made the greatest gains in attitude scores, the 30-40 year olds made only minimal gains while the 30 year olds and under scored a little less than on their pre-workshop questionnaires.

Again, where intentions to behave were maintained, attitude scores were increased. Where scores were not maintained, attitude did not significantly improve. Like the diploma registered nurse group whose average age was 49.9 years, the older age group were able to retain their behavioural intentions and increase their attitude scores supporting the argument that, for this workshop experience, age is an important factor in learning positive behaviours and developing a positive attitude toward the elderly.

Where the variable of number of years working with the elderly is considered, those with 10 years and less experience had approximately equal scores for intentions to behave post workshop and outscored the

10-20 years of experience age group. However, in the follow-up study, those working for 2-5 years lost more than 50% of their behavioural intentions and had a related drop in attitude scores to below their pre-workshop scores. Those with less than two years experience had a similar drop in behavioural intentions in the follow-up, retaining only 75% of their post workshop scores and this coincided with a drop in attitude scores over the same period.

Those working 5-10 years and those with 10-20 years experience retained their intentions to behave and made some small gains in scores and both made gains in attitude scores. These data are consistent with data related to age and suggest some internal consistency in scoring, since age and number of years experience are related. Again, those with more experience were able to use their new skills and this resulted in an improvement in their attitude toward the elderly. Those with less than 5 years experience who were of a younger age group had good intentions immediately following the workshop but were unable to retain those intentions over time, presumably because of factors associated with their age and the way they applied their knowledge.

VALIDITY OF THE WORKSHOP EVALUATION TO MEASURE INTENTIONS TO
BEHAVE POSITIVELY

There was no precedent for the ten item questionnaire designed to measure intention toward using positive behaviours. The items on the tool were developed from a list of commonly expected behaviours which nursing administrators felt represented issues which caused controversy

attitude scores also were greatly increased while, where behavioural scores were not maintained, attitude scores made only slight improvements.

This phenomenon of predictability provides sufficient validation for this tool for the purpose of the workshop evaluation. One criticism of the tool is that it provides no level of significance that allows the author to predict degrees of change or whether the change in behaviour is likely to improve the level of care.

CRITICISM OF THE STUDY

There were two major problems that became evident during this project. The first involved the failure to break the large groups into smaller working groups of 6-8 people. This compromised the basic principles of group dynamics. The second issue involved failure to provide a control group with whom the effect of the methods of teaching could be compared.

Group Leadership and Group Process

In forming the theoretical base for these workshop sessions, a great deal of emphasis was placed on the group process to resolve issues related to establishing a common set of beliefs and expected behaviours. Group process depends upon the sharing of information between group members and is dependent on the trusting, non-threatening relationship surrounding that discussion process. The fact that the groups each day could not be

broken into smaller, less-threatening working groups was significant in that the opportunity to share was compromised for many people who would feel inhibited sharing personal experiences in front of so many others. This, in turn, affected the opportunity for resolution of issues that would cause dissonance for any individual since personal beliefs would not be shared freely. The study should be repeated using small groups of no more than eight persons. The same group leader should be used to remove the effect of an uncontrolled variable that would be present if different leaders were leading different groups.

Control Group

The original premise of this study is that group sessions and experiential workshops provide a better learning experience than the usual didactic classroom presentation. The workshop content was designed with this premise in mind. The study provided no opportunity to compare teaching methodology although the results indicate that the method used was successful in producing change in attitude and behaviour. The question arises as to the effect of the workshop leader on the respondents and the probability that the same material presented in a series of lectures would produce the same affect in changing both attitude and behaviour.

The workshop should be repeated using a control group who receive the same information from the same workshop leader but the format should involve a straight didactic presentation of facts related to the issues in the original study.

CONCLUSIONS

Both the modified Attitude to Old People Scale and the Workshop Evaluation to measure Behavioural Intentions were validated by providing consistent scores for the three variables of age, level of education and number of years working with the elderly. The workshop itself appears to have produced positive change in attitude and intention to behave positively and suggests some interesting differences in response for the three variables. The methodology should be modified as suggested in the criticism to allow for group work and to establish a control group so that the method of presentation can be tested under more structured circumstances. The results will then be more credible in supporting the argument for group work and experiential learning.

CHAPTER IV

THE FAIRFIELD STUDY

THE FAIRFIELD STUDY

INTRODUCTION

Having established validity of the attitude measurement tool and the workshop evaluation tool to measure intentions to behave positively, the author designed a study to measure the efficacy of the workshop methodology (i.e. group process and experiential learning) against a more conventional presentation style (didactic presentation).

PURPOSE OF THE STUDY

The purpose of the study was to demonstrate that information related to the problems of ageing which is presented through group discussion and experiential learning would result in a higher degree of positive behavioural change and attitude change than the same material presented in a didactic, classroom setting.

METHODOLOGY

Content

The methodology and content for the workshop involving experiential learning and group process has been described in Chapter III. The content of the classroom presentations for the control group was developed from the material used for the group work and experiential learning workshop and involved discussion by the presenter of all the facts related to those issues and a persuasion toward adopting positive behaviours to accommodate those issues (see index).

POPULATION AND ASSIGNMENT

The population was drawn from staff currently employed at Victoria General Hospital, Fairfield, which has 120 long term, residential beds for the elderly. All participants were Licensed Practical Nurses who had limited experience working in geriatric nursing. The participants signed up for one of four workshops. Three of the workshops had no more than eight spaces so that all groups were limited in size. These groups participated in the group work and experiential workshop. The fourth group accommodated up to twenty people and received the didactic presentation. Assignment was random only to the extent that the participant decided which day he/she wished to attend and signed up for that day's workshop.

LEADERSHIP AND TEACHING METHODS

The same leader managed each workshop to provide consistency in content and delivery style and to remove an important variable in the method of presentation.

INSTRUMENTS

The two instruments that were tested and validated in the Lions Gate study were used to measure attitude and behavioural intentions. These instruments were applied as a pre-test and post-test and then three months following the workshop.

Modified Kogan Attitude to Old People Scale

This questionnaire was drawn from seventeen sets of positive and negative statements about ageing that were originally developed by their author to measure the degree of positive or negative responses to old people. The statements were intended to be used in a random list of other items and would have resulted in an extensive questionnaire which, if applied with the second instrument to measure behavioural intentions pre- and post workshop would have required considerable time to complete. Since the author did not wish to measure the degree of positive or negative attitude but rather whether attitude changed as a result of the workshops, the decision was made to take one negative item from the first pair and one positive item from the second pair and so on. This resulted in a questionnaire of seventeen statements which were used without effort to intersperse these items with other statements. The statements required True or False responses and were scored by giving one point for each correct response for a total of seventeen possible points.

This questionnaire was applied to 127 participants in the Lions Gate Study and validated by establishing consistency across the three variables discussed in the literature as affecting nurses' attitude toward the elderly. These variables are level of education, age, and number of years working with the elderly. Consistency of finding was also established by comparison with scores measuring changes in intention to behave more positively within the theoretical framework discussed in Chapter 11.

Validity of the tool was established as an indicator of positive or negative change in attitude but no level of significance was established

as a predictable measure of the degree of change which might be anticipated.

Workshop Evaluation To Measure Intention To Behave

A ten-item questionnaire was developed by a panel of Head Nurses and Nursing Directors who work with the elderly. These items involved common expectations of behaviour which tended to cause controversy in an institutional setting because they recognized the need for individualized approach to care and would probably require more time to carry out than commonly practiced procedure. Each item required a degree of response with four options ranging from agreeing "very much", "moderately", "a little" or "not at all". The items were scored "0" for the most unfavourable response to "3" for the most favourable response. Total possible scores for the ten items was "30".

The questionnaire was applied to 127 participants at Lions Gate Hospital and validated by establishing consistency across the three variables related to attitude that are discussed in the literature. These variables are level of education, age, and number of years working with the elderly. Consistency of findings was established by comparing scores measuring changes in intention to behave more positively with attitude scores within the theoretical framework discussed in Chapter II.

Validity of the tool was established as an indicator of intention to behave positively or negatively but no degree of significance was established as a predictable measure of the amount of change which might be anticipated.

METHODOLOGY

The methodology and content for the workshop involving experiential learning and group process has been described in Chapter III. This process will be presented in Workshop A to small groups of no more than eight persons. The workshop leader will be the same for each group.

The content of the didactic presentation was developed from the objectives used in Workshop A and involves discussion by the same workshop leader of all the facts related to those issues and persuasion toward adopting positive behaviours to accommodate those issues (see index for objectives). Content is described in Chapter I. This will be referred to as Workshop B.

The modified Kogan Attitude to Old People Scale and the workshop evaluation to measure intentions to behave was applied pre-workshop, post workshop and three months following the presentations for both Workshop A and Workshop B. Percentage scores were compared for the two dependent variables of age and number of years working with the elderly (level of education is not a variable in this study as all participants are Licensed Practical Nurses).

Dependent Variables

Age: The chronological age of each participant is considered within the three categories of age identified in the literature as significant - 40 years and over, 30-40 years of age and under 30 years of age.

Number of Years Working with the Elderly: The amount of experience of each participant in direct nursing care working in an institution for elderly patients. For the purpose of this study, this is divided into over 10 years experience, 5-10 years experience, 2-5 years experience and less than 2 years experience.

Independent Variables

Workshop B.

Didactic Presentation: The presentation of factual information in a lecture format which allows for questions of clarification with the lecturer but no free exchange of ideas between participants.

Workshop A.

Group Work: A working group of no more than eight persons where the presentation of information is open to discussion and the free exchange of ideas, reactions and expressions of approval or disapproval of the ideas presented.

Workshop A.

Experiential Learning: The presentation of information in a manner in which the learner can experiment with the facts within his/her own personal framework by acting them out, by imagining that they are actually happening to him/her or by actually applying the information in a practical, hands-on way.

SUMMARY OF RESULTS

This workshop evaluation was at best quasi-experimental and sought only to determine whether the method of presentation produced any difference in the degree of attitude or behavioural change of the participants and whether the degree of change was great enough to suggest variations in the presentation for the dependent variables.

A total of four workshops were held on different days. Three of the workshops involved group sessions and experiential learning (Workshop A) as described in Chapter III. One workshop (Workshop B) involved a didactic presentation by the same group leader covering the same material. All participants were licensed practical nurses working at Victoria General Hospital, Fairfield site. They all attended the workshops in the same room and the workshop leader was the same for each session.

A total of seventeen licensed practical nurses (LPN's) attended Workshop A which was held on three separate days. There were eight participants on Day I, five on Day II (one of whom was a degree nurse) and six on Day III (one of whom was a registered nurse). Responses from the registered nurse and degree nurse were disregarded because of their level of education.

A total of twenty-one licensed practical nurses attended Workshop B. Three others attending were registered nurses and their responses were discarded because of their level of education. Mean scores for Workshop A and Workshop B are compared in Table I and Table II for the two variables of age and number of years working with the elderly.

FAIRFIELD STUDY

COMPARISON OF MEAN SCORES AND PERCENTAGE DIFFERENCES FOR WORKSHOP A AND WORKSHOP B WHERE AGE IS A FACTOR

	PRE-WORKSHOP		POST WORKSHOP		MEAN DIFFERENCE PRE & POST WORKSHOP		3-MONTH FOLLOW-UP		MEAN DIFFERENCE PRE-WORKSHOP & FOLLOW-UP		LOSS OR GAIN IN SCORES IN 3 MOS.		
	No.	Attitude	Behaviour	Attitude	Behaviour	Attitude	Behaviour	Attitude	Behaviour	Attitude	Behaviour	Attitude	Behaviour
Workshop A 40 ↑	4	13.5	16.7	14.0	17.0	0.5 3 %	0.25 8 %	14.75	18.25	1.2 7 %	1.5 5 %	0.75 4 %	1.25 4 %
Workshop B 40 ↑	7	13.2	17.0	14.4	19.1	1.2 7 %	2.1 7 %	15.1	19.5	1.9 11%	2.5 8 %	0.7 4 %	0.4 1 %
Workshop A 30-40 Yrs.	6	13.0	16.4	13.5	18.6	0.5 3 %	2.2 7 %	14.7	18.8	1.7 10%	2.4 8 %	1.2 7 %	0.2 0.7%
Workshop B 30-40 Yrs.	6	12.3	16.2	13.4	18.0	1.1 6 %	1.8 6 %	13.8	18.6	1.5 8 %	2.4 8 %	0.4 2 %	0.6 2 %
Workshop A 30 ↓	7	12.4	18.7	14.1	21.7	1.7 10%	3.0 10%	14.6	21.9	2.2 13%	3.25 11%	0.5 2 %	0.25 0.8%
Workshop B 30 ↓	8	13.3	16.5	14.0	17.6	0.75 4 %	1.1 4 %	13.7	18.0	0.4 2 %	1.5 5 %	(0.35) (2 %)	(0.4) (1 %)
TOTAL MEAN SCORES													
Workshop A	17	12.9	17.5	13.8	19.5	0.9 5 %	2.0 7 %	14.7	19.6	1.8 10%	2.1 7 %	0.9 5 %	0.1 0.3%
Workshop B	21	12.9	16.5	13.9	18.2	1.0 6 %	1.7 6 %	14.2	18.7	1.3 8 %	2.2 7 %	0.3 2 %	0.5 2 %

TABLE I

FAIRFIELD STUDY

COMPARISON OF MEAN SCORES AND PERCENTAGE DIFFERENCES FOR WORKSHOP A AND WORKSHOP B
WHERE NUMBER OF YEARS WORKING WITH THE ELDERLY IS A FACTOR

	No.	PRE-WORKSHOP		POST WORKSHOP		MEAN DIFFERENCE PRE & POST WORKSHOP		3-MONTH FOLLOW-UP		MEAN DIFFERENCE PRE-WORKSHOP & FOLLOW-UP		LOSS OR GAIN IN SCORES IN 3 MOS.	
		Attitude	Behaviour	Attitude	Behaviour	Attitude	Behaviour	Attitude	Behaviour	Attitude	Behaviour	Attitude	Behaviour
Workshop A 5-10 Yrs. (Av. Age 48.5)	4	13.25	17.5	13.75	19.0	0.5 3 %	1.5 5 %	14.5	18.8	0.9 5 %	1.3 4 %	0.4 2 %	(0.2) (.7%)
Workshop B 5-10 Yrs. (Av. Age 46.2)	7	13.6	18.0	14.6	20.4	1.0 6 %	2.4 8 %	15.3	20.7	1.75 10%	2.7 9 %	0.75 4 %	0.3 1 %
Workshop A 2 - 5 Yrs. (Av. Age 33.5)	9	12.6	17.8	13.8	19.5	1.2 7 %	1.6 5 %	14.6	20.3	2.0 12%	2.5 8 %	0.8 5 %	0.9 3 %
Workshop B 2 - 5 Yrs. (Av. Age 34.2)	8	12.7	17.9	13.5	19.6	0.8 5 %	1.7 6 %	13.5	20.6	0.8 5 %	2.7 9 %	0 0	1.0 3 %
Workshop A 2 (Av. Age 25.0)	4	13.0	16.7	14.0	20.0	1.0 6 %	3.2 11%	15.5	19.7	2.5 15%	3.0 10%	1.5 9 %	(0.2) (.7%)
Workshop B 2 (Av. Age 25.2)	6	13.2	16.5	13.8	19.5	0.6 4 %	3.0 10%	13.9	18.5	0.7 4 %	2.0 7 %	0.1 0.6%	(1.0) (3%)

TABLE II

Comparison of Attitude and Age Pre-Workshop

A total of thirty-eight participants completed the pre-workshop questionnaire and the mean score for attitude was 12.9 (see Table 1). As in the Lions Gate Study there was little variance in scores related to age with those 40 years and over scoring only slightly higher (Workshop A 13.5; Workshop B 13.2) than those 30 and under (Workshop A 12.4; Workshop B 13.3) or 30-40 years of age (Workshop A 13.0; Workshop B 12.3). These scores are demonstrated by a bar graph Fig. (i).

Comparison of Attitude, Age and Type of Presentation: Post-Workshop and Three-Month Follow-up

Where pre-workshop scores were similar, post workshop scores demonstrated a great change in response to the type of teaching method used for the various age categories (Fig. ii-iii). The 40 years and older group from Workshop A had a minimal increase in mean scores for attitude gaining only 0.5 (3%) while their counterparts in Workshop B made a greater increase of 1.2 (7%) over their pre-workshop scores. In both instances scores were maintained over time and increased with participants from Workshop A gaining 1.2 (7%) in mean score over their pre-workshop mean scores in the three-month follow-up study and participants from Workshop B making total gains of 1.9 (11%) over pre-workshop mean scores in the follow-up study. The 40 years and over age group in the didactic presentation made the greatest gains although both groups improved their attitude scores over time.

FAIRFIELD STUDY

COMPARISONS OF PRE-WORKSHOP SCORES FOR WORKSHOP A
AND WORKSHOP B FOR ATTITUDE AND BEHAVIOUR WHEN AGE IS A FACTOR

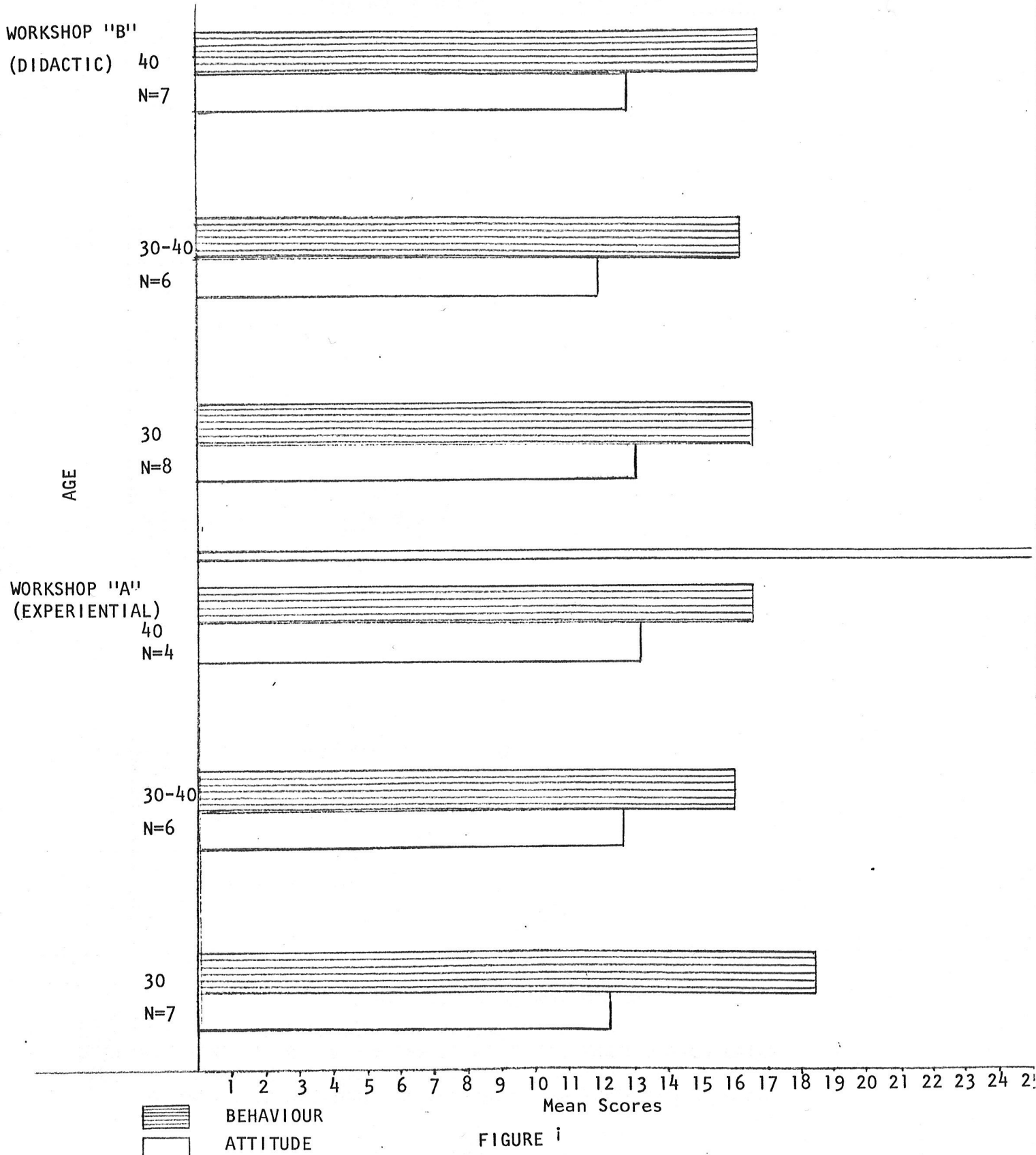


FIGURE i

FAIRFIELD STUDY

DIFFERENCE IN MEAN SCORES PRE AND POST WORKSHOP
AND PRE WORKSHOP AND THREE MONTHS LATER FOR
WORKSHOP A WHERE AGE IS A FACTOR

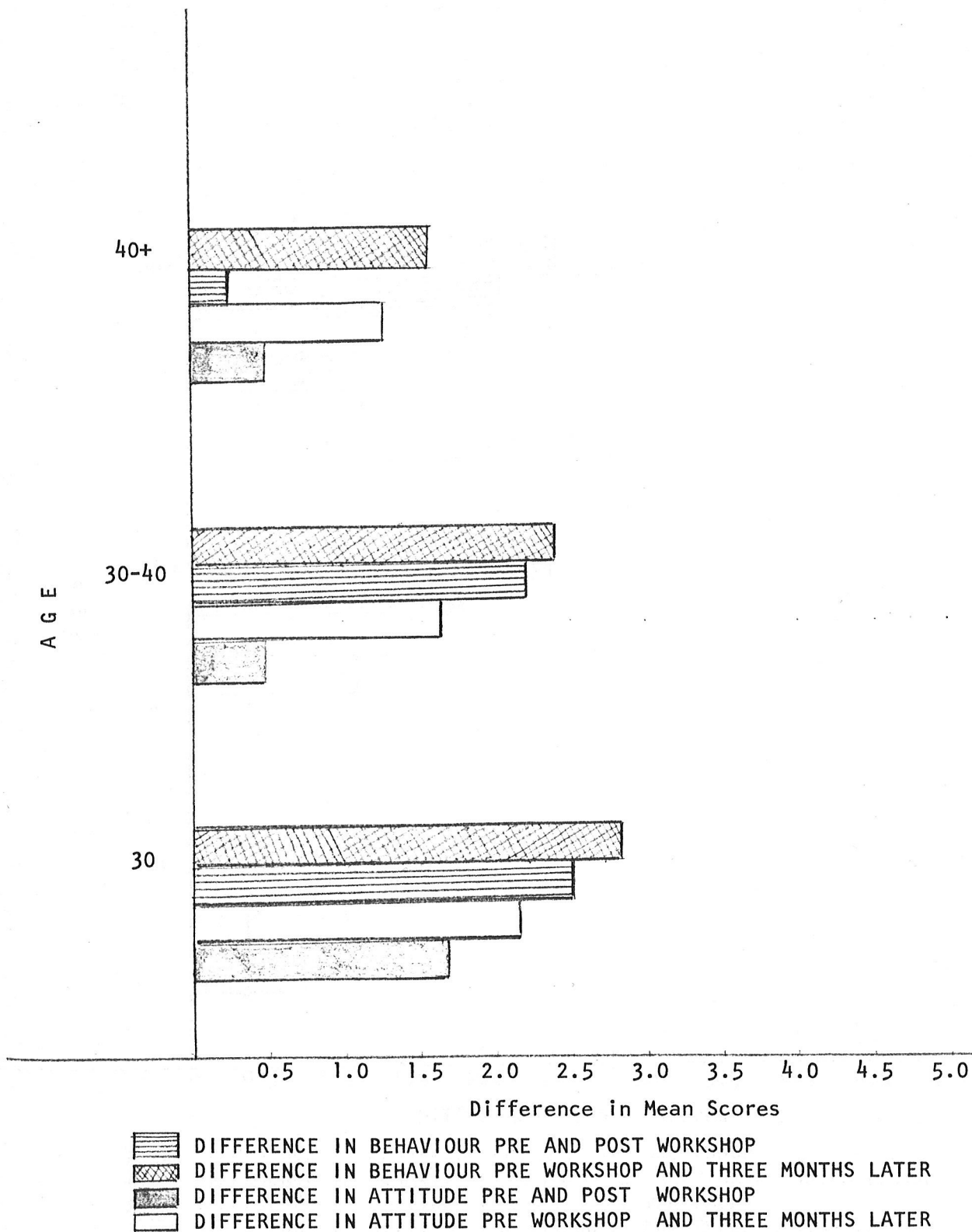


FIGURE ii

FAIRFIELD STUDY

DIFFERENCE IN MEAN SCORES PRE AND POST WORKSHOP
AND PRE WORKSHOP AND THREE MONTHS LATER FOR
WORKSHOP B WHERE AGE IS A FACTOR

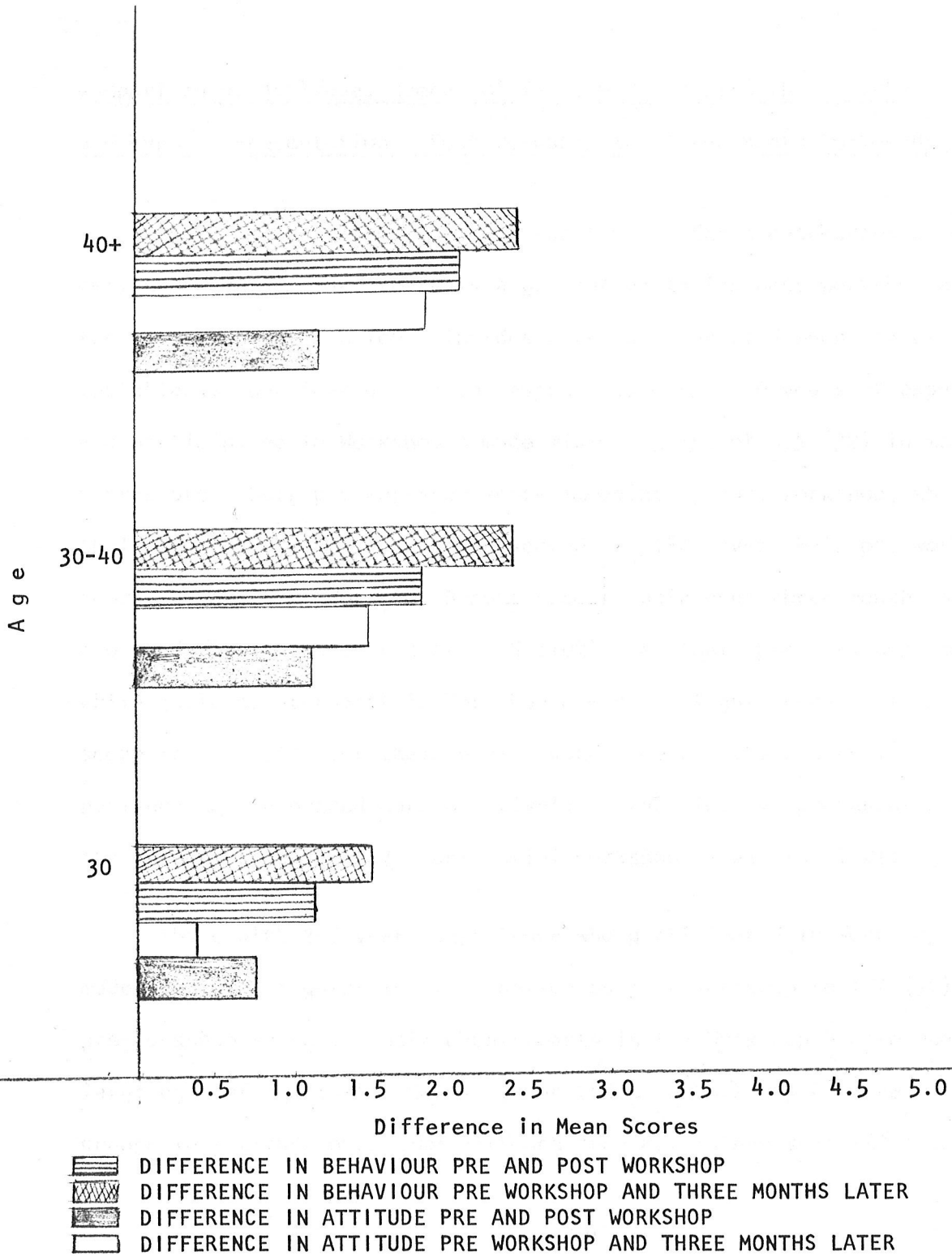


FIGURE iii

in the Lions Gate Study, there was little variance in score when the variable of number of years working with the elderly was considered. There were no respondents with more than ten years experience in geriatric care. (See Fig. IV).

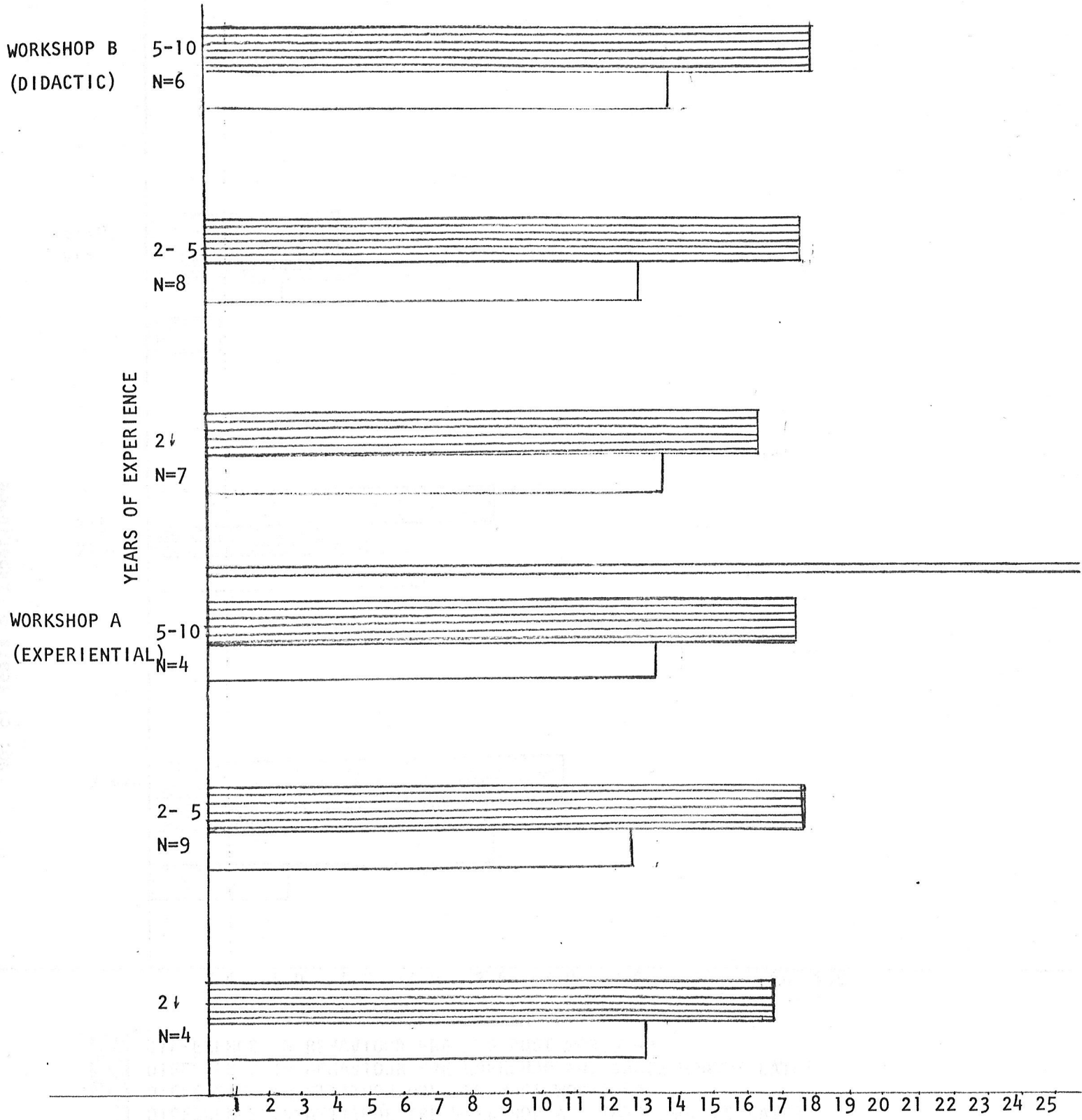
Comparison of Attitude, Number of Years Working with The Elderly and Type of Presentation - Post Workshop and Three Month Follow-Up

Again, where pre-workshop scores for the three categories of experience were similar, there is a greater variation post workshop and in the follow-up study which coincides with that reported when age as a variable was considered. Those respondents with 5-10 years of experience who participated in Workshop A made minimal gains of 0.5 (3%) in mean scores over their pre-workshop score immediately post workshop, while their counterparts in Workshop B scored 1.0 (6%) over their pre-workshop score. Those from Workshop B continued to gain over three months and produced final mean scores of 1.75 (10%) over their pre-workshop score while their counterparts in Workshop A made a slight increase in mean score to 0.9 (5%) over their pre-workshop score. Those with more experience had responded more positively to the didactic presentations than the group discussion and experiential workshop. (See Fig. V-VI).

Those with 2-5 years experience who participated in Workshop A made significant gains in attitude scores post workshop to 1.2 (7%) over pre-workshop scores. Their counterparts in the Workshop B also made a large gain of 0.8 (5%). However, for those in Workshop B there was no change in attitude over time although they maintained their 5% gain,

FAIRFIELD STUDY

COMPARISON OF PRE-WORKSHOP SCORES FOR WORKSHOP A
AND WORKSHOP B FOR ATTITUDE AND BEHAVIOUR WHEN
NUMBER OF YEARS WORKING WITH THE ELDERLY IS A FACTOR



 BEHAVIOUR
 ATTITUDE

Mean Scores

FIGURE iv

FAIRFIELD STUDY

DIFFERENCES IN MEAN SCORES PRE AND POST WORKSHOP
AND PRE WORKSHOP AND THREE MONTHS LATER FOR
WORKSHOP A WHERE NUMBER OF YEARS WORKING WITH THE ELDERLY IS A FACTOR

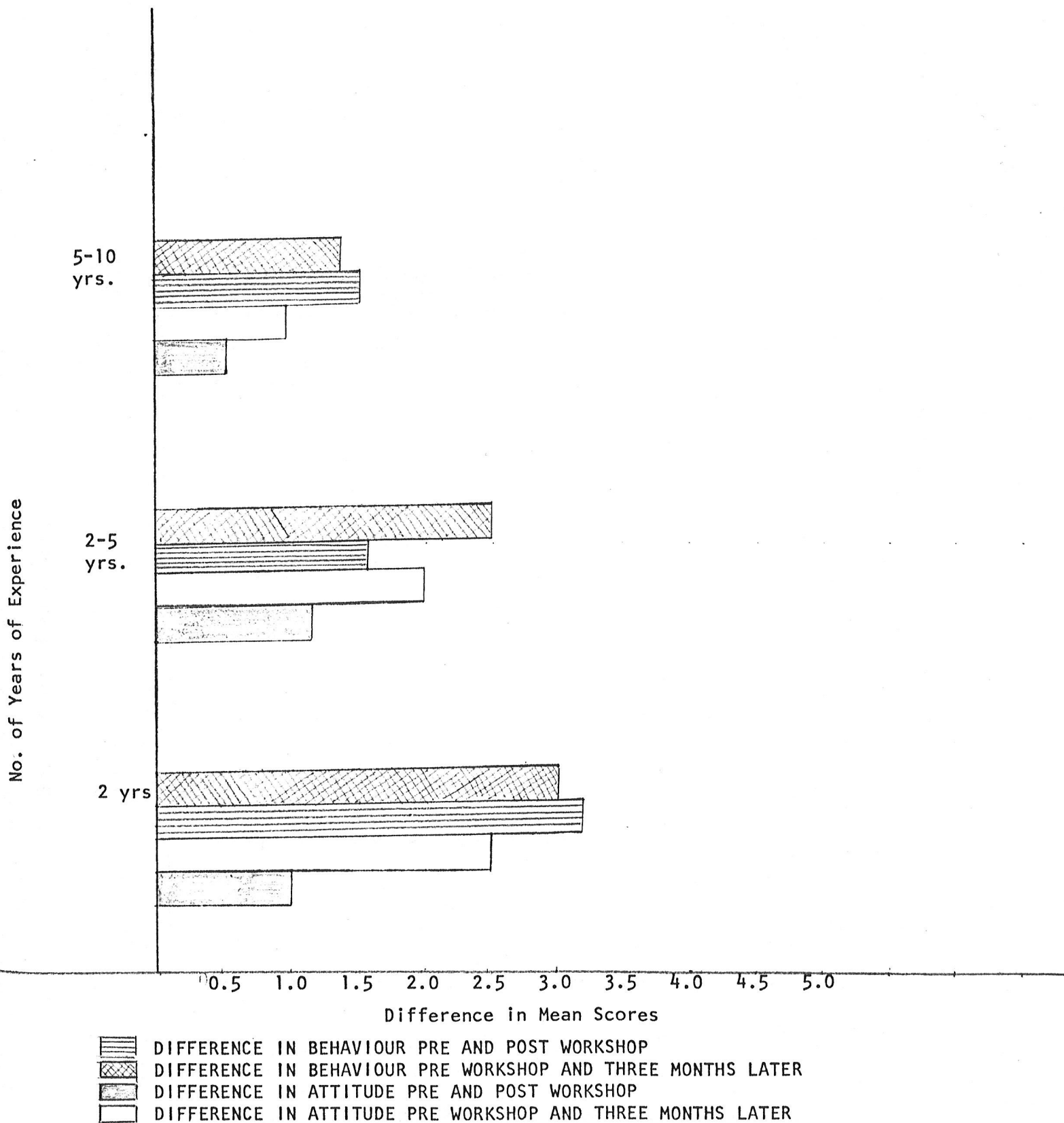


FIGURE v

FAIRFIELD STUDY

DIFFERENCE IN MEAN SCORES PRE AND POST WORKSHOP
 AND PRE WORKSHOP AND THREE MONTHS LATER FOR
WORKSHOP B WHERE NUMBER OF YEARS WORKING WITH THE ELDERLY IS A FACTOR

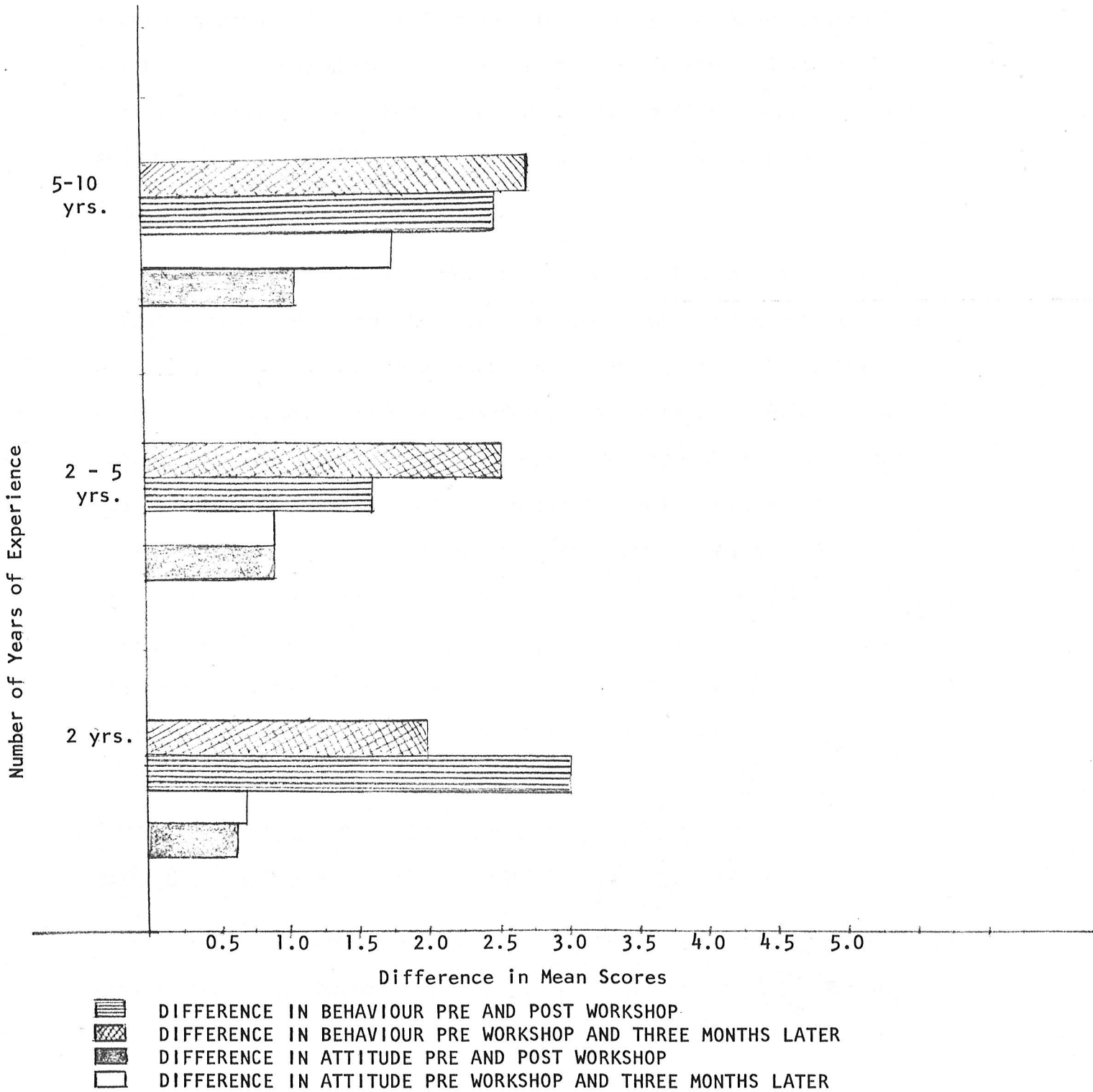


FIGURE vi

This picture was similar for the 30-40 age group. Those attending Workshop A had a mean score of only 0.5 or 3% increase in the post workshop responses compared with an increase of 1.1 (6%) for their counterparts in Workshop B. Those attending Workshop A did make greater gains over time increasing their score to 1.7 points (10%) over pre-workshop scores in the follow-up study while those who had attended Workshop B scored 1.5 (8%) over their pre-workshop score. While the initial scores post workshop had been quite different, the outcome after three months for both groups was about the same.

Those 30 and under responded to the two teaching methods in very different ways. Post workshop, this age group who had attended Workshop A had a greater increase in attitude scores of 1.7 (10%) while their counterparts in Workshop B increased their score by 0.75 (4%). Three months later the scores for participants in Workshop A in this age group had increased their score again for a total mean score of 2.2 (13%) above their pre-workshop score while their counterparts in Workshop B had a drop in score to 0.4 (2%) above their pre-workshop score (a loss of 0.35 (2%). The 30 years and under age group had apparently responded well to the group work and the experiential learning and had made gains over time while those in the didactic workshop had not done so well.

Comparison of Attitude and Number of Years Experience Working
With the Elderly and Type of Presentation - Pre-Workshop

A total of 38 participants completed the pre-workshop questionnaire and, as reported, the total mean score for attitude was 12.9. Again, as

while those in Workshop A made another gain of 0.8 (5%) to a total 2.0 (12%) points over their mean scores pre-workshop in the three-month follow-up study. Those with 2-5 years experience had apparently responded more positively to the group sessions and experiential workshop than the didactic presentation.

The two years or less experienced group who attended Workshop A made an increase in mean scores of 1.0 (6%) post workshop over their pre-workshop scores while those in Workshop B increased their score by 0.6 (4%). In the three-month follow-up study, the participants from Workshop A made a greater increase of 1.5 points (9%) to 2.5 (15%) over their pre-workshop score while their counterparts increased their scores by 0.1 (0.6%) to 0.7 (4%). These newcomers to geriatrics were apparently very sensitive to the group and experiential workshop process.

Comparison of Behavioural Intentions and Age - Pre-Workshop

For the 38 participants who completed the pre-workshop questionnaire, the total mean score for behavioural intentions was 17.0. Again, as with the Lions Gate study, there was little variance in scores related to age for those over 30, with those 40 years and over (N=11) scoring 16.8, those 30-40 years of age (N=12) scoring 16.3. However, the 30-years and under age group (N=15) had a total mean score of 17.6 which was considerably higher than their older counterparts. This varied with the Lions Gate findings where behavioural intentions for the younger age group scored slightly less than their older counterparts. However, referring to the Lions Gate study for level of education as a variable, Licensed Practical

nurses were found to have high attitude and behaviour scores generally.

Comparison of Behavioural Intentions, Age and Type of Presentation

Post-Workshop and In The Three-Month Follow-Up Study

Again, where pre-workshop scores for behavioural intentions were similar, scores demonstrated a difference in response to method of teaching post workshop and in the follow-up study. The 40 years and older group who attended Workshop A made an increase of only 0.25 (0.8%) in scores post workshop compared with an increase of 2.1 (7%) for those attending Workshop B. In the three-month follow-up scores, those participants 40 years and older from Workshop A had increased their scores to 1.5 (5%) above pre-workshop scores but still did not match the gains of their counterparts in Workshop B whose final scores in the three-month follow-up demonstrated an increase of 2.5 (8%) over their pre-workshop scores. The older age group had responded better to the didactic presentation than the group work and experiential learning. This coincided with the improvement with attitude scores and again, where attitude scores improved so scores for intentions to behave improved.

The picture for the 30-40 years of age group was also similar to that for the attitude scores. Those attending Workshop A scored 2.2 (7%) higher than pre-workshop scores in the post workshop responses and increased that score to 2.4 (8%) in the three-month follow-up. Those attending Workshop B had an initial increase of 1.8 (6%) over pre-workshop scores and increased that score also to 2.4 (6%) in the three-month follow-up study. Both groups had responded very similarly and did not seem to

indicate any special preferences for one teaching method over the other. Again, there was demonstrated a positive relationship between attitude scores and behavioural intention scores.

The 30 years and under age group again provided the most improved responses. Post workshop, those attending Workshop A scored 3.0 (10%) over their pre-workshop scores while their counterparts in Workshop B scored only 1.1 (4%) higher. The group from Workshop A increased their scores to 3.25 (11%) over their pre-workshop scores in the three-month follow-up while those in Workshop B made a minimal increase in score to 1.5 (5%) over time. The younger age group had responded best to the workshop session using group work and experiential learning while their older counterparts were more responsive to didactic presentation. While total mean scores pre-workshop demonstrated little difference between the groups in the amount scored for behavioural intentions or attitude, when the variable of age was applied to the data, greater differences emerged in the response of participants.

Number of Years Working with the Elderly and Behavioural Intentions

Pre-Workshop

Finally when pre-workshop scores were compared for the 38 participants, the total mean score was 17.0. There was little variance between scores when the variable of number of years of experience working with the elderly was considered.

Those with 5-10 years experience had a mean score of 17.7 while their counterparts who had from 2-5 years experience also scored 17.8.

Those with 2 years or less experience had the poorest scores with a total mean score of 16.6. These scores were consistent with those from the Lions Gate Study except for those with 2 years or less experience who scored slightly higher in that project.

Number of Years Working with the Elderly and Behavioural Intentions and Type of Teaching Method - Post-Workshop and In the Three-Month Follow-Up

Again, the scores post workshop demonstrated a response to the teaching methods and were consistent with attitude scores. Those with 5-10 years experience who attended Workshop A made a gain of 1.5 (5%) in mean scores over their pre-workshop scores while their counterparts in Workshop B scored 2.4 (8% higher). In the three-month follow-up, those attending Workshop A lost 0.2 (0.7%) of their gain in scores and had a final score of 1.3 (4%) over pre-workshop scores. Their counterparts in Workshop B made a small gain of 0.3 (1%) finishing with a total mean score of 2.7 (9%) over their pre-workshop score. Those participants whose average age was 41 had responded best to the didactic presentation.

For those with 2-5 years experience who attended Workshop A, the mean score post workshop was 1.6 (5%) higher than the pre-workshop score. This score increased to 2.5 (8%) in the three-month follow-up study. Those who attended Workshop B had a post workshop mean score of 1.7 (6%) above the pre-workshop score and this was increased to 2.7 (9%) in the three-month follow-up study. The scores for this group whose average age was 31.7 years, coincided with scores for the 30-40 years of age

group and was consistent with attitude scores for the same participants. The outcome for this group did not appear to be affected by the method of presentation.

Those with 2 years experience or less whose average age was 28, demonstrated the same results as previously discussed for attitude. For those attending Workshop A, the mean post workshop was 3.2 (11%) higher than pre-workshop scores. Their counterparts in Group B scored 3.0 (10%) higher in mean score after the workshop. For the participants of Workshop A, this score dropped slightly by 0.2 (0.7%) to a final mean score of 3.0 (10%) over pre-workshop scores. Those in Workshop B had a larger drop of 1.0 (3%) for a final score of 2.0 (7%) over their pre-workshop scores indicating that they were unable to maintain their new behaviours. This was similar to findings of the Lions Gate Study and coincided with a similar low score in attitude over the same period of time. While both the didactic and the group and experiential workshops had initially produced the same response in these inexperienced, younger participants, only those who attended Workshop A were able to maintain their full scores and increase attitude scores over time.

ANALYSIS OF RESULTS

In the Lions Gate Study, older, more experienced participants scored better for both attitude and behavioural intentions over time while their younger, less experienced counterparts appeared to have good intentions immediately post workshop but were unable to maintain those intentions over time. In this current study, this phenomenon was present for the

didactic presentation of the material but when small discussion groups and experiential learning were used, the situation appeared to reverse with the younger age group significantly improving both attitude and behavioural intention scores while their older, more experienced co-workers did not score so well. Since both groups received the same material in the same environment and were sent to practice the new behaviours described in the same workplace, then the only variable that would have influenced the outcome was the method of presentation.

In the Lions Gate Study, although the material had been prepared for group work and experiential learning, the presentation was severely modified because of the failure to provide sufficient group leaders for small group work. The result was a presentation which allowed for little exchange and sharing of ideas among co-workers and depended very much on the input of the workshop leader. This presentation method, although interspersed with some thought-provoking, participatory exercises, more closely resembled the didactic presentation. It is the author's contention that the older, more experienced participants were able to relate to this type of didactic presentation because it was a format that they found to be more familiar. Since they had had the life experiences which were being discussed, it is theorized that they could relate to the material more readily and did not need the experiential process to place the material on a more relevant level.

The younger, less-experienced participants however, lacked that life experience. While they were initially sympathetic to the difficulties of ageing, they were unable to internalize that sympathy sufficiently well to

maintain the intended behaviours over time. The experiential portions of Workshop A in the Fairfield study gave them the opportunity to actually place themselves in the scenerio of 'being old' and 'feeling' the effects of ageing and made an impression which helped them to maintain their intentions to behave positively.

The group sessions were intended also to reduce the cognitive dissonance which was anticipated to accompany requests to carry out positive behaviours which would require extra time and energy on the part of the caregiver. In a procedural oriented environment where rewards are generally given for efficient, custodial care, demands that staff take time to hold concerned conversations with residents (patients) and be prepared to sacrifice neatness and order for unique, personalized interactions, it was expected that some dissonance would result unless the new behaviours were agreed upon in an open discussion with fellow co-workers. While the opportunity to do this was present in Workshop A, it was missing in Workshop B and in the Lions Gate study. This did not seem to effect the older, more experienced participants but may have influenced the younger, less-experienced individuals. Since this group would be feeling more insecure in their roles and would be attempting to fulfill the perceived expectations of their peers to provide neat, efficient care, then they would need the opportunity to confirm with that peer group the values and behaviours that would allow for the less rigid approach. The group work gave them that opportunity and confirmed the values that supported the new behaviours.

Feelings of dissonance were probably not as intense for the older, more experienced age group since they had already learned through time working with the elderly that the behaviours which were discussed were the most appropriate to apply to enhance the quality of life. They needed some affirmation that these behaviours were acceptable and permission to place them above the traditional behaviours which provided a negative structure to care and they received this affirmation through the supportive environment created by the administration at Lions Gate and at Fairfield.

Both groups needed to understand that there was support in the environment for these new behaviours. In the Lions Gate study and the Fairfield study, environment was not a variable as all participants worked in the same facility. However, in both cases, environment played an important supportive role in reinforcing new behaviours. Without that reinforcement, behaviour may not have been maintained over time, especially if the rewards for working continued to be for efficiency and neatness rather than personalized, individual care.

The relationship between attitude and behaviour was maintained in both studies. Where behavioural intentions were maintained, so attitude improved. The greater degree of retention of behavioural intentions over time, the greater the improvement in attitude. This is consistent with findings of other studies but does not answer the question as to whether behaviours precede the change in attitude or whether a more positive attitude is necessary for a more positive behaviour. The purpose of this evaluation was to measure the effect of the workshop material and method of presentation on attitude and behaviour. Both attitude scores and

behavioural intention scores improved for all participants although the degree of improvement did vary across those variables of age and years of experience working with the elderly.

CRITICISM OF THE STUDY

There were three major criticisms of the study. The first involved the small groups used for analysis of the data. Total numbers of participants for Workshop A was 17. However, when this group was divided according to age and experience, some of the resulting sub-groups included only 4 persons. This may not have produced reliable results and may have accounted for low scores for the 40 years and older age group (N=4), 5-10 years of experience group (N=4) and under 2 years of experience group (N=4).

The second criticism involved the methodology of using a control group who were exposed over time to the behaviours of the test group. The fact that the participants all worked in the same facility was necessary to control the variables in the environment. However, there was no way to prevent individual participants working together, especially through the long hours of a night shift, from talking with each other and sharing experiences from the workshop or exchanging ideas and attitudes related to the subject matter. This in effect involves the process of group work and provides the kind of reinforcement necessary to maintain positive (or negative) behaviours. The attempt to provide some control group as a measurement against which the test group could be compared was probably confounded to some degree by this process.

Third, in neither study was there an attempt made to establish the significance of the scores relative to any degree of predictability with which outcomes could be measured. While scores may have improved, some more than others, there is no way of knowing, without providing further follow-up and observation, whether the improvement in scores actually resulted in an improvement in the approach to care. It was beyond the time and means of the author to provide this follow-up and would have required an inventory of behaviours before the workshop process.

CONCLUSIONS

The author set out to establish some evidence that a combination of teaching methods using group process and experiential learning could be used to effect change in attitude and behavioural intentions of nursing staff working with the elderly. Using established, basic material about issues in ageing especially those affecting the institutionalized elderly, the author used these two approaches and compared the outcomes with a didactic experience which dealt with the same material. Although there was little difference in overall outcome between the two workshops, different groups within the study responded in different ways to the two approaches. Some general statements can be made from this study:

1. Younger, less-experienced nurses respond more favourably to group work and experiential learning.
2. Older, more-experienced nurses respond more favourably to didactic presentations.
3. A change in attitude toward old people is positively related to change in behavioural intentions.

These statements would require testing under more controlled circumstances to determine their absolute validity.

REFERENCES

1. Auerbach, L., Gerber, A. Implications of the Changing Age Structure of the Canadian Population (Perceptions 2) Ottawa: Science Council of Canada
2. Baritz, Loren. The Servants of Power, A History of the use of Social Science in American Industry. Middletown Connecticut - Wesleyan University Press 1960
3. Benson, E.R. "Health Promotion for the Elderly: Clinical Learning Experiences in Non-Traditional Settings" Nurse Clinician North Am. 14(4) p. 577-584 1979
4. Blau, Zena S. "Structural Constraints on Friendship in Old Age" American Sociological Review 26: 429-39 1961
5. Bowker, L.H. "The Relationships among Medical-Model Dominance, Institutional Totality and the Humanization Level of Residents" Humanizing Institutions for the Aged - Lexington Books, Toronto 1982
6. Bradford, L.P. "The Teaching Learning Transaction: Human Forces in Teaching and Learning" Selected Readings, Series III Washington: N.T.L. Institute for Applied Behavioural Sciences, 1968
7. Brink, T.L. "Geriatric Psychotherapy" Human Sciences Press 72 Fifth Avenue, New York, N.Y. p. 78-79 - 1979
8. Brody, Elaine M. "A Million Procrustean Beds" The Gerontologist (Winter) 430-35 - 1973
9. Brower, H.T. "Social Organization and Nurses Attitudes Toward Older Persons" Journal of Gerontological Nursing Vol. 7 No. 5 p. 293-298 May, 1981
10. Caine, Lynn. Widow New York: Wm Morrow

11. Campbell, M.R. "Study of Attitudes of Nursing Personnel toward the Geriatric Patient" Nursing Research 20: p. 147-151 1971
12. Chaisson, M.A. "Life Cycle - A Social-Simulation Game to Improve Attitudes and Responses to the Elderly" Journal of Gerontological Nursing Vol. 6 No. 10. p. 587-592 October, 1980
13. Chamberlain G., Rawls, B., Powell, C. et al "Improving Students' Attitudes toward Aging" Journal of Gerontological Nursing 4(1) p. 44-45 1978
14. Chave, E.J., Thurstone, L.L. The Measurement of Attitude, A Psychophysical Method and Some Experiments with a Scale for Measuring Attitude toward the Church - Chicago, University of Chicago Press, 1970
15. Coch, Lester & French, John R.P. "Overcoming Resistance to Change" Human Relations 1: 512-32 1952
16. Coons, et al "Designing a Therapeutic Community for Geriatric Patients" Institute of Gerontology. The University of Michigan, Wayne State University - Ann Arbor, Michigan 1973
17. Delora, J.R., Moses, D. "Specialty Preferences and Characteristics of Nursing Students in Baccalaureate Programs" Nursing Research 18(2) p. 137-144 1969
18. Denton, Frank T., Spencer, G. "Canada's Population and Labour Force Past Present and Future" Aging in Canada Fitzhenry & Whiteside Ltd p. 10-26 1980
19. Devine, B. "Old Age Stereotyping: A Comparison of Nursing Staff Attitudes Toward the Elderly" Journal of Gerontological Nursing Vol. 6 No. 1 p. 25-32 1980
20. Dulude, Louise. Woman and Aging. A Report on the Rest of our Lives Ottawa: Advisory Council on the Status of Women 1978
21. Dye, Celeste A. "Attitude Change Among Health Professionals: Implications for Gerontological Nursing" Journal of Gerontological Nursing Vol. 5, No. 5, p. 31-35 Sept-October 1979

22. Evans, Jocelyn "Living with a Man Who is Dying: A Personal Memoir"
New York: Taplinger Fakhruddin, A.K.M. et al 1971
23. Ferrari, N.A. Institutionalization and Attitude Change in an Aged
Population: A Field Study and Dissidence Theory" Unpublished
Doctoral Dissertation, Western Reserve University, 1962
24. Festinger, Leon Retrospections of Social Psychology - New York:
Oxford University Press 1980
25. Festinger, Leon "A Theory of Cognitive Dissonance" Palo Alto,
Stanford University Press 1957
26. Fishbein, Martin, Ajzen, Icek "Belief, Attitude, Intention and
Behavior: An Introduction to Theory and Research" Addison Wesley
Publishing Co. Don Mills, Ont. 1975
27. Ford, A.B., Liske, R.E., Ort, R.S. "Reaction of Physicians and
Medical Students to Chronic Illness" Journal of Chronic Disease
15 p. 785-794 August 1962
28. Friedman, R.M. and Tobin, S.S. "Home Maintenance of the Future
Impaired Elderly" Paper delivered at Gerontological Society 27th
Annual Scientific Meeting
29. Futrell, M., Jones, W. "Attitudes of Physicians, Nurses and Social
Workers Toward the Elderly and Health Maintenance Services for the
Aged: Implications for Health Manpower Policy" Journal of
Gerontological Nursing Vol. 3 No. 3 p. 42-46 1977
30. Gillis, M. Sr. "Attitudes of Nursing Personnel Toward the Aged"
Nursing Research 22(6) p. 517-519 1973
31. Goffman, E. Asylums - New York: Doubleday & Co. Inc. p.61 - 1961
32. Goldfarb, A.I. "Institutional Care of the Aged" In Busse E.W.
Pfeiffer, E. (eds): Behavior and Adaptation in Later Life, Boston,
Little, Brown & Co. pp 289-312 1969
33. "G.R.A.S.P. - A Patient Information and Workload Management System"
by Diane Meyer - Published by MCS, Box 1774, Morganton, N.C. 1978

34. Gunter, L.M. "Students' Attitudes toward Geriatric Nursing" Nursing Outlook 19(7) p. 466-469 1971
35. Hart, L.K., Freel, M.I., Crowell, C.M. "Changing Attitudes toward the Aged and Interest in Caring for the Aged" Journal of Gerontological Nursing 2(4) p. 10-16 1976
36. Hartford, M.E. Groups in Social Work: Application of Small Group Theory and Research to Social Work Practice. New York: Columbia University Press, 1971 p. 68
37. Havens, B. "Differentiation of Unmet Needs using Analysis by Age/Sex Cohorts" Aging in Manitoba Vol. 1, 1973 reported in Aging in Canada Fitzhenry & Whiteside Ltd. p. 215-221 1980
38. Havighurst, R.T., Neugarten, B.L. and Tobin, S.S. "Disengagement and Patterns of Ageing" p. 161-77 in Bernice L. Neugarten (Ed) Middle Age and Aging - Chicago: University of Chicago Press 1968
39. Heider, Fritz The Psychology of Interpersonal Relations - New York Wiley 1959
40. Hirschfeld, M.J. "Research in Nursing Gerontology" Journal of Advanced Nursing - 4 - p. 621-626 1979
41. Hoffman, T.L., Reif, S.D. "Into Aging" Thorofare, New Jersey Inc. pp 5-15 1978
42. Hogstel, M.O. "Senior Citizens' Centers offer Learning Opportunities" Nursing and Health Care 1(5) p. 264-269 1980
43. Hogstel, M.O. "Nurses' Attitudes Toward Care of the Elderly Hospital Patients: Can Inservice Education bring about Positive Change?" Journal of Nursing Administration IX(6) p. 26 June 1979
44. Hovland, C.I., Janis, I.L. and Kelly, H.H. Communication and Persuasion - Yale University Press, New York 1953
45. Klein, A. Effective Group Work: An Introduction to the Principles and Method. New York: Association Press, 1972

46. Kogan, Nathan "Attitudes toward Old People: The Development of a Scale and an Examination of Correlates" Journal of Abnormal Psychology 62 p. 44-54 Jan. 1961
47. Krech, D. & Crutchfield, R.J. "Theories and Problems of Social Psychology - New York, McGraw-Hill 1948
48. Levine, Jacob & Butler, John "Lecture vs Group Decision in Changing Behaviour" Journal of Applied Psychology 36:29-33 1952
49. Lewin, Kurt, Field Theory in Social Science. Ed. D. Cartwright New York: Harper 1951
50. Lewin, Kurt, Resolving Social Conflicts, Selected papers on Group Dynamics, Edited by Gertrude Weiss Lewin (1st ed) New York, Harper 1948
51. Lewin, Kurt, A Dynamic Theory of Personality: Selected papers New York, McGraw-Hill 1935
52. Luft, Joseph, Group Processes - An Introduction to Group Dynamics Mayfield Publishing Co., Palo Alto, Calif. 1970
53. McKeachie, W.J. "Individual Conformity to Attitudes of Classroom Groups" Journal of Abnormal and Social Psychology 49: 282-89 1954
54. Marsh, Victor W. "Aging in Canada - Social Perspectives" Fitzhenry & Whiteside Limited, Don Mills, Ontario 1980
55. Martin, M. and Buckwalter, K. "New Approaches to Continuing Education for Gerontological Nursing" Journal of Continuing Education for Nursing, Vol. 5 No. 2, 1984
56. Mathews, Anne M. "Women and Widowhood" Aging in Canada Fitzhenry & Whiteside Ltd. p. 145-154 1980
57. MEDICUS - Medicus Systems Corp., Chicago, Illinois "Review and Evaluation of Nursing Productivity" in Volume III Literature and Research Review November 1975

58. Monea, H.E. Instructors Manual to Accompany Nursing and the Aged
New York, McGraw-Hill pp 39-41 1976

59. Myles, J. "Institutionalization of the Elderly: A Critical
Assessment of the Sociology of Total Institutions" Aging in Canada
Fitzhenry & Whiteside Ltd. 1980

60. Odiorne, A. "The Trouble with Sensitivity Training" Journal of
American Society of Training Directors 17: 9-20 1963

61. Ohlsen, M. Group Counselling New York: Holt Rhinehart and Winston,
p. 60 1970

62. "P.R.N.- The Choice of Toronto General: A Patient Classification
System" by Mina, E. in Dimensions 51 (11):22-4 November 1981

63. Powers, Edward A., Bultena, G.L. "Characteristics of Deceased Drop-
outs in Longitudinal Research" Journal of Gerontology 27(4): p. 530-
535 1972

64. Robb, S. "Attitudes and Intentions of Baccalaureate Nursing Students
toward the Elderly" Nursing Research Vol. 28, No. 1 p. 43-50 1979

65. Rogers, David n.d. The Necessary and Sufficient Criteria of Leader-
ship. Unpublished manuscript quoted in Group Processes. Joseph Luft,
Mayfield Publishing Company, Palo Alto, California 1976

66. Riley, Matilda W., Foner, A. Aging in Society, Volume I - An Inventory
on Research Findings New York: Russell Sage Foundation p. 159 1968

67. Ross, David P. Canadian Fact Book on Poverty Ottawa: Canadian
Council on Social Development p. 22-23 1975

68. Sarnoff, I. Personality Dynamics and Development - New York, Wiley
1962

69. Schwenger, C.W., Gross, M.J. "Institutional Care and Institution-
alization of the Elderly in Canada" Aging in Canada Fitzhenry &
Whiteside Ltd. 1980

70. Schwenger, C. "Health Care for Aging Canadians" Canadian Welfare 52(6): p. 9-12 1977
71. Schwenger, C. "Keep the Old Folks at Home" Canadian Journal of Public Health 65: p.417 1974
72. Shreiber, M.M. "The Age of the 70's - perspectives" p.2-25 in Lola Wilson (Ed), Report, Training Institute for Directors of Senior Centers, Ottawa: Canadian Council on Social Development.
73. Somers "The Small Group in Learning and Teaching" Education for Social Work, E. Younghusband (ed.) New York C.S.W.E. Vol 4, No. 4 1968
74. Stock, D. and Luft, J. "T.E.T. Design, A Modification of a T-Group Experience" Training designs for human relations laboratories - ed Douglas Bunker, Washington, D.C. National Education Association 1962
75. Taylor, K., Harned, T.L. "Attitudes Toward Old People: A Study of Nurses Who Care for the Elderly" Journal of Gerontological Nursing 4, p. 43-47 1978
76. Tobiason, S.J., Knudsen, F., Stengel, J.C. et al "Positive Attitudes Toward Aging: The Aged Teach the Young" Journal of Gerontological Nursing 5(3) p. 18-23 1979
77. Thurstone, L.L. & Chave, E.J. reported in "Belief, Attitude, Intention & Behavior: An Introduction to Theory and Research" by Martin Fishbein and Icek Ajzen - Addison - Wesley Publishing Co. Don Mills, Ontario 1975
78. Williams, R. and Ware, J. "An Extended Visit with Dr. Fox" Validity of Student Satisfaction with Instruction Rating after Repeated Exposures to a Lecturer" American Educational Research Journal 14.4 (1977) pp 449-457
79. Wolk, R.L., Wolk, R.B. "Professional Workers Attitudes Toward the Aged" Geriatric Social 19: p. 624-639 1971
80. Wylie, Betty Jane "Beginnings: A Book for Widows" Toronto: McClellan and Stewart

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APPENDIX I

G.R.A.S.P. WORKLOAD TOOL

UNIT WEEKLY UTILIZATION REPORT

The UNIT WEEKLY UTILIZATION REPORT is designed to provide a summary each week of activity by nursing unit and a management control tool for analyzing relationships between staffing needs and actual staff provided by day of the week. This report also then becomes the input to the Unit Four-Week Summary Reports.

DIRECTIONS - NURSING OFFICE:

- (1) Each morning the previous day's Nursing Office Report should be obtained and the Patient Care Units (PCU's), the Nursing Care Units (NCU's) and the Census (at 11 p.m.) copied off for each nursing unit on to the UNIT WEEKLY UTILIZATION REPORT by shift. (PCU's are calculated by multiplying total PCU's by 47% for Day, 34% for Evening, and 19% for Night). The Utilization Index (#13) is calculated by dividing the total PCU's (#11) by the total NCU's (#12). (#11 = #2 + #5 + #9) (#12 = #3 + #6 + #9)

Each morning the Average Hours of Care Required Per Patient Day are calculated by dividing the total PCU's (#11) by the Census (#1). This is recorded on Line #20.

Variance (#4, #7 and #10) is calculated by subtracting PCU's (#2, #5 and #8) from NCU's (#3, #6 and #9) for each day. Indicate variance with a plus or minus (i.e. more NCU's than PCU's +, less NCU's than PCU's -).

- (2) The WEEKLY SHIFT UTILIZATION is calculated by adding (Lines #2, #5 and #8, respectively) to get a weekly total for each shift and adding NCU's (Lines #3, #6 and #9, respectively) to get a weekly total of NCU's for each shift. The PCU's are divided by NCU's and recorded in Boxes #14, #15 and #16 (D, E, N).

Each week add each day's total PCU's and NCU's (across Lines #11 and #12) and enter the sum in the Weekly Summary Box on the right (#17 and #18). The WEEKLY UTILIZATION is calculated by dividing the Total PCU's by the Total NCU's. This is entered in Box #19.

Total variance for the week is found by adding Lines #4, #7, and #10 to get #4a, #7a, and #10a.

The Weekly Average Hours of Care Per Patient Day is calculated by adding each number in Line #20 and dividing by 7 (days). Enter this figure in Box #21 on the right. (Enter Budgeted Average PCU's for comparison from Budgeted NCU/PCU Information Sheet.) Actual NCU's from #18 is entered in Box #22. Budgeted NCU's from Nursing Office are entered in Box #23 and subtracted from Box #22. The answer is entered in Box #24. Variance should be indicated by a plus or minus (i.e. more actual NCU's than budgeted NCU's with a + and less actual NCU's than budgeted NCU's with a -). Budgeted NCU's are also entered in Box #25. Actual PCU's from #17 are entered in Box #26 and subtracted as in the above explanation. Finally, circle in red the day with the highest PCU's and the day with the lowest PCU's in green on Line #11.

- (3) On a weekly basis, distribute the completed report to the appropriate people for review (Nursing Administration, Supervisors, Patient Care Coordinators, Personnel Department, Staffing Coordinator and Admitting Office). The reports should be reviewed for extremely high (120%) or low (80%) utilization indices and its relationship to census and quality of care. The variance between budgeted and actual NCU's should be reviewed as an indication of how closely staffing is following the budget.

KEY:	MORE NCU'S = +	MORE PCU'S = -	
	MORE ACTUAL NCU'S THAN BUDGETED NCU'S	= +	
	LESS ACTUAL NCU'S THAN BUDGETED NCU'S	= -	
	MORE ACTUAL NCU'S THAN ACTUAL PCU'S	= +	
	LESS ACTUAL NCU'S THAN ACTUAL PCU'S	= -	

DAILY STAFFING REQUIREMENT REPORT

The DAILY STAFFING REQUIREMENT REPORT is designed to provide nursing supervision with a system for reviewing staff requirements for each unit before the start of the shift based upon the total patient care units (PCU's) required. Float staff can thus be allocated to units more accurately and additional staff can be called in if necessary.

ADMITTING CLERK/ACC - Each morning tabulate PCU's on one patient level by 10:00 a.m. Record PCU's for each nursing unit on the Admitting Office Work Distribution Form, estimate PCU's on new admissions and add new admissions' PCU's to the appropriate unit.

ADMITTING CLERK - Each afternoon record the most up-to-date PCU's for each nursing unit on the DAILY STAFFING REQUIREMENT REPORT in Column II (top half) and forward it to the Nursing Office by 1:30 p.m. Record the number of surgical admissions for each unit in a circle next to the PCU's (i.e. ③).

NURSING OFFICE (ACC) - Each afternoon at 1:30 calculate the PCU requirements for each unit for 2nd shift:

Column III: Multiply Column II by .34 (3 - 11 shift)

Record NCU's assigned (one nurse = 8 NCU's) to each nursing unit for all three shifts in Columns IV, VII and X. Calculate the difference between the PCU's and NCU's for 2nd shift and enter figure in Column V. A xerox copy is made and sent to the 3rd ACC, the original left in the Supervisors Office.

Column VI (NCU's) - Column III (PCU's) = Column V* (Difference)

ACC - Each evening update PCU Boards on units between 9:30-10:30 p.m., (1) adding points and converting to PCU's for new admissions and patients whose care has changed, and (2) retotaling the PCU Board, (3) recording total PCU's on Nursing Office Report on right hand side - "PCU's at 11:00 p.m.", and (4) making a note of the updated PCU's to send to the 3rd ACC by 10:30 p.m. At 10:30 the 3rd ACC completes the Daily Staffing Requirement Report for 3rd shift and 1st shift (next day) by recording the updated PCU's in Column II (lower half) and:

Column VI: Multiply Column II by .19 (11 - 7 shift)

Column IX: Multiply Column II by .47 (7 - 3 shift for the next day)

Column VII (NCU's) - Column VI (PCU's) = Column VIII* (Difference)

Column X (NCU's) - Column IX (PCU's) = Column XI* (Difference)

Send Report to Switchboard.

NURSING SUPERVISORS - Each shift review the differences (Columns V, VIII, XI) for possible staff adjustments. If the PCU's exceed the NCU's by more than 5.50 hours, float personnel may be considered for assignment to the unit. If the NCU's exceed PCU's by more than 5.50 hours, re-assignment of staff may be warranted. Emergency admissions will also be assigned to beds on the basis of these figures whenever possible. Note that the number of surgical admissions for each unit (circled) will somewhat inflate PCU's for 2nd shift.

* Indicate plus or minus numbers. A minus (-) number indicates a shortage of nursing staff; a plus (+) number indicates an abundance of nursing staff.

NOTE: ACC is equivalent of ward clerk.

WEEKLY SPOT-CHECK SHEET

Unit: _____

Signature: _____

Date: _____

PHYSICAL CARE ACTIVITIES
(CARE NEEDED)

DIET (Circle One, Highest Applicable)

	Room #				
Feeds self w/out help; or family feeds patient, or N.P.O.	1	1	1	1	1
Feeds self w/help; or tube/gastros.w/intermittent ck-Q6H	6	6	6	6	6
Tube/gastrostomy feeding w/intermittent check - Q4H	9	9	9	9	9
Total feeding by personnel	11	11	11	11	11
Tube/gastrostomy feeding with constant presence - Q6H	16	16	16	16	16
Tube/gastrostomy feeding with constant presence - Q4H	24	24	24	24	24

TOILET-OUTPUT (Circle One, Highest Applicable)

Toilets without supervision	1	1	1	1	1
Foley catheter (and bedpan)	3	3	3	3	3
Toilets with some help; or diabetic specimen collection	4	4	4	4	4
Commode chair; or bedpan; or perineal care of gyn. pt.	6	6	6	6	6
Toilets with constant supervision	8	8	8	8	8
Immediate post-op ostomies; or output per hour	10	10	10	10	10
Colostomy irrigation (and bedpan)	12	12	12	12	12
Drainage with dressing changes - Q4H (and bedpan)	14	14	14	14	14
Incontinent (B.M.); or dressing change 3x shift	18	18	18	18	18

VITAL SIGNS & MEASUREMENT (Circle One, Highest Applicable)

Routine vital signs (TPR, BP) - BID	3	3	3	3	3
Vital signs - QID; or Close Monitoring Q1H	4	4	4	4	4
Vital signs - Q4H	5	5	5	5	5
Post-op V.S.; or V.S. Q2H; or close monitoring Q30M	9	9	9	9	9
Special post-op vital signs (Q30M x 8)	12	12	12	12	12
Vital signs with neurological evaluation - Q1H	21	21	21	21	21

CLEANLINESS (Circle One, Highest Applicable)

Bathes self	2	2	2	2	2
Bathes self with help or supervision	3	3	3	3	3
Bathed by personnel	5	5	5	5	5
Bathed by personnel with special skin or decubiti care	7	7	7	7	7

IF APPLICABLE:

TURNING AND ASSISTED ACTIVITIES (Circle Highest, If Applicable)

Walk with help; or up in chair with help - OD	1	1	1	1	1
Walk with help; or up in chair with help - BID or TID	3	3	3	3	3
Walk with help; or up in chair with help - QID	6	6	6	6	6
Bedfast with help to turn - Q2H; or circo-electric bed	13	13	13	13	13
Bedfast with help to turn - Q1H	24	24	24	24	24

MEDICATIONS/FLUIDS (Circle As Many As Applicable)

Oral meds, drops, suppositories, ointments up to 4-6XQD	1	1	1	1	1
Injection - OD or BID (Estimate PRN's)	1	1	1	1	1
Oral meds, drops, suppositories, ointments - 8XQD	2	2	2	2	2
Injection - TID or QID (Estimate PRN's)	2	2	2	2	2
Oral meds, drops, suppositories, ointments - 12+XQD	3	3	3	3	3
Injection - Q4H (Estimate PRN's)	3	3	3	3	3
I.V. Medications	3	3	3	3	3
Blood transfusions	5	5	5	5	5
Intermittent I.V. therapy	9	9	9	9	9
Continuous I.V.	11	11	11	11	11

SUCTIONING & RESPIRATORY AIDES (Circle As Many As Applicable)

Trach suction - QID; or gastric or oral suctioning	4	4	4	4	4
Tracheostomy suction - Q4H	5	5	5	5	5
Tracheostomy suction - Q3H	7	7	7	7	7
Post-op cough and deep breathe and leg exercises	7	7	7	7	7
Tracheostomy suction - Q2H	11	11	11	11	11
Tracheostomy suction - Q1H	21	21	21	21	21

NUMBER OF POINTS DIFFERENCE

Reviewed with _____

YOUR POINTS

PCU BOARD POINTS

DIFFERENCE

(SEND TO NURSING OFFICE)

VICTORIA, B.C.

APPENDIX II

AGEING! MOI?

- POSTER
- WORKSHOP AGENDA
- WORKSHOP OBJECTIVES

AGING! MOI?



A PERSONAL GLIMPSE AT AGING DESIGNED TO:

- EXPLORE PSYCHOSOCIAL ISSUES OF AGING IN TODAY'S SOCIETY
- IDENTIFY ISSUES WHICH AFFECT THE ELDERLY RESIDENTS' ABILITY TO COPE IN AN INSTITUTIONAL SETTING
- LEARN TECHNIQUES THAT CAN PRODUCE A CARING, THERAPEUTIC ENVIRONMENT

**WORKSHOP LEADER: SUSAN ASTILL-McNISH, NURSE CLINICIAN
DEPT. OF GERIATRIC MEDICINE
VICTORIA GENERAL HOSPITAL, VICTORIA, B.C.**

AGEING ! MOI ?

WORKSHOP AGENDA

1. WHERE DO WE GET OUR ATTITUDES ABOUT AGEING ?
1 hour
COFFEE-BREAK
2. AGEING ! MOI ?
1½ hours
3. COME TO LUNCH (TEA) IN THE DAY ROOM
¾ hour
BREAK
4. POWER IN THE INSTITUTION - WHO HAS IT ?
¾ hour - discussion
5. LOSSES AND WHAT THEY DO -
1 hour
6. REMINISCING - WHO AM I ANYWAY ?
1½ hours
7. CLOSURE

*

WORKSHOP OBJECTIVES AND CONTENT

SESSION #1 WHERE DO WE GET OUR ATTITUDES ABOUT AGEING? 1 hour

OBJECTIVE: Each participant will recall one positive and one negative experience with an elderly person and recognize what impression that experience had on his/her attitudes about old people.

METHOD: Small group discussion (no more than 6-10). A moderator should be chosen to make sure that no one person monopolizes the discussion and that each person has a turn. Each participant should offer one brief story of a positive and a negative experience with an old person from his past. The moderator might choose to review all negative experiences first and then all positive stories. He/She may choose to begin the session with his/her own personal story, especially if no one steps forward to begin.

Things to be aware of: such reviews often evoke tears as old memories are revived. The group should be warned that this might happen and that accepting each others' tears is an expectation of the process.

SUMMATION: The group leader should sum up the discussion by referring the members back to the objective of the exercise and reiterating that all of these feelings help to form our attitudes of what it must be like to be old.

SUMMATION,
cont'd

Examples of positive characteristics: Old people are seen to be active, productive, good teachers with time and patience, wise, influential, proud, loving and caring.

Examples of negative characteristics: Old people are seen as lonely, frightened, helpless, angry, bitter, sick, confused and a burden to others.

SESSION II AGEING ! MOI ?

1½ hours

OBJECTIVE: Each participant will be able to relate the ageing process as it is viewed socially, to his own lifestyle and will recognize both positive and negative elements in that process.

METHOD: The group of 6-10 people will sit in a quiet room, away from distractive noise and interruption. The lights may be turned down and quiet music played to create a peaceful environment. The members of the group are asked to find their own space both physically and mentally and not to share information with one another.

A group leader will slowly read the instructions from Table #1 allowing adequate response time for each item. After completing the exercise in Table 1, the group should be given a few minutes to reflect on 'who they are' as an old person. Then the light can be turned up and the group can

METHOD
cont'd

discuss the items on the list in relation to the information they have about lifestyle and how current practices will affect their ageing process (e.g. smoking, overeating, etc.) and some of the sociological realities of how they will live as they get older.

Things to be aware of: The nature of the exercise lends itself to humour and so people may not take it seriously at first. It must be stressed at the beginning of the exercise that the process is only as effective as the members of the group make it.

People who have debilitating disease processes or who have family histories which suggest early infirmity and perhaps early death can take the exercise most seriously. The positive aspects of how early screening, diet and exercise and information about good health can prevent progress of such problems should be stressed. (It is interesting to note that if an age is chosen for the exercise beyond the suggested 72 years most smokers draw themselves in a box).

SESSION III COME TO LUNCH IN THE DAY ROOM

2 hours

OBJECTIVE: To provide the members of the group with the experience of being a patient and to demonstrate power and its' use through the structured behavior of staff in an institution.

METHOD: 6-10 people with two persons acting in the custodial role. Follow the directions in Table IV.

PART I -
(1 hour)

Things to be aware of: frustration, tears, anger and 'acting out' behavior are often expressed by the participants. Those persons whose behavior is particularly disruptive should be 'isolated' much as we would isolate 'problem' patients.

The people who demonstrate the strongest personalities in real life are often the ones that will be the most difficult to manage in this exercise. Be aware of some of the extreme measures suggested and used to contain that behavior. Be prepared to discuss this phenomenon during debriefing.

PART II -
(1 hour)

DEBRIEFING: DISCUSSION

Have people list the feelings that they had toward the 'caregivers' during this exercise. Discuss the feelings expressed. The list will include anger, frustration, fear, powerlessness, despair, withdrawal and even disorientation. Explore why these feelings occur. Who has the power? What choices do residents have? Are they able to maintain a sense of dignity and self-worth under these circumstances? What would be the natural process of such treatment for these group members if they were unable to step out of that role? Did the caregivers feel powerful?

SUMMARY:

The group should discuss these staff/patient roles and the resulting behavior and then consider the effect of this treatment on patients who have already undergone multiple losses.

SESSION IV POWER IN THE INSTITUTION - WHO HAS IT? 3/4 hour

OBJECTIVE: Members of the group will identify nursing behaviors which affect the residents' freedom to make choices about everyday life.

METHOD: Small group 6-10 people. The group leader will introduce the topic by discussing factors in our own life which we take for granted such as: privacy in our own room and in the bathroom, the choice of clothing, the choice of when to eat, where to eat and with whom to share the meal, the choice of activities, etc. etc. Special concern should be placed on the issue of the risks involved in giving residents their freedom.

SUMMATION: The group leader will sum up the discussion by listing the controlling behaviors and soliciting alternative approaches that nurses should use in returning power to the patient.

SESSION V LOSSES AND WHAT THEY DO 1 hour

OBJECTIVE: Each participant will recognize how the series of losses associated with their personal life can affect one's self-esteem and sense of identify.

METHOD: Small group discussion 6-10 people. A moderator should be chosen who will provide the directions from Table II. After each item is removed from the list, discussion should follow

METHOD
cont'd

about the effect of the loss of that item on the individual's sense of person and self-esteem.

Things to be aware of: This can be a most depressing exercise and some participants may become tearful as the sense of loss overwhelms them. The group should be warned of this and that accepting each others' tears is part of the process.

SUMMATION:

The group leader should relate the exercise to the experience of many people who are in a nursing home and who have suffered multiple losses of spouse, home, role, community and friends and finally, health.

FOLLOW-UP
EXERCISE

Each group member should review one history of a resident and count the losses that individual has suffered in the past ten years. A follow-up meeting of the group to share these stories of residents would provide the members with an opportunity to get to know their patients in a more personal way.

SESSION VI REMINISCING "WHO AM I ANYWAY"

1½ hours

OBJECTIVE:

Each group member will know some personal anecdote from the past of each of the other participants and will recognize that the roles we see others in are only a small part of who they are.

METHOD: Small group 6-10 people. A group leader should be chosen to follow the directions in Table III.

Things to be aware of: Surprises !!!

SUMMATION: The group leader should relate the exercise to the experience we have in taking care of residents in a sick, patient role. Sometimes we do not consider that they have another story. The therapeutic value of being able to tell that story, both to validate yourself as a person and to receive feedback from friends that you really are "O.K.!" should be discussed.

FOLLOW-UP EXERCISE "PEEGE" - a movie about communication and reminiscing.

CONCLUSION

These are just some of the techniques that the author has found useful in sensitizing staff to the needs of elderly residents in long term care facilities. Unlike the 'Ageing Game' and other elaborate techniques to create empathy for the elderly, these exercises are simple and require few 'props' and only the concern of a small group of people to explore the process in a personal way.

The author does not intend to suggest that nurses do not already have such information and skills. These exercises combine some valuable and much touted current techniques such as Life Review, Fantasy Validation and theories about grief and loss which are well established in the

field of psychology and mental health. The intention of this paper is to draw the best from each of these techniques and theories and package them so that nurses can share them effectively and within the limits described at the beginning of this article. More importantly, nurses who are concerned with the day to day care of patients can use them, revise them, be innovative with them and make them fit their special concerns. Hopefully they will spark further interest in some of the more formal techniques referenced below.

GOOD LUCK, AND HAPPY AGEING !

AN AGEING FANTASY

Each group member should have paper and a pencil.

The setting should be quiet, with lights dimmed and music playing softly. The group is first directed to project themselves into the future and think about growing old. They are told to think of themselves at 72 years of age.

The leader then directs the group as follows:

1. On a piece of paper, draw a picture of yourself at 72. Include any mechanical aids you might need at that age (glasses, canes, walkers, etc.). (approx 3-5 mins.).
2. Keep this picture of yourself in mind and respond to the following questions:
 - who do you live with ?
 - where do you live ?
 - do you have any other significant family members ?
 - where do those family members live ?
 - what is your income ?
 - how do you spend your time ?
 - are you healthy ?
 - do you have any pets ?

Allow adequate response time - Do not rush the group.

3. If you become disabled and you are admitted to an institution, describe what you would like the environment to be like. Consider your living space, list the things you would like to be responsible for and the control you would like to have over that space.

Allow at least 5 minutes response time.

4. Consider the staff of that institution. What would you like them to be like ?

Allow at least 3 minutes response time.

The group should then discuss the above material and make a list of environmental and attitudinal changes that staff in an institution could make without significantly changing ward routines or the physical layout of the building.

LOSSES AND WHAT THEY DO

Small group - 6-10 people
Paper and pencils

The moderator will read the following directions:

Each person will list 5 things which he/she most associates with himself as a person. These may include people, places, possessions or roles. (Allow 5 minutes response time, or until everyone appears to have finished)

1. Ask the members of the group to choose one item from the list and cross it off -Discuss.
2. Ask the members of the group to remove the item from their list which is closest to the bottom - Discuss.
3. Ask the members of the group to reach over (without reading their neighbours list) and cross off one item from the list of the person sitting to their left - Discuss.
4. Ask the members of the group to cross off the most valuable of the two items that remain -Discuss.
5. Discuss the effect of such losses if one's health and independence were also taken away.

REMINISCING - "WHO AM I ANYWAY"

Small group - 6-10 people

The moderator will direct the group members to take 5 minutes to think of a story from their own life which best reflects some aspect of who they are which is unrelated to their role at work as others see them. For example, someone might relate an experience that they had while living elsewhere in the country when they were involved in an art group or in making pottery. The stories should not relate to any aspect of their life as it is known now to other members of the group.

The moderator should allow each person 5 minutes to tell that story and an additional 2 or 3 minutes for other group members to ask questions and glean more details. Time should be monitored carefully.

The group should then discuss the change in perspective that they have about each other through the sharing of these brief glimpses into each others' lives. How does this exercise with each other reflect upon the impressions we have of patients in their sick role ? What stories would they tell ?

TABLE III

"COME TO THE DAY ROOM FOR TEA !"

Small group 6-10 people

Two persons acting as 'staff'.

Bibs, restraints, string, opaque tape, straws, 'tea'.

As the group arrive, they are individually assigned to wheelchairs or geriatric chairs. They are provided with 'deficits' (one lens on their glasses covered for hemianopsia, center of both lenses covered for cataracts, one arm tied to the chair-arm for hemiparesis, one leg on the same side tied to the wheelchair) are restrained, are provided with a bib and are labelled with large printed labels saying "I am deaf" or "I am confused" or "I can't speak". Each participant is told about his label.

The participants are seated around the table and served lukewarm tea (so that they don't burn themselves!) and cookies. Tea should be sipped through a straw. The 'staff' can be innovative in managing their patients, feed them, isolate them if they act out, take them to the bathroom (if they are on a 'bladder routine') and play 'nice' (loud) music for them so that they can enjoy themselves. Rubbing orange peel, strong soap or cleaner on the hands before offering fluids through a straw produces interesting reactions. The 'staff' can be as innovative as they like within reasonable and realistic terms.

After 30 minutes, "release" the participants and discuss the feelings that resulted from this activity. Who was in control ?

APPENDIX III

-SAMPLE OF ANECDOTAL FEEDBACK FORM

-WORKSHOP PARTICIPANTS LIONS GATE

HOSPITAL, SEPTEMBER 1983.

Responses to the Experiential Day on Empathy and Caring by Sue Astill-McNish
Held on September 16, 1983

What did you get out of the day?

I wanted to feel what it would be like to be in an elderly person's position and sitting in the dining room and being not able to move did that.

I learned in one day more about the people I will be working with than one generally does in several months, if ever. I also feel I will be in closer touch with what our patients have to deal with.

I've learned how to be more effective in dealing with the elderly in regards to nursing care and to see them as a person not as a body in a bed. That they have feelings though they may not be able to express them (ie. - confusion, disorientation).

Have met my objectives and very much more today. The movie (Peege) touched me deeply and kind of makes you take a second look at relationships within your own family. -What we've learned today cannot help but make us more aware of our "patients" as human beings and ourselves as fragile to the same problems in our future. Thank you so much!

The very true sense of loss that is experienced by a patient going into a long term care facility. Also the importance of family visits to these patients. To spend more time reminiscing with them, touching them, and being aware that their psycho-social needs are every bit as important as their physical needs.

I have learned more of how the resident feels; more about the people I will be working with; to understand positive feelings that I do get from the patient; how to cope with the anger and anxiety of patients and to visualize what losses they go through; be able to feel that we are trusted by them and a lot of times we are their only contact through the outside world.

The movie Peege is a very dramatic movie. I have seen it three times now but everytime I see it it has very strong feelings towards love ones, family.

I gained much more information about the personal lives of the people I will be working with. I know this will increase my understanding of them. I hope that this will mean we will work better together.

Although it's not unusual that we tend to disregard minor gestures of our patients, this inservice has done something to open up our minds that these small gestures or comments they are giving is for us to see them and not just disregard them as part of the routine.

I know that we are always informed to give "Tender Loving Care" and provide extra attention if they need help in what ever they do or they want to do. Most of the examples you're given are really similar to the one we've encountered that mostly we don't know how to cope with, but given such background we already have a baseline of what will be our positive responses.

Thanks a lot for a new and enjoyable experience of getting old.

Clearer vision of limitations and greater empathy towards the aged; greater appreciation of ways to enhance the dignity of the aged; much appreciated the portion of lecture re: reality orientation; increased knowledge re: bladder limitations of the aged. Thank you for an invaluable day.

Useful things - the concept of how I limit my thoughts of myself at 72 - appreciated that when making our list of 5 cherished things, you accept responsibility for removing some onto our neighbours. This gave me an altered perception of the exercise. I had done it before but in a different way (removing all items myself). One taught me a bit about loss and self-anger, the other about anger towards others.

To understand how the patient feels; to learn the best way to help them with their fears, losses and the emptiness; to be honest with them so they can be open and trust me as a nurse or friend.

I have learned today the value of being old. How meaningful it is for an elderly person to be able to express their feelings to their families and how they react to being alone in a nursing home. By seeing the movie Peege, it reminds me of my grandmother who passed away last year. She loved me very much. I had been in Canada for 5 years when she said she will not die until she sees me with my sister. We went home 2 years ago to see her and she was very, very happy. We took care of her as she did to us when we were younger. When she was really ill, we were in Canada. She apparently told my parents not to let us know how ill she was because we would be worried about her and it would interfere with our daily lives. The only words she said, I'm happy to go now, I've seen my granddaughters. I felt so guilty and I said to myself, I wish I could have done my very, very best to take care of my grandmother, the way I'm taking care of old people in Canada.

APPENDIX IV

-PROPOSAL FOR STAFF DEVELOPMENT PROGRAM
IN EMPATHY & CARING AT EVERGREEN HOUSE



lions gate hospital

FIFTEENTH STREET AT ST. GEORGES, NORTH VANCOUVER, B.C. V7L 2L7 PHONE:(604) 988-3131 TELEX:04-352605

October 17, 1983

TO: T. E. McMillan, Assistant Administrator
FROM: Dean Armstrong

As you are aware, some fairly major changes are taking place in Evergreen House in November. These designed changes in the staffing patterns and methods of giving care will allow us to more adequately and effectively improve on the quality care that we give. For example, we will have more staff available during the periods the residents have the most identified unmet needs. I am confident these changes will go a long way to improving the basic care of the residents by having more hands available at peak times and a better way to do the work.

Where it falls short is addressing the improvement of the "lot" of the old. This will only come about by changes in attitudes towards the old and I am convinced that we must have more empathy by the caregivers of the "plight of being old and dependent" for this to take place. Unfortunately, when thoughts go towards donations or spending money, we all tend to think of new and fancy equipment which is nice but -

Things don't care
and
Things don't comfort

People do

This letter is a request for funds to provide a package or program that would address my concern about how the needs of the old for dignity and respect are met. I understand there are funds that are available in the hospital that this proposal would be eligible for.

I propose that we provide a one day experiential day on "Empathy and Caring" for all staff members in Evergreen House. This would require replacements for the majority of staff. The reinforcement value of the staff getting in touch with their "caring emotions" and working on their "caring behaviors" at the same time suggests it be a one week blitz.

Because of the "expert" syndrome or myth, I feel we should import an "expert" for this program. We would use this experience to develop our own "experts" for our future needs.

There are a number of films that are a must for everybody that is working with the old to see. These should be purchased as they would be used on a regular basis and renting, or even borrowing, is costly in terms of mailing costs and time. Not owning reduces not only the number of times it is shown but eliminates any spontaneity.

I have attached a "We Care" pin which makes a powerful statement and believe all staff should be given one -- which also makes a powerful statement. It makes an excellent motto for those involved in the care of the old and the wearing of the pin would be a frequent reminder. It would make the staff feel special, which we know care givers in extended care don't feel enough of. And finally, I believe the staff would see it is a reward and we would give one to each new employee (including the expansion) with their successful three month probationary evaluation.

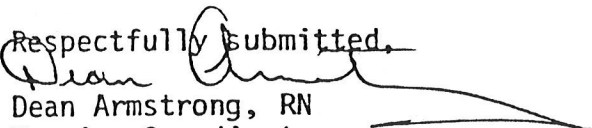
This package or program would consist of:

1)	One day's educational leave with pay for all staff (approximately 125 staff at \$100 per day)	\$12,500
2)	Resource person(s)	900
3)	Purchase of video tapes, films, etc.	1,200
4)	Purchase "We Care" pins for all staff (200 buttons at \$2.00 each - includes for staff in expansion)	400
		<hr/>
		\$15,000

A selfish reason for us to support and develop such programs was made at the First Annual Gerontological Nursing Conference in Victoria this summer. The first speaker pointed out that "If we don't make the necessary changes in attitude now, who will for us?" Another speaker pointed out that when we are asked the question "Can we afford to do that for 'them' and realize that 'them' will be us - of course we can".

I would strongly recommend that you accept this proposal and that the implementation be as soon as possible. It is very timely as our thrust for change was "improved resident" care and this would reinforce that. Another reason is that the changes we made in the rotations has caused the expected morale problems and this would partly counter this. It would also provide a well established, committed program for use with the expansion and all future staff. Last, but certainly not least, would be the effective major statement and commitment by Administration to "We Care" would have.

Respectfully submitted,


Dean Armstrong, RN
Nursing Coordinator,
Long Term Care

DA/lf

cc Lynette Best

APPENDIX V

-SCORES FOR THE VALIDATION OF INSTRUMENT
FOR BEHAVIOURAL INTENTIONS

WORKSHOP EVALUATION

N = 7

	VERY MUCH	MODERATELY	A LITTLE	NOT AT ALL
1. In most instances, old people should be restrained to keep them out of harm's way.			1	6
2. When old people cry and express sad thoughts, it is very important to change the subject immediately and remind them of how many things they have to be cheerful about.			1	6
3. Old people frequently are incontinent at night, so the staff should anticipate that and pad the bed and patient securely to keep them warm.			2	5
4. Male and female residents in an institution who demonstrate physical and emotional attraction and attachment to each other should be separated before an embarrassing relationship develops.			3	4
5. It is good for nurses to encourage old people to do things together even though they may never have liked to join groups before.			3	4
6. It is good for residents to all eat together even though they might have disabilities and require assistance with feeding.			1	6
7. Old people have the right to take risks.				7
8. It is the nurse's responsibility to protect residents so that they do not injure themselves.		6	1	
9. Knocking on the door of a resident's room is a waste of nursing time if the resident is confused or deaf.				7
10. Every resident should have a tub or bath at least three times each week because old people tend to neglect personal hygiene.			2	5

APPENDIX VI

-INSTRUMENTS

SPECIAL INFORMATION SHEET

1. MY AGE IS: _____

2. MY POSITION IS: _____

(BScN - R.N. - LPN - N.A. - ORDERLY)

3. IF N.A. or ORDERLY, PLEASE INDICATE WHERE YOU WERE TRAINED THROUGH A COURSE OR ON THE JOB:

4. HOW LONG HAVE YOU WORKED WITH OLD PEOPLE ?

CHOOSE ONE:

10-20 years _____

5-10 years _____

2- 5 years _____

2 yrs of less _____

PLEASE GO ON TO THE NEXT PAGE - REMEMBER !

THERE ARE NO "RIGHT" ANSWERS - JUST BE

AS HONEST AS YOU CAN THANK YOU !

PLEASE ANSWER THE FOLLOWING "TRUE" OR "FALSE"

TRUE FALSE

1. It would probably be better if most old people lived in residential units with people of their own age. _____
2. Most old people are really no different from anybody else; they're as easy to understand as younger people. _____
3. Most old people get set in their ways and are unable to change. _____
4. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody. _____
5. Most old people tend to let their homes become shabby and unattractive. _____
6. People grow wiser with the coming of old age. _____
7. Old people have too much power in business and politics. _____
8. Most old people are very relaxing to be with. _____
9. Most old people bore others by their insistence on talking about the 'good old days'. _____
10. Most old people tend to keep to themselves and give advice only when asked. _____
11. If old people expect to be liked, their first step is to try to get rid of their irritating faults. _____
12. You can count on finding a nice residential neighbourhood when there is a sizeable number of old people living in it. _____
13. There are a few exceptions, but in general most old people are pretty much alike. _____
14. Most old people seem to be quite clean and neat in their personal appearance. _____
15. Most old people are irritable, grouchy and unpleasant. _____
16. One seldom hears old people complaining about the behavior of the younger generation. _____
17. Most old people make excessive demands for love and reassurance. _____

WORKSHOP EVALUATION

	VERY MUCH	MODER- ATELY	A LITTLE	NOT AT ALL
1. In most instances, old people should be restrained to keep them out of harm's way.				
2. When old people cry and express sad thoughts, it is very important to change the subject immediately and remind them of how many things they have to be cheerful about.				
3. Old people frequently are incontinent at night, so the staff should anticipate that and pad the bed and patient securely to keep them warm.				
4. Male and female residents in an institution who demonstrate physical and emotional attraction and attachment to each other should be separated before an embarrassing relationship develops.				
5. It is good for nurses to encourage old people to do things together even though they may never have liked to join groups before.				
6. It is good for residents to all eat together even though they might have disabilities and require assistance with feeding.				
7. Old people have the right to take risks.				
8. It is the nurse's responsibility to protect residents so that they do not injure themselves.				
9. Knocking on the door of a resident's room is a waste of nursing time if the resident is confused or deaf.				
10. Every resident should have a tub or bath at least three times each week because old people tend to neglect personal hygiene.				

APPENDIX VII

-OBJECTIVES - DIDACTIC PRESENTATION

OBJECTIVES - cont'd

2. Ageing ! - Moi ?

Objective: Participants will be able to discuss the ageing process in relation to social issues in today's society.

Method: The workshop leader will give a 1½-hour presentation which will provide demographic and factual data related to the aged in today's society.

Content -

1. current data related to longevity for men and women and the number of people in Canada over 65 who are institutionalized;
2. the type of accommodations that are found in Canada among the elderly today;
3. the number of people living alone and in other arrangements in Canada today;
4. fragmented family supports and the realities of geographic distance between mobile families in today's society;
5. provincial legislation of health care services and its' implication for moving an elderly relative closer to family support;
6. retirement planning, retirement income, the Canada Pension Plan, Old Age Pension, existence of death benefits on pension plans and their effect on income in old age, particularly for women;

OBJECTIVES - cont'd

- Content -
7. the social and psychological impact of losses associated with ageing and how they affect health and the quality of life;
 8. the social and psychological impact of loss of independence and the admission to a nursing home or other like institution.

3. Come to Lunch in the Day Room.

Objective: The participants will be able to recognize the negative aspects of current institutional practice of insisting that everyone eat together and identify the negative behaviours which staff use to demonstrate their power over patients in such a setting.

Method: The workshop leader will describe:

1. the need to establish an environment that best suits the individual patients' past behaviours with regard to eating;
2. negative factors in the institutional dining room (e.g. noise, hurry, etc.);
3. the affect of various disabilities - blindness or impaired vision, paralysis, deafness, confusion, inability to speak, etc. - on dining;
4. negative behaviours staff use to expedite the mealtime process and to deal with unusual behaviour.

OBJECTIVES - cont'd

4. Power in the Institution

Objective: Participants will be able to identify nursing behaviours which affect the residents' freedom to make choices about everyday life -3/4 hour.

Method: The workshop leader will discuss:

1. privacy in the patients' living space;
2. privacy in the bathroom;
3. patients' right to choose clothing;
4. patients' right to choose what and when to eat;
5. patients' right to choose what activities to do and when to do them;
6. patient's right to take risks and to enjoy his life;
7. effect of controlling behaviours staff use, including physical restraints;
8. alternative approaches that nurses can use in returning the power to the patient.

5. Losses and What They Do

Objective: The participants will be prepared to relate the series of losses associated with ageing with loss of self-esteem and self-identity.

OBJECTIVES - cont'd

Method: The workshop leader will identify:

1. factors related to a personal sense of identity.
2. factors related to self-esteem.
3. losses associated with ageing.
4. the relationship of these losses and self-esteem and identity.
5. the physiological and psychological implications of multiple loss in the elderly.
6. the resulting common behaviours demonstrated by the institutionalized elderly suffering from such a series of losses.

6. Reminiscing.

Objective: The participants will recognize the value of reminiscing in maintaining self-esteem and personal identity in the elderly. 1½ hours.

Method: The workshop leader will discuss:

1. the sources of validation for the elderly.
2. the role of staff in providing validation.
3. the identification of different levels of confusion.
4. remedial approaches that can be used for confusion related to loss of identity -

OBJECTIVES - cont'd

4. cont'd
 - a) reality orientation
 - b) reminiscing.
5. some common responses which validate expressions of grief or loss for an individual.
6. resources that can be used for indepth therapy in the elderly.
7. some common symptoms of anxiety and depression resulting from loss of identity and self-esteem in the elderly.
8. how to reminisce with one individual.
9. how to run a reminiscing group.

This section will be followed up by the showing of the movie "Peege" a movie about communication and reminiscing.

APPENDIX VIII

LIONS GATE HOSPITAL STUDY

PRE-WORKSHOP AND POST WORKSHOP SCORES

Author's Note:

Because numbers of staff attending each day was limited, the variable of age and level of education and number of years experience could be matched sufficiently well to identify the pre-workshop and post workshop responses from the same individual.

This proved to be an added bonus in tallying scores both as a point of reference to gauge individual improvement and to avoid duplicating the tables pre and post workshop.

LIONS GATE HOSPITAL

PRE WORKSHOP AND POST WORKSHOP

Summary Scores - Nursing Assistants

Pre-Workshop Post Workshop

Day 2	N	Attit.A	Behav.B	Attit.A	Behav.B	Age	No. Yrs Experience
	1	12	16	13	21	22	↓ 2
	2	11	11	12	17	20	2- 5
	3	15	14	16	20	25	5-10
	4	11	9	14	16	21	↓ 2
	5	11	16	12	18	46	10-20
	6	15	18	16	22	24	2- 5
	7	13	18	13	20	21	2- 5
	8	13	20	16	22	28	↓ 2
	9	10	16	14	22	30	↓ 2
	10	13	17	13	19	42	↓ 2
	11	10	13	12	23	42	5-10
	12	8	17	9	20	49	10-20
	13	6	5	12	22	39	2- 5
	14	8	11	9	9	34	2- 5
Total Scores	14	156	201	181	271		

LIONS GATE HOSPITAL

PRE WORKSHOP AND POST WORKSHOP

Summary Scores - Nursing Assistants

Pre-Workshop Post Workshop

Day 1	N	Attit.A	Behav.B	Attit.A	Behav.B	Age	No. Yrs Experience
	1	7	13	8	18	33	5-10
	2	16	14	15	21	56	5-10
	3	14	16	15	20	56	2- 5
	4	10	15	14	20	34	10-20
	5	8	11	10	9	29	2- 5
	6	12	11	13	15	38	5-10
	7	10	12	7	15	39	2- 5
	8	10	13	12	19	21	2- 5
	9	10	11	14	9	47	10-20
	10	15	14	16	18	--	5-10
	11	13	13	12	19	36	5-10
	12	10	14	7	20	42	10-20
	13	14	18	13	18	31	10-20
	14	14	10	12	21	35	10-20
	15	9	14	10	13	24	2- 5
	16	13	16	12	21	22	↓ 2
	17	14	16	13	18	29	2- 5
	18	11	19	11	23	33	↓ 2
Total Scores	18	210	250	214	317		

LIONS GATE HOSPITAL

PRE WORKSHOP AND POST WORKSHOP

Summary Scores - Nursing Assistants

Pre-Workshop Post Workshop

Day 3	N	Attit.A	Behav.B	Attit.A	Behav.B	Age	No. Yrs. Experience
	1	12	17	12	18	38	10-20
	2	14	12	11	18	22	2- 5
	3	11	20	16	17	33	10-20
	4	8	11	12	13	34	5-10
	5	7	10	7	13	58	10-20
	6	4	8	9	16	27	2- 5
	7	14	18	13	19	38	10-20
	8	16	18	16	20	37	2- 5
	9	12	22	11	21	31	5-10
	10	14	11	13	20	21	↓ 2
	11	11	18	12	23	25	↓ 2
	12	14	10	15	19	27	2- 5
	13	11	16	10	20	23	5-10
	14	16	25	15	27	38	5-10
	15	11	18	13	18	40	↓ 2
	16	14	20	14	19	38	10-20
Total Scores	16	189	254	199	301		

LIONS GATE HOSPITAL

PRE WORKSHOP AND POST WORKSHOP

Summary Scores - Nursing Assistants

Day 4	N	Pre-Workshop		Post Workshop		Age	No. Yrs Experience
		Attit.A	Behav.B	Attit.A	Behav.B		
	1	14	29	13	24	46	10-20
	2	15	18	15	17	35	10-20
	3	11	18	9	23	24	2- 5
	4	13	15	13	16	21	2- 5
	5	11	13	11	18	40	5-10
	6	13	20	14	23	53	10-20
	7	10	20	9	18	27	5-10
	8	11	12	13	17	35	5-10
	9	15	16	16	22	59	2- 5
	10	10	16	11	15	24	2- 5
	11	14	21	14	19	29	↓ 2
	12	10	10	12	12	41	5-10
	13	10	20	13	17	46	10-20
Total Scores	13	157	238	163	241		

LIONS GATE HOSPITAL

PRE WORKSHOP AND POST WORKSHOP

Summary Scores - Nursing Assistants

Day 5	N	Pre-Workshop		Post Workshop		Age	No. Yrs Experience
		Attit.A	Behav.B	Attit.A	Behav.B		
	1	15	15	13	21	48	10-20
	2	7	12	9	11	31	5-10
	3	10	13	8	19	42	10-20
	4	12	16	13	19	42	5-10
	5	9	16	13	19	19	↓ 2
	6	7	10	6	17	37	5-10
	7	15	15	15	22	24	2- 5
	8	13	12	14	14	45	10-20
	9	9	16	13	23	43	2- 5
	10	8	14	10	18	25	5-10
	11	8	14	13	18	38	5-10
	12	6	11	12	11	40	10-20
	13	10	12	19	19	42	5-10
	14	13	18	14	26	39	2- 5
Total Scores	14	142	194	172	257		

LIONS GATE HOSPITAL

PRE WORKSHOP AND POST WORKSHOP

Summary Scores - BScN's, R.N.'s, S.W., LPN's and Others

Day 1	Pre Workshop		Post Workshop		Age	No. Yrs Experience	
	N	Attit.A	Behav.B	Attit.A.			Behav.B
R.N.'s	1	17	16	15	20	46	2- 5
	2	12	13	11	18	50	5-10
	3	7	10	7	20		5-10
	4	7	14	14	23	58	↓ 2
	5	15	18	15	21	39	5-10
	6	13	19	11	22	53	5-10
Totals:	6	71	90	73	124		
BScN	1	10	23	11	26	33	↓2
Total:	1	10	23	11	26		
LPN	1	14	17	15	19	32	10-20
Total:	1	14	17	15	19		
W/C	1	7	16	10	11	31	5-10
Total:	1	7	16	10	11		

LIONS GATE HOSPITAL

PRE WORKSHOP AND POST WORKSHOP

Summary Scores - BScN's, R.N.'s, S.W., LPN's and Others

Pre Workshop Post Workshop

Day 2	N	Attit.A	Behav.B	Attit.A	Behav.B	Age	No. Yrs Experience
R.N.	1	10	20	12	21	57	2- 5
	2	8	17	13	19	47	5-10
	3	11	19	16	20	58	10-20
	4	10	18	13	24	45	5-10
	5	8	13	9	21	41	5-10
Total:	5	47	87	63	105		
BScN.	1	15	21	17	24	36	5-10
	2	17	21	17	22	23	2
Total:	2	32	42	34	46		
OT/Aide	1	10	12	15	17	27	
	2	13	14	13	14	31	
Total:	2	23	26	28	31		

LIONS GATE HOSPITAL

PRE WORKSHOP AND POST WORKSHOP

Summary Scores - BScN's, R.N.'s, S.W., LPN's and Others

Pre Workshop Post Workshop

Day 3	N	Attit.A	Behav.B	Attit.A	Behav.B	Age	No. Yrs. Experience
R.N.	1	16	17	15	23	53	10-20
	2	12	19	11	19	45	5-10
	3	10	12	13	18	53	5-10
	4	15	16	17	23	59	5-10
	5	10	19	10	23	54	2- 5
	6	15	18	15	25	47	10-20
	7	10	14	13	20	38	10-20
	8	15	24	12	22	60	10-20
	9	13	18	12	18	50	2- 5
Total:	9	116	157	118	191		
W/C	1	17	18	16	20	40	2- 5
Total:	1	17	18	16	20		
LPN	1	21	16	20	29	29	5-10
Total:	1	21	16	20	29		

LIONS GATE HOSPITAL

PRE WORKSHOP AND POST WORKSHOP

Summary Scores - BScN's, R.N.'s, S.W., LPN's and Others

Pre Workshop Post Workshop

Day 4	N	Attit.A	Behav.B	Attit.A	Behav.B	Age	No. Yrs. Experience
R.N.	1	14	10	15	5	55	5-10
	2	15	22	15	25	48	5-10
	3	5	22	4	24	49	2- 5
	4	9	21	10	19	45	10-20
	5	17	19	17	23	57	5-10
Total:	5	60	94	61	96		
LPN	1	16	23	16	24	35	10-20
	2	14	14	10	21	37	2- 5
	3/2	9	18	--	--	28	5-10
Total:	3/2	39	55	26	45		
OT	1	10	24	11	25	42	10-20
	2	9	17	11	20	42	5-10
Total:	2	19	41	22	45		
BScN	1	10	24	10	25	35	2- 5
Total:	1	10	24	10	25		
MSW	1	13	24	14	23	46	√ 2
	2	12	19	13	21	44	2- 5
Total:	2	25	43	27	44		

LIONS GATE HOSPITAL

PRE WORKSHOP AND POST WORKSHOP

Summary Scores - BScN's, R.N.'s, S.W., LPN's and Others

Pre Workshop Post Workshop

Day 5	N	Attit.A	Behav.B	Attit.A	Behav.B	Age	No. Yrs. Experience
R.N.	1	12	21	14	21	49	10-20
	2	13	20	17	23	64	10-20
	3	13	21	14	21	36	2- 5
	4	12	18	10	20	47	10-20
	5	17	25	17	26	45	5-10
Total:	5	67	105	72	111		
LPN	1	12	16	13	23	33	5-10
	2	13	18	13	21	24	2- 5
Total:	2	25	34	26	44		
Physio Aide	1	16	20	16	23	60	5-10
	2	12	17	14	22	23	↓ 2
Total:	2	28	37	30	45		
BScN	1	10	19	10	23	58	2- 5
Total:	1	10	19	10	23		

LIONS GATE HOSPITAL

TOTAL MEAN SCORES - PRE AND POST WORKSHOP

FOR LEVEL OF EDUCATION

Level of Education	N	Attitude	Behaviour	Attitude	Behaviour
BScN	5	12.4	21.6	13.0	24.0
S.W.	2	12.5	21.5	13.5	22.0
R.N.	30	12.0	17.8	12.9	20.9
LPN	7/6	14.1	17.4	14.5	21.2
W/C, OT/PT Aides	9	11.7	17.8	13.3	18.7
N.A.	75	11.4	15.2	11.3	18.5
<u>FOR AGE</u>					
Age	N	Attitude	Behaviour	Attitude	Behaviour
40+	56	11.6	16.6	12.5	19.8
30-40	36	11.5	16.2	12.4	19.4
30↓	31	12.1	15.4	12.4	18.6
<u>FOR NO. OF YEARS WORKING WITH THE ELDERLY</u>					
No.Yrs.	N	Attitude	Behaviour	Attitude	Behaviour
10-20	32	12.0	17.5	12.8	19.3
5-10	42	11.7	15.6	12.8	19.0
2- 5	33	11.7	15.6	12.1	19.4
2↓	17	11.8	17.4	13.4	21.1

LIONS GATE HOSPITAL STUDY

THREE-MONTHS FOLLOW-UP SCORES

FOLLOW-UP SCORES LIONS GATE HOSPITAL

Social Workers

N.	Age	Years	Attitude	Behaviour
1	46	2	16	21

Activity Aides

1	54	10-20	12	13
2	29	5-10	15	23
3	31	10-20	16	24
4	42	2- 5	11	22
Total Scores:			54	82
Total Mean Score:			13.5	20.5

Ward Clerks

1	40	2- 5	16	19
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LPN's

1	24	2- 5	14	16
2	35	10-20	16	22
Total Scores:			30	38
Total Mean Score:			15	19

R.N.'s

1	57	5-10	17	21
2	55	5-10	16	18
3	47	10-20	11	24
4	45	10-20	17	24
5	--	5-10	17	23
6	49	5-10	15	22
7	50	2- 5	14	22
8	47	10-20	16	18
9	37	10-20	15	18
10	62	10-20	16	25

FOLLOW-UP SCORES LIONS GATE HOSPITAL

R.N.'s (cont'd)

N.	Age	Years	Attitude	Behaviour
11.	46	2- 5	14	19
12	57	5-10	9	15
13	46	5-10	10	20
Total Scores:			187	269
Total Mean Scores:			14.38	20.69

BScN

1	36	2	11	25
2	36	10-20	16	24
3	34	2	9	23
4	39	2	17	21
Total Scores:			53	93
Total Mean Scores:			13.3	23.3

Nursing Assistants

1		5-10	5	17
2	45	10-20	14	16
3	36	10-20	8	10
4	26	5-10	16	18
5		10-20	12	18
6	22	2	13	19
7	34	5-10	9	11
8	22	2- 5	13	17
9	39	5-10	12	23
10		5-10	14	16
11		2- 5	13	18
12	38	10-20	13	23
13		2- 5	11	25
14		5-10	13	24
15	28	5-10	14	16
16	21	2- 5	9	15
17	21	2- 5	12	18

FOLLOW-UP SCORES LIONS GATE HOSPITAL

Nursing Assistants (cont'd)

N	Age	Years	Attitude	Behaviour
18			14	17
19	31	5-10	11	15
20	58	10-20	6	14
21	--	10-20	15	20
22	34	5-10	10	10
23	28	2- 5	10	12
24	--	5-10	4	12
25	53	5-10	16	15
26	42	2	12	21
27	22	2- 5	13	13
28	20	2	10	22
29	24	2- 5	12	21
30	21	2- 5	9	19
31	35	2- 5	15	19
32	--	2	11	20
33	34	10-20	15	18
34	37	2- 5	12	16
35	31	5-10	11	22
36	24	2- 5	14	20
37	21	2	9	16
38	29	2	15	18
39	42	5-10	10	13
40	29	2- 5	7	11
Total Scores:			462	654
Total Mean Scores			11.5	17.2

LIONS GATE HOSPITAL

TOTAL MEAN SCORES - THREE MONTHS FOLLOW-UP

LEVEL OF EDUCATION

Level of Education	N	Attitude	Behaviour	Comments:
BScN	4	13.25	23.3	
MSW	1	16.0	21.0	
R.N.	13	14.38	20.7	
LPN	2	15.0	19.0	
W/C, OT/PT Aides	5	14.0	20.2	
N/A	40	11.5	17.2	

AGE

Age	N	Attitude	Behaviour	Comments
40+	18	13.6	19.6	
30-40	17	12.7	19.5	
30	17	12.1	17.3	13 respondents failed to report their age

NUMBER OF YEARS WORKING WITH THE ELDERLY

No. Yrs.	N	Attitude	Behaviour	Comments
10-20	16	13.6	19.4	
5-10	18	13.2	19.3	
2- 5	18	11.5	17.3	
2	9	12.4	20.1	4 respondents failed to report No. Years of Experience

APPENDIX IX

RAW SCORES - FAIRFIELD STUDY

FAIRFIELD STUDY

RAW SCORES

PRE AND POST WORKSHOP

WORKSHOP A

N=17

PRE WORKSHOP		POST WORKSHOP	
ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR
14	16	14	18
13	23	13	21
11	15	12	23
15	17	16	18
16	18	14	21
14	15	15	21
17	19	14	18
9	12	16	19
16	16	14	17
14	17	16	18
12	20	12	24
12	19	13	18
8	15	9	17
12	18	12	20
12	19	15	18
13	17	14	20
12	21	16	20
TOTAL	220	235	331
AV.	12.9	13.8	19.5

FAIRFIELD STUDY

RAW SCORES

PRE AND POST WORKSHOP

WORKSHOP B

N=21

PRE WORKSHOP		POST WORKSHOP	
ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR
12	14	15	18
12	16	13	18
15	17	14	15
10	13	12	16
12	15	16	18
16	14	16	14
9	18	14	23
16	17	8	17
9	13	14	23
12	24	15	19
14	20	12	19
13	19	12	17
11	15	14	20
16	17	16	24
14	22	15	14
8	14	17	15
15	17	9	18
17	21	16	19
13	12	17	17
16	16	12	22
11	13	14	16
TOTAL 271	347	291	382
AV. 12.9	16.5	13.9	18.2

FAIRFIELD STUDY

RAW SCORES

3-MONTH FOLLOW-UP

WORKSHOP A AND WORKSHOP B

WORKSHOP A		WORKSHOP B	
N=17		N=21	
ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR
14	18	10	15
12	19	17	16
12	16	16	20
12	17	14	19
14	19	15	20
12	17	16	17
13	18	17	22
15	20	15	21
15	18	13	22
17	19	14	16
16	21	11	18
13	19	15	19
17	23	9	16
18	21	17	18
16	22	15	19
19	22	13	16
15	24	14	21
		12	17
		17	19
		13	22
		15	20
TOTAL	250	333	298
AV.	14.7	19.6	14.2
			18.7

FAIRFIELD STUDY

RAW SCORES

AGE AS A FACTOR

WORKSHOP A

40 YEARS ↑ N=4	PRE-WORKSHOP		POST WORKSHOP		3-MONTH FOLLOW-UP	
	ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR
	16	14	16	20	16	19
	13	18	15	16	15	19
	14	18	13	17	15	18
	11	17	12	15	13	17
TOTAL	54	67	56	68	59	73
AVERAGE	13.5	16.7	14.0	17.0	14.7	18.3
30-40 YRS. N=6						
	15	17	12	19	18	22
	15	13	14	22	17	20
	12	16	16	18	15	19
	10	18	13	17	14	18
	13	20	11	16	12	16
	13	14	15	21	12	17
TOTAL	78	98	81	113	88	112
AVERAGE	13.0	16.4	13.5	18.6	14.7	18.8
30 YRS ↓ N=7						
	13	18	15	24	17	25
	16	20	16	20	16	24
	13	17	14	24	16	23
	12	18	13	22	15	22
	9	23	12	20	14	19
	11	16	12	19	12	18
	13	19	17	20	12	22
TOTAL	87	131	99	149	102	153
AVERAGE	12.4	18.7	14.1	21.3	14.6	21.9

FAIRFIELD STUDY

RAW SCORES

AGE AS A FACTOR

WORKSHOP B

AGE	PRE WORKSHOP		POST WORKSHOP		3-MOS. FOLLOW-UP	
	ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR
20 YRS↑ N=7	9	13	12	14	17	21
	11	20	14	16	17	22
	13	19	15	23	14	21
	15	17	17	20	15	19
	14	16	16	19	14	17
	16	19	13	20	16	18
	15	15	14	21	12	19
TOTAL	93	119	101	133	105	137
AVERAGE	13.2	17.0	14.4	19.0	15.0	19.5
30-40 YRS. N=6	13	21	11	24	16	22
	12	18	15	19	15	21
	13	13	13	15	14	19
	11	16	13	17	13	18
	15	15	15	16	13	15
	12	14	14	17	12	17
TOTAL	76	97	81	108	83	112
AVERAGE	12.6	16.2	13.5	18.0	13.8	18.6
30 YRS↓ N=7	16	17	14	17	16	18
	10	21	13	22	14	19
	13	16	14	19	15	21
	14	16	15	16	14	18
	11	13	12	15	12	17
	16	16	16	17	11	15
	13	17	14	17	13	18
TOTAL	93	116	98	123	95	126
AVERAGE	13.3	16.5	14.0	17.6	13.5	18.0

FAIRFIELD STUDY

RAW SCORES

NUMBER OF YEARS WORKING WITH THE ELDERLY AS A FACTOR

WORKSHOP A

1-10 YRS N=4	PRE WORKSHOP		POST WORKSHOP		3-MOS. FOLLOW-UP	
	ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR
	14	15	16	16	12	22
	14	19	14	21	15	20
	13	18	13	18	14	18
	12	18	12	21	17	16
TOTAL	53	70	55	76	58	76
AVERAGE	13.25	17.5	13.75	19.0	14.5	19.0
2-5 YRS. N=9						
	13	20	14	22	16	22
	14	19	14	21	14	17
	9	16	11	19	13	19
	11	14	12	18	15	22
	11	17	13	19	14	21
	15	19	14	21	17	24
	14	21	16	20	16	17
	12	16	16	17	12	22
	15	19	15	19	15	19
TOTAL	114	161	125	176	132	183
AVERAGE	12.6	17.8	13.8	19.5	14.6	20.3
2 YRS. ↓ N=4						
	12	19	14	23	14	22
	15	16	16	17	17	20
	13	19	14	22	15	19
	11	13	12	18	16	18
TOTAL	51	67	56	80	62	79
AVERAGE	12.8	16.7	14.0	20.0	15.5	19.7

FAIRFIELD STUDY

RAW SCORES

NUMBER OF YEARS WORKING WITH THE ELDERLY AS A FACTOR

WORKSHOP B

5-10 YRS. N=7	PRE-WORKSHOP		POST WORKSHOP		3-MOS. FOLLOW-UP	
	ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR	ATTITUDE	BEHAVIOUR
	14	20	14	21	17	17
	15	21	16	23	16	20
	12	17	12	18	17	19
	13	15	16	19	15	21
	12	22	14	22	17	22
	13	14	14	19	13	24
	16	17	17	21	12	22
TOTAL	95	126	103	143	107	145
AVERAGE	13.6	18.0	14.7	20.4	15.3	20.7
2-5 YRS N=8	PRE-WORKSHOP		POST WORKSHOP		3-MOS. FOLLOW-UP	
	16	20	16	24	16	18
	14	20	13	21	13	19
	13	16	14	18	12	19
	14	16	13	19	14	21
	11	17	13	18	17	20
	12	21	15	21	13	24
	9	15	11	16	11	23
	13	18	13	20	12	21
TOTAL	102	143	108	157	108	165
AVERAGE	12.7	17.9	13.5	19.6	13.5	20.6
2 YRS ↓ N=6	PRE-WORKSHOP		POST WORKSHOP		3-MOS. FOLLOW-UP	
	12	17	13	19	13	13
	14	15	14	17	16	23
	13	17	14	21	13	19
	13	14	14	21	14	18
	15	20	16	20	11	21
	12	16	12	19	16	17
TOTAL	79	99	83	117	83	111
AVERAGE	13.2	16.5	13.8	19.5	13.8	18.5