A COMPARISON OF PRACTICE NURSES' AND HEALTH VISITORS' CONSTRUCTIONS OF WORK WITH OLDER PEOPLE IN THE COMMUNITY.

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Ann Catherine Pursey.

Department of Nursing.

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No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or institute of learning.

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ABSTRACT.

The research study was designed to uncover the similarities and differences between health visitors and practice nurses constructions of work with older people in the community, particularly in the provision of anticipatory health care for the well older population. A review of the literature revealed that, whilst health visitors had a theoretical remit for visiting the well older population, GPs and practice nurses had the policy remit for visiting all people aged over 75 through the annual assessment visit required by the new GP contract.

A convenience sample was drawn from a population of experienced and student health visitors and practice nurses working in the North West of England. The study sample consisted of 25 experienced health visitors, 62 student health visitors and 49 practice nurses. A two-phase, multi-method approach to data collection and analysis was adopted:

Phase 1: A questionnaire consisting of forced-choice and open-ended questions about personal and professional characteristics was completed. The data were analysed using a statistical computer package (SPSS-pc+). Respondents were also asked to describe two incidents where they had been involved with older people: one where they felt they had been "effective" as a nurse (or health visitor) and one where they felt they had been "ineffective" (Flanagan's Critical Incident Technique).

Phase 2: Conversational interviews were conducted with a theoretical sub-sample of the questionnaire respondents. Eight practice nurses, eight student health visitors and six experienced health visitors participated in the interviews which focused broadly around the structural context of their work with older people. The critical incident and interview data were analysed using a thematic (or ethnographic) content analysis.

The study identified a continuum of models of practice nursing. This continuum is described in terms of the practice nurses' previous experience and relationships with their employing GPs. In the case of health visitors, the study shows that there has been little change in the focus of health visitors' work with older people since Dingwall's and Luker's research in the late 1970s. The central finding of this study is that practice nurses' and health visitors' work with older people is mainly oriented towards identifying and meeting already present functional deficits. It is proposed that this orientation militates against their involvement in anticipatory health care activities. The reasons for this orientation are described within the current professional and policy contexts.

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CHAPTER 1.

INTRODUCTION

1.1. BACKGROUND

This thesis presents a study which investigates health visitors' and practice nurses' constructions of work with the older population. As an undergraduate nurse the researcher had become concerned with the quality of care provided to older people. This interest stemmed from experience of working on a long-stay "geriatric" ward where both older people and the nursing staff working with them appeared to be marginalised. Not only were there problems in providing a "quality" service for older people, but nursing staff appeared demoralised and lacking in motivation. Research interest in nursing work with older people was further stimulated by the researcher's involvement in a large survey which aimed to investigate the health and functional status of the population over 65 years. The researcher took a particular interest in the concepts of life satisfaction and quality of life indicators as they appeared to the older people who participated in the survey. It was this work that drew attention to the fact that the majority of people over 65 rated their health status as "good" and that their life satisfaction and quality of life were closely linked with self-rated health status. Given the choice of pursuing a training in district nursing or health visiting in the fourth year of the undergraduate programme, the researcher

chose health visiting as it had a remit for work with the "well" older population.

During health visitor training, however, little emphasis was placed on developing the health visitor's role in the provision of anticipatory health care for older people. In fact it soon became apparent, when the researcher was working as a qualified health visitor in an inner city area, that older people were generally given low priority compared with families with children under five. It was experience in this field that led the researcher to become interested in uncovering why nurses and health visitors did not perceive a role for themselves in providing anticipatory health care for older people.

One of the assumptions underpinning this study is that anticipatory health care is of benefit to older people. There is a wealth of research evidence which shows the positive benefits to be gained when focused and structured intervention at an anticipatory level is provided for this group (among examples see Ouslander (1990) on promotion of continence, Vetter and Ford (1990) on smoking prevention, Vetter (1990) on dietary habits and the Royal College of Physicians (1991) on exercise).

Government health care policy, over the last ten years particularly, has become increasingly oriented towards the concepts of health promotion/ illness prevention as a way of reducing morbidity and the need for expensive

acute in-patient facilities. Few research projects have focused on the nurse's role in the provision of anticipatory health care for well older people, most have focused on the provision of services for the "frail elderly", particularly in the area of institutional care.

With this in mind, the research project was designed to uncover the similarities and differences between health visitors and district nurses with regard to their work with older people in the community. The planning phase of the study began in October 1989 and, by the end of November 1989, it became apparent that the new contract for general practitioners (GPs) (Health Departments of Great Britain, 1989) was to herald a new wave of responsibilities for GPs and their practice staff, particularly in the area of health promotion. There was evidence of a large increase in the numbers of practice nurses being employed by GPs as a consequence of these new responsibilities, one of which was the universal assessment of people aged 75 and over at home. It was speculated that many of these assessments would be undertaken by practice nurses. The policy of 'universal' assessment of people aged 75 and over meant that practice nurses would be visiting the "well elderly" as well as those with identified problems. Therefore, it appeared particularly pertinent that the policy of universal assessment as a mode for providing "health promotion" for older people (Health Departments of Great Britain, 1989) should be investigated. Although desirable, it was not feasible to study district nurses as well as health visitors and practice nurses, therefore whilst recognising the

significant contribution of district nurses to community nursing services for older people, they were excluded from the study population.

1.2. AIMS OF THE STUDY

The overall purpose of the study was to gain insight into health visitors' and practice nurses' constructions of effective and ineffective work with older people in the community. This overall purpose was divided into more specific aims which were as follows:

1) To describe the constructions of practice with respect to older people that student health visitors and practice nurses bring with them to community nursing from previous work in the institutional setting.

2) To explore, in the context of work with older people, the differences/similarities in constructions of effective and ineffective practice between health visitors and practice nurses and to gain insight into the criteria used to evaluate practice, particularly in the provision of anticipatory health care.

3) To uncover the structural contexts of health visiting (training and practice) and practice nursing and to explore the influence of structural context on:-

a) the training and education of student health visitors with regard to work with older people and

b) the role of health visitors and practice nurses in visiting older people at home.

A multi-method approach to data collection and analysis was employed as it was considered that this would enable the researcher to build a more complete picture of the issues involved in this work.

1.3. ORGANIZATION OF THE THESIS

The thesis is organized into nine chapters. The first three chapters introduce the study and relevant background literature which informed the study and its findings. The next chapter (chapter 4) discusses the theoretical basis for the methods used in the study, the exploratory and pilot work undertaken and the methods used in the main study.

The analysis of data and findings are presented in the next four chapters. Chapter 5 focuses on the description of the study sample with regard to demographic and professional characteristics and work circumstances. In addition, the statistical analysis of key variables is shown. Chapter 6 describes the experiences of work with older people which health visitors and practice nurses bring with them to the community from the institutional setting. In particular, the concept of routine care of the dependent older population is explored and some of the problems inherent in working with

this population are uncovered. Chapter 7 looks at the structural contexts of health visiting (in particular during training) and practice nursing and demonstrates how the "superior" actors in an organisation maintain practice within the boundaries of what is acceptable to them, rather than encouraging and facilitating innovation and new ways of working. Chapter 8 develops the theme of "effective" and "ineffective" practice, describing the key criteria which health visitors and practice nurses use to evaluate their work. In addition, the models of practice developed as a consequence of data analysis are described.

The final chapter (Chapter 9) discusses the significance of the present study within the policy context and examines the identified lack of focus within community nursing on the provision of anticipatory health care for older people within the context of society as a whole.

CHAPTER 2.

BACKGROUND: OLD AGE IN SOCIETY - CONSTRUCTION AND CURRENT POLICY ISSUES

2.1. INTRODUCTION

This chapter provides a critique of the changes in health care policy of the late 1980s and early 1990s which are relevant to a discussion of the provision of services for older people in the community.

As a backdrop to the discussion of current policy issues, the chapter begins with a brief discussion of the reasons why the older population has become a client group of interest to policy makers (Tinker, 1989), focusing on demographic changes in the population and, more specifically, the increasing proportion of society aged 65 and over. The use of chronology as a means of classifying client groups is also briefly considered. In addition, sociological research and literature are critiqued which describe the constructions of old age in wider society, in particular the issue of stereotyping. It is argued that whilst it is the demographic changes and the assumed concomitant 'rising tide' of morbidity and burden of dependency that have stimulated policy interest in older people (Tinker, 1989), there is research evidence showing that the reality for most older people is that they continue to live full and healthy lives (Johnson, 1972).

Following on from that, the relevance and potential effects of three current government policy documents, namely the White Papers "Working for Patients (DH,1989a) and "Caring for People" (DH, 1989b) (and the much delayed NHS and Community Care Act) and the 1990 Contract for General Practitioners (Health Departments of Great Britain, 1989), on the provision of services for the older population are discussed. It is argued that government policy of the late 1980s/early 1990s has been underpinned by the desire for government to relieve the state of the burden for caring and to shift responsibility for care and health onto individuals and families.

2.2. THE DEMOGRAPHIC STRUCTURE OF OLD AGE

This section provides a brief overview of the demographic changes in the older population, the use of chronology as a social classification and the health status and living arrangements of older people in Britain.

2.2.1. Demographic changes in the older population

Changes in the demographic structure of Britain have resulted in a high proportion of the total population being over 65 years of age and this upward trend is likely to continue through the 1990s. People over 65 years of age currently constitute some 16% of the population and it was predicted that, by the year 1991 they would constitute some 20% of the total population (HMSO, 1988).

However, older people are not a homogeneous group and it is suggested that there will be;

> "a sharp rise in the numbers of very old - from 1.8 million over 80's in 1985 to 2.4 million in 2001 and 2.6 million 10 years later".
>
> (Phillips, 1988).

The challenge of increasing numbers of very old people has only really been taken seriously by policy makers in the last two decades, although evidence of the upward trend in numbers has been available for most of this century (OPCS, 1984).

The increase in the proportion of older people within the total population has been shown to be mainly due to a decrease in birth rates since the Second World War coupled with improvements over the last century in social and physical environments which lead to disease, rather than from improved treatment of diseases once they have occurred (McKeown, 1979). Policy makers have, in spite of this evidence, concentrated their attentions on provision of care to meet the functional deficit needs of older people rather than focusing on preventive/environmental aspects of health.

2.2.2. Chronology as a social classification

The time of "old age" as 65 years and over can be seen as an administrative definition which traditionally correlates with the standard retirement age for men in Britain (Parker, 1980). Certainly, the social policies of the latter half of this century have used chronological definitions of old age as a way of

singling people out as worthy of special attention. However, chronological age is considered by some to be an unsatisfactory method of planning service requirements as it ignores the heterogenous nature of older people (Cornwell, 1986).

Indeed, Maclean (1989) suggested that;

> "The fixed start to old age tends to iron out the great differences in ability, activity and health status which exist between individuals of any age and which characterise successive cohorts of elderly people".
>
> (Maclean, 1989).

The evidence from research work is certainly that age differences in the over 65 population are at least as significant as those between children and teenagers, or people in their twenties and their forties (Cornwell, 1986). As a consequence of this evidence some authors have suggested that policies aiming to plan service requirements of older people would be better related to **functional** age, rather than to chronological age (Townsend, 1986).

Nevertheless, policy makers, health care administrators and professional groups alike use chronological classifications as a means of organising patients (or consumers) into groups in order to target services. Cheah (1992) discusses the history of "geriatric medicine" and the subsequent development of "geriatric nursing" as specialist areas of health care. The assumption behind the development of "geriatrics" as a specialist area is that people aged 65 and over have needs which are different to other

members of the population. In particular it stems from the notion that the medical "problems" of the elderly, especially multiple pathology and degenerative diseases, are not likely to be cured, unlike the medical problems of younger people (for a full discussion of this see Wilson et al, 1986). Chronological classifications within the policy and professional fields can therefore be seen as a way of singling out older people as a group with special needs through a system which has its roots in a model of old age which may not be the reality for many older people.

2.2.3. The health status of the older population

The health status of the older population and their requirements for health service provision are well documented (Donaldson & Donaldson, 1983) and they are reported to be the greatest users of health services. There is evidence that, in the population aged over 85, one in five have dementia (Report of the Royal College of Physicians of London, 1981) and three in five a limiting long-standing illness (OPCS 1982). In addition early studies reported large numbers of undetected illnesses and diseases in older people (Williamson et al, 1964), though more recent research describes older people not known to medical practitioners as a "low risk group" (Williams, 1984). Whilst it would be unreasonable to suggest that not all people without medically defined illness can be described as well, it would be equally unreasonable to believe that the existence of a medical problem automatically means that an individual is unhealthy (Freer, 1988).

The problem of health status in old age is that it is defined by a loose concept of what 'normal' ageing is. The search for a definition of 'normal' ageing has been on-going for the greater part of this century (Armstrong, 1983). This search was stimulated by the introduction of geriatric medicine as a medical speciality. Considering the development of geriatric medicine, Armstrong (1983) writes;

> "...where gerontology, in its surveys, discovered the considerable range of normal variation in the ageing trajectory, clinical medicine attempted to evaluate that same trajectory by reference to the norm. Geriatrics, therefore, perhaps more than any of the other disciplines of the survey, created a discourse which juxtaposed the norm to the normal".
>
> (Armstrong, 1983).

It is apparent that the search for a definition of 'normal' ageing is continuing within the fields of medical and social gerontology.

However, in some ways the search is unhelpful as;

> "The differentiation of 'normal' from 'pathological' ageing is often artificial".
>
> (Adams, 1977).

and the notion of a 'biological elite' cohort of healthy elders against whom 'normal' can be determined is misleading in that it represents but one extreme of a continuous distribution curve of health which has little to do with chronological age (Armstrong, 1983).

There are undoubtedly problems in persisting with the medical definition of an older individual as either well (or healthy) or ill in terms of planning public services, particularly when chronological age is the criterion by which 'normal' and 'abnormal' ageing are judged. It is in response to this that some studies have included the individual's rating of his or her own health (Mossey & Shapiro, 1982; Luker & Perkins, 1987). A recent British study which asked older people to rate their own health status showed that 90 per cent of the people questioned rated their health as being fair to good (Luker & Perkins, 1987). Self-rated health status can be seen to be important because of the discrepancies which have been shown to exist between the actual experience of old age and the beliefs and expectations held by younger adults about the health of older people, (Age Concern, 1977).

2.2.4. Living arrangements of older people

Currently around 5% of people aged 65 and over reside in institutional settings (OPCS, 1984). This percentage increases with increasing age; 9.6% of people aged 75 and over and 21% of people aged 85 and over were shown to be living in institutional settings on census night 1981 (OPCS, 1984)[1]. Whilst it is clear that individuals residing in institutional settings are **amongst** the most dependent of the older population, there is research evidence which challenges the assumption that they **are** the **most** dependent. For example, studies by Townsend and Wedderburn (1965) and Bond and Carstairs (1982) showed that for every severely physically

[1] It should be noted that figures from the 1991 census were not available at the time of writing.

incapacitated older person living in an institution there were four living in private households either alone or with other older people or in other types of households. There would also appear to be considerable numbers of older people living in private households whom professionals deem to be in need of services but for whom no service is provided (Williamson et al, 1964; Townsend and Wedderburn, 1965; Bond and Carstairs, 1982).

Townsend (1986) has argued that many people living in institutions could be cared for adequately in the community. It is in line with this that government policy of the last twenty years has promoted a move from residential/institutional care to care at home for older people and other groups such as the mentally ill and people with learning disabilities. The main aim of the policies has been to shift responsibility for long-term residential care from the public sector into the private sphere, whether this be private residential "nursing homes"/hostels/rest homes or care at home. Care at home is considered to be part of the 'private' sphere in that it depends on unpaid carers (usually relatives or friends and generally women) and the requirement for statutory/public services is therefore reduced (George and Wilding, 1984). Far from the increase in the total numbers of frail older people being matched by the provision of more beds or communal living spaces by the statutory services, places have been reduced (Andrews, 1985).

The Audit Commission report "Making a Reality of Community Care" (1986) provided clear evidence that there were problems in building alternative support systems to provide for those vulnerable and dependent individuals who would previously and justifiably have gained entry to the diminishing hospital sector. The main problem appears to be that the shortage of residential service provision is not being compensated for by high provision of community services (Davies, 1986). Certainly changes in the funding arrangements for residential care due to be implemented next year (1993) may create further problems for the overall care options for individuals (Bland, 1992).

Townsend (1986) notes that, in order to make care at home a real option for older people, an adequate level of resources would have to be made available to fund services for older people. He commented that;

> "...passive forms of community care have been developed in both capitalist and state socialist countries in ways which have created and reinforced the social dependency of the elderly. Such "structured" dependency is a consequence of twentieth century thought and action".
>
> (Townsend, 1981).

The suggestion that society, public policy and the framework of institutions are (at least partially) responsible for the creation and maintenance of the construction of ageing within society as a whole has been both supported (Phillipson, 1982) and challenged (Johnson, 1987; Dant, 1988). The following section considers the construction of old age within society as a

whole, examining the effects of stereotypes of old age on individual interactions with older people.

2.3. THE CONSTRUCTION OF OLD AGE IN SOCIETY

The construction of old age in society has been the subject of extensive research scrutiny, particularly in the field of sociology (for detailed discussions of the issues see particularly Fennel et al, 1988; Bond and Coleman, 1990). The literature is extensive and it is not the intention to provide an exhaustive review, rather to describe the broader issues which provide a back-drop to the on-going discussion about the construction of old age within the nursing profession (which will be dealt with in chapter 3). This section briefly considers the popular construction of old age as a time of dependency and examines literature and research which supports and challenges the existence of negative stereotypes of old age held by society.

2.3.1. Old age as a time of dependency

Generally old age is characterised within society as a time of dependency and deteriorating function (Norman, 1981; Johnson, 1990). This is not a new phenomenon, indeed Samuel Johnson wrote;

> "There is a wicked inclination in most people to suppose an old man decayed in his intellects. If a young or middle-aged man, when leaving company, does not recollect where he laid his hat, it is nothing; but if the same inattention is discovered in an old man, people will shrug up their shoulders and say "his memory is going".
>
> (Samuel Johnson (1709-1784).

This quotation reveals one of the central issues apparent in the discussion of the construction of old age in society. This is that certain behavioral characteristics may be associated automatically with old age in spite of evidence that they are not a 'normal' consequence of the ageing process. Johnson reveals the difference in attitude when a particular behaviour is demonstrated by an old person compared to when that same behaviour is evident in a younger person.

The assumptions that underpin how people in society view old age can have a profound effect on individual and collective interactions with the older population. The stereotype of "typical" old age as a time of dependency and deterioration is reinforced through the popular media (Norman, 1987; Featherstone and Hepworth, 1990) and is sometimes perpetuated by older people themselves by their behaviour (Brubaker and Powers, 1976; Johnson, 1990). With regard to this last point, Slater and Gearing (1988) suggest that;

> "when such a view (of inevitable decline) of old age is widespread in a society, despite evidence to the contrary, it can have a pernicious effect on individuals, sometimes producing the very effect it purports to describe".
>
> (Slater and Gearing, 1988).

In this way a societal construction of old age as a time of dependency could be seen as a self-fulfilling prophecy, as older people may behave in a way which conforms to the stereotypes.

The problem with stereotypical assumptions about what old age is, and about the characteristics associated with it, is that these characteristics tend to become incorporated into a definition of 'normal ageing'. For example, Gubrium (1986), in his sociological analysis of Altzheimer's disease, discusses how the behavioral changes associated with senile dementia (such as confusion, forgetfulness, loss of bladder and bowel control) are very similar to those associated with 'normal ageing'. Yet the reality for most people aged over 65 is that they do not have these behavioral characteristics. Given that most individuals acknowledge that they know individual people aged over 65 who do not "fit the stereotype", one must ask why the stereotype persists.

2.3.2. Ageism and stereotypes of old age

Many researchers and gerontologists have suggested that ageism (defined by Butler (1975)) as "a process of systematic stereotyping of, and discrimination against, people because they are old") is widespread within society (Hutsch and Deutsch, 1981; Phillipson and Walker, 1986), within the 'caring professions' (Norman, 1987; French, 1989) and is inherent in most government policies (Townsend, 1981).

In his classic paper on stereotypes of old age, however, Schonfield (1982) argues quite convincingly that ageism and negative stereotypes of old age are not characteristics of the population at large, rather he argues that there are 'seductive motives' (Schonfield, 1982) for gerontologists to persist with

the claim that society holds negative attitudes towards older people. He is supported in this suggestion by other gerontologists such as Kalish (1979) who discusses the "New Ageism" (Kalish, 1979).

Kalish (1979) indicates that many of the so-called "helping" agencies portray the following message to older people:

> "..."we" understand how badly you are being treated, that "we" have the tools to improve your treatment, and that if you adhere to our program "we" will make your life considerably better...we are finally going to turn our attention to you, the deserving elderly, and relieve your suffering from ageism".
>
> (Kalish, 1979).

Schonfield (1982) also claims that many researchers have confused the concepts of belief, attitude and behaviour with regard to the construction of old age. He writes;

> "Holding negative attitudes toward older people merely because they are old is immoral...but is there anything immoral about disliking *some* of the concomitants of ageing processes?...This does not, however, imply that all aspects of the aging process are unpleasant. Humans are rational beings able to have both positive and negative attitudes to the same object...each of us is likely to have more than one attitude toward our own aging, and these are normally distinct from our attitudes toward older people in general...".
>
> (Schonfield, 1982)

In this quotation, Schonfield (1982) reveals an aspect of stereotyping and attitudes that has been paid little attention in social science and nursing research. Much of the research has presented attitudes and stereotypes as uni-dimensional, being either 'positive' or 'negative' in nature. However, this

denies the almost undoubtedly multi-dimensional character of human feelings and emotions which are complex and multi-factoral in both causation and presentation.

2.3.3. Individual images versus collective images of old age

The problem with accepting too readily that society as a whole is inevitably and inherently negatively biased against old people is that it denies the inter-individual experiences that people have. Featherstone and Hepworth (1990) point to this is in the following paragraph;

> "The perpetual tension between social categories based on generalisation about ageing and actual personal experience of ageing in its diversity is of constant concern, and increasingly so for those who work with older people".
>
> (Featherstone and Hepworth, 1990).

Tajfel (1959), who has pioneered the theory of social categorisation in the field of social psychology, suggests that because younger age groups fear their own ageing they tend to exaggerate the differences between themselves and old people in general in order to reinforce the notion of them being a discrete group. In this way, social categorisation acts as a protection mechanism against over-identifying with potentially distressing effects of old age.

The inherent tension which exists in collective images and individual experiences of old age can lead workers and others to avoid contact with older people in the public sphere in order to reduce the potentially high levels

of dissonance. However, in the private sphere of the home, the family and, in some cases the community, older people can hardly be avoided. There appears to be a mis-match of the way that individuals feel about old age. One perspective is based on the bureaucratic characterization of old age. This is succinctly described by Haber (1983) who states;

> "once beyond 65, most persons are bureaucratically characterized as diseased and dependent...".
>
> (Haber, 1983)

The other perspective is located within the private sphere of individual relationships with older people that are fulfilling.

2.4. PUBLIC POLICY AND ITS EFFECTS ON OLDER PEOPLE

So how do the images of old age presented within the bureaucratic model influence public policy? It has been suggested that the crisis in public spending from the mid 1970s, coupled with demographic changes resulting in a larger elderly population, has been responsible for the view that older people are a burden on the economy and the state (Fennel et al, 1988). Financial and social commitments to older people were also seen as being a threat to Britain's economic recovery and to the living standards of working people (Walker, 1986). This led to a politicization of social gerontological theory (Phillipson and Walker, 1986) and a view of old age that reflected economic and political forces;

> "Retirement, poverty, institutionalisation and restriction of domestic and community roles are the experiences which help to explain the structured dependency of the elderly...In the

> everyday management of the economy and the administration and development of social institutions the position of the elderly is subtly shaped and changed. The policies which determine the conditions and welfare of the elderly are not just the reactive policies represented by the statutory social services but the much more generalised and institutionalised policies of the state which manage or change social structure".
>
> (Townsend, 1986).

This suggests that the status of older people in society, and the experiences they have, are often a result of the political economy more than the product of the natural ageing process. Sociologists have attacked the widespread blaming of older people for their 'burden' on society, stating that this is merely a means of shifting responsibility from the state to individual older persons or members of their families.

Whilst the following sections consider current government health policy documents which attempt to re-orientate health care from an illness model to one which encapsulates the concepts of health promotion and illness prevention, it will be argued that this actually translates in practice to a shifting of responsibilities from the state to the individual. This shift in policy mirrors similar moves in the United States of America over the past ten years (Estes, 1992). In addition the new funding arrangements for long-term residential care (which are not fully understood or explored at the time of writing) may have profound consequences for the burden of care that relatives and friends have to shoulder. Again, this is a shift of responsibility from state to individual.

Government policy of the last 15 years has emphasised the need to enable older people to remain in their own homes for as long as possible (DHSS, 1978; DHSS, 1981; DHSS, 1986), with the hidden aim of reducing the requirement for expensive hospital in-patient beds and long-stay or continuing-care institutions. This has brought the concept of community care clearly into the political agenda. In the current political climate, recent reforms in public policy (DH, 1989a) have been mainly targeted towards the improvement of efficiency, cost-effectiveness and consumer choice, as well as the denationalization of public services.

The current reform of the National Health Service (NHS) affects both hospital and community health services and involves, as its central component, the creation of "an internal market for health care" (DH, 1989). Various professional bodies (BMA, 1990; RCN, 1990) have accused the government of aiming to;

> "fragment the health service and open the way for privatisation".
>
> (Health Visitor Editorial, 1990).

and yet, in spite of these criticisms and a general lack of public support for the reform, the proposed restructuring of the NHS culminated in the passing through parliament of the NHS and Community Care Bill on June 29, 1990.

The bill was an amalgamation of the recommendations of two controversial and significant White Papers, "Working for Patients" (DH, 1989a) and

"Caring for People" (DOH, 1989b) which radically altered the way that hospital and community services are organised and delivered. However, the implementation of the Community Care Act, which outlined the changes in organisation and management of community services (in particular social services) was delayed from 1990 to April 1993, reportedly due to administrative problems but perhaps more to do with the government's electoral campaign. At this stage it can still only be speculated what effect this will have on the provision of services.

Alongside the Bill, dental and medical general practitioners were exposed to changes in the structuring of their terms of service (Health Departments of Great Britain, 1989). Analysis of their contracts reveals an attempt by the government to make these practitioners more accountable for their work and to decrease the level of autonomy that the professions hold. The outrage expressed by both professional groups about the new contractual responsibilities perhaps reflects a reluctance to accept a more prescriptive working contract rather than a concern about whether the needs of the general public will be better met under the new arrangement.

The following sections consider the effects of the Bill (with its component White Papers) and the new GP contract on health service provision for older people.

2.4.1. The White Paper; "Working for Patients"

The White Paper "Working for Patients" (DH, 1989a) focuses its attention mainly on the provision of acute services within the hospital sector, with very little mention of community care provision. The RCN, in a paper entitled "The White Paper: Not Working for Elderly People", claimed that the White Paper had "nothing to do with old people" (RCN, 1989), as 95% of people over 65 years of age live in the community. The contents of the document and the subsequent bill do, however, have grave implications for the older person.

One of the main aims of the White Paper (outlined in Working Paper Two) was to enable hospitals to become self-governing hospital trusts which form contractual arrangements with each other and with budget-holding general practitioners to provide specialist and generalist services. In this way hospital trusts become responsible for generating their own income by determining which services they will provide and at what cost. It has been suggested that they may have a vested interest in nurturing cost effective or popular services and have little desire to ensure adequate services for older people, which are notoriously expensive (RCN, 1989). It also means that patients will not necessarily be able to get treatment locally. Old people may need local services more than other groups as, with limited finances, transport and social support (Donaldson & Donaldson, 1983; Wright, 1988), they may find it impossible to travel long distances to receive treatment or attend consultations.

Working Papers Three and Eight addressed the issue of the provision of general practitioner services, and it has been suggested that the proposals;

> "do not appear to encourage general practitioners to work with and welcome elderly people to their list".
>
> (RCN, 1989).

The basis of the reforms is that GPs with patient lists over 7,000 are able to hold their own budgets with which to purchase services for those patients[2]. As older people have a high rate of hospital admission and average duration of stay (OPCS, 1988), it may be that some GPs will be reluctant to have high numbers of old people registered in their practice, as they are expensive consumers of health care services.

One of the claims of the creation of an internal market for health care has been the benefit of increased consumer choice. However, it has been argued that in fact the only choice the consumer has is a choice of GP and, in the case of older people, even this choice may be restricted by the reluctance of some GPs to;

> "accept patients who, in market terms, appear to be a *bad buy".*
>
> (Pollitt, 1990).

There is already some evidence from small-scale preliminary studies that this may indeed be the case (Wilson, 1992).

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[2]This figure originally stood at 11,000, was quickly reduced to 9,000 and now stands at 7,000 (Bradley, 1992).

Prospective self-governing trusts are obliged to apply to the Minister of Health for approval of their desire to "opt-out". Much controversy has surrounded this process as, in theory, prospective hospital trusts have to consult with the residents in their locality and with employees of the hospital. However, there is evidence that decisions regarding application for "opting-out" status have been made solely by the board of directors of hospitals and influential consultants. The Labour Party, with the support of many health service workers, launched a campaign in an attempt to combat the reforms (Labour Party News, 1990) and made the issue of health care provision a central aspect of their election campaign in 1992, though it was generally unsuccessful in forcing the government to reconsider its reforms. What appears to be certain, however, is that the reforms could well have a detrimental effect on the hospital services available to the public, in particular to groups such as the old and the mentally ill. However, as we have said, 95% of old people live in the community and it is to the government reforms of community care provision that this discussion turns its attention.

2.4.2. The White Paper; "Caring for People"

The delays in the implementation of the community care act to April 1993 mean that is difficult to assess the actual impact of these reforms on services for older people. However, the fundamental principles of the reforms are outlined in the White Paper "Caring for People" (DH, 1989b) which makes speculation about the **likely** effect of the reforms possible.

The recent White Paper "Caring for People" (DH, 1989b) affirms the government's belief that;

> "for most people community care offers the best form of care available.....community care means providing the right level of intervention and support to enable people to achieve independence and control over their own lives".
>
> (DH, 1989b).

The belief that community care is ultimately preferable to institutional care for older people has underpinned government policy since the publication of documents such as "A Happier Old Age" (DHSS, 1978) and "Growing Older" (DHSS, 1981), though many authors have argued that community care has still yet to become a reality (Walker, 1981; Hunt, 1982; George and Wilding, 1984; Kemp and Acheson, 1989).

The White Paper puts forward the suggestion that preventive health care strategies are the best means of encouraging independent living for "vulnerable groups" such as the older population. At the same time, however, the document emphasises the importance of targeting resources to those most in need. On the surface, both these suggestions may seem rational and reasonable. However, it could be suggested that the current definitions of "in need", which are underpinned by medical and social definitions of health and illness, do not include the "well elderly" population and their "needs" for preventive health care.

Within the proposals local social service authorities will be responsible for assessing the needs of older people (and other priority groups such as the mentally and physically disabled) and for drawing up packages of social and health care for individuals. Individual assessments will need to be made available by social services for every person in the community who requires some degree of social support. At this stage it is uncertain what the assessment of, for example, an older person will include. However, the outcome of the assessment should be to;

> "arrive at a decision on whether services should be provided, and in what form. Assessments will therefore have to be made against a background of stated objectives and priorities determined by the local authority. Decisions on service provision will have to take account of what is available and affordable".
>
> (DH, 1989b).

The issues of availability and affordability are of grave concern to social and health service providers. With no promise of extra resources for the establishment of the new system of need assessment, the implication that services will be limited in some way by their affordability means that proper assessment of people in priority groups will be hampered. Groups concerned with community care provision have called for the ring-fencing of funds for certain groups such as older people and the mentally ill. However, this suggestion was rejected by the government and it is unlikely that extra funds will be forthcoming (though Sir Roy Griffiths (1992) in a recent paper speculated that the government may reconsider this in the near future). There is also no assurance that a person's wishes will be taken into account

if they are deemed not to be in accordance with the assessed "needs". Thus "consumer choice", which the government claimed was one of the key aims of the reform, could be limited. One may also pose the question, is there any point in assessing need if the services required to meet the need are not available?

It can be seen that there is tension between the objectives of self-determination and independence on the one hand and the need to ration services (which underpin the White Paper). It has been suggested that reconciling these different objectives will be "as easy as squaring a circle" (Beardshaw, 1990) and that the challenge for local authorities lies in creating a system that genuinely centres on older peoples' needs and wishes, yet also ensures that available resources are not exceeded.

The White Paper places the responsibility for assessment of need firmly on the shoulders of social service authorities. The statements within the document concerning the provision of community health care services for older people are both vague and non-committal;

> "the key functions and responsibilities of the health service as a whole remain essentially unaltered by the proposals in the White Paper".
>
> (DH, 1989b).

So although social services are to be the guardians of need assessment, health authorities will be expected to ensure that the necessary health

service contribution is available. Questions about funding and working within multidisciplinary teams are not addressed at all and it has been suggested that the government have mistakenly split "health" and "social" care as though they are totally unrelated (Fawcett-Henessy, 1989).

In common with "Working for Patients", one of the central themes of "Caring for People" is the notion of "buying and selling" services and the creation of what Sir Roy Griffiths calls "an internal market for health care". This means that health authorities will have to meet the needs of their population by placing contracts with, for example, the private sector or with local authorities. They may also enter into contracts with individual general practitioners for the provision of, for example, a district nurse to visit patients on that general practitioner's caseload. Indeed, the government has outlined plans for general practitioners to "buy in" local authority community nursing services from April 1993 (Nursing Times News, 1992). Indeed there is evidence that this is already happening (Chernik, 1992). The danger here may be that, once money begins to exchange hands, consumers or clients will enter into the arena of buying services and a totally inequitable situation may arise where the service received will depend on the ability to pay. Consumers may be charged by local authorities for meals-on-wheels, home helps etc. (Potrykus, 1990). Given that many older people often find themselves in a poverty trap largely due to public pensions policy (Walker, 1992), it could be argued that they are the least likely "consumers" to be able to afford services for which they have to pay. The White Paper permits

local authorities to charge however much and for whatever they feel is reasonable and this in itself is likely to produce vast differences in care provision between local authorities.

In common with many previous documents on community health care, preventive health care strategies are seen to be the best means of encouraging independent living for groups such as older people (DH, 1989b), though there are no firm guidelines/proposals as to what "preventive health care" strategies should consist of. Of course such strategies are presumed to be a means of saving money by reducing the number of hospital in-patients and the demand on acute services. However, the effectiveness of preventive health care is notoriously difficult to evaluate and the White Paper does not tackle this issue. What does seem to be apparent is that a strategy for "preventive health care" may in fact mean that individuals are to be responsible for their own health status and in this way the responsibility of the state for health is reduced. A commitment to preventive health care is an easy one to make but, with little prospect of extra resources for health authorities, is the commitment more than empty rhetoric?

2.4.3. The 1990 Contract for General Practitioners

In support of the government's "commitment" to preventive health care for older people, the new GP contract which came into force in April 1990 (Health Departments of Great Britain, 1989) outlined general practitioners'

responsibilities towards their patients and committed a shift of resources to the provision of preventive health care. Special payments are now made to general practitioners to offer an annual home visit to each person over 75 years of age, to make an assessment of the physical, mental and social needs of the patient. The guidelines for this assessment were put under the heading "Health promotion/illness prevention" within the GP contract and are shown below.

1. To see the home environment and to find out whether carers and relatives are available.
2. Social assessment (life style, relationships)
3. Mobility assessment (walking, sitting, use of aids)
4. Mental assessment
5. Assessment of the senses (hearing and vision)
6. Assessment of incontinence
7. General functional assessment
8. Review of medication, (after Health Departments of Great Britain, 1989)

The general practitioner now receives an enhanced capitation payment of thirty-two pounds for **offering** this assessment (whether it is conducted by the GP or another member of the practice team). However, it appears that GPs receive this payment for merely **offering** an assessment to patients, whether or not it has actually been performed.

It should be noted here that the type of assessment outlined for general practitioners within the contract falls into the category of secondary prevention or screening. As GPs work mainly within a model which is fundamentally oriented around illness and disease detection, it was suggested that assessment of patients by them is;

> "likely to be at a secondary level i.e. to find ill-health which has already occurred".
>
> (Fatchett,1990).

The effectiveness and efficiency of universal screening programmes for the older population has been questioned by several researchers (Williams, 1984, Freer, 1988). Concern for "non-attenders" and unreported illness is often the basis for health screening programmes yet there is evidence from recent studies that older patients who do not attend the GP surgery, or who are infrequent attenders, are in general fit and well (Williams, 1984; Ebrahim et al, 1984; Williams and Barley, 1985). The desirability of detecting unknown disease has also been questioned;

> "...several authors have assumed that the discovery of unknown disease and social disadvantage must necessarily be beneficial. This clearly is questionable and it is difficult to see how anything short of a randomised controlled trial could answer the critical issues".
>
> (Grimley Evans, 1984).

In spite of the epidemiological reservations that are expressed about screening, professional bodies (BGS and HVA, 1986) and the government have continued to emphasise the usefulness of screening/universal assessment programmes for older people. The use and appropriateness of

the current assessment for people aged 75 and over contained within the GP contract have yet to be evaluated.

Given the evidence of low levels of un-met medical need and the questionable utility of universal assessment it could be argued that the type of intervention that would be of most benefit to the older population would be the provision of anticipatory health care (Luker, 1988). However, the GP contract does not emphasise this aspect of preventive health care, though GPs are expected to establish "health promotion clinics" for the adult population (which includes the 65-74 age group). The content and focus of these clinics, however, is at the discretion of individual general practitioners and the government has recently announced a moratorium on all new health promotion clinic funding pending a comprehensive review (Liverpool Primary Care News, 1992). Announcements regarding a new system of health promotion clinic funding will be made in April 1993.

The annual assessment of patients over 75 years of age may be undertaken by the GP or by another member of the practice team, and there is evidence that GPs have employed practice nurses specifically for this purpose (Bradley, 1991). In other areas GPs have been encouraged to employ link-workers who are lay-people trained specifically to undertake the assessments, usually with the aid of hand-held computers (Wallace and Young, 1992). The White Paper "Working for patients" outlined the governments proposals for GPs with patient lists over 11,000 to apply to

hold their own budgets, in order that they could "buy in" services for those patients. It is now apparent that, from April 1993, budget-holding GPs will be able to buy in, for example, part of a health visiting or district nursing service from a district health authority (DHA) to undertake home assessment of the over 75s (Nursing Times News, 1992). In some areas of the country, contracts have already been established between GPs and DHAs for precisely that purpose (Chernik, 1992).

There appears to be little incentive, however, for GPs to ensure accurate assessment of older people, as there may be a cost attached when treatment and/or referral are needed. One of the outcomes of assessing social, physical and mental well-being is likely to be referral to another service to meet assessed needs (Vetter, Jones and Victor, 1984). Indeed, the new general practitioner contract places them;

> "under an obligation to refer on patients where there are problems needing specialist services".
> (Health Departments of Great Britain, 1989).

The potential costs of increased referral rates to other agencies have not yet been calculated but the issue is not merely a financial one. The ethical implications of assessing need, when the resources may not be available to meet any needs uncovered, must be realised by all health service professionals involved in screening and case-finding programmes. It is relatively easy for government policy to place GPs "under obligation" to refer

patients, whilst not providing extra funds and resources to cope with increased referral rates to other agencies.

2.5. CONCLUSION

Policy interest in the older population has been stimulated by the predicted increases in the numbers of people aged 65 and over towards the next millennium. The government's reform of the NHS has come under attack from both professional and consumer organisations as there is wide-spread concern that the changes will result in a disjointed and inequitable health service. The emphasis within the White Papers on financial management of the health service and the creation of an internal market for health care is of particular concern when considering services for vulnerable groups such as older people, people with learning difficulties (a mental handicap), people with a mental illness, as they are notoriously expensive consumers of health and social services.

However, this concern is based on the idea that the older population are, in general, highly dependent and in need of high levels of services. Whilst this concern may be based partially on factual evidence, the reality for most older people is that they feel healthy and well (Johnson, 1972; Luker and Perkins, 1987). The government's strategy for preventive health care for older people has a hidden agenda of reducing the need for expensive acute services and long-stay care for older people and also for alleviating public/statutory responsibility for health status and care by deflecting it onto

the individual. The strategy consists exclusively of optional health promotion clinics and of basic screening of people aged 75 and over, both functions being the overall responsibility of the general practitioner. There seems to be "no overall commitment to other methods of health promotion action" (Smail,1990) for/with the older population.

CHAPTER 3.

BACKGROUND: NURSING AND COMMUNITY NURSING WORK [3] WITH OLDER PEOPLE - HOSPITAL AND COMMUNITY SETTINGS

3.1. INTRODUCTION

This chapter reviews the research and literature pertaining to nursing and health visiting work with older people. The first section briefly draws on the discussion in chapter 2 on the social and policy constructions of old age and considers the literature pertaining to the part that professionals working with older people play in maintaining these constructions. The second section considers nursing work with older people in institutional (hospital) settings, focusing on research which has considered the structure of institutional settings and nurses' attitudes towards older people.

The third and fourth sections of the chapter focus on health visiting work with older people and practice nursing work respectively. Particular attention is paid to the policy context within which this work takes place and its effect on employment, roles and responsibilities and interprofessional relationships. In addition, the training and education of practice nurses and

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[3]. It is not the intention of this chapter to provide an overview the full range of community ing services. Whilst the contribution of district nurses to provision of care for older people is gnised as highly important, the purpose of this section is to consider issues which are pertinent ıe study as a whole. Therefore, this chapter focuses attention on three groups of community es (in addition to those working in hospital) namely, health visitors, practice nurses and nurse titioners.

health visitors is reviewed and issues of accountability and competence for work are discussed.

The final section of the chapter briefly describes the introduction of nurse practitioners into the primary health care arena. Calls from within the nursing profession for the introduction of a new role and status for nurses within primary health care have led to increasing attention being paid to the roles and responsibilities of nurse practitioners (Salvage, 1991). Given the claims that some practice nurses and health visitors already work as nurse practitioners (Bowling, 1987a; Goodwin, 1991) it is considered pertinent to include this group in the discussion.

3.2. THE PROFESSIONAL CONSTRUCTION OF OLD AGE

In chapter 2, a brief overview of the sociological literature describing the social construction of old age in society was given. Several sociologists (in particular Townsend 1981; Phillipson and Strang, 1986; and Miller, 1987 in the United States) have suggested that health and social care professionals contribute to the reinforcement of the construction of old age as a time of dependency through their organisational systems and practices. As Miller (1987) writes;

> "...professionals and practitioners working in the field of gerontology must inevitably exert an influence on the way the elderly are seen by the public and on the determination of social policy in government".
>
> (Miller, 1987)

This statement implies that the professional construction of ageing is influential in determining both societal and policy constructions of old age. However, it would appear that the influence is not one-way, rather that it is the interplay of society, policy and the professions which determines the construction, as they influence each other. Townsend (1981) for example suggested that;

> "The duties of home helps and community nurses are also heavily circumscribed. The elderly are usually viewed as the grateful and passive recipients of services administered by an enlightened public authority. This can reinforce their dependency both in their own eyes and that of the public".
>
> (Townsend, 1981).

The circumscription of the work of professionals within the health and social welfare fields is determined by policy, both at governmental and local level. However, the reinforcement of dependency in old age by these professionals demonstrates the circular argument about the interplay of all the forces which influence the way in which old age is viewed. Fennel et al (1988) state that health and welfare professionals "reinforce the dependency created through the wider social and economic system" (Fennel et al, 1988) and go on to raise the questions;

> "How far do they (professionals) challenge the low expectations that elderly people sometimes have about services? To what extent do they contribute to the experience of old age as a period of dependency?".
>
> (Fennel et al, 1988).

The challenge for workers in the health and social services is very clearly there: to consider their own role in the maintenance of the position of older

people and to question government policies which see the older population as a social problem.

The issue of the socialisation of professionals during training has also been raised as one which deserves further consideration. Phillipson and Strang (1986) suggest that;

> "It might be argued that professional workers (and others) have been socialised into an approach to old age which emphasises its least attractive features. Their training will have invariably focused upon the experience of dependency and disability in later life, this being seen as biologically rather than socially constructed. Images of ageing tend to revolve around perspectives which see the elderly as a "demographic burden", or on loose notions of a "rising tide" of mental and physical frailty".
>
> (Phillipson and Strang, 1986).

This links in with the suggestion in chapter 2 that the definition of 'normal' ageing remains uncertain, particularly while biological/chronological characteristics of the ageing process inform the definition. It would appear, from this very brief mention of professional constructions of old age, that it is the interplay of society, policy and professional training and practice that serve to maintain the construction of old age as predominantly a time of dependency and disability. More central to this thesis, however, is the literature which examines the contribution of nursing and health visiting work with older people to this construction.

3.3. NURSING WORK WITH OLDER PEOPLE IN THE HOSPITAL SETTING

It is not the intention of this section to provide a comprehensive overview of **all** the research which has attempted to describe aspects of nursing work with older people in institutional settings. Rather, by reflecting on two key areas of research, it is hoped that this section will provide a useful back-drop to the discussion of health visitors' and practice nurses' work with older people, as both groups of nurses have experience of working with older people in hospital.

Previous research work examining nursing practice with older people in hospital settings appears to fall broadly into two areas. Firstly, there are research studies which have focused on the characteristics of the **structure** of nursing work and the nature of the organisation with regard to the care of older people. Secondly, there is a wealth of research literature which has attempted to investigate individual nurses' (particularly student nurses') **attitudes** towards work with older people. These two foci, for the sake of clarity, are considered separately.

3.3.1. The structure of nursing work with older people

The structure of nursing work with older people has been characterised in several research studies as being mainly concerned with the meeting of patients' physical needs and dominated by routine methods of organizing care (Baker, 1978; Wells, 1980; Evers, 1981c, 1984; Fielding, 1986; Reed, 1989).

Baker (1978) coined the phrase "routine geriatric style" following her participant observation study of two medical and two geriatric wards in one district general hospital.

She summarized the findings of her study as follows;

> "the organization of work according to the routine geriatric style was geared to getting the work done with the maximum economy of human resources".
>
> (Baker, 1978).

Baker (1978) considered certain structural factors to be associated with the development and perpetuation of the routine geriatric style, namely the physical and social isolation of the geriatric wards from the main part of the hospital combined with poor working conditions and the low status accorded to work with older people.

In a later, non-participant observation study, Evers (1981c,1984) found broadly similar styles of routine nursing care, drawing attention to the social context of nursing and making the, perhaps idealistic, recommendation that the status of old people in society be improved. Both Evers (1984) and Baker (1978) pointed to the key role of the ward sister/charge nurse in determining the style and nature of nursing care on the ward, and more particularly his/her influence on younger, less experienced student nurses (Baker, 1978) and the influence of his/her relationship with the consultant on patterns of care (Evers, 1984).

It might be supposed that the shift within the nursing profession towards a more individualised, patient-centred model of care (May, 1992) would mean that the routine geriatric style would no longer exist. However, two recent studies (Reed, 1989; Waters, 1991) have identified similar characteristics to the previous studies, namely that the routine geriatric style persists. What is notable about the similarities between the findings of these two more recent studies is that the classifications of the wards were different. Reed (1989) reported the pervasion of routinized care on long-stay wards for older people, arguing that the "cure" ethic within geriatric medicine remains dominant and that it leads to long-term care patients being viewed as failures of the system. By comparison, Waters (1991) studied 'elderly rehabilitation' wards yet still found that routine models of care dominated and suggested that there was a lack of belief on the part of the nursing staff that the patient's functional status would improve. It is interesting to note that, in the eleven years between Baker (1978) and Reed's (1989) work, the introduction of practices such as the nursing process and team nursing did not appear to have effected change in ward practice.

In another recent study Smith (1992) reported on the differences between general wards and acute wards as perceived by different levels of student nurses. She wrote:

> "Three general female wards were constantly cited by students as being at the bottom of the pecking order...because they admitted a high percentage of elderly patients. The wards were described as 'heavy' because of the high physical dependency of many of the patients. At best, these wards were seen as offering 'brilliant learning experience' for first-year students because of the 'good basic experience' they offered".
>
> (Smith, 1992)

In her study, older patients were rated by students at the end of training as generating a high physical workload and having poor learning potential for students. Smith (1992) suggests that the 'heavy' physical nature of work with older people leaves nurses with little time for considering individuals. Smith's (1992) study is interesting because it demonstrates a shift of emphasis through the course of student nurse training from a view of nursing as 'basics' and 'people' (at the beginning of training) to the absolute facts of 'diseases, drugs and therapy' (at the later stages of training). Older women were said to be generally unpopular with student nurses as their toileting requirements resulted in particularly hard work. Talking to patients was something to do after the 'real' work had been completed, with the exception of students at the beginning of training (Smith, 1992). She concludes by suggesting that whilst students have negative feelings towards work with older people they do not show it to patients with whom they establish (sometimes close) relationships. This reveals a difference between the general attitude towards **work** with older people and attitudes and behaviour towards older people themselves. This dichotomy of attitudes is considered in the next section.

3.3.2. Nurses' attitudes towards older people (the collective versus the individual)

Nurses' attitudes towards old people have been the subject of extensive research scrutiny over the past few years. In reviewing the literature, it is apparent that the bulk of research has focused on educational strategies for improving nurses' attitudes towards older people and on particular characteristics of nurses and patients. Most of the research to date has been underpinned by the assumption that the identified lack of desire in most student nurses for work with older people once qualified is due to the negative attitudes which those nurses hold towards older people themselves.

The majority of studies which have focused on attitudes within nursing work with older people have used measurement scales. Kogan's Old People (KOP) scale and the Tuckman Lorge Attitude Questionnaire (TLAQ) have been particularly popular scales for measurement within nursing research although there are many such scales available. The scores derived from the variety of scales used in research have been correlated with a wide range of variables such as age (Campbell, 1971; Wells, 1980), level of education (Campbell, 1971; Gillis, 1973), race, sex and religion (Burge, 1978), grades of nurses (Fielding, 1986), and patient dependency (Fielding, 1986), though there seems to be no clear indication of a definite link between any of these variables and attitude scores as many of the findings are in fact contradictory.

Several researchers have attempted to demonstrate the effects of educational intervention and experiential learning on changes (either positive or negative) in attitudes (Gunter, 1971; Dye, 1979). One of the few British studies (Hooper, 1979) used the KOP scale to examine the effects of student nurses' geriatric experience and found no statistically significant difference either between or within groups pre- and post-experience. In a more recent small-scale British study , using Kafer, Rakowski and Hickey's (1980) Ageing Opinion Survey, Treharne (1990) concluded that, overall, student nurses' attitudes to old people were neutral though they became

> "slightly more negative during the care of the elderly training module".
>
> (Treharne, 1990).

Another recent study confirms this finding of a slightly negative attitude towards old people (Makin-Bounds, 1990), though in this case it was qualified nurses and members of the general public who comprised the subjects under study. This study concludes however that the attitudes of nurses towards older people are no more negative than those of the general public:

> "it would seem reasonable to suggest that it is one's experience as a member of society rather than as a professional which moulds beliefs about elderly people".
>
> (Makin-Bounds, 1990).

Here we clearly see the use of the terms "attitude" and "belief" in synonymous use. This point will be picked up again later in the section.

Another set of attitude studies has attempted to establish a link between attitudes and behavioral intentions towards work with old people. Whilst most studies demonstrate a general reluctance on the part of nurses to specialize in work with older people (Campbell, 1971; Hooper, 1979; Robb, 1979) none of the studies considered the reasons for this and none attempted to examine nurses' actual behaviour with individuals.

It is this last point that reveals the short-comings of the vast majority of studies which have examined nurses' attitudes towards old people using measurement scales. The measurement scales currently in use appear to assess nurses' acceptance (or otherwise) of stereotypic views concerning the older population (Ingham and Fielding, 1985) and use the results as a demonstration of attitudes. However, social psychologists such as Tajfel (1959) have suggested that there is a difference between stereotypically held views about a group of people and views or behaviour based on actual experience or contact with individuals within that group. In addition, many of the researchers appear to have confused the concepts of attitude, belief and behaviour which, as Schonfield (1982) has pointed out, are not synonymous and may not in fact be even related when it comes to interaction with individuals.

Previous nursing research has not clearly demonstrated a link between attitude, belief and behaviour. Indeed many studies have used "questionable techniques" (Ingham and Fielding, 1985) and the conclusions drawn are

clearly ambiguous. Most studies fail to make the distinction between attitudes towards old people themselves and attitudes towards nursing work with older people. It is assumed that holding a positive attitude, as measured using any one of several scales, will demonstrate an increase in desire to work with this group, however this is a somewhat dubious assumption. Rather it would be reasonable to suggest that it may be the **structure** of nursing work rather than the client group themselves that leads to nurses' reluctance to undertake this work.

Few studies have attempted to examine this difference though Dougherty's (1981) study of student nurses' work with older people is a notable exception. The study demonstrates that students at the end of training were reluctant to work with elderly patients because they encountered poor standards of care, poor staff motivation and expressed the feeling that geriatric nursing was stigmatized. However, Dougherty (1981) shows that the students enjoyed working with individual older people and said that they "liked elderly people as individuals" (Dougherty, 1981). The schism between **attitudes and images of individual older people** and **collective attitudes and images of work with older people** is an important one and demands further, more rigorous research investigation, probably of a more "qualitative" nature than current measurement scales permit.

3.4. HEALTH VISITING WORK WITH OLDER PEOPLE

Health visitors have a theoretical remit for health promotion and education activities with individuals of all age-groups as well as with families and communities. This section provides an overview of current issues relevant to a discussion of health visiting examining the training, roles and work, both potential and actual, of health visitors in the provision of anticipatory health care for older people.

3.4.1. The relationship between health visiting and nursing

Nurse training as a prerequisite for health visiting was instituted in 1962, although previously it had been customary for health visitors to be nurse qualified. Historically, health visiting seems to have developed in response to the needs in society for the prevention of infectious disease and the promotion of "wellness" (Council for the Education and Training of Health Visitors, 1977). Focusing work on the well population, however, has had its problems for the health visiting profession, particularly in its alliance with other sections of the nursing profession.

Uncertainty about the role of the health visitor, both from inside and outside the nursing profession, appears to be a long-standing and unresolved problem. In one research study of health visiting, for example, Hunt (1972) claimed that health visiting was undergoing an identity crisis and that one of the causes was its uncomfortable relationship with nursing.

She wrote

> "In informal discussion with the health visitors and students many of them said they were often asked if they would not like to be 'proper nurses'".
>
> (Hunt, 1972).

In a later discussion of issues pertinent to health visiting, Fatchett (1990) also touched on the relationship between health visiting and other sections of the community nursing professions, claiming that health visiting was being marginalised by the latest health service reforms. She suggested that one of the reasons for this was that other professional groups (both within and outside of nursing) did not fully understand the basis of health visiting.

It appears to be the theoretical basis of health visiting with its focus on the preventive aspects of health care intervention that leads to health visitors being viewed in a different way to "proper nurses".

3.4.2. The theoretical basis of health visiting

Health visiting, in theory, consists of

> "planned activities aimed at the promotion of health and the prevention of ill-health",
>
> (CETHV, 1977).

and aims to contribute to individual and social well-being within society. Four underlying principles of health visiting practice were identified in the professional reappraisal which followed the re-organisation of the National Health Service in 1974, namely

1. The search for health needs.
2. The stimulation of the awareness of health needs.
3. The influence on policies affecting health.
4. The facilitation of health-enhancing activities."

(CETHV, 1977).

The identification of these principles was intended to provide a sound basis for health visiting practice and affirmed the health visitor's unique role in providing a service that was responsive to both individual, family and community need. They also form the basis of the training and education of health visitor students.

3.4.3. The training and education of health visitors

In order to be selected for the fifty-one week course, student health visitors are required to be registered nurses (RGN or SRN). Upon successful completion of the course, these nurses are then eligible to register and practice as health visitors within the National Health Service.

The practice of health visiting requires a definition which will then allow the assessment of a prospective practitioner as competent or incompetent to practice. The following definition is generally accepted;

"The professional practice of health visiting consists of planned activities aimed at the promotion of health and prevention of ill-health. It thereby contributes substantially to individual and social well-being, by focusing

attention at various times on either an individual, a social group or a community. It has three unique functions:

a) Identifying and fulfilling self-declared and recognised as well as unacknowledged and unrecognised health needs of individual and social groups.

b) Providing a generalist health agent service in an era of increasing specialisation in the health care available to individuals and communities.

c) Monitoring simultaneously the health needs and demands of individuals and communities; contributing to the fulfilment of these needs; and facilitating appropriate care and service by other professional groups."

(CETHV,1977).

The use of the word **unique** to describe the function of health visiting is of particular interest when discussing training for competence to practice. It implies that the practice of health visiting requires special skills, knowledge and values which are not held by any other professional group and that attainment of these skills, knowledge and values is essential in order to be a competent health visitor. This suggestion is confirmed within the Statutory Instrument 873, Part IV of the Health Visitor Training Rules;

"The kind and standard of training leading to qualification enabling an application to be made for admission to Part II of the register under this rule shall enable the student to acquire the necessary knowledge, skills and attitudes for her personal, professional development and for the student to develop the competencies required to practise health visiting which will require:

a) co-ordination of skills in health assessment, identification of need, planning, implementation and evaluation of health education and care;

b) co-operation with persons engaged in a wide range of primary health care and other colleagues;

c) encouragement of and community participation and use of voluntary workers in health enhancing activities. "
(English National Board, 1988).

The competencies identified under the Rules present difficulty in assessment because they are so broad and far-reaching, but this could be seen as a reflection of the diversity of the work of the health visitor, and the fact that the definition of health visiting itself is very broad.

Health visitor training involves periods of study in an institution of higher education and two distinct periods of "on-the-job" training. Students spend their first practical placement observing a field work teacher[4] who is specially trained to teach students. The second placement consists of "supervised practice" where the student takes responsibility for a small caseload of clients (approximately 100 families) under the supervision of an experienced health visitor. It is speculated that the knowledge, skills and beliefs/values required for health visiting practice are an amalgamation of what is learnt in the field and in formal education and what is brought from nursing or personal experience to health visiting practice. Dingwall (1977), however, has suggested that students are far more impressed with the models taught in the field than with those taught during the academic segment of training demonstrating that there may be an imabalance of influences.

[4]It is recognised that the term "field work teacher" has been replaced by the term "community practice teacher". However, as the respondents in this study used the former term, this is the term adopted for the purposes of the study.

During the health visitor training course trainees are expected to undergo a reorientation of values from curative nursing to preventative health visiting (Hendy, 1988). This can be a source of stress and anxiety for students as they are being asked to put many of the values and much of their knowledge of nursing to the back of their minds and to replace these with the new "health visiting mind set".

It has been questioned whether successful re-orientation from nursing to health visiting is possible during the course of the training;

> "It has long been acknowledged among teachers that the present post-registration course for health visitors, lasting fifty-one weeks, is barely of sufficient length for students to accommodate easily the change that is necessary to work with the well population in health promotion activities".
>
> (Hendy,1988).

The issue may not, however, be merely one of the length of time of training, but of the difficulty in re-orienting knowledge and beliefs from the "cure-oriented" hospital environment. It has been argued that health visitors are in an ideal position to fulfil the need for anticipatory health care with older people, as the profession has a central commitment to health promotion (Luker, 1988). However an examination of the statistics and research on health visitors' work reveals a failure on the part of the profession to give any real priority to the older population.

3.4.4. The work of the health visitor with older people

As health visitors are, in theory, trained to respond to changing needs within a community and, with a rapidly increasing population of people aged 65 and over, it might be imagined that health visitors would be increasingly involved with this age group. However, examination of the national statistics on health visitors' work shows that the percentage of older people in contact with the health visiting service has decreased over the last decade.

Current statistics show that older (over 65 years) people represent approximately 16% of the total population whereas children under 5 years represent 6% (DH, 1988). In 1977, statistics showed that, of the population over 65 years, 7.7% was visited by a health visitor (DHSS, 1982) compared with 5.3% in 1987 (DOH,1989)[5]. These figures can be contrasted with the statistics for the population under 5 years, of which 65-70% were visited (DH, 1988). As a backdrop to these statistics it should be mentioned that the over 65 population has increased over that period whilst the birth rate has dropped, and that the whole time equivalent of health visiting staff has increased from 7,602 in 1977 to 10,293 in 1987 (figures for England). Although some of the discrepancy may be accounted for by the shorter working week which decreased from 42 hours per week in 1977 to 37.5 hours per week in 1987, it appears unlikely that this would completely account for the difference.

[5] It should be noted that the way that statistics have been collected has altered during this time.

The current work of the health visitor is mainly oriented towards the child population (Phillips, 1988) with low priority being given to older people. Dingwall (1977), and Phillips (1988) have claimed that health visitors appear to dislike working with older people and it has been suggested that this is because health visitors lack an appropriate model or structure for their visits. (Luker, 1978).

There is evidence, however, that health visitors can be effective in working with older people (Luker, 1982; Barber, 1984; Vetter et al, 1984). A recent study of the attitudes of community nurses and general practitioners towards work with older people showed that health visitors considered that they should have a role, particularly in the area of assessment, and that they believed regular assessment for older people was necessary and important (Tremellen and Jones, 1989).

Other studies show that health visitors consider older people to be a high risk group (Black, 1987) but that they rationalise their lack of regular involvement with this group by claiming that the demands of their work with the under fives militates against them giving priority to the over 65s (Wiseman, 1982; Burridge, 1988). However, there appears to be evidence that if health visitors are given extra time and resources they tend to increase their work with young children, rather than with older people. (Dunnel and Dobbs, 1982).

Research has clearly identified a lack of adequate knowledge and training with regard to work with older people for student health visitors. While (1981), in an admittedly small study of 26 student health visitors, stated that

> "students felt that they lacked sufficient knowledge of the aims and objectives of health visiting practice with the elderly", (While, 1981)

and identified individual interactions with older people as focused on ill-health. She went on to suggest that the lack of practical field work experience of work with older people may predispose towards its absence in future health visiting practice. This suggestion is supported in research work by Dingwall (1977), Bergstrand (1985) and Fitton (1990), all of whom identified a lack of experience on the part of health visitor students with regard to work with older people.

It is well recognised that the health visitor's role with the older population is underdeveloped and that health visitors are trapped with the 0 - 5 age group (McClymont, Thomas and Denham, 1986; de la Cuesta, 1992). The general reluctance of health visitors to undertake this role fully has several possible explanations. First, it is possible that the unpopularity of nursing older people in the hospital situation means that students entering health visiting already have a negative stereotypical view of the older population. Second, the reality of the practice situation for student health visitors during field work and supervised practice may reinforce a negative view of work with older people (Hendy, 1988), especially as students on supervised

practice often have to manage caseloads that have no older people in them. Finally, Phillipson and Strang (1986) in their overview of health visitor training courses suggested that health visitor tutors failed to give priority to teaching topics which concerned older people and that the courses fostered the medically oriented, stereotypical view of older people within society.

Health visitors, in the main, set their own priorities for visiting often with very few guidelines for practice from their immediate line-managers or health authorities. It is therefore postulated that there is a degree of personal choice involved in the decision to allocate low priority to the older population. However, the influences on health visitors in terms of training and experience are unclear, and their reluctance to give priority to well older people may well be exacerbated by their lack of knowledge and skills.

3.4.5. Training for skills - the health visitor/client relationship

The relationship between health visitor and client is perhaps the central focus of health visiting work (Chalmers and Luker, 1991). Of the skills required to undertake effective health visiting;

> "perhaps skills in developing interpersonal relationships come first. Without these skills the health visitor could hardly hope to carry out her preventive work".
>
> (Raymond, 1977).

It is not only the nature of the work of health visiting which forces the relationship into the forefront of health visiting practice; it is the nature of the work combined with the main arena of activity, the home. Home visits

constitute 56% of health visitors' time with clients (Dunnel and Dobbs, 1982) and the importance of the home visit and the interpersonal skills required are strongly advocated by health visitors (Hendy, 1988).

The critical position of the relationship is also acknowledged in the Investigation into the Principles of Health Visiting (CETHV, 1977);

Essential factors for successful search (for health needs) are:

a) The initiation and development of the relationship such that any needs will become apparent and may be acknowledged.

b) The motivation and ability to initiate the search.

c) Knowledge.

d) Skills.

(CETHV, 1977).

However, the primacy of the relationship may also have detrimental effects on the work of the health visitor with clients. In a study of the role of the health visitor in child accident prevention, Laidman (1987) found constraints which reduced the effectiveness of their role in three areas - knowledge, opportunity and skills. The carefully nurtured relationship with clients caused health visitors to avoid contentious or difficult topics in fear of damaging the relationship. This was particularly noticeable with regard to health visiting students:

> "At the centre of all the above problems was the health visitor/client relationship. Concern was expressed about the relationship from the beginning of the course..... However, it was alarming to find at the end of the training so many of the students working in fear of breaking a relationship rather than using their skills to develop it".
>
> (Laidman, 1987).

It may be that there are many areas of health visiting work that suffer and areas of need that are not explored because of the stress and importance placed on the relationship with clients. Evidence from a study of health visitors' work with older people suggests that it is not necessary to build up a relationship before asking direct or intimate questions (Luker, 1979). Luker contends that it is less confusing to the client to use a direct approach, but stresses that a direct approach requires focused intervention and a clear agenda for the working relationship, characteristics which, it may be speculated, many health visitor interactions with older people do not possess.

The skills training that student health visitors undergo is influenced by both the education and service segments of the profession. The newly-qualified health visitor may perceive her/his role as uncomfortably ambiguous and without clear expectations, especially when the emphasis for the service segment, of which she/he is now a part, is on the building of relationships with the clients on the caseload. By comparison, the education segment of health visitor training encourages students to adopt an approach to their work and use of skills based on a community profile, which incorporates many client groups.

In reality, the health visitor is constrained by local policies and the assumed expectations of her colleagues which build the actual workload around the 0 - 5 age group. The gap between education and practice becomes clear as the role uncertainty which a newly-qualified health visitor experiences may lead her to settle for the more comfortable group identity of established health visiting practice as a way of reducing her own anxiety. Therefore rather than adopt a relationship-centred approach to work with older people, the health visitor may merely visit an old person when a referral comes from another agency. The key role of the health visitor would then be to assess the older person and refer on to other services when needed. Indeed Dingwall suggested that;

> "with old people the only important facts to be documented are that visits were made and that services which seemed to be relevant were offered...competent performance of work can be met by indicating a visit has been accomplished"
> (Dingwall, 1977).

It would appear that previous research has identified a lack of clear purpose and definition of health visiting work with older people, aside from merely accomplishing a visit and referring to other service agencies where appropriate. The establishment of relationships with older clients is an expensive luxury, allowed only when the priority of work with children aged under 5 is completed.

3.4.6. The effects of current policy on the work of the health visitor

The health care policies of the last 15 years have emphasised the need to enable older people (and members of other vulnerable groups) to remain in their own homes for as long as possible (see Chapter 2). However, recent policy documents appear to be increasingly concerned with the central role of the GP practice in the provision of primary health care services. The White Paper on primary health care "Promoting Better Health" (DHSS, 1987) was fundamentally concerned with the provision of medical services, putting general practice firmly in the key position for community health care provision and it virtually ignored the contribution of district nurses and health visitors (Clay, 1988). The latest White Papers (DH, 1989a and b) also made scant reference to community nursing care, prevention and health promotion.

In 1987, the Government stated that;

> "the next big challenge for the National Health Service, and one especially for primary health care, is to shift the emphasis from an illness service to a health service offering help to prevent disease and disability"
>
> (DHSS, 1987).

The key question, however is, how this can be achieved? The Cumberledge Report (DHSS, 1986) envisaged a key role for district nurses and, in particular, health visitors in the provision of primary health care and preventive services within the community. The recent White Papers (DHSS, 1987; DOH, 1989a and b) however, have shifted the responsibility for the

provision of preventive health care services firmly into the hands of the GPs and their practice staff. The question must be asked as to why the role of health visitors, who are

> "trained and educated to provide unsolicited primary prevention in health care in people's own homes",
> (Fatchett, 1990),

has been largely ignored in recent policy documents.

The government's strategy for the provision of "health promotion/illness prevention" for the older population consists exclusively of optional health promotion clinics and of basic assessment of people over 75 years of age, both functions being the responsibility of the GP. It was highlighted in chapter 2 that assessment by general practitioners is likely to be at a secondary level (Fatchett, 1990) and that there are no recommendations for general practitioners to undertake these assessments with people aged 65-74. With the government supporting an increased involvement by GPs in child health surveillance, an area which health visitors believe is their territory of work, it is possible that health visitors could seize the opportunity to establish a new role in the provision of anticipatory or primary preventive health care for the population aged 65 and over.

3.4.7. Health visiting and general practice

It appears that the role of the health visitor is slowly being marginalized and fragmented by government policy. This is evident in the increasing

involvement of GPs in health visitors' traditional territory of work. It has been argued that if health visitors were prepared to work more closely with GPs in the practice setting it would enhance understanding of their special knowledge and skills (Fatchett, 1990). In this way they could;

> "maximize the opportunity for using all learnt skills, and (to) put health promotion clearly on the practice agenda".
> (Fatchett, 1990).

However, in spite of the fact that many health visitors work within an attachment scheme to general practitioners (i.e. his/her caseload is based on the people registered with a particular GP), there remains a certain amount of confusion on the part of GPs as to the role of the health visitor. Many GPs

> "are not clear about the aspirations and the expectations of health visiting and find the numerous references made to it by those outside the profession confusing".
> (Royal College of General Practitioners, 1983).

Referrals of older people to the health visiting service frequently come from general practitioners (Bergstrand, 1985). However, Dingwall (1977) suggested that

> "...health visitors may feel some uncertainty in their role in preventive health care and may be put under pressure to accept referrals of secondary and tertiary preventive work with elderly clients (from GPs)".
> (Dingwall, 1977).

As older people have tended to contact their GPs for the solution of specific medical or functional health problems (Farquhar and Bowling, 1992), it is

hardly surprising that the referrals that GPs make to health visitors are generally for secondary or tertiary preventive work. However the new GP contract, with its emphasis on health promotion and primary prevention, could alter this.

The increasing responsibility of the GP for ensuring that preventive health care is available for his/her patients could be seen as an ideal opportunity for health visitors to ensure closer integration with GP practices (Fatchett, 1990) and to establish their true place within the primary health care team. The imperative for change within the profession has been presented to health visitors, not only in their "reluctant relationship" (Robinson, 1985) with GPs but within their work arena (Goodwin, 1988).

It appears that the imperative for change, however, is going to come from recent policy moves to encourage GPs to "buy-in" community nursing services from district health authorities (DHAs). From April 1993, budget-holding GPs will be encouraged to contract with DHAs to purchase nursing and health visiting services for the patients registered with their practice. There is already evidence that GPs are contracting with DHAs for health visitors to undertake the assessment of patients aged 75 and over at home (Chernik, 1992). Concerns have been expressed from within the profession about the potential for GPs to control the boundaries of health visiting work, given that they will be paying for it (Nursing Times, 1992). It remains to be

seen to what extent these new arrangements will alter the nature of health visiting practice.

3.4.8. Health visiting and older people - a summary

This section has provided an overview of the training, work and role of the health visitor with regard to work with the older population and has also commented on the potential role of the health visitor within the climate of government policy changes which put health promotion clearly on the agenda. It can be seen that the situation is multi-factoral and complex and there are clearly more questions to be posed about health visitors' lack of involvement in the provision of anticipatory health care for older people than there are answers.

Whilst the policy agenda (espoused by employing health authorities) appears to constrain the broader role potential of the health visitor by orienting it towards work with the under 5s, the professional rhetoric of the past ten years has attempted to encourage health visitors to increase their involvement with the older population. The statistics on visiting show that this attempt has been largely unsuccessful and this is perhaps partly due to the distinct lack of experience that student health visitors get of work with older people during their training. Even when visits are made to older people, the health visitor's focus appears to be oriented around referral to other agencies and the meeting of specific dependency needs, and the people that

they visit are not, in the main, the "well-elderly". Perhaps Garrett's (1984) contention that;

> "nurses hold a negative attitude towards the potential for preventive health care for the elderly once they have experienced illness-based nursing practice",
> (Garrett, 1984)

holds true for health visitors too, all of whom have experience of working with the most dependent of the older population in hospital during general nurse training. It would appear, from the current research and literature, that health visitors are not currently actively engaged in the provision of anticipatory health care for older people and the reasons for this require further investigation.

3.5. THE ROLE OF THE PRACTICE NURSE[6]

Due to the rapid increase in numbers of practice nurses during the period 1989-1991 (see Appendix 1) and the new responsibilities of the GP contract (see Chapter 2), there is a distinct lack of research which has examined the role of the practice nurse in work with different client groups (such as the older population)[7]. Therefore, this section is focused on more general issues about practice nursing work, for example issues of employment, training and accountability.

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[6] It should be noted that, for the purposes of this discussion, the term "practice nurse" is taken to mean those nurses employed by general practitioners and therefore excludes those employed by health authorities to manage clinics (clinic nurses).

[7] It should be noted that one of the central purposes of this research study was to identify the role of the practice nurse in work with older people (see chapter 1).

3.5.1 Employment of practice nurses

During the period 1989-1991 the number of practice nurses employed by general practitioners (GPs) increased dramatically (Nursing Times Ed., 1990). In 1986 the number of whole time equivalent (WTE) practice nurses employed in England and Wales was 2,642 and by 1989, the number was 4,898. By the end of 1990, however, the number had almost doubled to 8,155 (all figures from DH, 1991). In Mersey and North West Regions, where this study was undertaken, the number of WTE practice nurses doubled from 414 at the end of 1989 to 821 at the end of 1990 (DH, 1991). This explosion in numbers appears to be a direct result of the changes in the GP contract (Health Departments of Great Britian, 1989) which came into force in April 1990 and the fact that family practitioner committees, now called Family Health Services Authorities (FHSAs) actively encouraged GPs to employ practice nurses before this date, when new cash limits on employment of staff were imposed (Liverpool FHSA, 1990).

Before April 1990, general practitioners automatically received a 70% reimbursement of any employee's salary from FHSAs. Since April 1990, however, FHSAs have been forced by the government to maintain stricter controls over their annual expenditure and the percentage reimbursement of the salaries of staff employed by GPs has become discretionary (Liverpool FHSA, 1991). It is probable that the **rate** of employment of practice nurses will therefore have decreased from the end of 1990 to the present day (1992).

3.5.2. The role and work of the practice nurse - previous studies

Early small scale studies of the work of practice nurses showed that their role in the surgery was mainly limited to carrying out "traditional nursing" tasks such as height and weight measurement and temperature recording (Marsh, 1967; Baldwin, 1967). Reedy (1972) reviewed the practice nurse literature for the previous twenty years and found that, although no large scale surveys had been undertaken, there appeared to be 45 main tasks that were reported as being performed by practice nurses. Some of these were common nursing tasks and others were tasks which would ordinarily be performed by other "professions supplementary to medicine", such as ECGs (Reedy, 1972).

By 1976, Marsh and Chew (1984) had noted that the role of the practice nurse was beginning to change to include more complex functions such as family planning and women's health screening and later identified the work of the practice nurse in men's health clinics. A scheme in Oxfordshire used a facilitator to encourage GP practices to instigate preventive strategies by employing practice nurses to identify and modify risk factors associated with heart disease and stroke (Fowler, Fullard and Muir Gray, 1988) and demonstrated quite clearly how;

> "the development of the role of practice nurses can bring about major changes in primary care".
>
> (Fowler et al, 1988).

The wide range of technical tasks performed by practice nurses has been confirmed in several recent studies (Greenfield, Stilwell and Drury, 1987; Cater and Hawthorn, 1988) and the variation in the extent and nature of their contribution to the practice workload was noted in a report by the Royal College of Nursing (1984). The increasing involvement of practice nurses in the provision of anticipatory health care strategies within general practice is becoming more and more apparent and it has been suggested that they may be the nurses

> "who will lead the team in the health promotion of the future".
> (Fowler et al,1988).

However Greenfield et al (1987), in their survey of practice nurses' attitudes towards their work showed that, when asked for the most important factor which stopped practice nurses from extending their role, 45% of the sample responded that it was the GP's attitude. Given the evidence that some GPs lack commitment to the identification of needs for prevention in the practice population (Coulter and Schofield, 1991), it is apparent that the potential for practice nurses to be involved in health promotion/anticipatory health care requires further investigation.

3.5.3. The practice nurse's role in anticipatory health care

In chapter 2 it was mentioned that the major change in the terms of service for general practitioners was to make clear that

> "health promotion and disease prevention fall within the definition of General Medical Services....including the provision of advice and care through opportunistic screening and regular check-ups".
>
> (Health Departments of Great Britain, 1989).

In particular the establishment of health promotion clinics (for example focusing on anti-smoking, well-person and prevention of heart disease) and the offer of an annual assessment to patients aged 75 or over on the GP list are essential components of the practice's responsibilities towards its patients, although there has been a moratorium placed on the introduction of new clinics pending a government review (Liverpool Primary Care News, 1992). The contract states quite clearly that these services may be provided by the GP or another member of the practice team, such as a practice nurse. Undoubtedly many GPs have employed practice nurses specifically to undertake these functions on their behalf. Selby, Winkler and Brown (1992) showed that, in their survey of practice nurses in Barking and Havering health authority,

> "...in many practices the entire burden of health promotion work was being undertaken by practice nurses with little or no training in the field and whose previous experience was in an acute hospital",
>
> (Selby et al, 1992)

and go on to suggest that

> "serious issues concerning training, competency, indemnity and audit of work have to be addressed".
>
> (Selby et al, 1992).

In terms of the assessment of over 75s, the GP receives remuneration (called an enhanced capitation payment which currently stands at £32.00 per year for each person) for each annual health assessment of a person over 75 years and also receives up to 70% reimbursement of a practice nurse's salary. This means that, in effect, GPs are being paid twice over for work which they are not actually doing themselves and the ethics and financial viability of such an arrangement has been questioned (DHSS, 1986). However it appears that, within the new GP contract, there are an increasing number of functions (e.g. child immunisations, cervical smears etc.) which fall into this "item for service" category many of which are performed by practice nurses. The question of why nurses cannot receive financial enhancement for undertaking certain aspects of work remains unanswered.

The Oxford project demonstrated that practice nurses can be effective in the identification of risk factors in heart disease and in providing health education advice to the well population (Fowler et al, 1988). However, the project also maintained that practice nurses required specific training in order to gain the skills required for this work. However, a recent study shows that practice nurses undertaking health promotion activities in addition to other treatment room work have to "balance their dual roles" (Farquhar and Bowling, 1990) and tend to neglect health screening/education in favour of treatment room work. They go on to suggest that

"dual roles are less effective than single health promotion roles in improving practice performance in preventive health care" (Farquhar and Bowling, 1992).

Their study draws into question the policy of making health promotion activities a central function of the GP and their practice staff. In addition, the extent to which practice nurses have the training, knowledge and skills to undertake the wide variety of health promotion activities demanded by the GP contract and, in particular, assessment of people over 75 years at home needs to be considered.

3.5.4. The training of practice nurses

Currently there is no mandatory training for a practice nurse. Most possess the registered general nurse (RGN or SRN) certificate, though the requirements for additional training are under review by the professional bodies of nursing (UKCC, 1990). Many educational establishments run a 10-15 day post-registration course for practice nurses which must be approved by the English National Board (ENB). There is, however, wide-spread concern about the adequacy of such a course in preparing nurses for practice. An examination of the ENB outline curriculum (ENB, 1989) reveals a focus on the acquisition of specific practical techniques for treatment room work, with little emphasis placed on the acquisition of skills for effective health promotion, screening and patient education. As many practice nurses are being specifically employed to undertake the latter, an examination of the curriculum lends weight to the argument that the ENB approved course is unresponsive to the evolving needs of general practice (Robinson, 1990).

Much of the training which practice nurses currently receive is provided as "on-the-job" training with instruction from GPs or comes in the form of one day study courses provided by the district health authority or FHSA. Concern has already been expressed about the quality of the instruction some GPs give nurses who perform procedures such as cervical cytology (Bowling, 1988). One of the main questions about training for practice nurses results from their direct employment by GPs; namely, who is to pay for the training course? FHSAs have a discretionary power under Section 63 to reimburse GPs for up to two-thirds of staff training costs but, now that cash-limits are being imposed on FHSAs, there is a suggestion that GPs themselves will have to pay in full for training courses. Training for practice nurses could therefore depend upon the good-will of the employing GP and their belief in the value of post-basic training.

The Royal College of Nursing (1987), in its response to the Cumberledge Report (DHSS, 1986), recommended that there should be a mandatory training course for practice nurses and this suggestion is currently being examined by the UKCC and ENB. It is possible that a specialist practice nurse course could be included among the post-basic preparation courses which follow Project 2000 training (Bowling, 1988), putting it on a par with health visitor and district nurse training courses. Carr (1988) suggests that the way forward for community nursing as a whole lies in the development of "family nurse practitioners" who could be practice nurses, health visitors, district nurses or school nurses who had undergone a period of formal post-

basic education. These nurses would work in close collaboration with GPs and undertake both practice- and community-based work with clients focusing on preventive strategies.

It could be argued that, in order for practice nursing to be considered a legitimate area of professional practice, it is essential that there is a mandatory training course leading to a recognised national certificate of competence. In this way, control over membership of the profession and consequently professional accountability can be achieved.

3.5.5. Accountability in practice nursing

There has been much dispute about what tasks GPs should be permitted to transfer to nurses and confusion over appropriate roles and legal aspects of delegation of tasks has been widespread. It has been suggested that the appropriateness of delegated tasks should be determined by;

> "whether the task improves nursing practice or creates a competent physician's assistant".
>
> (Stilwell, 1990).

Stilwell seems to be suggesting that tasks should only be performed by nurses if they enhance the status of the profession, and makes little or no mention of patient outcome. However as the profession is attempting to move away from task-based practice to a more holistic philosophy of care (May, 1992) it is very difficult to assess at face-value what is a genuine **'nursing task'** and what is not. The issue of delegation appears to lie not just

with 'appropriate' tasks for nursing but must take consideration of issues of competence and accountability.

In 1977 the DHSS issued guidelines for acceptable delegation from doctors to nurses (see below) but it must be made clear that delegation from a doctor to a nurse does not mean that the nurse herself is absolved of professional accountability (UKCC, 1990).

* The nurse has been trained for the performance of the task and agrees to undertake it.

* This training is recognised by the professions involved and the employing authorities.

* The professions recognise that the task is suitable for delegation.

* Delegation is practised within the context of a clearly defined policy, based on discussion and agreement by those responsible for providing medical and nursing services.

(DHSS, 1977).

GPs are legally bound when delegating duties to ensure that the person to whom they delegate duties is competent to carry out the treatments or procedures but nurses are bound by their Code of Professional Conduct to refuse to accept delegated duties for which they are not competent (Clause

4). Undoubtedly there is a delicate balance between the nurse's own accountability and that of her employing GP. Not only is it essential that GPs understand the nurse's competencies, but that nurses themselves are clear about their competence to practice or perform certain tasks.

Many concerns have been expressed about the ability of practice nurses to perform assessment of people over 75 years of age particularly when the assessment is to take place in the person's home. These concerns have come from practice nurses themselves and from other community nurses, such as district nurses (DN) and health visitors (HV), who regard home visiting as one of their unique functions. Indeed, it begs the question, why do HVs need a 12 month training in order to be qualified to visit people at home for the purposes of health promotion and screening when practice nurses can do home visiting with no post-basic training at all? Suggestions were made early in 1990 that practice nurses should only visit people at home if they possessed a DN or HV certificate but the UKCC in their Statement on Practice Nurses (UKCC, 1990) failed to make this mandatory, perhaps afraid of the outcry from employing general practitioners which may have ensued. Instead they stated that, with regard to assessment of patients over 75,

> "it is essential that the practitioner conducting the assessment possesses the necessary skills to perform it competently.....Courses in District Nursing and Health Visiting are prime examples of the professional education and training which prepare nurses for such responsibilities"
>
> (UKCC, 1990).

The vagueness and lack of firm guidelines in this statement have resulted in a situation where individual practice nurses (or their employing GPs) decide whether they possess the necessary skills to undertake the assessment. The RCN document, Practice Nursing (RCN, 1990), is equally vague stating that, although the RCN will indemnify practice nurses when performing health checks with patients over 75, nurses

> "who do not possess a community nursing qualification (i.e. they are not health visitor or district nurse trained) need to be aware where their role ends and that of their community nursing colleagues begins"
> (RCN, 1990).

They go on to suggest that;

> "it may be useful for practice nurses and the GPs they work for to agree specific guidelines as to what activities the nurse will undertake as part of the home screening programme".
> (RCN, 1990).

Two problems are immediately apparent in the statements of both the UKCC and the RCN with regard to the accountability and role of the practice nurse in the assessment of the elderly. First, it is questionable whether a GP has the knowledge and experience with which to determine whether a nurse in his/her employ is capable of undertaking the assessments, or whether in fact the GPs main concern will be to fulfil the terms of his/her contract in order to be remunerated for the assessments. In this situation practice nurses may well be asked or told by their employing GPs to undertake tasks which they are not adequately trained to perform, placing the practice nurse in a compromising position. Indeed the RCN expressed its concern when a

member reported that she had refused to perform elderly screening because she felt herself unqualified and was told by her GP "simply to get on with it" (Nursing Standard, 1990). Dilemmas of this sort are often exacerbated by the fact that, as many practice nurses work less than 16 hours per week and consequently have no job tenure, they can be dismissed from work without any repercussions on the GP concerned.

Second, there are many questions regarding the content of the assessment of patients over 75. The guidelines in the GP contract (Health Departments of Great Britain, 1989) as described in Chapter 2 are naturally open to interpretation and there is already evidence that what the GP and the practice nurse consider to be a thorough or satisfactory assessment may be two very different things (Nursing Standard, 1990).

It is argued here that the professional bodies of the UKCC and the RCN have done little in their statements to stem the concern that is being expressed by practice nurses themselves about their accountability. The issue of whether practice nurses should be allowed to prescribe, under the new proposals for nurse prescribing, has caused widespread anxiety about the ability and competence of practice nurses to perform that task. However, until the range and depth of skill, knowledge and experience that practice nurses possess and the range of functions they are expected to undertake are fully explored, it is impossible to make accurate judgements about

practice nurses' abilities to prescribe or to undertake assessment of people over 75 years of age.

3.5.6. The place of the practice nurse in the primary health care team

The RCN statement (see 3.5.5.) that practice nurses "need to be aware where their role ends....." means that practice nurses require a depth of knowledge about the roles of community nurses such as health visitors and district nurses. The role uncertainty experienced by these professions themselves (see Hunt, 1972 & Hendy, 1988), coupled with the confusion of many GPs regarding the actual roles of community nurses (RCGP, 1983) may mean that practice nurses experience some difficulty in determining their own role in the primary health care team.

It has been suggested that the extending role of practice nurses into areas such as health promotion, assessment of the elderly at home and child immunisation may cause rivalry and conflict with health authority staff and that one solution to this problem would be a single community nursing team working within GP practices and employed by FHSAs (Robinson, 1990). Many members of the nursing profession believe that it is not in the interest of nursing for some of its members to be employed by another professional group (eg doctors) as this reinforces the subservient or "handmaiden" status of nursing. The Cumberledge Review Body (DHSS, 1986) brought this debate to the forefront and argued that employment by GPs led to a fragmented and separate workforce within the community. The Review Body

recommended that FHSAs should transfer money to the community nursing service budget to employ, allocate and manage practice nurses within the community nursing team, with the intention that the roles and responsibilities of each member of the team would be clearly defined. With the current White Paper recommendations (DH, 1989b), however, this is unlikely to happen.

There is evidence that some community nurse managers restrict the range of tasks that a community nurse may perform (Bowling, 1985) and it is argued that direct employment of practice nurses by GPs means that the practice team can adapt to the changing needs of the practice without having to negotiate with community nurse managers. However, aside from Bowling's (1981) study on delegation in general practice, the relationship between practice nurses and their GPs has not been the subject of research scrutiny to date. GPs have rejected employment of practice nurses by district health authorities because of concern about loss of control over the role of their practice nurses. There is also evidence that qualified community nurses are being tempted to take practice nurse posts thereby depleting the already inadequate community nursing services (Fatchett, 1990) adding to the concern about the general shortage of nurses within the NHS in the future which is a result of demographic changes (Livesley, 1989).

The roles of practice nurses, district nurses and health visitors have fluid boundaries, the differences reflecting the views of their employers, as well

as personal and professional preferences. In spite of the recommendations of the Cumberledge Review Body for an integrated community nursing workforce, recent changes in the GP Contract (Health Departments of Great Britain, 1989) put the GP practice firmly into the key position as;

> "the community distribution point for health care".
> (Fatchett, 1990).

It could be argued that, in order for client need to be met by an integrated and cohesive community nurse workforce, the GP practice should become the focal point for organisation and this would require the burying of interdisciplinary conflicts which have become so much a part of the primary health care team (Fatchett, 1990). Indeed one possible consequence of GPs buying in community nursing services may be a closer integration and team approach to meeting the needs of clients. The diversity and flexibility of the practice nurses' work provides an ideal opportunity for the gaps in community nursing service provision to be filled. This potential is perhaps particularly applicable in the consideration of service provision for the elderly in the community as it has been suggested that neither district nurses nor health visitors make "any special commitment to the care of older people" (Luker, 1988). Perhaps practice nurses, many of whom are visiting older people at home for the purposes of assessment, will be able to ensure that the older population are not deprived of community support, though this requires research scrutiny and investigation.

3.6 THE ROLE OF THE NURSE PRACTITIONER

The introduction of the nurse practitioner into the primary health care arena has been one of the most potentially exciting and controversial developments in nursing over the last decade (Salvage, 1991). The nurse practitioner movement in the USA began in the 1960s primarily as a result of the need for replacement physicians in rural areas. However, they now work alongside physicians and have a role in physical assessment, diagnosis and treatment for which they receive extra training, generally to master's degree level. Whilst nurse practitioners have been officially recognised in the United States of America since 1974 (Bliss and Cohen, 1977), it is only recently that the debate has begun into the educational requirements and role of nurse practitioners in the UK.

The term nurse practitioner has been defined as;

> "a highly trained nurse who in addition to carrying out routine nursing duties can act as a first contact for patients and perform some of the general practitioner's duties such as diagnosing illness",
>
> (Greenfield, 1992).

It has been suggested that health visitors and district nurses have been working as 'nurse practitioners' (excepting a clearly defined role in physical examination and diagnosis) for some time (Stocking, 1991).

Research evidence shows that nurse practitioners can be a valuable extra resource for the development of new areas of care within the primary health

care sphere, though it is emphasised that they should not be considered a cheap substitute for a GP (Salisbury and Tetterstell, 1988). In addition, researchers have claimed that patients consult nurse practitioners appropriately (Stilwell, 1987) and that they have skills which focus on caring and educational functions rather than on technical tasks alone (Edmunds, 1979; Diers and Molde, 1983; Allen, 1983). 1992 saw the first graduates from the Royal College of Nursing's nurse practitioner diploma course (Simon, 1992).

Whilst moves within the UK for increasing the number of nurses with nurse practitioner status and responsibilities have been welcomed from within the nursing profession, the suggestion that nurses should work in partnership with GPs (Salisbury, 1991) prompted an outcry from the medical profession. The Cumberledge Report (1986) suggested introducing nurse practitioners into the primary health care team but GPs rejected this recommendation, perhaps because they were fearful of losing control over the work of their practice nurses. Indeed, a very recent piece of research by the Georgian Research Society (1991) has shown that of a total of 104 GPs who took part in the pilot study, 87 expressed strong opposition to the idea of nurses acting independently to diagnose and treat, unless it was within agreed and defined protocols. Only 30% of the GPs agreed that nurses should be independent practitioners, suggesting again that GPs want to retain control of the practice nurse's role and its expansion.

The boundaries of the role and responsibilities of nurse practitioners in this country remain very unclear and undefined. One small pilot study of six nurses who had the title 'nurse practitioner' has shown that;

> "some of the nurses were continuing to function in a position subservient to their medical colleagues. Of the six respondents, only two worked in a way identifiably different from most practice nurses".
>
> (Bowles, 1992).

This reveals the as yet underdeveloped role of nurse practitioners and the problems involved in ascertaining the differences in functions between nurses who hold that title and those who hold the titles of practice nurse, health visitor or district nurse. The question of whether it is a new name for the same type of nurse or whether it is indeed a new role for nurses, denoting special skills and a unique function, requires further consideration.

3.7 CONCLUSION

This chapter has provided a brief overview of some of the current issues and research which focus on nursing and health visiting work with older people. There appears to be little doubt that nursing work in hospitals with older people remains a stigmatized and unpopular field and that it is characterised by routine methods of organizing care. Also evident is the fact that nursing research has so far failed to identify the differences between nurses' attitudes to the structure within which older people are cared for, their images of stereotyped old age and their attitudes and behaviour towards individual older people.

In terms of work with older people in the community, it is apparent that the GP practice is being promoted within the policy documents as "the community distribution point for health care" (Fatchett, 1990), especially in the field of work with the over 75s. GPs and their practice staff have been given the policy remit for assessment of the over 75s and for work with the "well elderly", whilst health visitors, who traditionally held the theoretical remit for work with this population, appear to be becoming gradually marginalised by policy. It is curious that health visiting is being marginalised at a time when health promotion and health education are central on the policy agenda.

The renewed emphasis on the care of older people in the community within the GP contract (Health Departments of Great Britain, 1989) has been welcomed by the professional body of nursing (UKCC, 1990), especially in the area of preventive or anticipatory health care. It could provide the ideal opportunity for health visitors to stake a claim for their expertise in this area, though it remains unclear whether they actually have an adequate package of knowledge, skills and values with which to make this claim. Many concerns have also been expressed about the knowledge and skills of practice nurses to undertake skilled assessment of people aged over 75 years of age.

As with most issues when a policy shift is under way, there are more questions than answers. The key questions that have been identified from

this review of the literature appear to be broadly centred around issues of competency and role with regard to assessment of the over 75s and the influence of experience of nursing work in hospitals with older people on subsequent nursing practice in the community. Given this situation it was considered appropriate to undertake a research study which would uncover the roles of health visitors and practice nurses with regard to assessing the health needs of people age 75 and over. The next chapter presents the theoretical basis and methods used in this study.

CHAPTER 4.

METHOD AND STUDY DESIGN

4.1. INTRODUCTION

This chapter is divided into five discrete sections. The first section (4.2) restates, for the sake of clarity, the aims of the study. The second section of the chapter (4.3) describes the **exploratory work** which informed the selection of methods for the main study. In the next section (4.4) the **theoretical considerations** of the methods used are introduced, placing emphasis on a research method known as the Critical Incident Technique (CIT) (Flanagan, 1954). The fourth section (4.5) describes the **pilot work** which informed the **main study design and methods**, described in the final section (4.6).

4.2. STUDY AIMS

For the sake of clarity the aims of the study are repeated here:

1) To describe the constructions of practice with respect to older people that student health visitors and practice nurses bring with them to community nursing from previous work in the institutional setting.

2) To explore, in the context of work with older people, the differences/similarities in constructions of effective and ineffective practice between health visitors and practice nurses and to gain insight into the criteria used to evaluate practice, particularly in the provision of anticipatory health care.

3) To uncover the structural contexts of health visiting (training and practice) and practice nursing and to explore the influence of structural context on:

a) the training and education of student health visitors with regard to work with older people and

b) the role of health visitors and practice nurses in visiting older people at home.

4.3. EXPLORATORY WORK

At the time of the exploratory work it was thought that a combination of interviews and observation might be the most efficient way to collect data concerning practice nurses' and health visitors' approaches to working with older people. In order for the researcher to ascertain whether these would be the best methods of collecting data to meet the aims of the study, a small exploratory study was carried out. The exploratory work was conducted for two reasons:

1) To provide the opportunity for the researcher to gain insight into the role of the "new" practice nurse and the role of the health visitor in visiting the older population, and

2) To give the researcher experience of conducting interviews with both practice nurses and health visitors allowing for evaluation of interviewing skills and techniques.

The following two sub-sections describe the exploratory work conducted with practice nurses and health visitors respectively.

4.3.1. Exploratory work - practice nurses

At the onset of the exploratory work it was apparent that practice nurses were somewhat of an unknown quantity in the North-West and Mersey regions. This was essentially due to the rapid increase in rates of employment of practice nurses (see Appendix 1) as a consequence of the introduction of the new contract for General Practitioners (Health Departments of Great Britain, 1989). No statistical or research evidence was available to enhance understanding of the work or characteristics of the "new" practice nurse.

Due to the largely unknown nature of practice nurses' work with older people, some preliminary observation work in addition to intensive

interviews was thought to be a useful way of helping to substantiate exactly what the role of the practice nurse was.

The exploratory study was conducted in four clinics and health centres in the Greater Manchester area, including one where the researcher had previously worked as a health visitor. This particular health centre was used as the health visitors and practice nurses were known to the researcher and had a sympathetic view of the research. This facilitated the researcher learning interviewing skills and allowed for honest feed-back and criticism of the interview technique. Access to the clinics and health centres was negotiated directly with the practice nurses and health visitors involved.

The exploratory work consisted of one week of observation of day-to-day work with each of two practice nurses. As the researcher was unsure about the range of responsibilities of practice nurses, the observation work was focussed on work in general and not related to a particular client group/work activity. This was followed by exploratory intensive/conversational interviews with four practice nurses. The interviews were generally focussed around practice nurses' work with older people. The interview guide used for the exploratory work is shown in Appendix 2. Notes were recorded in the field and the interviews were tape-recorded with the respondents' permission and subsequently transcribed by the researcher. An ethnographic or thematic content analysis (Altheide, 1987) was undertaken on the transcripts.

The observation work and interviews with practice nurses revealed many aspects of practice nurses' work that were previously unknown to the researcher. There appeared to be several issues of potential interest. These were as follows:-

a) There appeared to be a conflict of interest between the general practitioner and the practice nurse in their work with the elderly.

b) It was recognised that not all practice nurses working with GPs were involved in visiting older people at home for the purposes of assessment i.e. it was not a **universal** function of the practice nurse population. However, it was impossible to substantiate from secondary data sources/previous research work which practice nurses were involved in this activity on a regular basis.

c) There appeared to be a potential overlap between the work of the practice nurse and the role of the health visitor with the over 75 population.

It was thought that the exploratory work had enhanced the researcher's knowledge about practice nurses and their work and that it had been useful in generating ideas about alternative approaches to data collection. In particular, problems in undertaking observation work with practice nurses for the purposes of the main study were envisaged, mainly because of the

multi-functional nature of the practice nurses' role. Whilst three of the four practice nurses who took part in the exploratory work were involved in visiting older people at home, they did not appear to have pre-designated times in their working week to undertake this work. For example one practice nurse "fitted in" visits to older people when she did not have much other work to do. If observation work were to be carried out for the main study, the researcher a) would need to have a method of identifying practice nurses who were involved in work with older people at home and b) would require some means of predicting when the nurses were visiting older people. It appeared that, as much of this work was undertaken opportunistically, observing practice nurses during visits to older people would be unrealistic given the time and financial constraints of a small study.

4.3.2. Exploratory work - experienced health visitors

Exploratory work with health visitors consisted of interviews with six who were working in a district health authority in North-West Region. Interviews were arranged by the neighbourhood nurse manager on behalf of the researcher and were conducted in the staff sitting room of one local health centre.

Interviews took place over a period of two weeks. The interviews were tape-recorded with permission of the respondents and were subsequently transcribed by the researcher. The interviews were conducted on an informal

basis as suggested by Lofland (1971) and were broadly centred on health visitors' work with older people. A basic interview guide was used to structure the interviews and this is shown in Appendix 3.

The exploratory interviews revealed that respondents had difficulty in articulating in any depth the details of their work with older people. They appeared unable to explain why they did not give older people any priority within their caseload, apart from saying that they had little enough time to work with families with children under five years. During the interviews they continually diverted the conversation onto the structural constraints (e.g. the influence of the health authority) which influenced their lack of involvement with older people. Without exception, however, they believed that health visitors theoretically had a responsibility for visiting the "well elderly" population.

4.3.3. Conclusions drawn from exploratory work

Following the exploratory work the researcher (in consultation with the designated research supervisor) reviewed the methods to be used in the main study. A decision was made to divide the main study into two distinct phases. As aims 1 and 2 (see section 4.2.) of the study related to constructions of work with individual older people, a method was required which would enable respondents to describe **actual cases** of older people they had nursed in institutions/visited at home. Flanagan's (1954) Critical Incident Technique was considered an appropriate method for this purpose.

It was thought that collecting critical incidents by questionnaire (phase I of the study) would be the most efficient way of gathering this information and this decision was made for the following reasons:

Firstly, and this was particularly important in the case of practice nurses about whom little was known at the time the study was being undertaken, the use of a questionnaire would allow the researcher to gather information about the demographic characteristics of the groups under study in addition to collecting critical incidents. The exploratory work had revealed, for example, that assessment of the over 75s in their homes was not a **universal** function of practice nurses and there was no existing data or secondary sources which would allow identification of **which** nurses were involved in this activity. It was decided that gathering information by questionnaire would therefore allow the researcher to determine how many practice nurses in the sample were working with the over 75s at home and they could then be considered for the second phase of the study.

Secondly, it was apparent that collecting incidents by questionnaire would yield a larger number of incidents in a given time than could be collected by interview (Wilkinson, 1987). As with most research studies, time constraints were a consideration.

Thirdly, the exploratory work with experienced health visitors revealed that they had problems articulating their work with older people in any depth

during interviews. It was felt that using a questionnaire which incorporated the Critical Incident Technique would encourage health visitors to focus on contact with **specific older individuals** with whom they had contact during the course of their work.

Finally, the exploratory observation work with practice nurses had revealed that their visits to older people were somewhat unpredictable in terms of timing. It was thought that a method which would allow respondents to describe specific cases without requiring the researcher to observe those visits would be a more efficient way of collecting information about practice nurses' work during home visits to older people.

The third aim of the study (see section 4.2.) concerned the structural context of health visiting and practice nursing work and it was felt this would most easily be investigated through interviews (phase II of the study design) with a sub-sample of the original questionnaire respondents. A criticism of previous studies using the Critical Incident Technique has been that they have failed to return to respondents to "check-out" the conclusions drawn from the descriptions of critical incidents (Caves, 1988) therefore the follow-up interviews would provide the researcher with an opportunity to discuss these conclusions with interview respondents. This could then be seen as a measure of internal validity.

Following the conclusions drawn from the exploratory work, the researcher undertook an in-depth search of the available research literature in order to substantiate the suitability of the methods selected for the main study. The following section describes the theoretical basis of the methods used in the main study.

4.4. THE THEORETICAL BASIS OF THE MAIN STUDY

This section considers the theoretical basis for the study, covering previous research and literature which informed the selection of methods of data collection and analysis for the main study.

The section begins with a brief overview of the qualitative and quantitative paradigms of research as a backdrop to the multi-method approach used in this study. It will be noted that particular attention is paid in this section to the theoretical aspects of Flanagan's CIT, which was the chosen method for the first phase of the study. The reason for the detailed focus on this technique is that it became evident to the researcher (following a thorough search of the literature) that, although the technique had been adopted by several previous researchers to explore aspects of nursing work, few had devoted attention to a critical analysis of the assumptions and premises underpinning the technique. The section continues with a discussion of issues pertinent to intensive interviewing which was the method chosen for the second phase of the study.

Historically, nursing research has had a strong tradition of quantitative methods (Melia, 1982), perhaps partially due to its attempts to gain credibility in the predominantly 'scientific' world of the medical profession (which has a history of research in the 'natural scientific' method). The quantitative approach gives pre-eminence to systematic, 'objective' means of gathering data and is closely associated with the 'positivist' movement which seeks to confirm theory already present in literature through the use of experimental design (Haase & Myers, 1988).

Quantitative research methodology is largely represented by the 'scientific' approach to gathering, analyzing and reporting information. It places emphasis on empirical measurement and control of variables, whereby observations are quantified and analyzed to permit numerical comparisons, statistical probabilities and the certainty of a particular outcome (Duffy, 1985). The assumption behind quantitative methods is that the world can be described by objective forms of measurement that are grounded in a logical, deductive form of reasoning. Quantitative researchers emphasise the replicability and uncontaminated nature of the findings and are correspondingly sceptical about the rigour and reliability of qualitative research (Cook & Campbell, 1979).

For several years now, powerful arguments have been put forward for increasing involvement of nurse-researchers in qualitative methods, rejecting the idea that the paradigm of the natural sciences is the only truly scientific

methodology (Duffy, 1985). The argument parallels a change of focus in other disciplines such as sociology and social psychology but stems from the fact that the philosophies of measurement, prediction and causal inference (which underlie quantitative methods) do not sit easily with a discipline in which the variables under study are frequently concepts such as 'care', 'health' and 'participation' (Corner, 1991).

Qualitative methods are being seen as increasingly important in the development of nursing knowledge. They seek to examine phenomena in context. Unlike quantitative methods which attempt to minimize or eliminate researcher 'bias' to as great an extent as possible, the researcher and respondents in qualitative methods are considered participants in the process of data-collection and analysis (i.e. the researcher and subject are seen as part of a two-way process) and this adheres to a principle of "subjectivism". Unlike quantitative methods, no attempt is made by the researcher to control extraneous variables, as the natural context in which the phenomenon occurs is considered to be an essential part of the phenomenon itself.

Qualitative research is a process whereby theory is built inductively from the perspective of the participants in the research study. The main purpose is to **understand the meaning** of human action rather than to **predict** it.

Whilst there are epistemological differences between the quantitative and qualitative paradigms perhaps one of the most outstanding differences is the

mode of analysis. Qualitative research is essentially that which derives findings in a non-mathematical way, without attempt at quantification (Strauss and Corbin, 1990).

Clearly, both quantitative and qualitative research methods have their place within nursing research and the choice of one approach over the other is essentially linked to the theoretical assumptions and aims of any particular research study. The use of a multi-method approach (combining qualitative and quantitative research methods) to data collection and analysis enables the researcher to exploit the advantages of each paradigm. In the following sections (4.4.1. and 4.4.2.) the theoretical backgrounds of the two methods of data collection used in the two phases of the main study are considered.

4.4.1. Phase I: Flanagan's Critical Incident Technique

Flanagan's Critical Incident Technique (CIT) (Flanagan, 1954) is a method which was designed to draw upon the expertise of experienced professionals in order to make explicit the professionals' perceptions of what constitutes effective interaction (Goldman, 1976; Eraut, 1985). In this section the background and development of the CIT are discussed, with particular reference to its application in nursing research. In addition, the five procedural stages necessary to complete a CIT study are considered.

4.4.1.1. Background and development of the C.I.T

The C.I.T. for data collection has been widely used in the study of professions and, more particularly, in the study of competence. The origins of the technique lie in Flanagan's (1954) study of United States Air Force pilots' competencies during World War II. Flanagan (1954) described the technique as;

> "a set of procedures for collecting direct observations of human behaviour in such a way as to facilitate their potential usefulness in solving practical problems".
>
> (Flanagan, 1954).

Flanagan's study arose initially from his dissatisfaction with the vague criteria used to evaluate pilots' performances on training programmes and in combat leadership. Experienced instructors and pilots were asked to describe real situations in which they observed trainees acting in a way that they believed to be effective or ineffective, with the aim of deriving specific descriptions of competencies. By asking for descriptions of actual incidents, Flanagan hoped to avoid the vagueness often encountered when posing hypothetical questions about competence. Several thousand reports were obtained of behaviour that was especially helpful or inadequate in accomplishing an assigned mission. Analysis of the incidents provided a "relatively objective and factual definition of effective combat leadership" (Flanagan, 1954) and the descriptive categories resulting from the analysis were defined as "critical requirements" of combat leadership.

In the same paper Flanagan (1954) also described a study which focused on disorientation during flying, asking pilots to describe occasions when they personally experienced feelings of acute disorientation or strong vertigo. In this study self-reports were sought rather than other people's descriptions of incidents.

The underlying principle of the technique is that factual reports of behaviour in given situations are preferable to general opinions and impressions about abstract situations.

An 'incident' is described as

> "any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act".
>
> (Flanagan, 1954).

However, an incident can only be considered 'critical' if it occurs in a situation where the purpose and consequences of the act are

> "sufficiently definite to leave little doubt concerning its effects".
>
> (Flanagan, 1954).

In other words, the incident is 'critical' if it explicitly relates (in a positive or negative way) to the behaviour which the researcher wishes to study. This requires the researcher giving respondents adequate guidelines for the description of incidents related to the given aim (see page 112). Two assumptions underlie the technique as described by Flanagan (1954). The

first assumption is that observers of an incident will make deductions about the competence of the person they observe in a given situation or will make deductions about their own behaviour in cases of self-reported incidents. The second assumption is that the behaviour observed makes a significant contribution (positively or negatively) to the general aim of the activity. In all cases the emphasis is on 'extreme' behaviour, either positively or negatively related to the general aim.

Flanagan elaborated his definition of a critical incident in five criteria which he maintains should be applied to the incidents as they are collected:-

a) is the actual behaviour reported?

b) was it observed by the reporter?

c) were all the relevant factors in the situation given?

d) has the reporter made a definite judgement regarding the 'criticalness' of the behaviour?

e) has the reporter made it clear just why s/he believes the behaviour was critical? (after Flanagan, 1954).

The first three criteria are mainly concerned with validity (Norman et al, 1991). For an incident to be valid, Flanagan (1954) maintains that full details must be obtained concerning the incident and its context i.e. if any detail is missing or the incident is incomplete, then it may not be considered as a valid critical incident. The last two criteria require that the behaviours

described are meaningful and significant with respect to the aim of the activity and that the judgement is grounded in reason.

4.4.1.2. Use of the C.I.T. in nursing research

The technique has been used widely in the study of many professional and occupational groups. Flanagan (1954) discusses the use of the technique in occupational groups as diverse as dentists, psychology lecturers, industrial foremen and department store sales assistants. More recently, the technique has been used to identify critical factors in successful selling (Kirchner and Dunnette, 1967), to analyze the job of store managers (Andersson and Nilsson, 1964), and to identify competency in community pharmacy (Dunn & Hamilton, 1986) in addition to several projects focusing on aspects of the nursing profession.

The technique's major advantage is that it depends on descriptions of actual events rather than on desirable or ideal behaviours (Cormack, 1984). A number of British and North American researchers (for example Fox, 1976; Cormack, 1983; Benner, 1984; Wilkinson, 1987; Wilde, 1988; Callery, 1988; Norman et al, 1991) have utilised the technique, which has been described as a way of obtaining "snapshot views of the daily work of the nurse" (Clamp,1980).

A range of issues in nursing have been addressed using the C.I.T., demonstrating its flexibility in describing the complexity of nursing care. The

technique has been particularly popular in studies which have focused on evaluating nursing performance and in occupational description (Bailey, 1956; Rosen & Abraham, 1963; Sims, 1976; Long, 1976). More recently, Benner (1984) used a form of the C.I.T. to obtain descriptions from nurses of clinical knowledge by asking nurses at various levels of experience to describe the same incident. She "adapted" the technique for her purposes taking a "Heddegarian" approach to analysis which, although never fully explained in her book "From Novice to Expert", appears to share similar characteristics with the constant comparative method used in grounded theory (Glaser and Strauss, 1967). By using the technique, she was able to identify competencies at various levels of skill acquisition and developed a continuum from novice to expert.

The C.I.T. has also been used by nurse researchers to identify and compare satisfying and stressful experiences. Fox (1986) asked nurses to describe two recent personal experiences, one stressful, the other satisfying. From the large number of written descriptions of incidents he was then able to identify the criteria by which nurses conceptualised stress at work. Similar studies have been undertaken by Selleck (1982) who collected critical incidents from student nurses in a group interview setting, Wilkinson (1987) who collected self-administered questionnaires from 'cancer nurses' and Wilde (1988) who investigated difficult and rewarding situations in psychiatric nursing work.

Other researchers have used the C.I.T. to describe certain aspects of nursing work. Rimon (1979) used the technique to describe incidents that had occurred where nurses felt they had given psychological support to rehabilitation patients. Clamp (1980) investigated nurses' attitudes towards their patients, and Cormack (1983) used the technique to illustrate effective and ineffective nursing practice in the field of psychiatry. In a study of role negotiation between nurses and parents of children on paediatric wards, Callery (1988) used the CIT to investigate interactions between parents and nurses. One major strength of the CIT for use in nursing research is that;

> "it usually results in a specific description of what nurses actually do, rather than in a description of what respondents think they do or of what they should do".
>
> (Cormack, 1983).

4.3.1.3. Stages in the C.I.T

There are five stages necessary to complete a CIT study (Flanagan, 1954) namely; 1) Establishing the general aim of the activity, 2) Setting plans and specifications, 3) Collecting critical incidents, 4) Analysis of the data and 5) Reporting the findings. The first four stages are considered in this section, the fifth being the concern of the thesis as a whole.

1) **Establishing the general aim of the activity** is central to the development of the guidelines (see page 112) for describing critical incidents (Norman et al, 1991). However, after reviewing previous studies it appeared that many researchers who used the technique ignored or passed over this first stage.

The focus within Flanagan's original study was on the evaluation of specific behaviours related to a certain activity (i.e. the competent piloting of an aircraft). The general aim of the study, therefore, was "to establish the character of competent piloting" (Flanagan, 1954) and can be seen as a description of the interaction between pilot and machine.

Establishing a level of agreement between people familiar with a certain activity about the aim of complex human interactions can be problematic. The aim should be stated in a simple and clear form. For example Woolsey (1986), in a CIT study of the characteristics of same-sex bonds, consulted the theoretical and empirical literature (as Flanagan (1954) suggests) and then asked experts in the field to identify the main aim of same-sex social interaction. Taking the literature and expert reports into account, this aim was eventually identified as a 'deepening' and 'strengthening' of the relationship between two people of the same sex.

In nursing research, the problem of establishing the general aim of an activity is readily apparent. The emphasis of the C.I.T. on the identification of 'behaviours' could reduce nursing to the performance of tasks and it has been suggested that this;

> "sits uneasily with more recent conceptions of nursing which put 'caring' at the heart of nursing work (e.g. Kitson, 1987)."
> (Norman et al, 1991).

Given that the CIT was developed to allow investigation of specific behaviours it could be argued that it is inappropriate for use in a profession which is attempting to move away from a "task and procedure" approach to work. For example, Norman et al (1991) state that the general aim of their study of nursing was to uncover behaviours related to "the provision of high quality nursing care". By asking patients to describe incidents that were "meaningful to patients with respect to high quality nursing care", they hoped to avoid the tendency to reduce nursing to the performance of tasks.

2) **Setting plans and specifications.** This stage involves defining the target population, defining the context of the activities to be described and deciding which activities within each context should be noted. Most professionals work within a variety of contexts and the behaviours demonstrated in one context may be quite different from those required for another (Caves, 1988). If the contextual focus is highly specific (as Dunn and Hamilton (1986) advocate it should be), the identified behaviours will naturally be less 'generalisable'. A broader contextual focus (or high bandwidth approach) however would yield a small amount of information about a great variety of activities and interactions, so each researcher has to balance the specificity of the context against the generalisability of the findings. In the study of professional/occupational groups involved in a great diversity of work (such as nursing), a specific focus is recommended (Caves, 1988).

In a C.I.T. study, the sample size should be determined by the number of incidents that are collected, not by the number of respondents. Generally, the more complex the general aim of the activity, the more incidents are required to describe the aim comprehensively (Norman et al, 1991). In the absence of any firm guidelines for the minimum number of incidents to be collected, it has been suggested that collection should continue until the last 100 incidents fail to provide any new information (Flanagan, 1954; Dunn & Hamilton, 1986). How this figure was arrived at, however, is unclear. Also it would require the researcher to analyze and classify the incidents concurrently with collection. In many studies concurrent rigorous analysis is rarely possible, given constraints of time and the availability of respondents.

The issue of how many incidents are needed has received scant attention from the nurse researchers who have utilised the technique. Certainly, the level of internal validity would be increased by saturating the categories derived from the incidents, but the question has to be asked whether non-saturation renders categories totally invalid. There appear to be no clear answers to this. However, it is apparent that researchers need to be aware of the issue.

3) There are two ways of **collecting incidents**: by direct observation and by retrospective accounts. In most research studies, incidents have been obtained retrospectively, as Flanagan (1954) himself did. Retrospective

accounts may be collected by administering a C.I.T. questionnaire, for example Cormack (1983), or by interview, for example Benner (1984). There are advantages and disadvantages to both approaches.

Collection by interview has been the most commonly used technique in C.I.T. research (see studies by Benner, 1984; Dunn and Hamilton, 1986; Norman et al, 1991). The length of the interview clearly depends on the number of incidents collected from each respondent. Dunn and Hamilton's study of community pharmacists asked for two or three incidents from each. The interviews were consequently very short (about 20 minutes).

One of the main advantages of interviewing over questionnaires is that it allows the researcher an opportunity to probe incomplete responses and to clarify meanings of descriptions. In addition it increases the opportunity to gain the co-operation of respondents. Interviews with patients, for example, also enable the inclusion of respondents who may be unable or reluctant to provide written information (Norman et al 1991). This may not be a consideration when contemplating the collection of critical incidents from a professional group.

Collecting incidents by questionnaire involves respondents being asked to write an account of the incident following a few specific guidelines. The guidelines are intended to ensure that respondents only describe incidents related to the general aim of the research. For example, Flanagan (1954)

used the following guidelines in the questionnaire he gave to flying instructors:

> "Think of the last time you saw a trainee pilot do something that was effective/ineffective.
>
> What led up to this situation?
>
> Exactly what did the man do?
>
> Why was it effective/ineffective?"
>
> (Flanagan, 1954).

These guidelines were intended to prompt the respondents to describe specific incidents which were examples of effective/ineffective flying behaviours. By asking the three questions directly in the questionnaire, Flanagan (1954) was able to ensure that instructors gave specific information about the incident and explained why they had classified the behaviour as effective/ineffective.

This approach has been used by several nurse researchers (Fox, 1976; Cormack, 1986; Wilkinson, 1987). There are advantages to using a questionnaire in that it gives the respondents the opportunity;

> "for careful reflection both before and during the composition of answers".
>
> (Caves,1988).

Perhaps the main advantage of using a questionnaire approach is the greater standardisation afforded by the written format. This eliminates interviewer bias and ensures that all respondents receive the same information prior to

describing the incidents. In addition, it enables the critical incidents to be incorporated into a larger questionnaire which may contain other details about the subject under study (see Wilkinson, 1987).

Cormack (1983) used a postal questionnaire to collect incidents from psychiatric nurses, giving them guidelines to follow which requested nurses to describe "effective" and "ineffective" interactions with patients. He found that the nurses could quite successfully describe incidents in a written format and that the incidents were of sufficient detail. However, the main problem with this study was the low response rate (around 30%). Response rates could be improved by administering the questionnaire directly to respondents and collecting them back at the end of an allocated period of time.

Wilkinson (1987) collected critical incidents from groups of registered and enrolled cancer nurses by administering a self completed questionnaire to each individual. The guidelines for describing incidents were that they should be examples of "stressful" incidents and "satisfying" incidents with cancer patients. Ten nurses were then randomly selected from the original total of 88 for follow-up interview.

Group-administered questionnaires have the advantage of cutting down some of the costs involved in administering questionnaires separately to individuals, as a group of forty people can be gathered together and seen at

one time by the researcher (Oppenheim, 1966). Often the most straight-forward way of gaining access is to seek permission to study groups of students in schools of nursing or higher education colleges (Wilson-Barnet, 1984). Ideally, a session of defined time should be allocated for completion of the questionnaire, thereby ensuring that each respondent has the same amount of time to answer the questions. Another advantage is that the researcher has the opportunity to explain the purpose of the research study and is present to give guidance on completion if necessary.

Most researchers have followed Flanagan (1954) in asking for incidents which reflect extreme behaviour or performance of particular tasks/activities. The underlying rationale for this is that, for example, descriptions of both effective and ineffective action result in a more complete description of the subject of the research (Norman et al, 1991). In addition, respondents are more likely to recall incidents which were of particular significance to them. Asking for descriptions without guidelines for both the positive and negative aspects of work may result in respondents only describing the positive incidents in an attempt to reflect their professional practice in a favourable light (Rimon, 1979).

Although most researchers have used two criteria (e.g. Flanagan (1954) and Cormack (1983) used "effective" and "ineffective", Wilkinson (1987) used "stressful" and "satisfying") some researchers have used more than two criteria as guidelines for the type of critical incidents that should be

described. For example Wilde (1988), in a study of student psychiatric nurses, asked respondents to describe incidents where a) they had encountered a difficult situation at work and coped with it well; b) they had encountered a difficult situation that they would like to have coped with better and c) they had encountered a satisfactory or rewarding situation.

An issue requiring consideration is whether respondents should be told in advance (e.g. one or two days before data collection) that they will be required to recall incidents matching certain criteria. Rimon (1979) described the problems that some of her respondents had in recalling incidents spontaneously and was undecided whether this was due to a general lack of co-operation on the part of certain respondents, or whether it was in fact difficult for them to "recollect concrete incidents". Recently researchers have seemed to favour informing respondents in advance (Benner, 1984; Wilde, 1988).

However, there is one main disadvantage in giving respondents the opportunity for reflection prior to data collection, namely that respondents who are known to each other or who work together in close proximity will undoubtedly discuss incidents between them. It is quite possible that any discussion with colleagues may influence or bias some respondents towards describing particular types of incidents or may lead them to certain types of description. Thus, in a study for example where attitudes of nurses are under being investigated, a fair reflection of each individual nurse's attitudes

may not be demonstrated in the data yielded to the researcher. In addition, the focus on "extreme" behaviours (e.g. "effective" and "ineffective") should mean that spontaneous recall of incidents (rather than giving opportunity for reflection) would result in the respondents recalling those incidents which were uppermost in their minds and which were therefore the most influential/significant incidents.

4) **Analysis of critical incidents** typically involves inductive classification of the information and the construction of a hierarchy of categories. After the incidents are collected they are inductively sorted into clusters that seem to group together (Dunn & Hamilton, 1986). The categories that are developed will depend on the purpose of the study. Alternatively a theoretical framework may be applied to the incidents in order to facilitate classification. Incidents may be classified using a two or three-tiered system which starts with a fairly general description and progresses to a more specific one.

Flanagan's description of data analysis is closest to content analysis methods described by Holsti (1969) and Krippendorf (1980) as the induction of categories is recognised as a necessarily subjective process. Flanagan (1954) commented:

> "The induction of categories from the basic data in the form of incidents, is a task requiring insight, experience and judgement. Unfortunately, this procedure is, in the present stage of psychological knowledge, more subjective than objective".
>
> (Flanagan, 1954).

Involving respondents in the process of developing categories, or presenting them with preliminary findings for comment is viewed as one way of reducing the likelihood of misinterpretation (Caves, 1988), but this has rarely been attempted by researchers (the exception being Fivars & Gosnell, 1975). Alternatively, independent judges or 'experts' can be consulted to see whether the categories are meaningful (Flanagan, 1954). The problem of subjectivity can be dealt with by a test of Inter Rater Reliability (Cormack, 1983; Callery, 1988). The level of percentage agreement, whilst not a measure of validity itself, is an essential precondition of validity.

The classification of the qualitative categories developed from critical incidents can also be analyzed quantitatively if required. The number of respondents who mentioned a particular competency or type of incident could be recorded and percentages and frequencies calculated. If other variables such as demographic characteristics of the respondents or scores for attitude scales were recorded, it would be possible to analyze the competency ratings along with other variables (Callery, 1988).

There are problems with the analysis procedure described by Flanagan (1954) which suggests that each critical incident must be a clearly demarcated and detailed account. Norman et al (1991), in recent research on indicators of high and low quality nursing care in hospital, suggest that, in nursing, critical incidents are "often not clearly demarcated". They describe how, in many interviews with respondents, the incidents described

were in fact a summary of the respondents' overall experience of a particular aspect of nursing care. In spite of not meeting Flanagan's criteria, Norman et al (1991) argue that these 'overall experience' incidents are clearly valid because they are generally an amalgam of incidents of similar type, although not a single event. They are clearly important data as they may be descriptions of over-arching impressions of particular types of situations/incidents. Excluding these amalgamated incidents from the data set, as Flanagan suggests, may result in the loss of data which reflect common or regularly occurring incidents which respondents may find difficult to articulate as one specific incident.

In addition, Norman et al (1991) argue that if a respondent considers an incident to be important enough to describe, either verbally or in written form, then, as a researcher, one should consider this data automatically valid by virtue of that attached importance.

The other issue that must be considered when analyzing critical incidents is the notion that the critical incident itself is the basic unit of analysis. This is certainly the approach advocated by Flanagan (1954) and has been adopted by subsequent researchers. However, it should be remembered that Flanagan's technique was devised to investigate man-machine interactions. It is possible that in an activity such as nursing, which essentially consists of human-human interactions, the idea that the incident itself lies at the crux of the discovery of the nature of nursing care may be denying the

complexity of nursing work. Norman et al (1991) suggest that analysis of nursing activity should aim to highlight specific activities or 'critical happenings' within incidents and to attempt to understand the meanings behind those happenings. Therefore 'critical happenings' should be used as the basic unit of analysis. They go on to suggest that the term critical incident should be replaced by 'revelatory incident';

> "We suggest that an incident is revelatory if, and only if, it contains (or reveals) 'critical happening' that are 'critical' by virtue of being significant (important) with respect to the general aim of the activity under investigation".
>
> (Norman et al, 1991).

The suggestion that each incident should be broken down into 'happenings' for the purposes of analysis is not new in C.I.T. research, particularly in nursing. Benner (1984) for example looked for meaning and content in the incidents described to her. Wilde (1988) used an adapted form of latent content analysis to analyze the descriptions of the incidents she gathered in terms of the relationships the nurses formed with patients, and thereby identified common areas that student psychiatric nurses found particularly stressful or satisfying. Woolsey and Adler (in Woolsey, 1986) also rejected the incident as the basic unit of analysis. In a study of women's self-actualization they categorized descriptions of relationships, as the incidents themselves appeared to be unimportant to the women. Norman et al (1991) conclude that;

> "the technique may be misleading when applied to the social context of nursing....human beings will inevitably describe one

incident in the light of related incidents and the 'meaning' of observable events is of crucial importance" .

It would appear acceptable within social science research to treat Flanagan's (1954) suggestion that the incident itself should be the basic unit of analysis with some scepticism. Certainly analysis of the **content** of the descriptions, rather than focussing on the incident itself, has been favoured by most researchers involved in the study of the social context of behaviour (for example see Borgen and Amundson, 1984; Woolsey, 1986; Norman et al, 1991).

It is apparent that Flanagan's Critical Incident Technique has been a widely used research method both within the field of nursing research and in other social science disciplines. Following a review of the available literature it was considered, with careful consideration given to the mode of analysis, to be a suitable method to meet the first two aims of the research study. The following section describes the theoretical basis of intensive interviews, the method selected to meet the third aim of the study (phase II).

4.4.2. Phase II: Intensive interviewing as a technique for collecting data

The research interview can be seen as a purposeful exchange of information between people in a face-to-face setting (Carr, 1984). However, the type of interview undertaken will depend heavily upon the purpose of the research (Chalmers, 1989). This sub-section begins with a brief overview of the types of research interview commonly undertaken and continues with a more

detailed discussion of intensive interviews (Lofland, 1971). It ends with a critical appraisal of the available methods for recording interviews.

It is apparent from a review of the literature that many different terms are applied to the variety of interview techniques employed in research. These include focused, informal, structured, unstructured, semi-structured, in-depth, conversational and intensive interviews. It would appear that some of these terms are over-lapping or interchangeable in their essential nature.

In essence, a major difference in approach to interviewing can be seen between that used in quantitative research and that used in qualitative research. Structured, semi-structured and intensive (conversational/ unstructured) interviews appear to lie along a continuum which is defined by the degree to which questions are predetermined by the researcher.

Quantitative researchers tend to use a structured approach to interviewing which fits with the underlying philosophy of confirming or rejecting hypotheses derived from previously described theories (Lofland, 1971). Intensive or unstructured interviews, on the other hand, are commonly used in qualitative research to explore new territory with respondents (or participants). The essential purposes of structured and intensive interviews are grounded in different philosophical and methodological assumptions. Both are considered reliable methods of gathering information, providing the interviewer has the experience and knowledge with which to undertake

them. Their suitability is essentially determined by the aims and focus of individual research projects.

Qualitative methods have an underlying philosophy of creating or generating theory in areas that are previously un-researched, therefore a conversational style of interviewing is commonly adopted (Schatzmann & Strauss, 1973). Although the style of interviewing may be conversational in nature, however, this does not mean that the interviews lack purpose. In general, interviews become more formalised as the research progresses, in order that tentative hypotheses that have been developed as a consequence of the earlier, less formal interviews may be tested out.

The term 'unstructured' interview has been criticised as it implies that the researcher has made no suppositions regarding the broad areas that might be covered by the research (Jones, 1985). Lofland (1971) suggests the term 'intensive interview' more readily describes an interview which aims to

> "elicit from the interviewee what he considers to be important questions relative to a given topic...its object is to find out what kinds of things are happening, rather than to determine the frequency of predetermined kinds of things that the researcher already believes can happen"
>
> (Lofland, 1971).

In intensive interviews it is acceptable to have a mental or written check-list of general areas which the researcher wishes to explore. However, this is not intended to impose a set of rigid questions on the respondents. Rather it serves as a memory-jog, ensuring that the areas the researcher wishes to

explore are discussed. Researchers using intensive interviews as a method of collecting data therefore require the ability to make decisions and judgements regarding which lines of inquiry to pursue in depth, and to be able to control the interview to pursue those lines without directly controlling the interviewee.

Conducting any type of interview is a task requiring planning and consideration. The intended length of the interview will influence how the interview is managed (Chalmers, 1989). The literature suggests that interviews should not last for more than one hour (Field and Morse, 1985). In the case of intensive interviews, however, it is suggested that, as the interview itself is a participatory process between the interviewer and interviewee, the length of the interview should be determined by the interaction that takes place during the interview (Benjamin, 1981). It could be considered un-ethical to terminate an interview at the end of one hour if the interviewee is eager to continue talking. As the intensive interview is essentially a "guided" or purposeful conversation between two people (Burgess, 1984), there is a certain donation that the researcher should give to any respondents that request it, as the time and energy investment that some respondents make to the research project is high (Flatley, 1992).

It has been suggested that, in qualitative research,

> "early interviews may look much more like 'guided conversations' ...interviews often become more focussed as the interviewer uses more topic guidance to explore areas of

> special interest, begins to test preliminary findings, or begins to look for areas of commonality and difference in respondents' stories (Antle May, 1989).

This demonstrates the progressive nature of qualitative research interviews; that initially the interviews are intensive (unstructured) in nature and become more focussed as the research progresses. This is largely due to the process of "concurrent analysis", where analysis and development of categories derived from the initial interviews inform and guide the later interviews.

4.4.2.1. A note on theoretical sampling

Theoretical sampling is frequently used in qualitative research. Antle May (1989) states that:

> "Selection of the informant must also be determined initially by the research question and availability of informants and then modified as needed, based on experience gained in the field about who or what is the "natural unit" of analysis".
> (Antle May, 1989).

This way of sampling for data collection has been pioneered by proponents of the grounded theory method (Glaser and Strauss, 1967; Chenitz and Swanson, 1986) where events are sampled on the basis of concepts that are relevant to evolving theory (de la Cuesta, 1992). The term theoretical or purposeful sampling refers to a system whereby the researcher selects "key" respondents (or informants) as the research progresses i.e. respondents who are thought to be most able to clarify aspects of the research question. Morse (1989) states that

> "rather than selecting a sample using criteria based on typical or representative population characteristics, such as age...(in theoretical sampling) the sample is selected according to the informants' knowledge of the research topic".
>
> (Morse, 1989).

It is therefore important that the researcher has a means of identifying who has the information/knowledge before the informant is invited for interview.

4.4.2.2. The relationship between interviewer and respondent

Trust and respect are two vital components of the relationship between the interviewer and the respondent during an intensive interview (Benjamin, 1981). Building trust can be facilitated by the researcher making clear that the interview is confidential and that any information that the interviewee volunteers will be treated respectfully. It also involves the researcher/interviewer listening attentively and with interest to what the interviewee has to say (Lofland, 1971). In particular, the researcher has to ensure that he/she does not excessively control the interview as that may lead to preconceived ideas being imposed on the respondents (Antle May, 1989).

In intensive interviews the role of the researcher may not always be as a purely "objective and detached" interviewer, as would be espoused by the quantitative/scientific approach to research. Rather, in for example feminist research, the interviewer may be required to make an emotional investment in the relationship which is equal to that of the women studied (Oakley, 1981; Flatley, 1992). As intensive interviews are essentially communicative

rather than elicitive in nature, the skills of interpersonal communication and a dedication on the part of the researcher to the idea of reciprocity within the relationship are key factors (Briggs, 1986; Morse, 1989).

4.4.2.3. Recording interviews

Recording research interviews can be performed in one of two ways, namely note-taking or tape-recording. There appear to be advantages and disadvantages to both techniques.

Note-taking is a highly specialised and skilled form of recording an interview because it generally requires the researcher to summarise the respondent's comments as the interview is taking place. In intensive interviews, this selective form of recording data may add to the criticism regarding the essentially subjective nature of qualitative methods. It is important that the interviewer decides which aspects of the interview he/she wishes to record. For example, note-taking does allow the researcher to record aspects of the interview other than the actual conversation, such as physical gestures and facial expressions (Benjamin, 1981). However, it has been suggested that note-taking may have an inhibitory influence on the relationship between the researcher and the respondent (Kratz, 1975).

Audio or video tape-recording has the advantage of providing a complete record of what was said in the interview and, in the case of video-taping, gives a visual record of the interview. In this sense, the record of the

interview is highly accurate. However, the time (and often expense) involved in transcribing the interviews can be seen as a distinct disadvantage. Nevertheless, for the inexperienced researcher, the tape-recording provides an opportunity not only to consult a third-party (such as a research supervisor) on the content of the interviews, but also on the interview technique employed, so that each interview becomes a learning experience (Benjamin, 1981). An evaluation of each interview therefore provides the opportunity to improve the interviewer's technique for the next.

Another aspect of tape-recording interviews is the effect that it has on the interviewee. Bozet (1980) suggests that the ease with which the researcher handles audio equipment can affect the level of intrusiveness and acceptability to respondents. It is important to ensure that the interviewee is aware that the interview is being recorded and that the opportunity for refusal is allowed. In addition issues of confidentiality, (in particular how the interviews will be transcribed and how material which may easily expose the identity of the interviewee will be handled), should be fully discussed before the interview takes place. Although some interviewees may initially be perturbed at the thought of their conversation/responses being recorded it is generally felt that, after the first few minutes, the interviewee does not react to the tape-recording machine (Benjamin, 1981). In addition, suggesting that the interviewee may listen to the tape after the interview if he or she so wishes may relieve some of the concerns that respondents express about "going on record".

4.4.2.4. Coding and analysing intensive interviews

The method of coding and analysing intensive interviews depends to a large extent on the overall method employed in the research study. In grounded theory studies for example, which often use intensive interviews as a mode of data collection, there are specific guidelines for coding interviews and for form ng links between codes and conceptual categories developed during the course of the analytic procedure (Strauss, 1987). Where qualitative content analys s is the method of analysis employed (such as in this study), categories for sorting pieces of interview data are not established prior to the analysis. Instead they partially emerge from the data, the context is taken 'nto account, and

> "data are often coded perceptually, so that one item may be relevant for several purposes",
>
> (Altheide, 1987).

'Coding' refers to the discovery and naming of categories. A piece of interview text is usually read several times and the researcher allocates a code which briefly describes the meaning and content of the piece of text. The category depicts the essential relationships between data and theory (Glaser and Strauss, 1967). In grounded theory, electing and naming the category is the first step in the coding process, the second is establishing relationships between categories (Swanson, 1986).

Qualitative content analysis of interview data shares a similar epistemological and procedural basis with the grounded theory method in

that it attempts to establish linkages between/among the elements of the data that the researcher has identified and classified. The purpose is to develop propositional statements or to make assertions regarding the structure or the linkages, or to relate concepts in order to discover the underlying principles (Fielding and Lee, 1991). As analysis of the data proceeds, codes and categories can be refined and developed and in this way the analysis is dynamic. In other words the codes and categories identified during the initial stages of analysis may require refinement in the light of material analysed during the later stages of the content analysis. A description of key words and code words and their use in qualitative content analysis of critical incident and intensive interview data is given on pages 142 & 157.

4.4.3. Summary

It was considered by the researcher, following the review of the theoretical basis of the methods selected for the main study, that the methods would be suitable to meet the aims of the study. However, as the first phase of the study concerned collection of data by questionnaire, it was necessary to design a questionnaire and then to conduct a pilot study to ensure the suitability of the design to meet the first two aims of the study. A description of the pilot work is given in the following section.

4.5. QUESTIONNAIRE DESIGN AND PILOT WORK

The exploratory work (described in section 4.3.) informed the design of the questionnaire and the selection of methods for the main study. However, it was necessary to conduct a pilot study to investigate the suitability of the questionnaire design. The questionnaire was designed following the guidelines in Oppenheim (1966). The main aims of the questionnaire were;

1. To collect information about the respondents' demographic background (i.e. age, cultural background) and their professional background (i.e. previous professional experience and training, length of time in current profession, reasons for entering the profession).

2. To collect information about respondents' current work contact with people over 65 years of age (i.e. number of home visits to older people/clinic sessions with older people).

3. To gain insight into respondents' constructions of effective and ineffective practice with the older people by asking them to describe two critical incidents; one in which they felt they were particularly effective and one in which they felt they were particularly ineffective (after Flanagan's CIT, 1954).

Three questionnaires were developed which would allow these aims to be met (see Appendices 4, 5 and 6 for final/revised versions.)

4.5.1. Design of the questionnaire

The questionnaire was designed to take approximately one hour to complete. The first part included a mixture of forced choice and free-response questions which related to the areas of respondents' demographic and work backgrounds in which the researcher was interested. At the end of the questionnaire, the request for description of two "critical incidents" (one description of "effective" practice and one of "ineffective" practice) was made.

The aim of the critical incident section was to establish the constructions of effective and ineffective nursing and health visiting practice with older people. Guidelines were developed (see Appendices 4, 5 and 6) which would assist the respondents in their descriptions of incidents and would ensure that the descriptions were relevant to the aim.

4.5.2. Piloting the questionnaire

The sample for the pilot study was taken from health visitors and practice nurses practising in the same district health authority in the North-West. A sample of 6 health visitors and 6 practice nurses was considered sufficient to assess the suitability of the questionnaire. Access to the group of health visitors was initially negotiated by telephone through the Director of Community Nursing Services. Access was readily agreed and a contact number was given for the Health Visiting Manager who agreed to arrange

for 6 volunteer health visitors to complete the questionnaire. A sample of the questionnaire was sent to this manager for her reference.

Access to the practice nurses was negotiated via a practice nurse known to the researcher. The practice nurse sent to the researcher the names and addresses of five other practice nurses working locally who had volunteered to complete the questionnaire. Questionnaires were sent to the 6 practice nurses by post along with a stamped addressed envelope and a covering letter briefly explaining the research and requesting participation.

Five out of the six practice nurses returned the questionnaires sent to them (85% response rate). The five respondents completed the whole questionnaire, though one stated that she could "think of no case where (her) visit was totally worthless" and therefore was unable to cite an incident where she was ineffective.

With regard to the sample of health visitors, although access was agreed and in spite of countless telephone calls and two letters, the Health Visitor Manager was unable to negotiate 6 volunteer health visitors to participate in the pilot study, therefore access had to be agreed in another health authority. Questionnaires were sent to the health visitors concerned. 4 out of the 6 questionnaires sent were returned (66% response rate).

Following their return, the questionnaires were examined in some detail and a thematic content analysis (Altheide, 1987) was conducted on the critical incidents described by respondents. Several recommendations for editing the questionnaires were made following in-depth consultation with the researcher's supervisor. It is not possible or appropriate to go into detail of all the editing recommendations that followed the pilot work. However, most of the recommendations centred around altering questions to suit the particular contextual characteristics of practice nursing and health visiting work. For example, the original questionnaire contained questions about "caseloads" held by respondents (see question 10). The pilot work revealed that practice nurses did not carry "caseloads" as such, rather they worked with patients registered with the GP practice. It was apparent, therefore, that the questionnaires would have to be specifically tailored for the three groups. Whilst many of the "basic" or core questions were identical, three separate questionnaires were developed which were group-specific (i.e. one questionnaire for the student health visitors, one for the experienced health visitors/field work teachers and one for the practice nurses).

The revised versions of two of the three group-specific questionnaires (minus the critical incident section) were piloted with four health visitors and four practice nurses. These respondents were not part of the first pilot sample and all were known to the researcher. Analysis of the completed questionnaires revealed that both groups were able to answer the questions comprehensively and that the questionnaire appeared to be appropriate to

meet the aims of the study. It was not possible to pilot the student health visitor questionnaire as none were available at the time of the pilot study. The revised versions of the questionnaire are contained in Appendices 4, 5 and 6.

With regard to the collection of critical incidents, the completion rate of 66% (in the case of the health visitor group) and 85% (in the case of the practice nurse group) was judged to be satisfactory. It was recognised that there was a great variation in the quality of the description of interactions with elderly people. For example, critical incidents in one questionnaire consisted of five sentences about the person, whereas in another the description was two pages long. However, two of the respondents involved in the pilot study who wrote short descriptions of critical incidents commented that they did not have enough time at work to fill in the critical incident section. A decision was therefore made that, for the purposes of the main study, the questionnaire could be completed individually in a group setting with an allocated amount of time for completion. This would ensure that respondents had adequate time to finish the critical incident section of the questionnaire.

4.6. THE MAIN STUDY

This section is divided into three parts which describe the study design and subsequently the two phases of data collection and analysis. A description of the administration and analysis of questionnaires which incorporated the

Critical Incident Technique is given (phase I). The follow-up phase (phase II) of interviews, which was designed to allow exploration of the structural contexts of practice nursing and health visiting work, is also described.

4.6.1. Main study design

The study was designed to gather data which would answer the study aims. Three population groups were selected for the purposes of data collection:

Group 1 : Student health visitors at the beginning of the health visitor training course at Institutes of Higher Education.

Group 2 : Practice nurses attending ENB practice nurse courses at Institutes of Higher Education.

Group 3 : Health visitor field work teachers responsible for supervising student health visitors and experienced health visitors (defined as those with two or more years experience.

The study was designed in two phases of data collection and analysis which related to the aims of the study. The first phase related to Aims 1 and 2. Questionnaires, which included a combination of forced-choice and open-ended questions, were used to gather data on demographic characteristics of a convenience sample of student health visitors, experienced health visitors and practice nurses. The questionnaires incorporated a section asking for the description of two incidents where respondents had been involved in work with older people (defined as aged 65 or over) in the

community or in hospital settings, one where they felt they had been "effective" as a nurse (or health visitor) and one where they felt they had been "ineffective".

The second phase of the study involved follow-up intensive interviews (Lofland, 1971) with a theoretical sub-sample of the original respondents (Strauss and Corbin, 1990) and aimed to provide insight into the structural context of respondents' work with the older population (Aim 3).

4.6.2. The main study: Phase I (questionnaires)

4.6.2.1. Questionnaires: Population and sample

The population for this study was health visitor students and practice nurses attending courses at institutes of higher education in the North West of England and health visitor field work teachers allocated to student health visitors. It was originally hoped to include experienced health visitors attending the Community Practice Teacher/Field Work Teacher[8] course at each institution, however due to financial constraints within higher education and a lack of funded students, no such courses were running during the period 1990-1991.

[8] Please note that the term health visitor "field work teacher" was replaced by the term "community practice teacher" in 1991. The term adopted for the purposes of this study is "field work teacher" as this is how respondents identified themselves.

The original aim of the study was to attempt to recruit 50 respondents in each of the three groups. This figure of 150 total respondents was arrived at following consultation with a statistician (who gave guidance on the analysis of demographic and professional variables) and consideration of the time required to analyze the potential total of 300 critical incidents (2 incidents from each respondent; one description of "effective" practice and one description of "ineffective" practice).

As with many studies of this type, the nature of the detailed and time-consuming questionnaire necessitated that the sample be one of convenience. Plans were built into the research proposal to investigate whether people who chose not to participate in the study differed significantly from participants by checking student records.

4.6.2.1.1. Access to respondents

Access to the study sample was negotiated directly with the course leader of the health visiting or practice nursing courses in four institutes of higher education in the North West of England, either by telephone or by letter (see Appendix 7). In the case of the field work teachers allocated to health visitor students, the poor response rate (see page 140) necessitated a subsequent attempt to recruit additional respondents directly from the field. Access to these respondents was negotiated directly with each individual using a list of practising health visitors supplied by tutors at one institute of higher education.

In the case of the student health visitor and practice nurse groups, the researcher approached the course tutors and requested a session within the time-table of the course for the purposes of completing the questionnaire. The tutors were asked by the researcher to ensure that they had the permission of the students for the researcher to attend the session beforehand. Tutors were asked to briefly explain that the researcher was interested in their experiences of the course and of work in the field and that their cooperation with the study would be discussed before they were asked to participate. The researcher then attended the allocated sessions which were one hour long.

4.6.2.1.2. Response rates

At the beginning of the sessions allocated for completion of the questionnaires by practice nurses and student health visitors the researcher explained that the aim of the study was to investigate nursing work and training for work with older people. Issues of confidentiality and anonymity were raised and the potential respondents were assured that they were not obliged to complete the questionnaire. In the event a 100% response rate was achieved in the practice nurse and student health visitor groups which resulted in a study sample of 62 student health visitors and 49 practice nurses. In the case of the experienced health visitor/field work teacher respondents, however, more problems were experienced. The experienced health visitor sample was 25 (response rate 29%) and the reasons for the

low response rate are outlined on page 140. The total study sample for the first phase of data collection was 136 respondents.

4.6.2.2. Questionnaires: Data collection

The student health visitor (n = 62) and practice nurse (n = 49) respondents were all attending courses in establishments of higher education. The questionnaires were therefore completed in a classroom setting at those establishments with respondents sitting at desks which they had chosen themselves. If they so wished, respondents were able to discuss questions and issues as they proceeded to complete the questionnaire. The researcher was also present during the sessions and several respondents requested further explanation about particular questions.

In particular, a few respondents raised questions about whether they could write about their general impressions of work with older people as they could not think of one concrete example of "effective" or "ineffective" practice. As the researcher had decided to include amalgamated incidents in the data set (see discussion of this issue on page 119), the respondents were informed that it would be appropriate to include these over-arching impressions in their descriptions.

4.6.2.2.1. The experienced health visitor group

It proved very difficult to get all the potential experienced health visitor respondents to agree to a time and a place to complete the questionnaires

as a group. When the researcher met the field work teachers at the four institutions of higher education where they were attending a meeting about their prospective students, they were encouraged to complete the questionnaire there and then. Sixty two field work teachers were asked to participate in the study and 48 (77.4%) agreed to complete a questionnaire. However, even though they agreed to participate in the study, without exception the field work teachers wished to take the questionnaire with them to complete. They gave their reason for this as having to return to work as quickly as possible following the meeting. The researcher gave each health visitor a stamped-addressed envelope to return the questionnaire and they were asked to provide the researcher with a list of their names and contact addresses. In spite of two follow-up letters, only 18 of the 48 returned the questionnaire and 4 of the returns were not completed at all. This resulted in a completed response rate of 29%.

As the study aimed to recruit 50 respondents from each group, attempts were made to contact other experienced health visitors working in the field. A list of practising health visitors was provided by the health visitor tutors at one institution. Questionnaires were sent to 22 health visitors with a covering letter and a stamped-addressed envelope for its return. 7 of the 22 questionnaires sent out were returned completed (31.9% response rate). The constraints of time required that the researcher be satisfied with a total sample of 25 for this group.

4.6.2.3. Questionnaires: coding and analysis

Following completion of the questionnaires, the responses to forced-choice questions (which were pre-coded) were entered onto a Lotus Symphony spreadsheet. An example of the type of spreadsheet used is shown in Appendix 8. Any missing answers were coded 99 so that they could be easily excluded from data analysis. Once the spreadsheet was complete, it was entered into an SPSS-pc+ V 2.0 data entry facility for subsequent statistical analysis.

The open-ended questions in the questionnaire were coded and analysed using a classical content analysis (Holsti, 1969), which required the researcher counting the number of times a specific response to the question was mentioned by respondents. This numerical data was then included in the spreadsheet.

A statistician was consulted regarding coding and statistical analysis of the data. Both parametric and non-parametric statistics were used for the purposes of analysis. The statistics used in this study are outlined in Appendix 9.

4.6.2.3.1. Coding and analysis of critical incidents

The critical incidents described by respondents were typed onto a computer using a word processing facility. Each respondent was allocated a separate file for storing the incidents they described and each file was allocated the

respondent number for reference purposes. Each file was then converted to an ASCII file and entered into a software computer package called the Ethnograph (Seidel & Clark, 1984). Briefly, the Ethnograph is a programme which facilitates text coding and retrieval and was developed for use in grounded theory studies (for full details of the Ethnograph, its aims and facilities, see Seidel & Clark (1984)). This enabled a print-out of each file to be produced, each line of which was allocated a line number (see Appendix 10).

Each critical incident was coded in two ways. Firstly, as Flanagan (1954) suggested (see page 117), the incident was used as the basic unit of analysis. A **key** word was allocated to each incident which encapsulated the **main** focus of the incident i.e. this was a word which summarised the critical incident as a whole. An example of a critical incident described as "ineffective" practice by one respondent is given here for demonstration purposes;

> **Respondent 114:**
>
> "The patient was over 75, male, working class background and British. I was asked by the GP to do an elderly assessment on this patient. Following my visit the patient needed chiropody, bath aids or help getting into the bath. I made the necessary referrals knowing that the waiting list for chiropody was 6 months and OT assessments were very overworked. I felt I had built false hopes for the patient."

Here the key word **referral** was allocated, as this was the main overall aim of the activity the nurse was involved in during the incident following her assessment. This enabled the researcher to count the number of incidents with the same overall aim of activity and to provide a numerical record of them. As the respondent had described the incident as an example of "ineffective" practice, the word **ineffective** was attached to this section of the file so that effective and ineffective incidents would be easily identified and retrieved.

Secondly, the incidents were analyzed using a qualitative thematic (or ethnographic) content analysis (Krippendorf, 1980). Ethnographic content analysis is described as the "reflexive analysis of documents" used to "understand the communication of meaning" (Altheide, 1987). Each incident was read through several times by the researcher and the main **themes** contained within the incident were noted.

Code words were attached to **segments** of the text. The differences between key words and code words are that key-words are one-word summaries of the content of a text segment while codes are abbreviations of categories. For example, in the incident shown above the section which begins "I made the necessary referrals... I felt I had built false hopes for the patient" (114) was given two code words; 'long wait' (which was used to abbreviate the respondent's comment about long waiting lists following referral) and 'false hope' (which denoted segments of text where the

respondent had described building up the patient's hopes/expectations of services). Each code therefore represents an item or category for organizing the data. In a further example given in Appendix 10, the code words allocated to specific sections of the incident are shown.

The Ethnograph facilitates retrieval of each piece of text which has been allocated a particular code or key word, in order that associations between codes can then be developed (see Appendix 10 for an example). The purpose of this is to enable the researcher to make assertions or propositional statements regarding the links between pieces of text given the same code word.

4.6.2.3.2. Validity of the key and code words

A fellow researcher (not involved in the study) was asked to review a 10% sample of the critical incidents and to analyse the data using key and code words. The external validator was not required to code the text using key words which were **identical** to those the researcher had used, rather to interpret the **meaning** of the data in the same way. The coding frames developed by each researcher and the validator were then compared and discussed until a 95% level of agreement was reached. Whilst not a measure of validity in itself (see page 118), this reduced the level of subjectivity involved when one researcher takes sole responsibility for interpreting and coding the data.

4.6.3. The main study: Phase II (follow-up interviews)

Follow-up intensive interviews were conducted to allow the researcher the opportunity to gain insight into the contextual and structural issues which shaped health visitor training and experienced health visitors' and practice nurses' work with older people which related to Aim 3 of the study (see section 4.2.). The interviews with practice nurses and experienced health visitors were conducted approximately six months after completion of the questionnaires, which allowed sufficient time for the questionnaire data to be coded and analysed. In the case of the student health visitors, the questionnaires were completed at the beginning of the health visitor training course and the interviews were conducted towards the end of the supervised practice section of training. This enabled the researcher to gain insight into the respondents' experiences of health visitor training (both field work and supervised practice) and ensured that the respondents had completed their examinations and assessed course work before the interviews took place. This section describes the way that potential interview respondents were sampled, how interviews were conducted and recorded and the coding and analysis of interview data.

4.6.3.1. Interviews: Population and theoretical sampling

The population for phase II (interviews) of the study was the respondents who had participated in phase I (questionnaires) of the study. The sample was therefore drawn from a total of 62 student health visitors, 49 practice nurses and 25 experienced health visitors/field work teachers (total

population of 136 respondents). It was originally hoped to interview approximately 8 respondents from each of the three groups (which would yield a total number of 24 interview respondents). This figure was selected for purely pragmatic reasons, given the time involved in transcribing and analyzing each interview. However, the figures were flexible in that the researcher decided that, following analysis of the data from the first 8 interviews, selection of potential respondents for interviewing would continue until no new concepts/categories were revealed.

Theoretical sampling is a means of deciding what data to collect next and where to find it. In this study, the first three respondents in each group selected for interview were chosen on the basis of information provided in the questionnaire, which then enabled "key" respondents (i.e. those who were thought to be able to make a significant contribution to the study in terms of interesting or particular aspects of their work) to be identified. The sampling of the three groups of respondents will be considered separately.

4.6.3.1.1. Sampling and response rate: practice nurses

Of the 49 original practice nurse respondents, 29 (59%) were involved in assessing people aged 75 and over at home on a regular basis. As the study aims focused on this particular aspect of work, these 29 practice nurse respondents were considered for follow-up interview.

The first three practice nurse respondents were selected for interview because they were health visitor or district nurse qualified and had worked as community nurses immediately before entering practice nursing. It was considered that these respondents may be able to shed light on the differences and similarities between the roles of practice nurses and other community nurses. Following analysis of the data from these initial interviews, two more respondents were selected because they had substantial previous experience of work with older people in institutions but did not hold a community nursing qualification. It was thought that they may be able to shed light on the influence of previous experience of work with older people in institutions in terms of visiting people at home. Three more respondents were then selected for interview who had no previous nursing experience of work with older people before entering practice nursing.

In total 8 (16% of the original questionnaire sample of 49) practice nurse respondents were selected on the basis of their potential contribution to the study. All 8 respondents were contacted by the researcher by telephone and were asked whether they would be prepared to participate in an interview. The researcher gave the purpose of the interview as intending to find out more about the structure of their work with older people. Of the 8 practice nurse respondents contacted, all agreed to be interviewed (100% response rate).

4.6.3.1.2. Sampling and response rates: Student health visitors

The first three student health visitor respondents were selected for interview because in the questionnaire they had stated that they had particularly disliked their previous experience of working with older people. These respondents were of potential interest as the researcher wished to uncover how these experiences were constructed and what possible influence they might have on constructions of work in general with older people. It was apparent during these interviews that the experience that respondents had gained of work with older people in the community during health visitor training were limited. Therefore a further two student health visitor respondents were selected because they had substantial previous experience of working with older people in the community before entering health visitor training. The remaining three respondents were selected because they had no previous experience of working with older people in the institution or in the community.

Of the original questionnaire sample of 62, 8 (12.9%) were selected for follow-up interview, again on the basis of their potential interest to the study. All 8 respondents were contacted by the researcher by telephone and were asked whether they would be prepared to participate in an interview. The researcher gave the purpose of the interview as intending to find out more about health visitor training for work with older people. Of the 8 student health visitor respondents contacted, all agreed to be interviewed (100% response rate).

4.6.3.1.3. Sampling and response rates: Experienced health visitors

Due to the problems experienced in collecting questionnaires from experienced health visitors (see page 140), the researcher decided to randomly sample the potential interview respondents from this group. Of the 25 questionnaire respondents 8 (32%) were randomly selected by another researcher from a shuffled pile of the respondent numbers. The potential respondents were contacted by telephone and asked whether they would be prepared to participate in an interview about their role in training student health visitor for work with older people. Of the 8 experienced health visitors contacted, two declined to participate, one because she felt she did not have time and the other because she was about to go on maternity leave. This resulted in six (24% of the original questionnaire sample of 25) interviews being conducted with experienced health visitors. Due to the time constraints involved in the study, it was not possible to re-sample this group.

4.6.3.2. Interviews: Data collection

4.6.3.2.1. The structure of the interviews

The style and structure of the interviews altered as each successive interview took place, in keeping with the theoretical basis of intensive/qualitative interviewing (Antle May, 1989). The first three interviews conducted with each group of respondents were intensive/ conversational in style. These initial interviews were "guided" by the

researcher to focus on general structural issues which influenced respondents' work with older people in the community (see Appendix 11). In addition, an attempt was made to "check-out" the categories derived from analysis of the critical incident data with the respondents. It was apparent that the categories derived were accurate in the view of these respondents but that there were structural issues which had not been clearly identified in the critical incident data but which had, nevertheless, a high degree of influence on the way that respondents' constructed their work with older people.

The initial interviews were conducted in a conversational/intensive style, where the researcher allowed the interviewees to discuss issues of importance to them as well as those which fitted into the researcher's agenda. The advantage of this type of interview is that the researcher does not impose his/her own constructions of important issues onto the interviewee. This is in keeping with the construction of intensive interviews as a reciprocal interaction between two people.

In the case of the first three interviews with practice nurses, for example, the researcher guided the conversations to general issues involved in the assessment of older people. This issue had been flagged up by respondents during the exploratory work and was also a category developed following analysis of the critical incidents described by practice nurse respondents in their questionnaires. In addition, the holding of a community nurse

qualification on the way that these respondents viewed their work was explored. The respondents themselves highlighted the importance of the GP-practice nurse relationship as the key structural issue in the control and organisation of their work and this was discussed in some depth. In this way the interviews were reciprocal in that they enabled the agendas of both the respondents and the researcher to be pursued.

With regard to the student health visitor group, the first three interviews were focused generally around their experiences of health visitor training for work with older people. In the case of interviews with experienced health visitors/field work teachers, the general area of conversation was oriented around their views on the structural context of health visitor training and caseload management once qualified.

As the interviews were analyzed concurrently (see Strauss and Corbin, 1990), categories or ideas that had been made apparent in the initial interviews were "checked out" with subsequent interview respondents. This was done by the researcher asking questions starting "some people have said that..." or "other people I've spoken to have suggested...what are your feelings about that?" Subsequent interviews therefore became more focused and structured. In this way the categories developed from the initial interviews could be explored further to see whether certain experiences were universal or were peculiar to particular respondents. It was also a way to confirm, or alternatively put into question, the validity of the categories.

For example, the practice nurse respondents in the initial interviews had appeared eager to discuss the GP-practice nurse relationship in some depth. In the subsequent interviews, the researcher included this issue on the agenda for the interview, asking respondents for more specific details on the operation and characteristics of the relationship that they had with their GPs. In spite of the slightly more focused or structured approach to the later interviews with each respondent group, the researcher ensured that respondents remained free to identify their own issues of importance during the interview. In this way, the interviews remained intensive in style and approach.

4.6.3.2.2. Interviews: Settings

Interviews were conducted in a place that was convenient for each individual respondent. With the exception of one practice nurse respondent who chose to be interviewed in her own home, all the interviews were conducted in health centres or clinics where respondents were working.

There were several disadvantages to conducting interviews in the work place. Firstly, some practice nurse respondents were aware that their employing general practitioners were often present in the clinic during the interview. This meant that some issues raised during the course of the interview were discussed in hushed voices. The respondents appeared anxious that the general practitioners should not be able to hear some of their responses.

Secondly, the conducting of interviews during work time and in the work place meant that the interviews were prone to interruptions by the telephone, by clients calling unexpectedly to see the nurse or by queries from other colleagues working in the health centre or clinic. In one case, the room the respondent selected for the interview was a through-route from one part of the clinic to another. This resulted in several interruptions during the interview by people wishing to pass through the room.

4.6.3.2.3. Interviews: Length and Recording

In keeping with the intensive approach to interviewing, the researcher's own agenda was to avoid imposing a time-limit on the interview. When respondents were initially contacted by telephone to ask whether they would agree to be interviewed, the researcher made it clear that the interviews would last approximately 45 minutes to one hour. However, on occasions where the respondent expressed a desire to continue the interview past this time, the researcher respected that wish.

Audio taping was considered to be the most effective and practical method of obtaining an accurate record of each interview. At the start of each interview a new C90 audio-tape was used and, if necessary the tape was turned over after 45 minutes to allow recording to continue on the other side. In 23 of the 24 interviews this tape-length was adequate with the majority (n = 20) of interviews lasting between 40 and 60 minutes. However, one interview continued past the audio-recording. In this case, a

practice nurse respondent expressed an eagerness to "off-load" some of the stress she was experiencing during the course of her work onto the researcher. Due to the obligations of research inquiry, the researcher felt bound to allow the respondent to use the interview as a therapeutic medium, thus acknowledging the time and energy investment that the respondent herself was making to the research project.

The researcher was careful to gain permission from each respondent to tape-record the interview. Although several respondents expressed a level of anxiety stemming from the presence of the recording equipment, after five or ten minutes of the interview had passed, they appeared to relax and become more comfortable with it.

During two interviews, respondents asked the researcher to switch the recorder off during the interview because they wished to say something they did not want to be quoted on verbatim. The researcher respected this request, whilst emphasising that notes would be made on the issues that had been discussed but not recorded. In both cases the issues were about accountability to "more powerful" members of the professional hierarchy, either health visitor managers or general practitioners and were essentially critical comments on the influence of these people on work practices.

4.6.3.3. Interviews: Preparing the transcripts

Following completion of each tape-recorded interview, the audio tapes were carefully listened to by the researcher either once or twice depending on the length and detail of the interview. This allowed the researcher to revise interviewing techniques for subsequent interviews and for brief notes to be made about the other aspects of the interview such as setting and the body language that were used by both the interviewee and the researcher.

The tapes were then transcribed directly onto computer with the aid of a transcription machine. Of the 22 interviews conducted, 16 were transcribed by the researcher. Due to time constraints, the remaining 6 were transcribed by a secretary.

The guidelines for transcription were that pauses in the conversation would be indicated by a series of dots. Three dots (...) indicated a gap in the conversation. With the exception of three interviews which were conducted in rooms with poor sound quality, the interviews were generally audible and straightforward to transcribe. One of the three interviews of poor sound quality was so inaudible that notes had to be made by the researcher on the general content of the interview. The other two were transcribed but large sections of the interview had to be omitted from the transcription due to the poor sound quality.

When each interview had been transcribed and checked by the researcher for accuracy it was stored in a word-processing file. Each interview was then converted through an ASCII file into the Ethnograph computer package. An example of the print-out and coding of interviews is given in Appendix 12.

4.6.3.4. Interviews: Coding and analysing the transcripts

The printed copies of interview transcripts produced with the aid of the Ethnograph package were read through twice by the researcher before coding commenced. For the first three interviews with each group, line-by-line coding was performed using a thematic or ethnographic content analysis the same as that described in the section on analysis of the critical incidents (see page 144). When common and important themes had been established, the coding became more discriminatory i.e. the analysis actively sought out those common themes and the line-by-line coding was not deemed necessary.

After all the interviews had been analyzed, the researcher returned to the preliminary interviews to check the coding and to ensure that key themes had been coded in the same way. This was done with the assistance of another researcher. Each code-word was recorded, and fed back into the Ethnograph package.

As described on page 145 and Appendices 10 & 12, the Ethnograph computer programme allows for sections of transcripts to be retrieved by asking the computer to recall all sections containing the same category code-word. When more than one code-word has been given to a particular passage, the programme recognises this and gives the researcher the other code-words applied to that passage. In this way, links between categories can be established.

4.6.4. Main study: Writing up the findings

As the coding and analysis of the interviews took place, it was important for the researcher to keep a record of the categories and to develop a way of integrating the data in a meaningful way. This was achieved by the writing of theoretical memos similar to those undertaken in a grounded theory study (See Strauss & Corbin, 1990). Initially the memos were essentially conceptual, containing one idea at a time. As analysis of the interviews progressed, attempts were made to develop memos which linked the critical incident and interview data. This facilitated refinement of the categories and allowed for discussion about possible links in the data with the researcher's supervisor.

The creative effort of writing (Lofland and Lofland, 1974) both of the memos and of the final thesis, furthered the development of ideas and links and allowed for refinement of the analysis. Analysis of the interview and critical incident data therefore continued up to the final writing of this thesis.

4.6.5. Main study: Ethical Issues

4.6.5.1. Respondent anonymity and confidentiality

Given the research design, it was necessary for the researcher to be able to contact and identify a sub-sample of the questionnaire respondents for subsequent interview. Each questionnaire was therefore allocated a respondent number which was written on the first and second pages of the questionnaire (see Appendices 4, 5 & 6). On the front page, each respondent was asked to write their name and a contact address and/or telephone number so that they could be contacted to negotiate the possibility of participating in an interview. Respondents were reassured that, by agreeing to complete the questionnaire, they were in no way **obliged** to agree to be interviewed. Following completion of the questionnaires, the front page was detached and the names and addresses were stored separately in a locked filing cabinet to which only the researcher had access. This ensured that, during coding and analysis of the questionnaires, the respondents were identifiable by number only and thereby their anonymity was preserved.

4.6.5.2. Naming clients and other professionals

The descriptions of critical incidents required respondents to describe actual clients that they had been involved with as nurses. Respondents were asked to use pseudonyms or abbreviations to denote the client in order to protect anonymity and confidentiality. During transcription of the interview data,

client names or the names of other professionals mentioned were deleted from the transcriptions and replaced by a pseudonym.

4.6.5.3. Work-place issues

One issue that was raised during the negotiation for access for the pilot study was the issue of removing practitioners from the work place during work time. One health authority manager raised the issue of payment by the researcher for the time period of the interview, as the health visitors concerned would not be available to pursue their day-to-day responsibilities for that period of time. However, this was not raised as an issue in the main study, although one experienced health visitor contacted to negotiate interview time refused as she said she had too much other work to do.

In the case of student health visitors and practice nurse students, the time allocated for completion of the questionnaire was written in as part of their course timetable. One practice nurse raised the issue of removal from the work place for the purposes of conducting an interview and the interview was conducted after work hours.

4.7. SUMMARY

The study was designed to gain understanding of student health visitors', experienced health visitors' and practice nurses' constructions of effective and ineffective work with older people in both the hospital and community

settings and to identify the structural contexts within which this work was constructed.

Data collection was undertaken in two phases. The first involved the collection of questionnaires incorporating Flanagan's (1954) Critical Incident Technique from 62 student health visitors, 49 practice nurses and 25 experienced health visitors. Respondents were asked to describe two incidents, one where they felt they had been "effective" in their work with an older person/people and one where they felt they had been "ineffective". In the second phase of the study a theoretical sub-sample of the questionnaire respondents was interviewed about the structural contexts of their work and training. Eight student health visitors, eight practice nurses and six experienced health visitors participated in tape-recorded intensive interviews.

The next four chapters present the findings of the study. Chapter 5 describes the personal, demographic and professional characteristics of the respondents and presents statistical associations derived from analysis of key variables. The next chapter describes the experiences of working with older people that student health visitors and practice nurses have from previous work in institutional settings (Chapter 6), followed by a discussion of the contextual and structural issues involved in health visiting and practice nursing work (Chapter 7). Chapter 8 concerns the respondents' constructions of practice with older people.

CHAPTER 5.

SOCIO-BIOGRAPHICAL AND WORK CHARACTERISTICS OF THE SAMPLE

5.1. INTRODUCTION

The population for this study was practice nurses and student health visitors attending training courses at institutes of higher education and experienced health visitors working in the field (defined as those with two or more years post-registration experience as a health visitor). The sample was one of convenience and consisted of 49 practice nurses, 62 student health visitors and 25 experienced health visitors. This resulted in a total sample of 136 respondents.

The first sections of this chapter (5.2.- 5.6.) provide an overview of the biographical characteristics of the sample and information about their work circumstances, giving specific details of some aspects of their work with the over 65 population. The final section (5.7.) describes the associations between variables considered pertinent to the aims of the investigation, namely, previous work with older people, current work with older people and related variables such as age, general satisfaction with work with older people and expressed preparation (training and competence) for home visiting. The researcher has been deliberately selective about the statistical associations presented in this chapter, as the main aim of the questionnaire

was not to develop a large body of statistical data, rather to collect critical incidents and gain enough information about respondents to guide the theoretical sampling frame for the follow-up interviews.

5.2. SOCIO-BIOGRAPHICAL INFORMATION

Biographical information collected included details of the age, gender and ethnic origin of the sample. The distribution of these variables between the groups is shown on Table 5.2. below:

	Practice Nurses	Student Health Visitors	Experienced Health Visitors	All
Total Number of Respondents	49	62	25	136
Mean Age	33 years	25 years	44 years	32 years
Gender	49 female 0 male	60 female 2 male	25 female 0 male	134 female 2 male
Ethnic Origin	49 Caucasian British	56 Caucasian British 3 Afro-Caribbean 1 Asian 1 Irish	22 Caucasian British 4 Irish	127 Caucasian British 3 Afro-Caribbean 1 Asian 1 Irish

Table 5.2. Respondents' biographical information

As table 5.2 shows, the majority of respondents were female (n = 134; 98%), and Caucasian British (n = 127; 93%). Ages ranged from the mid-twenties in the case of student health visitors to the late fifties in the case of experienced health visitors, with the majority of respondents in the 30-45 age range.

The lack of representation of ethnic groups other than Caucasian British or Irish, particularly in the practice nurse and experienced health visitor samples, is noted as worthy of attention. It is recognised that ethnic groups are generally under-represented within the nursing profession (National Association of Health Authorities, 1988). Health visiting and, to a lesser extent, practice nursing are recognised to possess a level of high status within the nursing profession and it has been well documented that members of ethnic groups other than Caucasian can be discriminated against when it comes to career progression (National Association of Health Authorities, 1988). With reference to this, the low representation of groups other than Caucasian may be accounted for by two factors: firstly that members of ethnic groups are discriminated against at application and interview for community nursing jobs or secondly that members of these groups do not, for some reason, apply for community nursing positions.

5.3. PROFESSIONAL QUALIFICATIONS

Respondents were asked to list the professional qualifications they possessed. Table 5.3. (overpage) shows the qualifications held by the three groups of respondents.

	Practice nurses	Student health visitors	Experienced health visitors	All
No. of respondents	49 (36%)	62 (45%)	25 (18%)	136 (100%)
No. holding Degree or diploma	4 (8%)	6 (10%)	1 (4%)	11 (8.1%)
No. holding post - basic RGN qualification	26 (53%)	50 (81%)	25 (100%)	101 (74.8%)
No. holding HV certificate	3 (6%)	N/A	25 (100%)	N/A
No. holding DN certificate	5 (10%)	1 (2%)	3 (12%)	9 (6.7%)
No. holding midwifery qualification	14 (29%)	28 (45%)	18 (75%)	60 (44.4%)
No. holding RSCN certificate	6 (12%)	11 (18%)	1 (4%)	18 (13.3%)

Table 5.3. Professional qualifications held by respondents

It should be noted that experienced health visitors inevitably hold a post-basic qualification by virtue of their profession and that student health visitors would not hold registration as a health visitor.

Two points are worthy of mention here. Firstly, there is a notable difference in the numbers of student health visitors (n=28; 45%) and experienced health visitors (n=18; 75%) holding a midwifery qualification. From 1989, it was no longer mandatory for student health visitors to hold an obstetric certificate or midwifery qualification (ENB, 1989). This would explain the lower percentage of registered midwives in the student group. Secondly, it should be noted that while three practice nurses held a health visitor

certificate and five the district nursing certificate, two of the respondents held both qualifications. Therefore, it can be said that six practice nurse respondents held a qualification in community nursing.

5.4. PROFESSIONAL EXPERIENCE

Respondents were asked to state whether they had previously held a job as a qualified nurse in a care of the elderly setting. Responses are shown in table 5.4. below:

	Previous job in care of the elderly (post-basic)	Not held previous job in care of the elderly (post-basic)
Practice nurses	13 (26%)	36 (74%)
Experienced Health Visitors	2 (8%)	23 (92%)
Student Health Visitors	28 (46%)	33 (54%)
TOTAL	43 (31.8%)	92 (68.2%)

Table 5.4. Number of respondents in each group with post-basic experience in care of the elderly settings

As table 5.4. shows, the majority of respondents (n=92; 68.2%) had no post-basic experience of work with older people in specific care of the elderly settings. It should be noted that many respondents had come into contact with older people during the course of their work as nurses but that these encounters were in general settings such as medical or surgical wards, accident and emergency units etc. As the researcher was interested in

specialised training and experience of working with older people these were not counted as "care of the elderly settings".

5.4.1 Student health visitors' work satisfaction with different groups

Tables 5.4.1 summarises student health visitors' responses to the two questions "In general, how satisfying do you find work with the elderly?" and "In general, how satisfying do you find work with children?".

	Satisfaction rating (children)	Satisfaction rating (older people)
Very satisfying	33 (53%)	12 (19%)
Satisfying	23 (37%)	33 (53%)
Not satisfying	0	9 (15%)
Don't know	6 (10%)	8 (13%)
TOTAL	62 (100%)	62 (100%)

Table 5.4.1. Student health visitors' expressed satisfaction levels of work with children and older people

Several features of this table are worthy of mention. Firstly, none of the student health visitors rated work with children in general as "not satisfying" compared to 9 (15%) who rated work with older people as "not satisfying". Secondly, the number of respondents rating work with children as "very satisfying" was 33 (53%) compared to 12 (19%) who used the same rating for work with older people. A total of 56 (90%) of the student health visitor respondents rated work with children as "very satisfying" or "satisfying". It

is possible that it was the recognised child-focus of health visiting work (Dunnel & Dobbs, 1982) that originally attracted student health visitor respondents to the training course.

5.5. WORK CIRCUMSTANCES

Health visitors and practice nurses work in various settings and, whilst there are areas of overlap in their roles and work circumstances, for the sake of clarity the groups will be considered separately. The student health visitors are excluded as they were all attending a full-time course in an institute of higher education at the time of the study and therefore questions about current work circumstances were not relevant.

5.5.1. Practice nurses

5.5.1.1. Grading

Table 5.5.1.1. shows the clinical pay grading of the practice nurse respondents in this study.

Grade of employment	Number of practice nurses
E	1 (2%)
F	16 (33%)
G	30 (61%)
H	1 (2%)
Non-Nursing Pay Scale	1 (2%)
TOTAL	**49 (100%)**

Table 5.5.1.1. Clinical grading of practice nurse respondents

The majority of practice nurses (n=30; 61%) were paid on a 'G' grade, which is the grading normally awarded to qualified community nurses, such as health visitors and district nurses[9]. Given that only 6 (12%) of the practice nurse respondents were qualified community nurses, the number that were being paid a G grade appears quite high. However, it again reflects the rapid employment of practice nurses during the latter half of 1989 to April 1990 before the GP contract (Health Departments of Great Britain, 1989). Cash-limits on the employment of new staff were imposed on GPs after that date and there is already anecdotal evidence that Family Health

[9]. It should be noted that the advent of skill-mix into the primary health care arena means that that qualified health visitors and district nurses can no longer expect a "G" grading.

Service Authorities are beginning to look more closely at the grading of practice nurses in an attempt to ensure that the grading reflects qualifications, experience and responsibilities (Liverpool FHSA, 1991).

5.5.1.2. Length of time employed

The majority (n=47; 96%) of the respondents had been employed as practice nurses for less than four years with 26 (55%) of them being employed as practice nurses for less than a year at the time of completion of the questionnaire. Again, this reflects the fact that Family Health Services Authorities had actively encouraged GPs to increase their employment of practice nurses in the period September 1989 to March 1990 (Liverpool FHSA, 1991).

5.5.1.3. Working hours

Of the 49 practice nurse respondents, 41 (84%) worked part time (this was defined as less than 37.5 hours per week). Of these, 13 (26% of the total) worked between 30 and 37.5 hours per week and 26 (53%) worked between 20 and 29 hours per week. The remainder (n=2; 4%) worked between 10-19 hours per week. Nearly half of the respondents (n=20; 41%) stated that the opportunity for part-time hours was one of the factors which led them to choose practice nursing as a job. The issue of part-time employment and the consequences of it on job-security will be discussed in Chapter 8.

5.5.1.4. Colleagues in the working environment

Practice nurse respondents were asked how many GPs they worked with. The number of respondents who worked in single-handed practices was relatively small (n=3; 6%), the remaining 46 respondents (94%) worked with from two to nine general practitioners. The mean number of GPs worked with was four.

Respondents were also asked whether there were other practice nurses employed by their practice. The majority (n=30; 61%) of practice nurse respondents worked in practices where one or more other practice nurses were employed. The remaining 19 respondents (39%) were the only practice nurse employed in the practice. Although the majority said there were other practice nurses employed by the practice, given the part-time nature of most of their contracts (see page 170), it would not necessarily follow that they worked at the same times as the other nurses.

5.5.2. Experienced Health Visitors

5.5.2.1. Grading

Of the 25 experienced health visitors in this study, 21 (84%) held an H grade position. This is the normal grading expected of a qualified field work teacher/community practice teacher. The remaining four (16%) were graded on a G, the usual grading, at the time of data collection, for a practising qualified health visitor.

5.5.2.2. Working hours

The majority (n = 24; 96%) of the health visitor respondents worked full-time. The remaining health visitor respondent worked between 30 and 37 hours per week.

5.5.2.3. Determination of caseload

Just under half (n = 12; 48%) of the health visitor respondents worked under a system of GP attachment. Of the others, six (24%) worked within a geographical area and seven worked with particular GP practices but also held responsibility for a defined geographical area. Respondents were also asked how many children and older people were registered on their caseloads. The following table (5.5.2.3.) summarises the number of children and older people registered on experienced health visitor respondents' caseloads.

	Number of Respondents	Mean	Standard Deviation	Minimum	Maximum
Children	24	327	80	200	507
Over 65's	22	37	36	0	84

Table 5.5.2.3. Number of children and people aged 65 and over registered on the caseloads of experienced health visitor respondents

As table 5.5.2.3. shows, there is a large difference between the mean number of children (n = 327) and the mean number of people aged 65 and over (n = 37) registered on health visitor respondents' caseloads. The

constructions of the caseloads reflect the continued child-focused nature of health visitors' work (de la Cuesta, 1992).

5.6. CONTACT AND FEELINGS ABOUT WORK WITH OLDER PEOPLE

A series of questions was asked about health visitor and practice nurse respondents' contact with people over 65 years of age and, more specifically, contact with people over 75 years of age. Where appropriate, data pertaining to both respondent groups are compared in this section.

5.6.1. Assessment of people over 75 years of age

Of the 49 practice nurse respondents, seven (14%) stated that the practice they worked for had no current system for visiting the people over 75 within that practice for the purposes of assessment. The other 42 (86%) practice nurses worked in practices where there was a system of assessment for visiting but there were a variety of professionals responsible for performing the assessments (see Table 5.6.1.).

Responsibility for assessment of people aged 75 and over	Number of practices
Practice nurse only	10 (20%)
GPs only	12 (25%)
Other practice nurse in practice	1 (2%)
All practice nurses and GP	17 (35%)
All practice nurses but not GPs	2 (4%)
TOTAL	42 (86%)

Table 5.6.1. The division of responsibility for assessing people aged 75 and over within GP practices

Table 5.6.1. shows that 10 (20%) respondents were solely responsible for assessing the people aged 75 and over registered with the practice. 19 (39%) respondents shared responsibility for undertaking this activity with either the GPs, other practice nurses or both. Consequently 29 (59%) respondents were responsible to some degree for undertaking assessments of people aged 75 and over.

Of the practices that had a policy for assessing people aged over 75 years (n=42), 36 (86%) permitted assessments to be performed either in the home or in the surgery. The remaining six (14%) practices had policies of performing assessments in the home setting only.

5.6.2. Home visits to people aged 65 and over

Table 5.6.2. summarises practice nurse and health visitor respondents' home visits to people aged 65 and over in the previous month.

	Number of practice nurse respondents	Median (25th & 75th quartiles)	Number of health visitor respondents	Median (25th & 75th quartiles)
Aged 75 and over	33	10 (1; 20)	25	2 (1; 6)
Aged 65 - 74	23	0 (0; 4)	25	2 (0; 3.5)
Total aged over 65	33	12 (3; 20)	25	4 (2, 10)

Table 5.6.2. Number of home visits to people aged 65 and over in previous month by group

Several points about the data presented in table 5.6.2 should be noted. Firstly, 33 (67%) practice nurse respondents said they had visited people aged 75 and over. However, only 25 of these had performed home visits to over 75s in the previous month for the purposes of **assessment.** The remaining eight respondents had visited people over 75 for reasons other than assessment (e.g. for specific tasks such as cytamen injections, ear syringing etc.). These respondents are included in the total figures as this demonstrates **contact** with the over 75s at home in general. Similarly, 23 (47%) practice nurse respondents had visited people aged 65-74 years in the previous month. Again, these people were not visited for **assessment** but for reasons such as those outlined above.

All (n=25; 100%) the experienced health visitor respondents had visited people aged 65 and over in the month preceding data collection. By comparing the median values between practice nurse respondents and health visitors, it can be seen that the <u>total</u> number of visits undertaken by health visitors was markedly lower than the number undertaken by practice nurses. However, whilst the median value for practice nurses' visits to the 65-74 age group was marginally lower than the value for health visitors' visits, the value for the 75 and over age group was markedly higher. This point will be discussed further on pages 187-188.

When asked if they thought that routine assessment was in the best interests of the older people, 63 (85%) of the practice nurse and health

visitor respondents (n = 74) replied that they believed it to be in their best interests. 4 (5%) stated that they believed it was not in the best interests of older people and 7 (10%) replied that they did not know.

5.6.3. Other contact with people aged 65 and over

Practice nurse respondents were also asked whether the practice they worked in had any system for providing preventive health care or assessment for the 65-74 age group. Of the 49 practice nurse respondents, 19 (39%) stated that there was a system for providing preventative health care to this age group, but descriptions of the system employed by the practice, in all cases, focused on the provision of tertiary preventive strategies such as monitoring of patients with hypertension, or monitoring of diabetes in specialist clinic situations or occasionally at home. There appeared to be no strategies for providing a universal screening or assessment service for the 65-74 age group.

Other contacts with older people (apart from home visits) by practice nurses occurred mainly within a generalist clinic session when patients were attending for procedures such as ear syringing. 46 (94%) respondents stated that they had contact with people aged over 65 within this setting. Two (4%) of the respondents stated that they ran well-elderly clinics on a weekly basis and one (2%) respondent **only** came into contact with older people in the home setting.

Of the 25 health visitor respondents, 12 (48%) stated that they did have contact with older people other than for the purposes of visiting them at home. In six (24%) cases these contacts were during home visits to children under five, and in the remaining six (24%) cases, health visitor respondents were involved in running diet clinics, well-women clinics or look-after-yourself courses which were open to people of all ages.

5.6.4. Preparation for home visiting and assessment

Given the on-going professional debate about the suitability of practice nurses to visit older people aged 75 and over at home for the purposes of assessment (Nursing Times, 1991), practice nurse and health visitor respondents were asked how well prepared (in terms of training/ competence) they felt for undertaking this activity. The responses are summarised in table 5.6.4. below.

Level of preparation	Practice nurses	Health visitors	Total
Very well prepared	11 (22%)	11 (44%)	22 (30% of total)
Adequately prepared	22 (45%)	13 (52%)	35 (47% of total)
Not adequately prepared/completely unprepared	16 (33%)	1 (4%)	17 (23% of total)
TOTAL	49 (100%)	25 (100%)	74 (100%)

Table 5.6.4. Practice nurse and health visitor respondents' stated levels of preparation for undertaking home visits to people aged 75 and over for the purposes of assessment

Table 5.6.4. shows that 16 (33%) of the 49 practice nurse respondents felt inadequately prepared for undertaking assessments of the over 75s at home, compared to only 1 (4%) of the 25 health visitor respondents.

Sections 5.2.-5.6. have provided an overview of the socio-demographic characteristics of the sample. The aim of the following section is to provide evidence for statistical associations between variables.

5.7. ANALYSIS OF ASSOCIATIONS BETWEEN KEY VARIABLES

This section will provide evidence for associations between variables which were considered by the researcher to be particularly pertinent to the general aims of the study. The constraints of time and space demanded that analysis of statistical associations between variables was highly selective.

Please note that the significance level for rejection of the null hypothesis for all the statistical tests used is $\alpha \leq .05$. Full descriptions of the statistical tests used for the purposes of analysis are given in Appendix 9.

The comparisons between variables considered in this section, and the reasons for their selection, are as follows:

a) The differences in age between the three groups of respondents. Although it was presumed that the experienced health visitor group would be on average older than the other two groups, the degree of difference in age between student health visitors and practice nurses was unknown.

Therefore, it was important to establish whether the age differences between these two groups were statistically significant.

b) The relationship between the age of student health visitors and their ratings of satisfaction of work with older people in general. Given that previous research studies examining age differences with expressed preference for work with older people (e.g. Campbell, 1971; Gillis, 1973) had been inconclusive and sometimes contradictory in their findings, the association between age and satisfaction of work was of interest.

c) The difference between the numbers of student health visitors who have held a previous post-basic position caring for children compared to the numbers who have held a post caring for older people. Given research evidence showing the child-focussed nature of health visiting work and the lack of priority given to other groups such as old people (de la Cuesta, 1992), it was considered important to establish whether there was a significantly higher level of previous work experience in the student health visitor group with children than with older people.

d) The relationship between student health visitors' specific previous experience of work with older people and rating of satisfaction of work with older people in general. Again, previous research studies have been inconclusive in establishing a link between experience of work with older people and positive attitudes or willingness to work with them (Brower,

1985). Therefore the assocation between these two variables was of interest.

e) The relationship between practice nurses' expressed preparation (training and competence) for undertaking assessments of people aged 75 and over in their own homes and their responsibility for undertaking home assessments. This was of interest given the anecdotal evidence that many practice nurses were being asked by GPs to undertake this work whilst they themselves were unsure of their competence (Nursing Times News, 1991).

f) The difference between the number of home visits per month to people aged 65 and over undertaken by practice nurses and experienced health visitors. Health visitors have a theoretical remit for visiting people aged 65 and over whilst practice nurses have the policy remit for visiting the over 75s, therefore the differences in levels of visiting of people aged 65-74 and people aged 75 and over between the two groups were of potential interest.

5.7.1. Age differences between groups

Table 5.7.1. summarises the age distribution in the three groups of respondents.

Statistical tests: To test the null hypothesis, the data were submitted to statistical analysis using the Chi Square statistic.

	Practice nurses	Experienced health visitors	Student health visitors	Row Total
Age 20-29	7		34	41
Age 30-39	20	3	19	42
Age 40-49	19	8	8	35
Age 50-59	3	13	-	16
Total (%)	49 (36.6%)	24 (17.9%)	61 (45.5%)	134 100%

(1 non-respondent)

Table 5.7.1. Cross-tabulation of age against respondent group

Table 5.7.1. shows that there is a significant difference in the ages of the respondents across the three groups ($x^2 = 24.27$; $df = 2$; $p < 0.001$). Therefore it is possible to reject H_0 in favour of the alternative hypothesis. It can be seen that the student health visitors were the youngest group, the practice nurse group was somewhat older and the experienced health visitor group was the oldest. It might be supposed that it is the influence of the experienced health visitor group on this association that makes it significant. They could be presumed to have a higher average age than the other two groups as they all held the health visitor certificate (which is a 52 week course) and were "experienced" which, for the purposes of this study, was defined as having worked in the field for two or more years. However, when the experienced health visitor group was excluded from the analysis, there remained a statistically significant difference in age ($x^2 = 24.27$; $df = 1$; $p < 0.001$) between the practice nurse and student health visitor groups.

5.7.2. Relationship between age of student health visitors and their satisfaction of work with older people

Table 5.7.2. summarises the association between age of student health visitors and their satisfaction of work with older people. For the purposes of statistical analysis, the student health visitor respondent group was divided into two age-bands, 20-29 and 30+. In addition, the "don't know" responses were excluded for the purposes of statistical analysis.

Statistical tests: To test the null hypothesis, the data were submitted to statistical analysis using the Chi Square statistic.

	Very Satisfying	Satisfying	Not satisfying	Don't know	Total
20-29 years	6	17	6	5	34 (56%)
30+ years	6	16	3	2	27 (44%)
Total (%)	12 (19.7%)	33 (54.1%)	9 (14.8%)	7 (11.5%)	61 100%

(1 non-respondent)

Table 5.7.2. Cross-tabulation of age against student health visitors' ratings of satisfaction of work with older people

It can be seen from table 5.7.2. that the difference between student health visitor respondents' ages and their ratings of satisfaction of work with older people was not significant at the $\alpha \leq .05$ level ($x^2 = 0.74$; $df = 2$; $p \leq 6.91$). It is therefore possible to reject the alternative hypothesis in favour of H_0.

Whilst previous researchers have sought to establish a link between the age of nurses and their **attitude** towards older people (McCabe, 1989), it would appear that, for the student health visitor respondents, there was no significant association between level of expressed work satisfaction with older people and respondent age.

5.7.3. The difference between the numbers of student health visitors who had previously held a post-basic position caring for children and the numbers who had previously held a post-basic position caring for older people

Statistical tests: To test the null hypothesis, the data were submitted to statistical analysis using the McNemar test.

	Held post-basic position caring for older people	Not held post-basic position caring for older people	Total
Held post-basic position caring for children	22	27	49 (80%)
Not held post basic position caring for children	6	6	12 (20%)
Column total	28 (46%)	27 (44%)	61 (100%)

(1 non-respondent)

Table 5.7.3. Numbers of student health visitors who held post-basic posts caring specifically for children and/or older people or neither

The table shows that there were 34% more respondents who had held a post-basic position caring for children (80%) than there were respondents who had held a post-basic position caring for older people (46%). This

difference is significant using McNemar's test (x^2 = 12.12; df=1; p < 0.001) and the 95% confidence interval is (16%, 54%). Therefore the null hypothesis (H_0) is rejected in favour of the alternative hypothesis. Looking at the direction of the difference, it would appear that student health visitors were more likely to have held a post-basic post caring for children before entering training than they were to have held a post caring for older people. Given the predominantly child-focus of health visiting work (Dunnel & Dobbs, 1982), it is probable that the profession attracts more people from paediatric/midwifery backgrounds than it does from care of older people positions or that there may be a bias in recruitment of students to the course which disadvantages those with experience in caring for older people.

5.7.4. Relationship between student health visitors holding a previous post caring for older people and their rating of satisfaction of work

Statistical tests: To test the null hypothesis, the data were submitted to statistical analysis using the Wilcoxon Rank Sum test.

	Very satisfying	Satisfying	Not Satisfying	Don't know	Total
Previous post caring for older people.	11	14	3	0	**28**
Not held post caring for older people	1	19	6	7	**33**
Total	**12 (19.7%)**	**33 (54.1%)**	**9 (14.8%)**	**7 (11.5%)**	**61 (100%)**

(1 non-respondent)

Table 5.7.4. Cross-tabulation of student health visitors holding a previous post caring for older people and their rating of satisfaction of work with older people

There is a significant relationship between the holding of a previous post caring for older people and rating of satisfaction of work with older people (Wilcoxon Rank Sum: $Z = -3.82$; $p < 0.001$). Therefore it is possible to reject H_0 in favour of the alternative hypothesis. Given the direction of the difference, it appears that student health visitors who have held a post-basic position caring for older people are more likely to express a level of satisfaction of work with older people in general than people who have never held a position in that field.

5.7.5. The association between practice nurses' expressed levels of preparation for undertaking home visits to people aged 75 and over for the purposes of assessment and their responsibility for undertaking that activity

Statistical tests: To test the null hypothesis, the data were submitted to statistical analysis using the Chi Square statistic.

	Very well prepared	Adequately prepared	Not adequately prepared	Total
Visit older people at home	10 (20%)	17 (35%)	5 (10%)	32 (65%)
Do not visit older people at home	1 (2%)	5 (10%)	11 (23%)	17 (35%)
Total (%)	11 (22%)	22 (45%)	16 (33%)	49 (100%)

Please note: 1 (2%) respondent ticked the category "completely unprepared". For statistical purposes this respondent has been included in the category "not prepared")

Table 5.7.5. Table showing relationship between level of preparation for undertaking home assessments of people aged 75 and over and responsibility for this activity

There is a significant difference between level of preparation and responsibility for undertaking assessments of people aged 75 and over in their own homes ($x^2 = 12.99$; $df=2$; $p < 0.005$. Therefore the null hypothesis H_0 can be rejected in favour of the alternative hypothesis. Looking at the table, it can be seen that the practice nurse respondents responsible for this activity generally felt more prepared (training and competence) to undertake it.

5.7.6. Differences between average numbers of people aged 65 and over visited at home in previous month by health visitors and practice nurses

Statistical tests: To test the null hypothesis, the data were submitted to statistical analysis using the T test.

For the 33 practice nurse respondents (see section 5.6.2.) who had visited people aged 65 and over at home in the previous month, the mean number of visits was 14.5 (standard error = 2.28), whereas for the 25 health visitor respondents the mean was 7.4 (standard error = 1.67). The difference in means was therefore 7.1 and is a significant difference (t value = 2.53; df=53.33; $p < 0.05$), with a 95% confidence interval of (1.9, 12.7) visits per month. Therefore the null hypothesis (H_0) can be rejected in favour of the alternative hypothesis. However, it should be noted that the older population are not a homogeneous group. GPs and their practice staff have been given particular responsibility for visiting the **over 75s**, whereas their responsibilities remain the same for the 65-74 year old population as they are for the rest of the adult population (Health Departments of Great Britain, 1989). It was decided to look at the two age groups separately in order to establish whether there was a difference between them in terms of the numbers visited.

5.7.6.1. Visits to people aged 65-74 years by health visitors and practice nurses in previous month

Statistical tests: To test the null hypothesis, the data were submitted to statistical analysis using the T test.

The mean number of home visits in the previous month undertaken by practice nurse respondents (n=23) to people aged 65-74 was **2.22** (standard error 0.785) compared to the mean number of visits undertaken by health visitors (n=25) to people aged 65-74 which was **2.56** (standard error 0.64). The difference between the mean number of visits to people aged 65-74 and over undertaken in previous month by health visitors and the mean number undertaken by practice nurses was 0.34 and is not a significant difference (t value = -.34; df=43.3; $p > 0.05$). Therefore the null hypothesis (H_0) can be accepted in favour of the alternative hypothesis.

5.7.6.2. Visits to people aged 75 and over by health visitors and practice nurses in previous month

Statistical tests: To test the null hypothesis, the data were submitted to statistical analysis using the T test.

The mean number of home visits in the previous month undertaken by practice nurse respondents (n=33) to people aged over 75 was **12.51** (standard error 2.15) compared with the mean number of visits undertaken by health visitors (n=25) to people aged over 75 which was **4.8** (standard

error 1.15). The difference between the mean number of visits to people aged over 75 years undertaken in the previous month by health visitors and the mean number undertaken by practice nurses is 7.71 and is significant (t value = 3.16; df=47.73; $p < 0.05$). Therefore the null hypothesis (H_0) can be rejected in favour of the alternative hypothesis.

In section 5.7.6. it was shown that there was a significant difference between the mean numbers of home visits to people aged over 65 undertaken in the previous month by practice nurses and health visitors. However, by sub-dividing the over 65 population into two groups (65-74 and 75+), it can be seen that it is the visits to the people aged over 75 which account for the significant difference. A comparison of the means of people aged 65-74 visited by the two groups shows no significant difference. Although, given the terms of the GP contract (Health Departments of Great Britain, 1989), this may have been a predictable difference, it demonstrates that practice nurses, who have a **policy** remit for visiting the over 75s do more home visits than health visitors who have a **theoretical** remit for visiting the over 75s (BGS & HVA, 1986). In addition the statistics show that, whilst practice nurses undertake a substantial amount of work with people aged over 75, they have no more involvement with people aged 65-74 at home than do health visitors.

5.8. CONCLUSION

This chapter has provided an overview of the socio-biographic and work characteristics of the sample of student health visitors (n = 62), practice nurses (n = 49) and experienced health visitors (n = 25) and has drawn attention to the statistical analysis of a few variables considered particularly pertinent to the aims of this study. It should be noted, however, that a large amount of information was collected from the questionnaires and that this chapter in no way reflects all the information collected. The researcher intends to publish the findings from in-depth statistical analysis of other variables included in the questionnaire at a later date (as a series of papers). Nevertheless, the chapter does provide some useful background information which assists in the understanding of the roles and responsibilities of practice nurses and health visitors with regard to the older population and some of the issues raised are explored further in the discussion section of this thesis.

CHAPTER 6.

CONSTRUCTIONS OF OLD AGE FROM EXPERIENCE OF NURSING WORK IN INSTITUTIONAL SETTINGS

6.1. INTRODUCTION

This chapter is underpinned by the notion that the biographical and professional experiences which individual nurses bring to health visiting and practice nursing from nursing work *in institutional settings have important consequences for subsequent practice. The chapter draws mainly from* critical incident data which pertains to nursing work with older people in institutional settings[10], in particular incidents described by the student health visitor and practice nurse respondents[11].

It will be shown that the predominant professional experience of work with older people that student health visitor and practice nurse respondents in

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[10] On occasions where interview data is used for illustrative purposes the abbreviation "I" will follow the respondent reference number.

[11] It should be noted that student health visitor respondents and those practice nurse respondents who did not have experience of work in the community setting with older people were asked to reflect back on experiences in the hospital setting. Incidents described by experienced health visitors did not include any from the hospital setting, therefore they are not considered within this chapter.

Whilst the total number of student health visitor respondents was 62, 56 respondents described incidents (either effective or ineffective or both) which were pertaining to the institutional setting. In the case of practice nurses, where the total number of respondents was 49, 6 described incidents pertaining to the institutional setting. Therefore, for the purposes of this chapter, where the number of respondents describing a particular phenomenon/category is referred to, the total sample number (n) is 62 (56 student health visitors and 6 practice nurses).

this study brought to their community nursing practice had its roots in a disease/illness model. To be more specific, the images that respondents had of older people were fundamentally images of sickness, of vulnerability and of dependency. These images stemmed mainly from the institutional environment of the hospital where the notion of 'cure' is paramount but frequently inappropriate when it comes to the end goal of the care of older people (Reed, 1989). The data also clearly reveals the problems faced by respondents working on wards where routine methods of care dominate.

In spite of the fact that some respondents expressed satisfaction with their work with individual older people, especially those with whom they had established a "good" relationship, in general the feeling was of reluctance to work with this group. The additional but vital dimension of the influence of respondents' visions of their own future ageing and that of significant others will be discussed as a possible causative factor.

This chapter demonstrates that respondents entered the community nursing sphere with varying degrees of experience of dependent old people but with little or no knowledge and experience of work with the "well elderly".

6.2. STRUCTURAL FEATURES OF WORK WITH OLDER PEOPLE IN INSTITUTIONS

Memories of student nurse and staff nurse placements on "geriatric" wards prompted vivid descriptions from respondents of bias, intolerance and abuse of older people. The descriptions of "geriatric nursing" also highlighted the dependent status of older people in institutional settings and the focus within the nursing profession on meeting patients' physical needs whilst giving low priority to social aspects of daily life.

Whilst working on wards specifically for care of older people, respondents were faced with situations which caused anxiety and at times provoked anger. One student health visitor respondent summed up the feelings of many when she wrote about her experience as a staff nurse;

> "I worked on a long-stay geriatric unit...I only stayed there 10 weeks...many incidents happened on this ward of which I was unhappy. In turn it made me miserable". (305)

The descriptions of work with older people in institutions were taken from several contextual settings (for example rehabilitation wards, long stay care, general medical wards etc.) and there were common threads in the experiences of the respondents, independent of the specific context. Similarities in styles of practice of trained nursing staff in acute and long term care of the elderly wards have been pointed out elsewhere (Reed & Bond, 1991).

The majority of respondents (n=44; 71%) expressed a great deal of frustration directed towards a system which they felt presented barriers to "effective" nursing practice (see page 195). In four (7%) cases, this had caused qualified nurses to leave the ward they were working on and move to another field of nursing. In the case of student nurse placements, some respondents (n = 5; 8%) mentioned that the care of older people was an area which they would try to avoid once they qualified and they based this decision on the experiences they had as student nurses. One student health visitor respondent stated that she had almost left nursing altogether because of her experiences during her "geriatric module":

> "As a student nurse during my geriatric module I wrote out my resignation several times. I felt despondent and ineffectual, a lot of the care...was given due to tradition and not necessarily for the good of the patients". (333).

The critical incident data indicate that there were two key structural features which influenced the experience of work with old people in institutional settings:

1) the structure of ward routines[12], and

2) the permanent ward staff.

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[12] In view of the retrospective nature of the descriptions of critical incidents, the age of the respondent describing the incident is given. Whilst recent research has shown that routine methods of organizing care continue to dominate settings where older people reside (Reed, 1989), it may be speculated that these retrospective incidents could describe now "out-dated" methods of organizing care. Although respondents were not specifically asked how long ago they had trained, the age of the respondent describing the incident gives some indication of how long ago the incident will have taken place.

It is recognised that these features are interlinked (indeed it is probable that permanent ward staff are responsible for the determination and perpetuation of ward routines), however for the sake of clarity they will be considered separately.

6.2.1. The ward routine

The most dominant category (n=44; 71%) evident in the data was the influence of the "ward routine", which to a large extent determined the type of care respondents were able to deliver on the ward. The ward routine was a source of much frustration as it appeared to undermine the **standard** of care that respondents felt they **should** be able to give to patients. One student health visitor respondent (aged 20-29) described her experience as a third year student on a male "geriatric ward":

> **"I felt that the nursing care these people received was extremely institutionalised and very undignified...the ward...had a routine** of choosing the patients' clothes the night before.. these clothes had a label A1 ward emblazoned across the FRONT of their jumper. I felt this was very undignified that a 20 year old girl was choosing a 60 yr old man's clothes, even down to his underpants...to be stripped of his dignity in this way, **I felt was abhorrent and extremely institutionalised...they had a bath on certain days and this was ticked in a bath book, along with it if they had their hair washed and nails clipped!...this experience affected my whole attitude to nursing of the elderly".**
>
> (303, my emphasis).

The rigid routine that operated on this ward appeared to limit the degree of dignity which the respondent felt the patients had. The "undignified" and institutionalised" (303) organisation of the ward can be seen as a way of

reducing the possibilities for individualised patient care, as the goal of care appeared to be the successful meeting of what could be considered basic physical needs: the regular "bath", the "hair wash" and the "nails clipped" (303). The implication of these activities being "ticked in a bath book" (303) is that it was necessary for them to be recorded and regulated, highlighting the importance of the tasks.

Routine methods of organizing patient care commonly involve treating all patients the same (Wells, 1975) and are underpinned by the assumption that all patients have the same needs. One respondent (aged 20-29) described the "toileting" regimen in operation on a ward where she had worked as a student nurse:

> "...elderly patients were made to do certain tasks at certain times and not allowed to act as an individual. Such tasks as toileting them every three hours when they didn't want to go but perhaps an hour later would ask somebody to take them and the elderly person would be told that they had just been so the answer was no. The outcome would most likely be that the patient would be wet at the next toileting time..."
>
> (354, my emphasis).

It has been suggested that routines serve a specific purpose in institutional settings as they ensure that each day runs smoothly according to some preconceived notion of what the basic standard of care for the patients should be (Townsend, 1962). They are designed to fulfil the official aims of the institution rather than the specific needs of each person residing there (Goffman, 1961; Weber, 1968). The description above, however, with the likely outcome of a patient being "wet at the next toileting time" (354)

implies a very basic (most would consider unacceptable) standard of physical care for the individual patient. The aim of the institution was to ensure that each patient was "toileted" three-hourly with total disregard for individual difference and preference. Refusing a patient's request to go to the toilet also results in a reinforcement of that person's dependent status, as patients unable to get to the toilet independently rely heavily on the nursing staff. The suggestion that routines may not ensure even the most basic standards of care to meet patients' needs is supported by other researchers (Wells, 1975; Procter, 1989).

A practice nurse respondent (aged 30-39) described her experience as a student nurse on a "geriatric" ward in the following way:

> "...**many of them were left in bed all day and sedated as it was easier for the staff...**I felt very angry and upset that because they were old and didn't have families to look after them they were treated inhumanely".
>
> (136, my emphasis).

Again, this demonstrates that care practices can be dominated by the needs of the permanent ward staff rather than oriented towards the needs of individual patients.

Several respondents (n=4; 7%) felt that wards where patients resided for "long-term care" should attempt to reconstruct, to as great an extent as possible, the home setting. For example, one respondent (aged 20-29)

explained why she had avoided working with older people once qualified:

> "I did not enjoy my experience working in geriatrics. **It was classed as an "acute medical ward" but was effectively the home for many of these people. However, it was run like a mini-intensive care unit** and had very little personal touches to enable these people to retain some dignity and pretend that it was home for them...I felt we did not allow the patients to direct their own lives. It was a rigid routine which they had to abide to. **I am fond of elderly people but this experience as a student nurse has always directed me away from working with the elderly because I feel so much of the work was depressing and very ineffective"**
>
> (313, my emphasis).

The 'depressing' aspect of caring for older people in this case was not directed towards older people themselves. The respondent considered that the "mini intensive-care unit" and the substitute "home" had markedly different underlying value-systems and that the needs of the patients residing in these wards were different. Whilst the ward was classified as "an acute medical ward", many of the patients were presumably resident for long periods of time. The implication is that cure-oriented settings, such as intensive-care, are not required to mimic the characteristics of "home". The respondent seemed to feel that where patients are resident for longer periods, and the focus of care is not cure, it is inappropriate to function under a rigid routine and to tend only to physical need.

Researchers have suggested that nurses often consider the goal of "cure" to be unrealistic for older people, both in long-stay and acute care settings (Reed & Bond, 1991). Reed (1989) argued that the "cure" ethic dominates geriatric medicine, to the extent that long-term care patients are viewed as

"failures" of the system. Underpinning this is an assumption that older people are on a downward trajectory of physical well-being. Problems can arise in acute settings where the pressure on beds is high and older patients not likely to be "cured" are considered inappropriately placed. For example, one respondent who, immediately before entering health visitor training, had been a ward sister on a medical ward described the consequences of the admission of an 86 year old woman who had suffered a stroke:

> "...(she) was thought to survive for only a short period of time...However **the lady survived but was unable to communicate and was now a person who required daily total care and eventually "blocked" an acute bed...the geriatricians refused to take her care over** and the relatives were then asked to find a nursing home... the relatives felt obviously that the fate of their elderly mother was not being taken seriously by nursing and medical staff".
>
> (347, my emphasis).

The "blocking" of acute beds by older people requiring long-term residential accommodation has been the subject of research scrutiny (Currie, Smith and Williamson, 1979; Covell & Angus, 1980) and is becoming an increasingly important issue in the current policy climate, which places emphasis on increased throughput of patients and faster discharge to the community (DH, 1989a & b).

Previous research studies have clearly identified the presence of a routinized model of care in long-stay geriatric hospital wards (Baker, 1978; Evers, 1984). In settings dominated by routines, the rights and responsibilities of any one individual are often weighed against those of the whole group and

this inevitably involves limits on personal choice. In this study the respondents considered that ward routines served a regimenting function, denying patients and their carers any opportunity to exercise choice based on individual circumstances. For example, one student health visitor respondent (aged 20-29) described her involvement as a fourth year student nurse in "laying out" a woman who had just died:

> "...I did not give the daughter time with her mother before starting to lie J. down etc. **Looking back, I know that all the routine "laying out" is not important compared to giving people time to sit with their loved ones to talk to them...This incident will always stick in my mind as one where nurses are far too involved with routine".**
>
> (308, my emphasis).

The description above indicates that, even after the death of a patient, the "physical" preparation involved in "laying out" took precedence over the psycho-social needs of the relative.

Historically, nursing has been mainly concerned with the meeting of physical need (Altschul, 1972). Melia (1987) suggests that in order to ensure the paramount importance of physical care of the body, nursing work was broken down into routinised and basic tasks. More recently, however, there has been a shift within the profession to increasing involvement in psycho-social aspects of care (May, 1992). In the academic (school) segment of nurse training, students are taught to place high value on individual patient care and, more particularly, the establishment of "good" relationships with patients (Clark, 1978; Melia, 1981).

The majority of respondents in this study considered the successful provision of psycho-social care to be an important indicator of "effective" nursing practice (n=35; 56.5%). For 14 of these respondents (23%) psycho-social care was described in terms of establishing a "good" relationship with patients and/or their families. Conversely the lack of opportunity to provide psycho-social care within the ward setting was described directly by 18 (29%) respondents. Without exception, routine, physically-oriented care systems were described as the cause of this.

Established routines and the requirement for only a basic standard of physical care apparently undermines nurses' desires to offer psycho-social care. One respondent (aged 20-29), who had worked extensively with older people as a staff nurse and ward sister, discussed the reasons why she became dissatisfied with the system in which she was expected to work:

> "I thoroughly enjoyed working with the elderly people but **often felt dissatisfied with my work on the whole** - not with nursing care but the general system...I feel that more time should be spent talking to the elderly during the day and giving them the opportunity to ask questions etc. **But so much of the day is spent trying to get all the routine work and office work completed to their detriment really".**
>
> (342, my emphasis)

The respondent describes "talking" and "routine work" (342) as two different paradigms of care. The implication is that "routine" is synonymous with physical care and that, on wards where routines dominate, talking to patients is an indulgence, only possible if time allows.

6.2.2. The ward staff - confrontation or conformity?

The intransigence of some permanent ward staff on "geriatric" wards was a source of frustration and anger for several respondents (n = 16; 25.8%), particularly when they had been student nurses and had felt very powerless to influence a ward situation. Given that 37 (59.7%) of the respondents who described incidents from institutional settings had no specific post-basic experience of work with older people, it is inevitable that the majority of descriptions are of experiences as student nurses.

Whilst it may be presumed that all nurses share a common construction and interpretation of the ward system and of work with older people, in fact the experiences of student nurses and newly qualified staff nurses as compared to the permanent ward staff were very different. Faced with difficult or ambiguous situations on wards, students and staff nurses were presented with a choice of how to resolve areas of conflict when it came to the care of older people.

In his "Frame Analysis", Goffman (1974) suggests that the social reality of everyday situations involves the resolution of ambiguities between the superior and subordinate actors in those situations. He sees the final outcome of the struggle to resolve these ambiguities as either

a) a negotiated settlement,

b) the imposition of one framework (usually that of the superior) on the other actors or

c) disengagement from participation of some or all of those involved

(after Goffman, 1974).

Of the three strategies, the first is the only one which results in a constructive situation which is open to change (Goffman, 1974). This strategy is rarely utilised in hierarchical structures such as hospital wards (Burns & Flam, 1987).

In a ward situation the "superior" actors are those permanent staff and members of the medical staff who have control and power in the ward situation. The "subordinate" actors are nurses who enter the ward system from outside, often for limited periods of time (such as students nurses on placement or newly qualified staff nurses) and who possess little power and influence within the hierarchy. The data in this study indicate that subordinate nurses commonly use the last two strategies to resolve conflicts with permanent ward or medical staff, particularly when the care of individual patients is being questioned. A negotiated settlement was only apparent in one situation where the respondent had been in a position of power and had the respect of other staff (see overpage).

6.2.2.1. Negotiated settlement

There was only one incident that gave an indication of a negotiated settlement taking place between a charge nurse on night duty on a "busy geriatric ward" (330) and the medical staff. This particular respondent had several years' experience of work in a hospice and stated that he was knowledgeable regarding "good and bad attempts at pain control" (330). The incident concerned a man who was dying of primary cancer of the bladder:

> "(I) was amazed when I went to work at H. (the hospital) to find such things as temgesic being given with morphine, only very small doses of morphine etc. etc...the list goes on. So the man in question I catheterised him and drew up a care plan for bladder washouts/bowel actions, but **most of all the reason I felt particularly effective when I tackled the medical staff over his pain control which was negligible. We eventually got a satisfactory pain control regime set up** and I did a few teaching sessions...regarding correct pain control regimes".
>
> (330, my emphasis)

The superior knowledge about pain control that this respondent had from previous experience afforded a powerful position within the ward team regarding this area of care. The respondent wrote "we eventually got a satisfactory pain control regime set up" (330, my emphasis). Given that medical staff have to write up and sign any prescribed medication, the implication is that the regimen was negotiated by the respondent and the medical staff.

Whilst there is no clear evidence[13] within this study that male nurses were able to negotiate with medical staff more readily than female nurses it is nevertheless worthy of note that this particular respondent was one of the two male student health visitors who participated in the study. It can be speculated that this led the superior actors (in this case the medical staff) to acknowledge and respect the respondent's knowledge base in a way which they may not have done had the respondent been a female nurse.

Given the evidence demonstrating the existence of the doctor-nurse "game" (Stein, 1967; Stein, Watts and Howell, 1990) in institutional settings, this process of negotiation between doctors and a nurse could be seen as an unusual occurrence. It is speculated that it is only possible when the superior knowledge base of the normally subordinate actor is overtly acknowledged by the superior actors.

6.2.2.2. Imposition of superior frameworks

Some respondents (n=9; 14.5%) were moved to confront the ward staff regarding issues of ward routine. However, one of the problems with routine organizations is that they are notoriously resistant to change and innovation (Goffman, 1974: Burns & Flam, 1987)) and respondents who adopted a confrontational approach often met with unyielding attitudes from the permanent ward staff.

[13]. It should be noted that 134 (98%) of the total 136 respondents in this study were women, herefore it would be inadvisable to make concrete judgements about gender differences within the ursing profession.

Several respondents (n=6; 9.7%) described incidents which they felt constituted abuse of older patients' rights. It was apparent that they felt particularly strongly about the treatment of older people, perhaps partly because they saw some patients as incapable of self-advocacy. One respondent described her distress at the treatment of a patient on a "psychogeriatric ward" where she was based as a student and the action she tried to take:

> **"I found the permanent staff on the ward to be quite indifferent to the patients most of the time**...on one particular occasion, when the patients were sitting around the four walls of the lounge area in chairs (normal practice!) two particularly nasty auxiliaries decided to liven things up and so they proceeded to aggravate (including kicking in the leg) a patient...to make her sing..I expressed my disapproval and proceeded to the office to report the incident to the trained staff. **I was told that this sort of thing is commonplace as the permanent staff were over-worked and frustrated.** Nothing was done, but the remainder of my time on that unit was made very uncomfortable" (327; my emphasis).

The organisational framework acceptable to the permanent and more powerful ward staff was adopted and maintained in spite of the student's protestations. The lack of respect accorded to the student nurse by ward staff of all grades reflects the power of the hierarchy which operates within rule-based organizations such as hospital wards. As she was only placed on the ward for a short and predetermined period of time, it was sufficient that the permanent staff made "the rest of (her) time on that unit very uncomfortable" (327). In this way, they demonstrated to the student that

she was not in a position to question their way of working, thereby reinforcing her subordinate status.

In this particular situation the nurse described having been "very fond" (327) of this particular patient. It was apparent in this study that there are particular conditions which apply to situations where subordinate nurses take action on behalf of older patients. More specifically, the establishment of a "close" relationship with an individual patient and subsequent abuse or ill-treatment of that patient by other staff may prompt nurses into adopting an advocacy role on that patient's behalf.

Subordinate status limited the degree of confrontation which the respondents were prepared to adopt on behalf of an individual patient. One nurse described her experience as a first year student on a "geriatric" ward, explaining how she had tried to prevent exacerbation of pressure sores on a stroke patient. This example demonstrates quite clearly how routines and rules can lead to inflexibility where a patient's needs are concerned. She commented:

> "...spending the whole day propped up in a chair was viewed as preferable to having short rests in bed. I remember asking the ward sister if I could put Mr X into bed but was told that "it wasn't time", all the patients were put back to bed after supper. **Being a first year student on my first ward I wasn't going to argue with the sister"** (358, my emphasis).

"Being a first year student" (358) is a position accorded little status and power within a ward setting. The socially shared rule system within the

nursing profession results in a situation whereby young, unqualified and inexperienced nurses feel unable to question older, more powerful staff, sometimes to the detriment of patient care and standards. By having such a rule system the stability and organisation of a professional group may be maintained and conflict is thereby reduced (Goffman, 1974). Feelings of inability to influence or change the circumstances of patient care were common amongst respondents who considered themselves to be subordinate. Another respondent confirmed this when she wrote:

> "As a student, elderly patients were made to do certain tasks at certain times and not allowed to act as an individual...**As first warders, we were not in a position to change these patterns...**" (354, my emphasis).

These feelings of inability to act as a change agent resulted in the framework of the superior actors being imposed onto the comparatively powerless and less experienced subordinate and the status quo was therefore maintained. Another respondent described what had happened when she had questioned the routine on the "long stay geriatric ward" where she was placed as a student nurse:

> "The ladies wore all the same hospital type clothing, were given the same food, given suppositories and baths on different "set" days, were "toileted" at regular (same) intervals...My biggest upset was to find that I was expected to get the ladies up in the morning by;
> 1. wash their bottom (face and hands washed by night staff) 2. swing them onto commode. 3. dress them whilst sitting on commode. 4. sit them on chair (without knickers) and back of dress open. 5. go onto next lady and use same "bum" water!

> This continued until you'd finished "your side" but before Sr. came on (10 ladies in 1 hour). I was appalled...My only "personal" contribution was to apply make-up to those who liked...**I complained to the nurse manager about the set-up and some brusque nurses - only to be told that "they really had hearts of gold"...how would things ever change without support from SR., staff and managers and such?"**
>
> (317, my emphasis)

The quotation above typifies the routine style of care on long-stay wards described by respondents in this study. Of interest here, however, is the reported reaction of the nurse manager when the respondent (a student nurse at the time) complained "about the set-up and some brusque nurses" (317). The respondent described the manager as suggesting the permanent staff "really had hearts of gold" (317). The common problems of low staffing levels and poor morale (Reed, 1989) on long-stay wards coupled with the image of work with older people as generally depressing and unfulfilling (Norman, 1987) can result in managers being reluctant to criticise permanent staff, perhaps because they feel that staff are already doing a difficult job. Problems in the recruitment of nurses to work with older people have been pointed out elsewhere (Norman, 1987) and it may be that managers are reluctant to criticise individuals for fear of unbalancing already tenuous staffing levels on the ward. However, the consequence is that it then reinforces the feelings of subordinate student nurses that management and permanent ward staff are intransigent and unwilling to change practice.

In one case, however, a respondent described how her status as the superior actor had facilitated what she saw as a higher standard of patient

care. She described her approach to a nursing auxiliary who had left the door open whilst a patient was on the toilet:

> "...I asked the aux.(iliary) involved "would you like to sit in such an embarrassing position and exposed for all the world to see?" I also stated "would you like your own mother to be in that position?" She said no, she never did this again, or at least not while I was on duty...**I was an SEN in charge of the ward**". (304, my emphasis).

Being "in charge of the ward" gave this respondent the power to question practice without fear of reproach. This particular incident demonstrates that the imposition of superior frameworks can have positive as well as negative consequences for patient care.

6.2.2.3. Disengagement strategies

In situations where nurses are not prepared to accept or conform to the framework dictated by the more powerful members of a situation they must utilise another strategy. Four (6.5%) respondents described incidents where they had resorted to total disengagement from a situation because of conflicts that arose. All four were qualified nurses but were "outsiders" entering a new ward situation where they experienced incidents which they felt were highly unsatisfactory for patients[14]. In the following example a respondent described how, as a newly qualified staff nurse, she had

[14] It is evident that this strategy is rarely an option for student nurses as they are allocated to a ward for a prescribed period of time. After that given period they leave the particular ward and move on to another clinical setting. It is therefore reasonable to suggest that this strategy is only used by qualified ward staff.

attempted to influence other ward staff by direct confrontation because of what she considered to be poor standards of patient care:

> "I was seconded to a geriatric rehabilitation unit where stroke victims were meant to receive constant physiotherapy and speech therapy..... It was on this unit that I met Mr B. who had not only had a CVA but also had senile dementia. He was soon incontinent and needed changing and washing umpteen times a day. The method of changing patients horrified me. The patient was rarely given privacy during this procedure. No curtain was provided to screen him. He was stripped in full view of anyone walking into the unit. He was not washed with soap and water each time thus he stank, as did the unit, and he became sore. **I took quite a number of staff to task about all the above points only to find myself laughed at. In fact I was even asked by a senior nursing officer not to try too hard. It was a matter of wait and see, another couple of days and she'll settle down.** Needless to say it was a downhill struggle to keep standards up. **I left soon afterwards".**
>
> (151, my emphasis).

Maintenance of stability within a highly rule-based system involves an acceptance of the rules by any outsider (Burns & Flam, 1987). In this situation, the outsider refused to accept the rules of the system and ended up leaving the ward. Although not **forced** to leave (i.e. sacked), this staff nurse felt she could not stay due to the intransigence of the "superior" staff and their refusal to negotiate. The comments about being asked "not to try too hard" and the assumption that the nurse would "settle down" (151) demonstrate that new nurses entering that situation were expected to conform to the already established system in operation on the ward.

Another respondent described finding herself in a similar situation as a staff nurse on a long-stay geriatric unit. The incident involved a patient, Mary (pseudonym), who had a badly ulcerated leg. She wrote:

> "Unfortunately I only stayed there 10 weeks...**Many incidents happened on this ward of which I was unhappy...In my quest to be accepted by the ward team, I did not do anything until Mary** (one of the patients). Mary's leg had been badly dressed. She was hurt and crying "don't say anything, they won't listen to you!" I redressed Mary's leg. Then took the bull by the horns. **The team did not support me. So I took the matter further - making it impossible for me to stay.** I was told that things would improve. They didn't for Mary who died six months later and I had left".
>
> (305, my emphasis).

This respondent felt it was "impossible for (her) to stay" (305) because of the lack of support accorded by the team for her decision. Initially she expressed that she had wished to be "accepted by the ward team" (305) and consequently had not done anything about incidents with which she was unhappy. This demonstrates the complexity of the position of staff in a "new" situation which can result in a feeling of inability to alter the status quo. When the subordinate party cannot negotiate or impose their own framework on a situation and cannot accept the status quo, it appears their only remaining option is disengagement.

6.2.2.4. The image of nurses who work with older people

The data suggest that in a few cases (n = 3; 5%) nurses who are considered incompetent to work in other areas may be placed to work with older people. In one case a respondent suggested that work with older people

may be used a punitive measure by the nursing management structure. She described what she saw as the consequences of this:

> "I feel that nurses' work with the geriatrics would improve if it was approached in a more positive way. **I feel this particularly needs to be recognised by the management. I have recently experienced working with nurses who have recently been disciplined, for a variety of reasons, and then found themselves transferred to a non-teaching geriatric ward! When geriatric nursing is seen as punishment (or a last resort for jobs) then there can be little doubt that motivation and quality care will be limited to a few dedicated individuals who have chosen that field.** They then have the further struggle of working with people who have no desire to be there".
>
> (329, my emphasis).

It is inevitable that if work with older people is being used as a punitive measure, the nurses who are **forced** to work on those wards will recognise it as such and may therefore lack dedication and interest in their work. This image of nurses who work with older people may influence younger, inexperienced nurses and direct them away from this area.

Another respondent described how her experience as a student on a rehabilitation ward influenced her view of nurses who worked with old people:

> " I was asked to get a patient out of bed...I was in the process of encouraging him to get out of bed and planned to see how much he could do for himself. **The SEN however took over and literally dragged him out of bed and dressed him herself. Considering it was supposed to be a rehab ward I felt that it totally defeated the object. I was very upset and horrified at the treatment of the patient".**
>
> (319,my emphasis).

Previous research by Waters (1991), based on observational evidence, has shown that the style of nursing practiced on "rehabilitation" wards for older people closely resembles the style identified on long-stay care wards for older people. The above quotation is supportive of this, highlighting perhaps that the aim of care on this particular "rehab" ward was the meeting of basic physical needs rather than facilitating improvement in health status/ability to undertake activities of daily living.

The respondent continued her description of the nurses on the ward commenting:

> **"It appeared to me that not very highly motivated people went into geriatric nursing...the majority of staff were...not enthusiastic about their work".**
>
> (319, my emphasis).

Whilst it is recognised that nursing work with older people remains a generally unpopular choice, there is a vicious circle in that jobs with low prestige tend to attract the least skilled or competent workers (Norman, 1987). This may lead nurses who have alternative career choices to avoid working with older people.

6.3. NURSES' CONSTRUCTIONS OF OLD AGE FROM INDIVIDUAL INTERACTIONS - THE IMPORTANCE OF "RELATIONSHIPS"

Between 5 and 6% of older people reside in institutional settings (OPCS, 1990) and they are likely to be amongst the most dependent of the older population (Johnson, 1990). As the incidents described in this section of the

study came from the institutional setting it can reasonably be assumed that the older people described in the incidents had fairly high levels of dependency.

This section draws on data from critical incidents described by respondents as examples of "effective" and "ineffective" practice. It is interesting to note that incidents described as "ineffective" also facilitate insight into how "effective" practice is constructed (and vice versa). In terms of interactions with older people, this section demonstrates that the provision of psycho-social care and, more particularly, the establishment of "good relationships" (n=14; 23%) with patients was the main concept through which respondents defined "effective" nursing *practice with older people.* Conversely, some respondents (n=10; 16%) expressed frustration and felt "ineffective" when dealing with patients with whom relationships were difficult to establish. In addition the images of increasing levels of dependency and disability, especially with patients whom the respondents viewed as having been previously active and capable individuals, proved to be a source of distress to a few respondents (n=9; 15%).

6.3.1. Images of dependency

The experience of contact with individuals who are deteriorating and are becoming increasingly dependent appeared to be disturbing and upsetting for some respondents (n=9; 15%). For example, one respondent described

her feelings about working with an old man with Altzheimer's disease:

> "He was doubly incontinent, had no communication and was very physically active and aggressive. All attempts at continence improvement failed...He did not sleep and so wandered all night frequently waking the other patients. With his double incontinence it was a battle to keep him clean, changing his clothes usually involved considerable aggression...**The overwhelming feeling in caring for him was of futility and hopelessness. The hope that he would die soon!**"
> (356, my emphasis)

The feelings of futility and hopelessness that this respondent expressed stemmed from the lack of possibility of "cure" for the patient and from the "battle" to maintain even a minimum standard of hygiene ("keep(ing) him clean" (356)). The respondent wrote that she hoped that "he would die soon" (356). This could be considered to be contrary to predominant ethos within nursing and medicine of preservation of life at whatever cost (Lamerton, 1973). However, the respondent could only see a future of further deterioration for the patient and implied that death would be a preferable option. The feelings of futility expressed by this respondent, however, demonstrate the obvious difficulties that some nurses may have when dealing with patients who are becoming increasingly dependent (Morgan, 1991) or aggressive.

The descriptions of the experience of nursing patients with increasing levels of dependency were particularly poignant with patients whom respondents considered to have been active individuals with a high quality of life before admission to hospital. For example, one practice nurse respondent described

her distress at the deteriorating function of a previously intelligent and active man:

> "..a male patient about 70 years of age was terminally ill patient on a chest unit with C/A bronchus. He looked very old and very ill. He did not recognise his relative or surroundings. His wife kept a very quiet and calm vigil by his beside. **I found it very hard to believe, seeing this man at this time, that he had been a practising solicitor and had a fairly well off background. Other than the usual terminal nursing nothing could be done to save him. I am left with an abiding memory of a once proud and intelligent man reduced to a shrivelled confused body rattling the cot sides and unable to communicate with his fellows. How very sad."**
>
> (153, my emphasis)

There are two issues evident in the description above. Firstly, the statement "other than the usual terminal nursing nothing could be done to save him" (153) highlights the impotence that the respondent felt because there was no hope of "cure"for the patient. Secondly, it is apparent that the respondent found the role-loss of this particular man disturbing. There is research evidence which demonstrates that social class differentials show a consistent gradient of disability at all ages (Victor, 1987) and that those in social classes 1 and 2 show lower levels of disability than those in 4 and 5 (DHSS, 1980). Research on admissions to hospital suggest that admission rates rise with declining social class (DHSS, 1980), therefore it seems reasonable to postulate that nurses working in institutions are more likely to have more experience of dealing with individuals from social classes 4 and 5 than with those from "higher" social classes. The fact that this "proud and intelligent" man (153) was now severely disabled and dying and was reduced to a "shrivelled confused body" (153) saddened the respondent.

The concept of social loss has been intensively discussed in the area of death and dying (Glaser and Strauss, 1965; Sudnow, 1967; Field, 1984). The research suggests that nurses find caring for dying people who they perceive to have high "social value" more difficult or stressful than caring for other patients. Whilst the death of an older person has been described as easier to accept than the death of a younger person or child (Quint, 1967), Glaser and Strauss (1965) and Sudnow (1967) have pointed out that high social status is at least as significant a factor in the difficulties nurses experience.

Another respondent described an older patient with motor neurone disease as "an intelligent man who had been very active all his life" (313). She continued:

> "He was very frustrated and I could empathize with him... I also felt frustrated because I could not see how to help him alleviate his sadness" (313).

Previous research suggests that basic care nursing work with older men can be easier than with women because it does not confront nurses with a poignant image of their future selves (Evers, 1981c). However, the data in this study suggest that complete deterioration of function in older men of previous social standing and responsibility may in fact be very difficult for young female nurses to deal with. Five (8%) respondents described incidents where they had been nursing men who had held responsible jobs before retirement. All were described by the respondents as interactions

demonstrating "ineffective" nursing practice. In all cases the respondents expressed a level of empathy regarding the role-loss that these men were experiencing. In three (5%) of these incidents the distressing element of the incident for the respondent was the frustration felt by the patients themselves regarding their illness/disability.

The issue of older patients who wanted to die also appeared to cause distress for some respondents (n=3; 5%). Respondents felt they were inadequately trained to provide the counselling and support required for people who had lost the will to live. For example, one respondent described a 90 year old retired GP she had nursed when working as a staff nurse in a nursing home:

> "...(I asked) him to make sure he rang for a nurse before transferring from bed to chair as **he had had numerous falls...he said he didn't mind if he fell and fractured a bone as he would then end up in hospital which is where elderly people often died...he said that as he was 90 he felt that his useful life was over and it was time he died...he had previously been very active and was now confined to a wheelchair...**I made a token gesture of saying that there were still things for him to look forward to. But I knew we were both just going through the motions...**I felt I was very inadequately equipped to deal with the incident re my training and experience. I had very mixed feelings about the incident. I had known other elderly people who said that they were ready to die as they had lived their life but always felt that they were not 100% in earnest...I felt sorry for him**". (331).

Again, the patient this respondent was dealing with had "previously been very active" (331) and had been a GP. She also described making "the token gesture of saying there were still things for him to look forward to" (331).

However, it appeared that the respondent was not convinced that there was anything for the patient to look forward to as his future was likely to consist of further deterioration and dysfunction. The image of this now dependent man who said that it was time he died led to the "mixed feelings" of the respondent. Dealing with dying patients can often create feelings of conflict for nurses (Morgan, 1991) but in this particular case the man was not dying in the immediate physiological sense, rather he was expressing the **wish** to die. It was this wish to die, rather than live a dependent life, that was a source of distress to the respondent.

6.3.2. Difficult patients

Dependent and incommunicative older patients can be difficult to establish relationships with (Gubrium, 1986). The data in this study demonstrate that some respondents (n=10; 16%) experienced problems in establishing relationships with particular older patients. The age-gap between health and social workers and older clients can create a situation where there is little common ground or understanding (Biggs, 1989). Whilst nurses may attempt to empathise with their older patients, they find that they often know little or nothing about the social backgrounds of those clients and therefore frequently fail to understand the psychological aspects of growing older (Gubrium 1986). Previous authors have suggested that there is an assumption that older people should be "grateful recipients of care" (Townsend, 1981) provided by formal agencies. However it has been

pointed out that each patient possesses the latent power to disrupt nursing work through non-compliance (May and Kelly, 1982).

It is demonstrated in the next section (6.3.3.) that respondents gained a level of satisfaction in work with older people when a patient was grateful and complied with the care prescribed. However, when patients demonstrated a reluctance or outright refusal to conform to prescribed care, it created a situation of anxiety for respondents. For example, one respondent described her feelings of inadequacy when a patient refused to conform to the prescribed care:

> "he refused a male nurse to bed-bath him, refused to wear a urideme (catheters failed as he pulled them out), refused to eat and when he did speak he intimated that he wanted to die. **I decided that a one-to-one approach would be best as he could build up confidence in one person however I failed miserably - he continued to refuse medication, food, drinks etc. He wouldn't communicate with me. At the time I felt totally inadequate and a little angry that I wasn't getting anywhere.** However I persevered and tried to build up a caring relationship...despite attempts by other members of staff to help him he died a week later of pneumonia".
>
> (355, my emphasis).

The attempts to "build a caring relationship" (355) can be seen as the medium through which the respondent felt she could have persuaded the patient to accept help. Dingwall, Rafferty and Webster (1988) have observed that the formulation of "good" interpersonal relationships between nurses and patients have the effect of making the patient more malleable. The inadequacy and anger the respondent described at failing to persuade the patient to form a relationship, and consequently to conform to the care

she felt would benefit him, demonstrates an underlying assumption that prescribed care was ultimately for the good of the patient.

Rejection by a patient appeared to make some respondents feel inadequate or angry perhaps because it compromises nursing's underlying principles of benevolence and "caring" (Kitson, 1987). One nurse described her feelings when a patient discharged herself from the ward against her advice:

> "**She was a most difficult client who would refuse most of the care offered to her,** in fact if anything I found myself drawn towards her trying to make her change her mind...she went home having discharged herself against advice and then had the social worker writing a letter complaining about the care she received etc....**initially I felt angry and bitter towards her, I couldn't help but feel so inadequate that we couldn't persuade her to *accept help***".
>
> (342, my emphasis).

Feelings of inadequacy were common amongst respondents in interactions with difficult patients. They felt that they should be able to persuade patients to accept the prescribed care and it was seen as a personal failure when this was rejected. A degree of ambivalence is evident in the situation described above as the respondent had to balance her feelings of anger and frustration about the patient's behaviour with the right of the patient to personal choice. In the following example the nurse acknowledged that the patient's behaviour had been a source of frustration to her;

> "...I attempted to stop her by taking hold of her arm. She became very aggressive and pushed me against a wall...As the incident was taking place I was thinking that I had to stop her from leaving the ward without using physical force. **I was**

irritated by her actions. After the incident I felt a dislike of the patient, especially as she used to hurl abuse at me..."
(314, my emphasis).

The respondent commented that she felt "a dislike of the patient" but justified this in terms of the abusive nature of the patient's behaviour. The justification of this dislike could be taken as an indication that the respondent realised that nurses are supposed to care for all patients indiscriminately (Altschul, 1972). The dislike of the patient that the respondent described appears to stem from the patient's lack of conformity to the prescribed care. She did not want the patient to leave the ward as she considered it would be to her detriment. Balanced against this was the patient's behaviour which the respondent found disturbing and difficult.
The preference of some nurses for more compliant older patients or the more "straightforward" cases has been pointed out by other researchers (Evers, 1981a & c).

6.3.3. Establishing a "good relationship"

The data shows that one of the major indicators of "effective" interaction with older people was the establishment of a "good" relationship (n = 14; 23%). In 12 (19%) cases the establishment of relationships with patients appeared to be sanctioned by the ward philosophy, which was oriented towards individual care. In the other two (3%) cases, as we shall see, the relationships were established "regardless of the ward routine" (302 & 319). It was postulated in section 6.2.1. that the ward routine appeared to

undermine respondents' desires to be involved in psycho-social as well as physical aspects of patient care.

Researchers have suggested that psycho-social aspects of patient care are currently incorporated into the **definition** of what constitutes nursing work (May, 1992)[15] whereas previously they had been an **informal** part of nursing work. It is apparent in this study that a few respondents found some older people interesting and enlightening to talk to and the establishment of a "good relationship" facilitated the delivery of what nurses saw as a good standard of care. One respondent described her experience as a staff nurse, on a ward using a patient allocation system, in caring for a man who was dying of cancer and his wife:

> "Mrs S. came in each day to see him and I felt as though I was caring for them both, they were to me one family which I cared for as one unit...**each day I bed-bathed him, fed and gave drinks to him and we talked of many things - I learnt a lot from him and felt that when he passed away his death was with dignity because myself and the ward team had worked together in providing a safe and dignified environment...**I feel proud to have cared for Mr S and privileged to have known these two people...".
>
> (305, my emphasis)

Establishing good relationships lies at the core of nurses' constructions of practice (Melia, 1981). In this respect, working with older people could be seen as no different from other types of nursing. However, as the focus of

[15] May (1992) argues that psycho-social intervention with patients had previously been undertaken **informally** by nurses i.e. it was not **expected** as part of "routine" nursing work. However, more recently there has been an incorporation of this paradigm into the definition of what constitutes nursing **work**. In this way, he argues, "friendly and familiar encounters are transformed into the site of work rather than a relief from its routines".

care could generally not be "cure", a focus on the more psycho-social aspects of peoples' daily lives was seen by respondents as a **vital** component of quality care for older people. The importance of attention to psycho-social need in areas such as terminal care (where "cure" is also an unrealistic goal) have been argued for elsewhere (in particular see the seminal work on terminal care by Kubler-Ross, 1970), though there is evidence that conversing with dying patients is still not generally regarded by nurses as "work" (James, 1987).

One respondent described how, as a student nurse, she had made a particular effort to build a relationship with a 65 year old man who had recently suffered a stroke and that this had enhanced her understanding and level of empathy with dependent stroke patients:

> "As a previously very articulate gentleman and only just retired he was particularly distressed by his now dependent status and his inability to communicate. The decision that I made were that, **regardless of the ward routine, I would make time to sit with him and talk through his anxiety with his wife...I felt that I had gained a great deal of experience and slightly better understanding of how it must feel to be in this situation.."**
> (302, my emphasis)

Again, the issue of the previous social status of the patient is evident here. It is possible that this respondent made a particular effort to establish a relationship with the patient because she identified with his social role loss. Describing the patient as a "previously very articulate gentleman" (302), it could be argued that the respondent had an enhanced level of empathy with him and his wife. However, there are two other important issues evident in

the above description. Firstly, there are indications in the passage that the nurse's level of empathy was enhanced by discussing the patient's situation with his wife. As the interaction was constructed by the respondent as an example of "effective" practice, it is suggested that the respondent established a "surrogate" relationship with the patient's wife in order to "talk through his anxiety" (302). Secondly, the respondent stated that talking to the patient's wife had enhanced her understanding but that this had to be done "regardless of the ward routine" (302). Making time to sit and talk to patients appeared to be valued by respondents in that it enhanced the standard of care that they felt they were able to give. However this had to be balanced against the risks of abandoning or jeopardising the "ward routine". The institutional system frequently presented barriers to the establishment of relationships with clients because of the emphasis on the routine aspects of care (see 6.2.1.).

One respondent suggested that being a student nurse on a ward had enabled her to become more easily involved in talking to a woman who was recovering from a mastectomy. She wrote:

> **"I felt it was important to get to know her better and see how she was coping.** This was obviously important to her because she was able to talk to me quite openly about her feelings about death. **At the time I found it hard to grasp that she was confiding in me...later I realised that she had no-one else to confide in (the trained staff were too busy with the practicalities of the ward)".**
>
> (319, my emphasis)

It has already been described that student nurses (particularly in the first year) may have to conform to the organisation of work determined by the permanent ward staff (see page 202). However, in the above quotation there is a suggestion that the respondent's status freed her up to do work other than that involved in "the practicalities of the ward" (319).

This is corroborated by the following example where a respondent describes her care of an old man who was admitted to the ward. As a first year student on a ward where they practised a patient allocation system for students, the respondent described how being able to build a relationship had resulted in a patients' gratitude for her care to her satisfaction:

> **"This took place many years ago but the ward was particularly innovative and I was asked if I would like to be "his" nurse for the period of my allocation.** It was my first day, he was the first patient I had admitted...I was asked if I would like to be 'his' nurse for the period of my allocation... during the following weeks I began to know O. very well...I became very fond of O. and found that he liked me to perform his care, indicating that he preferred to wait for things to be done until I came on duty...one day I came on duty and went to say hello as was my custom. As I got close to him, he smiled and in barely audible words said "my nurse"!...**it was probably one of the most rewarding moments of my student years...someone who mattered very much was grateful for my care".**
>
> (306, my emphasis)

The example above demonstrates clearly the satisfaction gained by nurses who build a successful relationship with a patient. However, as we have seen, building a successful relationship is dependent on the cooperation of the patient, cooperation which is not always readily forthcoming. Nurses

who strive unsuccessfully to build a relationship may become demoralised when that relationship is not valued by the patient (see section 6.3.2.)

6.4. TRAINING TO MEET DEPENDENCY - KNOWLEDGE, SKILLS AND BELIEFS

It is apparent from respondents' descriptions of work with older people in institutions is that the main goal of the system was the successful meeting of physical dependency needs. The routine methods of patient care described in section 6.2.1. serve a purpose in that they ensure a minimum standard of basic nursing care, which focuses predominantly on physical needs. Whilst some respondents expressed that this was "not enough" and attempted to provide "psychosocial care" through the building of relationships, there appeared to be little orientation or encouragement for them to develop their skills and knowledge of the wider social implications of the ageing process.

The model which is adopted in institutional settings appears to be oriented around the notion that older age is a time of functional dependency. It has been argued that a view of old age and dependency as synonymous is held by the public and health professionals alike (Norman, 1981). It is assumed that the 5% of older people that reside in institutions tend to be amongst the most dependent of the older population (Tinker, 1984). However, research evidence suggests that functional capacity is not a good predictor of admission to institutional care, rather that social issues such as support

from relatives, widowhood etc. are the key determinants of admission (Townsend, 1965; Graham & Livesley, 1983; Booth, 1985).

Although there is little focus on the "cure" of patients residing in institutions, as this is considered inappropriate for many older people (Reed and Bond, 1991), it has been suggested that both nurses and social workers rely on knowledge and skills from other health care settings, borrowed in particular from the discipline of medicine, in their interactions with older people (Phillipson and Strang, 1986; Bowl, 1986). The goal of nursing care of older people appears to be the prevention of further deterioration and the maintenance of the status quo, with little or no emphasis on improvement of health status. The knowledge and skills which nurses develop in these settings focus on achievement of this goal.

6.4.1. The knowledge base

It would appear that the knowledge base that student health visitors and practice nurses possess from their work in institutions rests fundamentally within the discipline of geriatric medicine. The basis for geriatric medicine lies in the assumption that increasing age goes hand in hand with increased levels of disability and dependence. Whilst there is some evidence for a significant increase in incapacity beyond the age of 70 (Johnson, 1990), the self-perception and reality for most older people is that they are fit and continue to lead active lives (Johnson, 1972).

The perspective of geriatrics has dominated teaching in both general and community nurse training (Phillipson and Strang, 1986). The basis for the care of older people in institutions focuses on deteriorating function, illness and functional dependency (Reed, 1989). This is then absorbed and interpreted by nurses as "normal ageing". It could be argued that nurses' constructions of "normal ageing" are actually based on experience of "abnormal ageing", as the older people they have contact with in institutional settings are amongst the most vulnerable and dependent of the older population. It would therefore be reasonable to suggest that the nursing care of older people has a very scant and frequently misinformed knowledge base when it comes to working with a wider cross-section of the older population.

Knowledge and experience are undeniably connected. Much knowledge in itself is derived from direct human experience of a particular phenomenon (Kant, 1951). The knowledge base that nurses possess for the care of older people is based on experience of interactions with the most vulnerable and dependent. It is the case, therefore, that knowledge of this proportion of the older population is an inappropriate basis for work with the majority of the older population, most of whom are neither vulnerable nor dependent.

6.4.2. Skills utilisation

As a consequence of a scant knowledge base of the facts about "normal ageing", the skills that nurses utilise and develop when caring for older

people are also oriented around the meeting of dependency needs. It is suggested that this focus may actually increase the level of dependence of some older people (Townsend, 1981). One respondent suggested that this was the case:

> "..my thoughts now are that my care was just an unquestioning continuation of a routine that resembled a prison sentence - and that perhaps **her potential to live in the real world had not even been considered and that we had, as professionals, contributed to her decline".**
>
> (334, my emphasis)

It would appear that nurses working in institutional care of the elderly settings utilise a predominantly problem-oriented approach to nursing care (Reed, 1989). This is fostered through the task-oriented approach to the organisation of work in hospital wards and the meeting of patients' physical needs. However, Reed (1989) suggests that this approach is inappropriate as nurses rarely "solve" older people's problems. Whilst respondents viewed psycho-social care as a vital component of "effective" nursing care, it would seem that, on most wards which care specifically for older people, the emphasis is on the successful attainment of the physical activities of daily life. This emphasis arises from the high value placed by permanent ward staff on physical aspects of patient care and the correspondingly low value attached to aspects such as psychological status and social activities.

Whilst the emphasis is on skill to meet physical need, many nurses consider that this is only one aspect of total patient care (May, 1992). In their individual interactions with older people and their families, nurses have the

opportunity to deal with issues other than physical care, for example bereavement counselling. However, in the case of the student or newly qualified nurse, little support, guidance or education is given from more experienced staff to facilitate the development of skills necessary for a broader nursing role. One respondent described her experience of a death on a ward:

> "...The patient died in the middle of the night, just as his daughter had gone home to check on her own children. So **I was faced with explaining to her what to do following a death, because death was something she had not been prepared for psychologically. I was given a bereavement leaflet and told to speak to her by the night sister.** I refused and said **I felt incapable of dealing with the situation...I was unable or did not have the experience to deal with the situation. I felt after that incident that I should have been more supported".**
>
> (306, my emphasis).

The evidence in this study points to the high value attached by permanent ward staff to the meeting of physical need and the low value given to other skills such as communication. It was suggested that the provision of basic physical care may be considered synonymous with "routine" or basic care. Another respondent, who was highly experienced in work with older people, summed up why she had moved onto a new career in nursing:

> "when you are only able to offer a very basic level of care your working day ends with feelings of what you could have done (or should have done)...morale is obviously affected by this" (329)

The expectation of nurses that they should be able to offer more than a basic level of care stems from moves within the profession for nursing to treat the patient as a "whole" (Melia, 1981; May, 1992).

6.4.3. Beliefs about ageing

The beliefs and attitudes that nurses hold regarding older people are reflected in both their behaviour and their language. Because of the experiences that most nurses have of work with older people, their belief systems appear to be oriented around old age as a time of dependence. This is clearly demonstrated in:

a) descriptions of older people and

b) in the assumptions that individual nurses make about old people and their abilities.

6.4.3.1. The use of age-specific language in nursing

Belief and value systems are frequently portrayed in the language that we use and are shaped by the language we hear (Nuessel, 1982; Barbato and Feezel, 1987). Whilst the written form of language (such as in the critical incident section of this study) may be more formalised and carefully thought out, it still reveals underlying attitudes and beliefs which the writer may be unaware of. Words used to describe older people can be divided into language focusing on the context and that which focuses on individuals.

6.4.3.1.1. Contextual language

In this study, the use of the term "geriatric" as a noun to describe both individual older people and the settings in which older people are cared for was common. Norman (1987) complained of the way the term "geriatric" is used as a noun suggesting that the many euphemisms used to replace the word "old" suggested an essentially negative view of old age which avoids referring to it in a straightforward way. However, in the context of this study, it is suggested that the common use of this term by respondents reflects the fact that the structure of institutional settings is often determined by the medical profession (Illich, 1977).

The term "geriatric" is in popular use as a derogatory stereotype used to reflect the deleterious effects of ageing. It has its roots in medical terminology and its common use in nursing portrays the underlying influence of the medical profession in defining the purpose and function of institutional care (Goffman, 1961). Whilst social scientists favour the term "gerontology" which encapsulates a broader, more socially oriented construction of older people's lives, this concept was not evident in nurses' descriptions of interactions with older people.

However, some nurses appeared to treat the term "geriatric" with a degree of scepticism. Several respondents used the word to describe either the setting or individual older people but placed it within inverted commas (for examples see 330 and 353) which suggests that whilst the term is in

common use within the nursing profession, it may be appropriate only in the absence of alternatives.

Alternatives to "geriatric" were however evident in some respondents' descriptions of work with older people. Wards on which older people were cared for were frequently termed "care of the elderly wards". This phrase demonstrates the underlying age stratification system which operates in institutional settings, where older people are often separated from other adults purely by virtue of their age.

6.4.3.1.2. Individual descriptions

Individual older people were described with care by the respondents. Because the written word stands as a testimony for the future, it is suggested that descriptions of interactions were more formal and pre-meditated than verbal descriptions might have been. There was no evidence of use of the term 'geriatric' to describe individual older people, reflecting a difference between generic and individual terminology.

One nurse described a patient as "usually just pleasantly confused" (357), continuing that the patient had become more of a problem in the nursing home when she became "increasingly agitated". This suggests that, for this respondent, senile dementia may lie along a continuum from "pleasant" to "unpleasant". In general, nurses expressed difficulty in dealing with the behaviour of some older people with senile dementia, in particular those who

displayed aggressive behaviour. The idea that senile dementia is acceptable and easy to handle if it results in a state of pleasant confusion, but is otherwise problematic in terms of nursing management of patients, may reflect a desire to avoid the more depressing aspects of the ageing process.

6.4.3.2. Assumptions about old age

The influence of the powerful images of ageing that nurses have can lead some to make assumptions about the behaviours and needs of older people. Some of these assumptions serve as a reminder of the differences in life-perceptions of the younger nurse and the older patients and may prevent the nurse from establishing meaningful relationships with patients. The establishment of meaningful relationships with older clients is often avoided by younger helpers as it prevents the inconvenience and pain of confronting their own future ageing (Biggs, 1988).

One student health visitor respondent described her feelings about the wife of an older man she was nursing who had suffered a severe stroke and subsequent mid-thigh amputation. She described the situation for the couple in the following way:

> "The elderly wife had been cossetted most of her life and would, much as she loved her husband, **have coped more easily being a widow than suddenly having a totally dependent husband on her hands**".
>
> (301, my emphasis).

Assumptions about older people's inability to cope with changing circumstances are underpinned by a mental model of older people as inflexible and intransigent. In fact, the research evidence shows that older people are capable of defining their own needs (Johnson, 1972). The realisation of the actual capacities of a person whom a nurse has assumed is dependent and incompetent can be a humbling and revealing experience. For example, one nurse described two older women she had worked with, one (L.) who was extremely deaf and the other (A.) who had senile dementia and was often out of touch with the present. The nurse had approached L., who was reading a newspaper, and offered her the glasses that were on her locker. She wrote:

> "She declined but I persuaded her to wear them. Every time I passed her bed she offered me the glasses. I said "No, you must wear them L." in a very slow clear voice. Meanwhile A. was wandering around the ward asking if anyone had seen her glasses. Initially I presumed she had misplaced them, being forgetful. Until I realized my own mistake! I felt very humble and embarrassed at my attitude. (360).

The presumption that the older person was in error rather than the nurse herself demonstrates clearly an underpinning belief that older people are incapable of judgement. Whilst this particular nurse found the experience "humbling", the real issue has to be whether experiences such as these facilitate a change in attitudes.

6.5. VISIONS OF THE SELF AND SIGNIFICANT OTHERS

The data indicate that work with older people led some respondents (n = 10; 16%) to question their own future old age and to speculate about their own

mortality. Coming to terms with one's own mortality and morbidity can be problematic in a society which places a high cultural value on independence, youth, and vitality (Featherstone & Hepworth, 1990). Although nursing work in general often involves confronting the reality of suffering to a greater extent than most lay people have to (Menzies, 1960), the visions of deteriorating function and imminent death aroused by work with older people stirred up particularly powerful emotions for many respondents (see also section 6.3.1.).

It is apparent that, for nurses, the predominant image of old age that they are presented with in institutions is one of decay, degeneration and increasing dependence. Whilst this may make them question their own future old age, it may also direct them away from work with older people as a strategy to avoid confronting these issues. Evers (1981c) has highlighted the particular difficulties that some female nurses may have in working with older women because of the image of their future selves.

Rejection of work with older people due to the powerful images of what the ageing process involves is not uncommon. One nurse described in the questionnaire that she had written out her resignation several times during her 'geriatric' placement and was asked in the follow-up interview why she had felt like this. She said:

> "It upset me basically. There was so much lack of dignity...I don't believe in doing the job by halves and that's what working with the elderly was...**it was just like they were**

> **waiting to die. It was awful. It makes you question your own mortality a bit. You think, you know, is that how life ends for people?...it was awful, I hated it."** (333 (I), my emphasis).

Exploring one's own mortality can be a painful and revealing process for many nurses, particularly when the images of ageing in institutions tend to conform to the stereotypes of ageing held by the wider society (Barrow, 1986). The feelings of ambivalence associated with exploring one's own mortality have been identified in other specialties such as care of the dying (Morgan, 1991). This ambivalence has been identified as a source of anxiety for student and newly qualified nurses when working with older people (Parkes, 1985).

A degree of ambivalence about work with older people was evident in respondents' descriptions of their interactions. Many respondents expressed concern for the old and frail whilst on the other hand revealing a degree of anxiety about working with them. The respondent quoted above demonstrated this ambivalence quite clearly when she was asked why she had "hated" working with older people:

> **"It was because of the staff and the system. I liked working with the people...I just think, I enjoyed it, I found them very interesting, the elderly people, but it was the care and the system. It was awful.** There was no respect for the fact that they had lived their lives" (333 (I), my emphasis).

This quote shows clearly the difference between interactions with individual old people, who the respondent found "interesting", and the structural system within which those people were being cared for.

Exploring the reasons why professional helpers such as social workers find work with older people problematic, Biggs (1988) suggests that younger helpers try to avoid an examination of their own future old age and therefore are reluctant to work with this group, the images of whom lead them to question their own future. In the example above it is apparent that this particular respondent was faced with a poignant image of her own possible future when she looked at the old people she was working with, so much so that she almost left nursing as a consequence (333).

Nurses may attempt to use adaptive strategies such as disengagement to avoid confronting their own ageing, but on an emotional level the images of old age in some institutions cannot fail to disturb. Ego defensiveness, recognised by Katz (1960) as a major influence in attitude formation, serves to protect individuals from threats to their self-esteem. Avoiding work with older people altogether may therefore reduce the risk to student nurses' already vulnerable self-image (McCabe, 1989).

Whilst a general reluctance to work with older age-groups has been well-documented in the nursing literature (Hardie, 1975; Treharne, 1990), nurses' own fears about their own old age are rarely mentioned as a possible causative factor. Caring for the old and more particularly the dying has, however, been identified as a source of anxiety for student and newly qualified nurses (Parkes, 1985).

Nurses who choose not to reflect on their own future old age may instead deflect their emotional response to the negative image of old age which they are confronted with onto other members of their family, particularly parents and grandparents. If the nurse herself has ageing relatives, working with older people may lead her to speculate about the future for those people. One nurse expressed her fears about her relatives and older friends being cared for on the ward where she was placed as a student nurse:

> "...my contact prior to nurse training with elderly people were my own relatives and neighbours, a mixed bunch, from varying backgrounds with very different views, interests and lifestyles. To my horror these qualities were not respected by fellow nurses and other professionals on the "long stay geriatric ward" where I worked as an 18 year old student nurse....I left the ward and **just dreaded the thought of my friends and relatives who were elderly ever being there**".
>
> (317, my emphasis).

It appears that there may be a mis-match of perceptions of old age when comparing personal and professional experiences of contact with older people. This mis-match stems from the experiences of old age from interactions with old people on an individual level, who this respondent described as having "different views, interests and lifestyles", and the experiences of work in institutional settings. The predictive element of these perceptions is the knowledge that relatives, friends and ourselves are gradually ageing. Several respondents in the study said that whilst they enjoyed the work they had done with individual older people, they did not like working with "the elderly". This reveals a tension between social

categories based on generalisation about ageing and actual personal or work experience with individual older people.

Being faced with visions of the dependent status of patients in institutions may increase nurses' feelings of ambivalence about work with older people. Another respondent, who had found her student placements with older people in institutions "really distressful" (330-) explained her experiences further in the interview. She said:

> "I found care of the elderly stressful...there was one nurse who would strip people off, naked, get three of them lined up on a commode, do their business and have them wash naked. I just found it so undignified and all the time I was thinking that could be my parents..." (330 (I))

The idea that the people being cared for on this ward "could be (her) parents" coupled with the "undignified" nature of the care appeared to create the stress that this respondent associated with work with older people.

By comparison some respondents who had personal experience of caring for friends or relatives who are old revealed an increased degree of empathy and understanding of older people and their needs. One respondent described how she felt when an older patient died without any close relatives present:

> "...The patient had died. I felt so sorry that the relatives had not been able to say goodbye, and that a relative was not present. I was sat talking and holding the patient's hand, but I don't feel this is quite the same...**I felt very sad, I've also**

> **been in the position of not being able to say goodbye to a loved one."** (304, my emphasis).

Although this nurse directly expressed feelings of regret for the relatives that were not able to be present, she also clearly felt the dying patient had been denied something as well. Whilst some nurses try to be surrogate relatives in caring for patients, they may feel that the level of support or care is not "quite the same" as that which could have been provided by significant others. Nevertheless, this level of empathy with the patient and his/her family stemmed from this nurse's experience with her own family. On one level it could be argued that this "personal" perspective on what is desirable for a dying patient is little more than dubious self-projection. It certainly could militate against the maintenance of what Altschul (1972) terms a desirable level of "professional distance" in nursing. However, the respondent who described the above incident commented on the philosophy that underpinned her whole approach to nursing work:

> "...it's not just a job. You're involved with people and emotions. **I always tell the students, treat people how you yourself would wish to be treated.** With this in mind I don't think one can go far wrong"
>
> (304, my emphasis).

Whilst it has been suggested that, in the case of older people, imagining oneself to be old can be a painful and revealing experience (Biggs, 1988), this respondent believed that empathy ["projecting one's personality into the object of contemplation" (The Concise Oxford Dictionary)] was a key aspect of providing "good" patient care.

Self-reflection can also have other positive consequences for the care that some nurses deliver to older people. Nurses who realise that they too will have to cope with their own old age one day may feel they have a vested interest in improving the image of old age that society projects (Featherstone & Hepworth, 1990). One respondent described how she thought she would feel about being called "elderly" when she is older:

> "I think the term elderly is a misleading and inappropriate title. I certainly hope I'm not categorised like this when I'm older than I am now" (334)

Another respondent reflected back on her experiences of work with older people during her nurse training (six years previously) and suggested that she had subsequently become interested in that group as a consequence of her parents growing older:

> "I was pushed towards these old people being told to talk to them - which I didn't know how to. **With maturity, especially seeing your own parents becoming "elderly people" I think you have more to offer".**
>
> (318, my emphasis).

As was shown in chapter 5, there was no statistically significant difference in this study between age groups with regard to the levels of satisfaction expressed about working with older people. However, it would appear that, for some nurses, the experience of personal contact with older individuals may enhance their professional practice with that age group. "Having more to offer" in this context is taken to mean that there is an increased level of understanding between the nurse and old people in general because of

personal experience. Biggs (1989) suggests that the life-projects of young and old may be so different that there is no shared common ground for understanding. It may be that the establishment of close relationships with older people (such as parents) is the key to enhanced understanding between different age groups.

6.6. CONCLUSION

This chapter has provided evidence from data collected in the form of critical incidents which supports the contention that the care of older people in hospitals remains characterised by routine organisation of care and a focus on the meeting of physical need (Baker, 1978; Reed, 1989; Waters, 1991). Routine organisation of care militates against the establishment of "good" relationships with patients, which many nurses see as the main indicator of a high standard of care in areas where "cure" is generally considered unrealistic.

The images of deteriorating life trajectories and increasing levels of dependency in older people have been shown to be a source of distress and frustration for many nurses on a professional and a personal level as they confront nurses with a poignant image of their own future ageing and that of significant others.

It is assumed that previous experiences of nursing work with older people have important implications for subsequent work in the community with this client group. It is respondents' work in the community setting with older people that will be the subject of the following chapters.

CHAPTER 7.

THE STRUCTURAL CONTEXT OF HEALTH VISITING AND PRACTICE NURSING WORK WITH OLDER PEOPLE

7.1. INTRODUCTION

This chapter describes the structural contexts of health visiting (training and practice) and practice nursing work, examining data which arose mainly from interviews with student health visitor (n=8), practice nurse (n=8) and experienced health visitor (n=6) respondents[16]. For the sake of clarity, the chapter is divided into three parts. The first (section 7.2.) considers the structural context of health visitor training whilst the second and third (sections 7.3 & 7.4.) focus on the structural context of practice nursing work. The data demonstrate that the policy agenda and other organisational influences on both health visiting and practice nursing work serve to contain practice within the boundaries of what is required or acceptable to the superior or more powerful actors (Goffman, 1974) within the system.

In the case of student health visitor respondents, the data make it evident that the influence of field work teachers and other experienced health visitors during training serve to maintain the orientation of practice to work with the under fives. This is further compounded by the rigid guidelines

[16]. Where data from critical incidents is used for illuminative purposes, the abbreviation "CI" will be inserted after the quote.

given by some health authorities for visits to the under fives which leave health visitors with little opportunity and incentive to visit other groups, including older people. The difference between the model of practice espoused in the academic segment of training and that experienced in the field (the theory-practice gap), in particular the requirement of the course for students to visit what is described in this chapter as "the token elderly", is described as a source of frustration and disappointment to health visitor students.

The data from the practice nurse respondents demonstrates that the influence of the employing GP over practice nurses is of paramount importance in defining the boundaries of practice nursing work. The policy agenda dictates that the relationship between the two groups operates on the basis of employer-employee and, consequently, the GP has the potential for a substantial degree of control over his/her practice nurse's work. In particular, practice nurse respondents described having difficulties with income generating activities and with the delegation of what they saw as "doctor's work". The strategies that respondents used in order to establish control over their own work content and conditions are described in detail.

7.2. THE STRUCTURAL CONTEXT OF HEALTH VISITOR WORK AND TRAINING

Health visitor training has, as one of its primary aims, a change of focus from the "cure" orientation of general nurse training[17] to a focus on strategies for health promotion, health education and the searching out of health needs (CETHV, 1977). There are three essential components of health visitor training: the academic input from higher education, field work experience and supervised practice.

Research by Dingwall (1977) has suggested that of these three areas, student health visitors are more impressed by the models of practice presented by their field-work teachers[18] than by those presented in the education segment. The data from this study demonstrate that field work and supervised practice serve to maintain "traditional" and established patterns of health visiting practice, thereby limiting opportunity for the type of practice espoused by the educational establishments (the academic segment of training).

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[17] It is acknowledged that the advent of Project 2000 heralds a change of focus within general nurse training to encapsulate the concept of "health" as well as illness. However, none of the respondents in this study would have undergone P2000-style training.

[18] It is recognised that the term "field work teacher" has been replaced by "community practice teacher". However, as the student health visitor respondents used the former terminology, that is the term used for the purposes of this study.

7.2.1. Realising the theory-practice gap - field work

Respondents described the theoretical/academic segment of health visitor training as presenting them with an "idealistic" version of health visiting practice. One student commented:

> **"It's very idealistic, the course is very idealistic,** you know, you will do this and you will do that. **You get out here and you realise you're not super-woman and you're not going to change the world.** I think they give you that kind of euphoria almost that the community are waiting for you. And they're not..." (333, my emphasis).

The high expectations that this respondent had, when she left the academic segment, of what was achievable in practice were not matched by her experiences of field work. She described the course as "idealistic" implying, therefore, that the expectations of the academic segment of what was achievable in practice were not realistic.

In particular, the academic input on the course encourages increased involvement with older people and attempts to direct student health visitors away from the "limited" focus of work with under fives (Chernik, 1992). This could be seen as a response to calls from within the professional bodies of health visiting for practitioners to be increasingly involved in work with older people (BGS & HVA, 1986).

One student described the difference between her image of health visiting from the academic segment and her field work experience in the following way:

> "...in the first three months from September we did a lot on elderly and we neglected quite obviously the children, the nought to fives. **I was disappointed** (in field work), **because I had got it in my mind that we must do quite a few elderly visits, to actually come out in the community and do very little."**
>
> (325, my emphasis).

The academic segment appears to create an expectation on the part of students that moving outside the boundaries of what could be seen as "traditional health visiting" (i.e. work with the under fives (Dunnel & Dobbs, 1982; Goodwin, 1988)) is both desirable and achievable. This respondent described her "disappointment" when she realised the mis-match between the academic part of the course and the realities of health visiting practice.

There is evidence in the data that field work experience is designed by field work teachers to mirror the realities of day-to-day health visiting practice to as great an extent as possible and to enable students to grasp the concepts and skills which they will require once qualified. When asked about the purpose of field work experience, one experienced health visitor (who was a field work teacher) said:

> **"...I think students have to realise that the reality isn't..it is going to be harder when they have a full caseload and they have to set priorities so in some ways it is preparing them for real practice** and perhaps being a bit more selective about what they do... (006, my emphasis).

It is apparent in this statement that this field work teacher respondent attempted to take a pragmatic view of what students should experience in the field. The aim was not to present practice as espoused in the academic segment, but to present it as it really is. By "preparing them (the students) for **real** practice" (006, my emphasis) the field work teacher implied that her aim was to ensure that students gain experience of the model of health visiting already being used in the field. Another experienced health visitor said:

> "We'd all like to visit the elderly more...but it's a question of time really. The under 5's take up all my time anyway..." (103).

Although this respondent gave "time" as the main reason for her lack of involvement with older people it could be argued that it is really a matter of how health visitors set priorities within their caseloads. Given that visiting older people was low priority for field work teacher respondents within their own caseloads and that field work experience is designed to mirror the realities of actual practice, it seems reasonable to assume that the experience students get of work with older people during field work is limited. Whilst students feel that they **should** give priority to older people within their caseloads, the qualified health visitors they come into contact with demonstrate a reluctance to undertake this work. The subordinate status of student health visitors during field work practice means that they are not in a position to challenge established practice.

7.2.2. Visiting the "token elderly" - an ethical dilemma

In order to fulfil the requirements of health visitor training, respondents were required to visit one older person and write up a "family case study" on the input they had with the person. However, the input was recognised to be in some way artificial, as the students knew that qualified health visitors did not have that intensive input with older people. By comparison, the families with young children appeared to be carefully chosen by the field work teacher for their suitability for the students.

Students recognise very quickly the theory-practice gap when it comes to visiting older people. They can feel very guilty about the input they give to the "token elderly" person that they visit for their family case study because they know that their input will be for a limited time and that it will not be followed up by their field work teacher. This differs from the input that they give to families with children under five, where they feel the family will be visited again by the field work teacher. One student health visitor respondent commented on the morality of the "elderly family study":

> "I think visiting the elderly as a family study is immoral because they get visited by the students once a month if not more and then I know for a fact, not because my field work teacher doesn't want to, she hasn't got the time to visit the lady and so I don't think she has been visited once since I left. **You give them all this input and you promise them the world and then it's a complete cut-off and it's just like a little time-warp when they are intensively visited and they get all this attention and then they are just cut off. I don't know, I think it's immoral. We are using them aren't we, the students?** (333, my emphasis).

Realising the limitations of health visiting practice once qualified, respondents questioned the whole purpose of the "elderly family study". Whilst they enjoyed visiting older people as a change from families with young children, the ethical dilemma it presented was at times a source of distress. In addition, the respondents appeared to recognise the risks of increasing an older person's dependence on them. One respondent described an older woman she had visited quite intensively for the purposes of completing her family study. She said:

> **"I felt it was wrong to suddenly withdraw it and even though I did say to her, 'The lady who came to see you before, the field work teacher will try to pop in to see you', I knew that she wouldn't be able to...**I tried to arrange social visits for her from other agencies. She didn't want that, she wanted me to go and see her because she had got to know me...just to leave her isolated...I don't think it is right." (318 my emphasis).

There is evidence in this statement of a feeling of guilt on the part of this respondent because she felt that the older lady had become quite dependent on her as a consequence of the visits. Recognising that the field work teacher would not continue visiting this person, she attempted to reassure the woman and tried to absolve the guilt she felt by arranging alternative visitors. However, the nature of the relationship she had built with the client meant that alternative visitors were not an adequate replacement. Because of this, the visits could be seen as having the effect of disempowering the client.

The two quotes above again reflect the recognition by the respondents of the theory-practice gap in health visitor training. Aside from the moral/ethical aspects, it is evident that students leave their period of field work with highly ambivalent feelings about the nature and purpose of health visitors' work with older people. The field work teachers themselves, whilst acknowledging the problems from the clients' point of view, rationalise the contact they arrange with older people by deeming it essential experience for the student. One field work teacher commented on her feelings about visiting "the token elderly" person:

> "I feel that it's unfair too on the clients but at the same time I think it's necessary for the students to gain experience".(003).

By comparison with the mixed feelings about the value of visiting older clients, respondents felt that visits to families with young children done during the course of their field work reflected true health visiting practice more accurately. The intensive visiting involved in undertaking a family study on this client group appeared to present fewer dilemmas. One student health visitor respondent reflected on the difference:

> "If it's a very young baby then they would be visited quite regularly by a health visitor anyway and particularly if it's a family with a problem they would still be visited by the general health visitor probably as often as the student visited" (112).

This demonstrates a recognition on the part of the respondent that health visiting work is predominantly child-focussed. Some respondents felt comfortable with the visiting of young families during field work because it

reflected **real** health visiting practice and was therefore not viewed as artificial.

7.2.3. Getting through the course - ensuring safe passage

It is evident from the data that there was a distinct need for the student health visitor respondents to ensure safe passage through the course. Gaining the approval of the field work teacher and, during supervised practice, other health visitors, often creates a false situation during visits to older people. Previous research has shown that students will make an extra effort to secure a successful referral in order that the field work teacher will assess their visiting as successful (see Dingwall, 1977). The desire to be approved of by the more powerful qualified health visitors is not a unique feature of health visitor training (see Melia (1981) on student nurse training).

Getting through the course successfully not only requires the students to pass the relevant examinations, but also to satisfy the field work teacher and supervisor that they can perform the activities required of a health visitor to a satisfactory standard. The pressure of getting through the course successfully and gaining the approval of established health visitors provides a disincentive for students to challenge established practice. In addition, student health visitors undergoing training are generally seconded by a district health authority. It is this health authority that frequently provides them with employment once qualified. This may also prove to be an added incentive to adhere to established models of practice.

Getting through the course requires the student to "fit in" and to adhere to the construction of practice demonstrated by the field work teacher. Being seen to be **doing** things for clients is an important part of satisfying the field work teacher. One student described the pressures of getting on well with her field work teacher:

> "I mean **I was having to pass an exam, my field work teacher had to be pleased and I had to get on well with her and I had to be seen to be doing things** (for older people)."
>
> (326, my emphasis)

This respondent felt it was important to please her field work teacher and to "get on well with her" (326). Being **"seen to be doing things"** for older people was a way of satisfying the field work teacher. The respondent continued:

> **"...it was a means to an end for me to do it (the visit) and to get him sorted out and to do what I needed to do. Or be seen to be doing things for him.** And whether he went at the end of the day, **I was only visiting him for a limited period of time anyway. And whether he took it on or not, really didn't make any difference to me because I just wanted to pass my exams and that was the end of it".**
>
> (326, my emphasis)

The idea that visiting an older person is "a means to an end" reveals the tension inherent in the artificial nature of field work where students only visit clients for a "limited period of time" (326). The respondent described "just want(ing) to pass (her) exams" (326). The emphasis within the training on getting through the course means that students adhere to the model of

health visiting practice prescribed by the field work teacher during that period.

For the respondents the conflict between the academic segment and practice/management policy pervaded not only through field work experience but into supervised practice as well. They continued to feel that the attempts of the education segment to re-orientate practice were unrealistic. One student commented on the organisation of her supervised practice caseload:

> **"...even though the course this year, they tried very hard to move away from the nought to fives,** health visiting is seen very much as a nought to five thing. I'm a great believer that a health visitor should be a family visitor, but **I don't really think it works that way. The people I am visiting now, a hundred families, they are all children nought to five. I haven't got one elderly..."**
>
> (333, my emphasis).

With regards to supervised practice, students felt that they must continue to adhere to styles of practice espoused by the "superior" actors in the interaction i.e. the experienced health visitors. This has similarities with the issue of the subordinate status of student nurses discussed in Chapter 6.

Although, by the time they are undertaking supervised practice, the students have passed (or failed) the academic part of the training, they must still gain safe passage through the supervised work. This means gaining and maintaining the approval of the allocated supervisor, even if it is at the expense of the student's own priorities. One student, who had previously

been a health visitor assistant with particular responsibility for the elderly described the pressures of learning and playing by the rules of the system:

> "I was allocated one hundred families but three elderly were among these. I have been to see the three elderly and **I have been told, because I have an interest in the elderly I have to be careful and try to visit younger families because if I am seen to visit the elderly too much I could be penalised because of it".**
> (323, my emphasis).

The respondent did not expand on what she meant by "visit(ing) the elderly too much" (323). However, in the light of the fact that five of the eight student health visitors interviewed had no older people allocated to their supervised practice caseloads, it might be reasonable to suggest that any visits at all might be "too many" (323). This respondent implied that the opportunity for priority setting within her caseload was limited, given the priority she was expected to have was to "younger families" (i.e. those with children under five years).

Because health visitors themselves and in some cases health authorities place high priority on work with children under five, students undergoing supervised practice are expected to emulate the patterns of work of qualified health visitors. The respondents considered that prioritising their caseload in a way that was acceptable to both experienced health visitors and the health authority was a necessary part of ensuring their future employment.

One student health visitor respondent commented:

> "You have got a hundred families and so much time to visit them in that time. **You've got to be careful that you do actually prioritise in terms of area health authority policy, that you get your screenings done and you have your eight months assessments, that these are all done. And if you visited your elderly perhaps on three occasions you are not seen to be prioritising properly...in terms of the overall contract, or your maybe future employment.**
>
> (323, my emphasis).

Some respondents felt that their performance during supervised practice may affect their ultimate employment prospects. At a time when resources are scarce, the students involved in the study did not have a guaranteed contract of health visiting employment on qualification, therefore they were particularly anxious to impress the health visitor managers and experienced health visitors. This placed pressure on the degree of autonomy and choice which they could exercise when it came to setting their own priorities for their case-load.

The respondents felt that they were rarely encouraged to give any priority to older people in their area. This respondent said that she had to be seen to be "prioritising **properly**" (323, my emphasis). By this she obviously meant prioritising in a way acceptable to the health authority. This demonstrates that the image of health visitors as autonomous practitioners who set their own priorities according to the needs of the clients they visit is somewhat of a fallacy. The rhetoric of priority setting within caseloads for

both student and qualified health visitors appears to actually mean visiting according to health authority policy.

Another respondent, whilst reiterating the theory-practice gap, also shed light on the combination of individual health visitor's preferences for visiting and what was required by the policy agenda:

> "...with the academic input it was being pushed on us that this [visiting older people] should become part of the job but when you see it in practice...if you listen to others [other health visitors] **they don't want to do it and they don't have to...**"
> (318, my emphasis).

This respondent suggested that health visitors "don't want to" (318) visit older people. Whilst previous studies have suggested that health visitors express a preference for the continuation of their orientation towards work with the under fives (Dingwall, 1977; RCN, 1983), the quote above reveals another aspect of health visiting work with older people. The comment that health visitors "don't **have to**" (318, my emphasis) visit older people implies that it is not a part of health visiting practice required by health authority policy. This compares with work with under fives, for which "minimum visiting" is often prescribed by health visiting management (Connolly, 1983). One student health visitor respondent described the frustrations of having a requirement for minimum visiting of children under five as prescribed by health authority management:

> "...we (student health visitors) just feel very frustrated about what the role of the health visitor, what exactly does the health visitor do. We have these four year screenings...there is

the health visitor one and then they actually have a full medical as soon as they go into school...on our caseload we have got to chase up the children who are four and see them hop, skip and jump and they are going to have that anyway in school in a few months time. To me, you prioritise and there is no prioritising at the moment..." (320)

I: "Who exactly told you you have to do these?"

"The health authority" (320)

I: "Was that directly?"

"It was actually here, it's in the records, it is actually a screening procedure..."(320)

This respondent felt that the four-year/pre-school visit was unnecessary because it would be repeated within a few months when the child entered school. However, because it was part of health authority policy, the health visitors had to do the visits. She implied that this undermined any opportunity for health visitors to prioritise within their caseloads. In this way, experienced health visitors can be seen to be powerless subordinates to health authority management, in that they feel unable to challenge health authority policy.

Another student respondent described how her supervisor had selected the hundred families that she would visit for her supervised practice:

"Initially when I was given the patients, she was picking the patients out, she was avoiding the elderly, she kept on avoiding the elderly. And I kept on telling her that I needed, I wanted elderly as part of my training....so I've got them now but she said, 'Well, when you get time and you've got...fit it in round everything else'" (326).

This comment reveals the low priority given to gaining experience of work with older people during health visitor training. Though this may seem hardly surprising, given the intention of supervised practice to reflect "real" health visiting practice, the likely consequence is that the health visiting profession merely encourages a perpetuation of the same way of working. This is highlighted in the following comment by a student health visitor respondent:

> "I get the impression that with the health visitors it's like, **it's not really our remit, we are here for the children so then consequently it is shelved and it goes on and on doesn't it?** (118, my emphasis).

The intransigent attitude of supervisors and field work teachers towards changing models of practice differs greatly from the encouragement of the education segment for the opposite. Coupled with health authority policies for minimum visiting of the under fives, it can be seen that there is little opportunity for student and qualified health visitors to give priority to other client groups. The respondents made it evident that they were not encouraged within field work and supervised practice to give any priority to older people. The health visiting profession therefore ensures a stable continuation of "traditional" models of practice whilst also crushing innovation and change.

7.3. THE STRUCTURAL CONTEXT OF PRACTICE NURSING WORK

By comparison with health visitors, who look to health authorities for employment contracts, practice nurses are employed directly by general practitioners (GPs). Their role is to undertake a range of tasks within the GP

practice (such as running clinics and performing activities such as immunisation) and also, in some cases, to visit patients registered with the practice at home. The policy agenda determines that relationships between GPs and practice nurses operate on the basis of employer-employee. The data demonstrate that this relationship puts GPs in a position where they are able, to a greater or lesser extent, to define the boundaries of practice nursing work. In particular, "delegation" of work by GPs and "income generating" activities within the GP practice were the two issues described by respondents as having the most profound effect on the nature, quality and conditions of their work. The final part of this section will describe the strategies that practice nurse respondents use in their relationships with GPs in order to establish some degree of control over their own work.

7.3.1. "Doctor's work" - delegation and accountability

The delegation of medical tasks by GPs to practice nurses has been described in previous studies by Bowling (1981) and Greenfield et al (1987). These studies demonstrated that a wide range of what had traditionally been seen as "doctor's work" was in fact being undertaken by practice nurses, who may or may not have received adequate training to undertake this work.

Respondents in this study described several situations where they felt they had been expected to do what they saw as "doctor's work". This involved the respondents acting as the first port of call for patients, filtering for the

GP by deciding which patients really needed to see a doctor and which did not. This filtering function was not merely a matter of the respondents passing on patients to the doctor. It sometimes involved them diagnosing a condition and prescribing appropriate treatment. One respondent described her function in diagnosis and treatment as follows:

> **"You get people, you know, "I've had ear-ache, will you ask the nurse to look in my ear?" Which really is the doctor's role, it's not for a nurse to diagnose whether a patient's got an ear infection or whether their ears need syringing...**But if a patient comes into me with ear-ache, if I look and I can see they need syringing, you know I can just say, "Oh use such a drops and come back to me in three days, I'll syringe them...**there's that type of thing that...I suppose the books would say is a doctor's job that nurses do...** and things like infections, leg ulcers, things like that, that erm..a leg ulcer'll come in and I'll say what treatment it should have. Which really should be the GP..."
>
> (128, my emphasis)

This respondent stated that diagnosing conditions and prescribing treatment was theoretically the "doctor's role" (128). These activities have also been claimed as one of the key functions of the "nurse practitioner" (Stilwell, Greenfield, Drury and Hull, 1987). Proponents for an increase in the numbers of nurse practitioners in this country have emphasised, however, that it is essential for those aspiring that status to undergo special training (Jesop, 1986).

The key to the difference between nurse practitioner status and that of the respondents in this study was that the responsibility for doing "doctor's work" was delegated by the GP, rather than being part of a nurse

practitioner's remit because of special skills and training (Stilwell et al, 1987). It was apparent that respondents felt they sometimes had to accept tasks delegated by GPs because of their employee status. For example, the respondent who described the situation above continued:

> "...you feel as well, you know, that **you've got to do as they tell you because they're your boss** and sometimes it's awful." (128, my emphasis).

Practice nurses acting as pseudo-GPs is not uncommon (Greenfield et al, 1987). It is certainly of benefit to the GP as it means he/she can delegate much of his/her work to the nurse. The hierarchy of power, which results from having the GP as a boss, means that some practice nurse respondents demonstrate their reluctance to assert and establish their own professional boundaries. However, the role of pseudo-GP was an *uncom*fortable one for respondents as they did not feel trained to do doctor's work and they were concerned about their professional accountability.

One respondent commented:

> "A lot of patients usually as well, to see a doctor, they'll come in say with an infected boil or something and they'll (the receptionists) say er, 'Because there's no appointments for the doctor, well can nurse have a look at it?' **And then the nurse looks at it and the nurse, to cover herself, has to get the doctor in to look at it anyway"** (152, my emphasis).

This comment reveals the complexity of the situation where nurses who are not trained to diagnose and prescribe are used as the first contact for patients. The respondent described having to "cover" herself by getting the

doctor to see patients who have an illness requiring diagnosis and treatment. When it comes to doing doctors' delegated work, the practice nurse has to ensure she consults the GP about the decisions she makes in order to "cover herself" in terms of professional accountability. It could also be seen as unnecessary duplication of work, as the patient actually has to see two health care professionals for the same condition. A further example of this was given by the following respondent who said:

> "for example I had a girl booked in last week. **...there's no appointments for the doctors so they've (the receptionists) booked her in to see me....."** (115)

In this particular situation the practice nurse diagnosed the condition that the patient had (in this case an allergic reaction to Trimethoprim) but still had to gain confirmation of the diagnosis from the doctor. She continued:

> **"now he wouldn't have had enough time because of the surgery, it was fully booked up emergency included...So I pick up the phone and say, 'Could you come and see so and so'....**so he came over, 'Yeah I think you're right it's Trimethoprim' **...Whereas if the girl had insisted on seeing the doctor he'd have blown his top...and I see quite a lot of the ones that he needs to see."**
>
> (115, my emphasis).

It appears that some practice nurse respondents were used by the receptionists as a back-up service when there were no appointments available for patients to see the GP. In this way, the practice nurse could be seen as acting as a GP substitute. For patients with a condition requiring diagnosis and treatment, however, this appeared to be a self-defeating

object as the respondents described having to consult the GP anyway to make or confirm the diagnosis.

The power hierarchy is also very evident when it comes to the relative importance of the doctor's time versus the nurse's time. In the previous two descriptions, the respondents described that patients were booked in to see them by receptionists because there were "no appointments for the doctors" (152 and 115). One respondent said that if the patient had insisted on seeing the GP "he'd have blown his top" (115). The implication here may be that nurses are more willing or able to "fit people in" or that their time is somehow less important than that of the GP. The nurse can consequently save the GP's time by filtering patients, deciding which conditions require medical attention and which do not.

There is evidence in the data that some GPs also appear to consider their practice nurse's time to be less important than their own. One respondent said:

> **"One thing that does annoy me is a nurse can have a big long list and be very, very busy and, this is a nursing role but...**a patient will book an appointment with the doctor and will walk in and the doctor'll say, 'Yes what have you come for?' and they'll say, 'Ear syringing' and they'll say, 'Nurse!'. **They wouldn't do it coz, you know, why have a dog and bite yourself?"**
>
> (128, my emphasis).

The respondent acknowledged that ear syringing was a "nursing role" but complained that the GP would pass this work onto her, regardless of how

busy she was. The issue in evidence here is the lack of reciprocation between the GP and the practice nurse. Whilst practice nurses feel that they alleviate the GP of some of their work by filtering patients and doing "doctor's work", they feel that the GP is not prepared to undertake "nursing" roles, even when the nurse is under pressure for available time. Again, the employer-employee relationship reduces the possibility of reciprocation as, essentially, the practice nurse is employed to facilitate the GP's work, not the other way around.

Practice nurses can also feel compromised by their vulnerable status as employees of the GP because of the power that the GP has over their job security. For example, one respondent described the problems she faced in telling her employing GPs she did not feel happy to undertake some of the tasks they had delegated to her:

> "...you're on very dicey ground aren't you because **they could, at the drop of a hat, sack you. Really and then where d'you stand? So it's very difficult to start saying, 'I'm not happy to do that and I'm not happy to do this'.** Coz they'll just say, 'Well what are we paying your wages for? Coz you're obviously not going to do what we've taken you on to do'."
> (125, my emphasis).

It appears that this respondent felt she was treading a thin line between professional accountability and her vulnerable status as an employee of the GP. This is an issue of particular importance for nurses who are working part-time in GP surgeries. There is evidence that part-time work is characterised by poor levels of job security and limited power over working

conditions in many occupations including those in the health service (Beechey & Perkins, 1987). Given that the majority (n=41; 84%) of the practice nurse respondents in this study worked part-time (see page 170), the issue of job security was naturally of some concern to them.

7.3.2. Income generating aspects of practice nursing

The GP contract (Health Departments of Great Britain, 1989) exerts a powerful influence on GPs and practice nurses as it orientates the practice towards being involved in income generating activities. The GP has a vested interest in ensuring that these activities are satisfactorily performed as his/her salary is largely dependent upon them.

Much of practice nurses' clinic work involves generating income for GP practices. This includes running health promotion clinics, giving immunisations and vaccinations and performing smear tests. The employee status of practice nurses results in a feeling of obligation towards the GP to ensure that the income generating aspects of the contract are fulfilled. This appears to infringe not only on the quality of the work that they do but the problems they face in ensuring they are adequately trained to do that work.

7.3.2.1. Problems in providing a quality service

The emphasis on income generation within the GP contract with the additional "fee for item of service" payments meant that some respondents in this study felt they were not able to do the job properly because they

were not able to offer the patients the service they deserve. One respondent commented:

> **"It's getting like a cattle market...I think it's the fact that nursing wise I just, there's no caring in it, you've just got to book in as many patients as possible in a certain length of time.** Got to see all those patients and then fill in the clinic form **and then they've got the money** ...the blood pressure clinic, they're just in and out. **Where I want to spend more time with them but I can't."** (118, my emphasis).

This respondent expressed that she couldn't spend the time with patients that she wanted to. There could be two possible reasons for this. Firstly it is possible that the demand from patients was so high that it was impossible for the respondent to see all the patients if she did not limit or ration the time spent with each. Alternatively (and more probably), the demands of her employing GP are such that he/she requires the respondent to see as many patients as possible in the blood pressure clinic. This would fulfil two objectives for the GP. Firstly, the conditions of reimbursement for clinics are such that there is a minimum number of patients required to be seen in each clinic and secondly, a high throughput of patients then frees the practice nurse to perform other activities with her contracted hours.

The emphasis on financial aspects of care provision is one with which most nurses are unfamiliar. The fact that the GP employs the practice nurse means that she has very little opportunity to deliver the care that **she** wants for her patients. Instead she must balance the interests of her patients with her feelings of obligation towards the GP, her employer. The production line

approach to patients appears to disturb practice nurses. They feel that they want to be able to have time to spend with each patient they see, to be able to form relationships with the patients.

There are common threads here with respondents' experiences of work in institutional settings where routines predominate (see chapter 6). In the institution, "extra" time could be spent with patients only when the "routine work" had been completed. The respondent quoted on the previous page, in her description of the blood pressure clinic, implied that she would like to spend more time with each patient. However, the crucial determinant of payment for the clinics is the number of patients seen, therefore the length of time practice nurses have available to spend with each patient is limited.

The issue of control by the GP of practice nurses' time is vital. In a study of social workers and general practitioners, Huntington (1981) suggested that GPs were preoccupied with the pressure of time and were unlike other health care workers in their time orientations. Time is undoubtedly an important commodity within the GP practice, particularly where "fee-for-service" payments are concerned (Abel-Smith, 1976). It is questionable, however, whether the eagerness of GPs to improve their time effectiveness is related to their own aims or those of their patients (Pritchard, 1981; 1992). It appears that some GPs expect their practice nurse's time to be as "well spent" as their own, particularly where income generating activities are concerned.

Other respondents suggested that their GPs only valued them for the income generating aspects of their work. One respondent described what benefit GPs get from employing a practice nurse:

> "I mean there's some GPs who are absolutely fantastic, you know some of the other nurses'. And then there's others that just give them no help at all. **You know they just want them to earn the money. I think most of them want the money earned, I mean that's why most of them have got us, I'd say 99 per cent of them"** (153, my emphasis).

This respondent acknowledged that there were differences between GPs in terms of the help that they gave their practice nurses. Some GPs were obviously considered to be better to work for than others, but the respondent considered that "99 per cent" (153) of the GPs had only really got a practice nurse working for them because they earn money for the practice.

Another respondent described how she felt the GPs viewed her function within the practice:

> **"I think everything now is so money orientated** erm...I think really **as long as this contract is seen to be fulfilled..."** (125, my emphasis)

She continued:

> **"As long as you're immunising babies and as long as you look as if you've got full um...a full session of patients, you know, that's fine.** And that's all they're interested in."
> (125, my emphasis)

There are indications that some GPs are more interested in the **amount** of work (and consequent generation of income) that practice nurses undertake as opposed to the **quality** or focus of their work.

Another respondent, who was the first practice nurse in this particular group practice, described the problems she had had being accepted by the GPs when she started work. She said:

> **"I think the only reason I sort of got accepted (by the GPs) in the end was that the clinics did get set up...they can see an income now generating you see.** I'm giving a lot of vaccinations, we're running quite a few clinics and that..." (128, my emphasis).

As GP work moves further towards target payments for clinics and fees for items of service, so the emphasis on generation of income for the practice will increase. Martin (1987) has suggested that the financial benefits of employing a practice nurse (70% of whose salary is reimbursed by the Family Health Services Authority) can be substantial.

7.3.2.2. Problems in working conditions

The financial emphasis on the work in the surgery also extends into more basic aspects of the working life of a practice nurse, such as taking annual leave and going on continuing education courses. Asking for time off for holidays can present problems as the following respondent commented:

> "It's not nice having the GP that you work for as your boss....things like holidays, going asking your GP can you book

a weeks holiday, you know? And it's up to him to say yes or no..." (113)

The employer status of the GP gives him/her the power and opportunity to extend their control over the practice nurse into the private sphere of their lives. By controlling annual leave and days off, the GP can reinforce his superior status within the GP-practice nurse relationship.

Asking for a day off may therefore provide the GP with an opportunity to remind the practice nurse of her subservient status:

"He'll come out with comments like 'I've got to give you a day's holiday, I'm already paying you enough' and all this. Which, you know, it's not nice". (128)

This enforced deference to the GP's decision increases practice nurses' feelings of subservience and employee obligation, a situation in which they lack experience having previously worked within the bureaucratic machinery of a large organisation such as the NHS. One practice nurse respondent discussed the problems of getting a pay rise from the GP compared with when she worked for the health authority:

"Things like your pay rises, you know, I'm due a pay rise next month. It's not good going asking them, you know. Whereas when you've always worked for a health authority, you got your increments and that was that. If there was a query over your wages you just rang wages and sorted it out..." (144)

At the time of this study, strictly controlled contracts for nurses working within the NHS meant that their annual leave and increment entitlements were clearly defined[19]. However, given that Family Health Service Authorities were slow to facilitate contracts between GPs and practice nurses (Hogg, 1990), it is probable that, for many of these respondents, these were left to the discretion of individual GPs. The tenuous position of part-time workers has already been discussed (see page 268) but it can be speculated that part-time practice nurses' concerns over job-security may lead them to be wary of requesting time off for holidays and study days.

Going on courses and study days is another aspect of work which requires deference to the GP's will. One respondent described why her GP was reluctant to let her go on courses which she felt she needed to do the job:

> "...they want a certain amount of work out of practice nurses and aren't prepared to release them to do courses coz it costs money, although they get reimbursed quite a lot. And you're away from the practice." (003)

It is not just the cost of the course itself that may make GPs reluctant to let practice nurses attend training updates. A large proportion of practice nurses' work is involved in income generation for the practice therefore, when they have a day off, they are not available to do that work. Another respondent commented:

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[19]With the advent of "trusts" within the NHS it is now becoming evident that employers are negotiating new terms of contract with workers, which are not so strictly controlled nationally (Nursing Times, 1992). However, at the time of this study, the respondents would not have been subject to this new system.

"Because you see the day you're not here is a day you're losing him money. You could have given fifteen tetanus that day and run a clinic and saw ten patients. So you know you're losing them about fifty pounds that day you're away". (128)

The income generating activities that practice nurses undertake can be seen to limit their opportunities for training.

7.3.3. STRATEGIES FOR WORKING ROUND GPS

It has been shown that the balance of power in GP practices is placed firmly in the hands of the GP as a result of their status as the employers of practice nurses. However, the data from respondents in this study demonstrate that they do use strategies in their relationships with GPs to establish some control over their work. These strategies or approaches have been developed analytically from the data and are broadly divided into three categories which, for the purposes of this study have been called:

1. Confrontational
2. Convoluted
3. Deferential

The three categories will be considered separately.[20]

[20] Although these categories are distinct it should be noted that individual practice nurses use different strategies for establishing control in different circumstances. The respondents appeared to deploy these strategies/tactics depending on their appropriateness in any given interaction with the GP.

7.3.3.1. The Confrontational Strategy

The confrontational strategy is defined as a situation whereby the practice nurse is prepared to directly and actively challenge the employing GP on the decisions he/she makes about the nurse's work. It involves the nurse opposing or resisting the GP's control by a direct refusal to conform to his/her suggestions or mandates.

It appears that the confrontational approach to relationships with GPs is only actively undertaken by practice nurses who feel very confident with their role, areas of responsibility and professional status. One respondent (previously a district nurse) described how she had approached the job when she started:

> **"I think you've got to come in and stand up for yourself** and you've got to say, because they refer things to you, you're not just going to do it....**I think some of the GPs...see a practice nurse as being somebody who would come in and do what she was told.** And I think when you say, 'Well no, you know, I'll do it this way"...I think they're a bit shell-shocked....You've got to from day one stand up for yourself and say, 'Well, you know, I'm not doing it'" (125, my emphasis).

This respondent commented that some GPs see a practice nurse as someone who would "do what she was told" (125). In her case, she felt that she could stand up for herself and assert control over her own work. In this way, the respondent could establish her own boundaries for work. The experience of having been a district nurse or a health visitor may give practice nurses confidence in dealing with GPs because of the contact that they had with them when they worked for the health authority. Reflecting

on the effect of previous community nursing experience the same respondent continued:

> **"I'd had GP contact before and you're going into surgeries...the guidelines that were brought out by the UKCC were a bit iffy weren't they?** So I think if you weren't a district nurse or health visitor trained you would wonder how you stood really wouldn't you? And as I say so many GPs will let you do anything that you're happy to go out and do and I think some practice nurses are too frightened to say, 'Well, I'm not happy to do that'" (125, my emphasis).

Having previous community experience means that the nurse is not only used to dealing with GPs, but also that she is very clear what she is or is not experienced, trained and competent to do. Commenting on the UKCC guidelines on delegation of work to practice nurses by GPs, the respondent said they were "a bit iffy" (125). The guidelines state that tasks should only be delegated to practice nurses that the nurse is **competent** to perform. Competence, however, *is to be assessed by the GP, who is ultimately* accountable for the work that his/her employees undertake. As this respondent was a qualified district nurse she suggested that she was quite clear about her role and competence. However, she suggested that nurses without a community nursing qualification might "wonder where (they) stood" (125). The implication is that these nurses may not be quite so clear about their competence and about what activities were appropriate for them to undertake and also, lacking experience of dealing with GPs, that they might be more frightened than she was to stand up for themselves.

The confidence that comes from previous experience in dealing with GPs also seems to influence the demands that practice nurses make with regard to their responsibilities towards patients, in particular the amount of time spent with each patient. One respondent, previously a health visitor, described what happened when her GP tried to dictate the amount of time she could spend with each patient when doing smear tests:

> **"I just said from the beginning. The doctors that did smears had always had ten minutes allocated...But I said, 'Well, if you want me to do smears I will only do them if I can have half an hour for each patient.'** So I suppose all those other things that I talk about with patients when they're here for a smear...well I think that's important. But they (the GPs) don't really...they wouldn't spend that long." (116)

This respondent implied that if the GPs had refused to give her half an hour for each patient she saw then she would not have been prepared to undertake smear testing. This could be seen as a highly confrontational approach, given that the GP is her employer and she may have risked her job security. However, because this nurse respondent valued being able to talk to patients about things (perhaps not even associated) other than the specific reason for which they were attending the surgery, she was prepared to voice that to the GP.

In the main, however, the confrontational approach was rarely used by respondents in this study. This can be explained by the fact that confrontations are not familiar territory for most nurses, who have been trained and educated in the frequently oppressive and unquestioning

environment of the hospital. It requires a level of assertiveness from the nurse which appears not to be present in those nurses with no community experience.

7.3.3.2. The Convoluted Strategy

A more "female" strategy for dealing with difficult interactions is to win people over by subtly working them round to your point of view. Techniques such as this were frequently described by respondents when talking about their interactions with GPs. They involved the respondent taking responsibility for making decisions about her work and about patient care whilst at the same time appearing passive.The convoluted strategy has been developed as an analytical category which encapsulates all the approaches to interactions with GPs which involve "working round" them in order to avoid confrontation. This strategy is very reminiscent of the doctor-nurse game which has *been described by Stein (1967)*[21].

The convoluted approach to relationships with GPs appeared to be adopted by the majority of respondents in this study. It involves "working a way around" the GP and thereby avoids confrontation. There are two analytically distinct aspects to the convoluted strategy, namely overt and covert.

[21]Stein (1967) and Stein et al (1990) described how the dominant-subservient relationship between doctors and nurses operates and discusses the reasoning behind the function of game-playing in working relationships. Stein contends that the game operates with the goal of maintaining a peaceful situation with minimum disruption to the status-quo. The nurse communicates her recommendations without overtly making a recommendation statement. The doctor may request a recommendation from the nurse but does so without appearing to be asking for it. Stein suggests that the game reinforces the stereotyped roles of male dominance and female passivity.

7.3.3.2.1. The overt convoluted strategy

The overt convoluted strategy involves openly approaching the GP with a suggestion, but phrasing it in such a way that the GP will find it impossible to refuse. It also means the practice nurse gives a reason or an excuse for the demand. For example, one practice nurse described how she had persuaded her GP to let her attend a study day:

> **"You have to learn to be as crafty as them...**I said, 'Look can I go on this study day?', **I said, 'Before you say anything, for me to re-register you've got to allow me to go on them anyway or I can't re-register which means I can't work'.** So, 'How many study days a year do you have to do?'. **So you could tell him any number, you know...so you get round it that way** and they think they've got to let you go on these things..."
>
> (128, my emphasis).

The respondent in this situation was careful not to **demand** to attend the study day. She said she had to be "crafty" in the way she approached the situation, implying a non-confrontational but, nevertheless, successful approach. She gave reasons why she felt the GP **had** to let her attend the study day, whilst allowing him to make the final decision. The nurse's approach to getting her educational needs met could be seen as slightly deceptive. It left the GP in a situation whereby he/she could hardly disagree with the request. However it is a strategy that has advantages for both the nurse and the GP, namely that it avoids employer-employee conflict (Stein et al., 1990).

Even requesting necessary equipment for the practice may require the practice nurse to "work round" the GP. The practice nurse may feel unable

to demand that the equipment is bought, as it is the GP who must pay for it. So other ways of achieving the desired goal have to be found. In the situation described below, the respondent wanted the GP to buy a dressing trolley for her to use in the surgery:

> "..so I got the brochure with the price and he was going on about the price. But I just said to him, 'Well, if you're doing minor surgery and the FPC come and check up we'll all be in trouble...and you need a dressing trolley for your minor surgery and other procedures and it'll last you twenty years at least'. So you get around it in that way" (118).

Again, this respondent found a way of getting around the GP by suggesting that the practice would be "in trouble" if he did not agree with her request. This strategy appeared to have the desired consequences for the respondent but it can only be used when there is a semi-legitimate professional lever for the nurse, i.e. when the consequences of refusing the request are put to the GP in such a way that they would seem to compromise his professional integrity. This differs from the covert approach which involves a greater degree of acquiesence and subservience on the part of the nurse.

7.3.3.2.2. The covert convoluted strategy

The covert convoluted strategy is perhaps more subtle than the overt. It involves the practice nurse making suggestions to the GP, but in such a way that the GP can then claim the idea/recommendation as his own. The practice nurse and the GP could be seen as collaborators in this approach as it would be reasonable to suppose that both parties are probably aware of the subtleties of the interaction, but avoid acknowledging them directly. The

approach fulfils the requirement of avoiding open confrontation or disagreement and maintains the status quo of the power relationship. One respondent described her relationship with the most senior partner in her practice as follows:

> "I wouldn't just go in to him (pointed to the senior partner's room next door) and say, 'I'm not doing this'. But **there's a way of doing it isn't there really?** And I think particularly (pointing again to next door)...it's the way you handle them really, you know. And **then he does eventually come round to your way of thinking, you know, and then he'll say it back as though it was his idea in the first place....**" (125, my emphasis)

This respondent was the ex-district nurse who described her "confrontational" approach on page 277. It is interesting to note that she made the point about the way she handled the senior partner. It is possible that, for this respondent, there was a difference in her approach between the senior partner and the other GPs (this point will be the focus of discussion in section 7.3.4.).

Careful handling of the GP is a feature of all practice nursing work. Another respondent described her interactions with the senior partner in the practice:

> "The senior member of the practice is quite strange. He was the one that originally sort of had these ideas to sort of develop my role and things. But **he loses his temper, he's terribly moody so you have to be very careful how you handle him**" (116, my emphasis).

Keeping the GP happy is vital for the practice nurse as it is the doctor who ultimately controls not only the content of work in the clinic, but working conditions such as holidays and study days (see page 273). The

respondents appeared constantly aware of the GP's power over their working lives, and the consequent need to avoid conflict or disagreement if possible.

In some situations the process of avoiding conflict involves "acting stupid". One respondent described what happened when she went out to assess an older person and found that someone was taking medication which she considered to be inappropriate:

> "..half of them (the elderly) are on tablets they don't need to be on, but **I mean I can't really say anything...I don't say to them, 'You don't really need to be on that' or, 'What are you on that for?' I go to Dr V. and I just say, 'Why is he on this?' or, 'What's this for?'. You know...act stupid....and I think a couple of times he's said, 'Oh well, I'll cross them off, they don't need to be on it'....but I've not pushed myself...**"
> (118, my emphasis).

There are several issues evident in the quotation above. Firstly, the respondent reveals a key aspect of the nurse's status and her role as a diplomat between the patient and the GP. The respondent said that she "(couldn't) really say anything" to patients if their medication seemed inappropriate. This demonstrates the nurse's reluctance to undermine the GP's "superior" knowledge and status in front of a patient, coupled with the fact that she is not legally able to alter the medication herself. Secondly, it reveals how some nurses behave when they feel they are questioning a doctor's professional or medical judgement. Being aware that the GP supposedly has more knowledge about medicine than she has herself, the respondent used this to her own advantage to flatter the GP and yet achieve

her goal. By "acting stupid" she forced the doctor to question his own medical judgement but did so in an indirect and non-threatening way.

Picking the right moment to talk to the GP is also an important aspect of this approach. Sometimes respondents seemed to put their needs on hold until they found an appropriate moment to discuss them with the GP.

> "I think there is an attitude, with the senior one there is. Now and again he **has got this male-female attitude and I'm the boss,** type of thing. **And as long as you go along with that, you know, he's quite happy**....if he's being like that a little bit with me, **I'll just give little digs and comments so he'll eventually pick up on it and say, 'Have I been awful lately?'. So I'll say, 'Well, yeah', you know and get it round that way rather than storming in there...**"
>
> (128, my emphasis).

This respondent described how she went along with the GP, allowing him to assert himself as "the boss". She also described the GP as having a "male-female attitude". This point is picked up in section 7.3.4. The GP in this situation was allowed to make the first direct approach to the respondent to discuss the problem in their relationship (i.e. that of him being the boss). The respondent, by giving "little digs and comments", made it obvious that there is a problem, but by approaching it in this way she permits the GP to take credit for solving the problem and for initiating a discussion about it. Consequently, the respondent perpetuated the status of the GP as "the boss", but also instructed the GP that being the boss was only allowed to go so far.

The convoluted strategy for handling GPs could be seen as a subversive way of maintaining the balance of power and of inhibiting true recognition of nursing knowledge and experience. It could also be seen as a barrier to real and effective communication between the two professional groups as it de-values the contribution of nurses in decision-making processes, resulting in a lack of honesty in the interactions.

7.3.3.3. The Deferential Approach

This approach is defined as a situation where the practice nurse yields to the GP's decisions. It is a submissive, obeying interaction and recognises, without question, the superiority of the medical profession. It involves the practice nurse abiding by the GP's decisions and requests without negotiation or compromise. It could be seen as a typification of the traditional "handmaiden" approach to nursing.

Some respondents appeared to have difficulty saying "no" to their GPs, or even finding ways to work around the GP so that he/she realises the request is unreasonable or inappropriate. For example, one respondent said:

> "You know, **he'll say, 'Can you deal with this?'. Usually I'll say, "Yes". I mean I don't usually stick my heels in and say, "No".** I find that very difficult. **It's the handmaiden touch,** isn't it?"
>
> (116, my emphasis).

This respondent revealed a key issue of the strategies that have been described, that is that no one strategy was used exclusively by any one

respondent in their dealings with GPs. The respondent said "usually I'll say "yes"" (116), indicating that in some circumstances she might "stick (her) heels in and say "no"" (116). This demonstrates the flexibility of respondents in selecting the strategy to use. It is speculated that the strategy selected to a large extent depends on the importance of the issue to the practice nurse. It would appear reasonable to suggest that practice nurses mainly utilise the convoluted strategy with their employing GPs because of the tenuous nature of their status as employees. A confrontational approach might place their job-security in jeopardy.

One of the consequences of the deferential approach to relationships with GPs is that the practice nurse could work almost exclusively under the auspices of the medical model. By adopting the deferential approach the nurse would depend heavily upon the GP to make decisions for her. It is speculated that would result from a lack of confidence in her own decision-making ability on the nurse's part. In this study it was particularly apparent with the most inexperienced and youngest practice nurse respondent. In one situation the respondent had referred a woman with suspected diabetes to her GP, but felt that the woman needed educating about living with diabetes:

> "I spoke to the GP and said, '**Do you want me to go back and see her, see how she's getting on**...'Oh, no, no, no. The hospital's looking after her, she's alright'...but **I would have been quite happy to go back and see her...but he said,** 'She's being fully cared for by the hospital, **there's no need**'"(119, my emphasis).

This respondent felt that the patient would have in some way benefitted from some input but deferred the decision about a follow-up visit to the GP. Throughout the interview, this respondent referred to patients she had visited and talked about asking her GP for advice/instruction as to the appropriate action to take to meet their needs. This respondent was an exception in that she showed no indication of using anything but a deferential strategy in her interactions with the GP. It could be speculated that this stemmed primarily from her own uncertainty about her knowledge base and decision-making ability. She consequently relied on someone from whom she could seek reassurance about her nursing intervention. Given that this particular respondent worked in a small rural practice in isolation from other nurses, the only person she could consult was the GP.

7.3.4. Gender issues in GP-practice nurse interactions

The strategies used by practice nurses in their interactions with female GPs appeared to be slightly different. Whereas the respondents described the "hand-maiden touch" (116) and the "male-female attitude" between employer and employee (128) in their descriptions of interactions with male GPs, their relationships with female GPs appeared to be built much more on a basis of mutual cooperation and respect.

Respondents working in a surgery where there were both male and female GPs remarked on the differences in their interactions with the different sexes. One respondent said:

> **"I think she's got more respect for me.I mean she's gone out of her way** with these fifteen examinations that I need to do; breast, pelvic and smears, she's gone out of her way to arrange for me to attend the family planning clinic. She's made the phone calls, getting the o.k.'s. And she's been very good like that. **And he (the senior partner) can be very condescending. If I go in with a query, she'll answer me and give me different examples and he can be quite condescending"**
>
> (115, my emphasis).

The female GP in this practice appeared to be more willing than the male senior partner to help the respondent develop her role, particularly in terms of educating her in a helpful and constructive way. The "condescending" attitude of the male GP was compared with a relationship with the female GP which was based on respect. The female GP was prepared to answer the queries of the respondent and to ensure that the respondent's educational needs were met. However, female GPs seem not only willing to provide information or education on request, but will offer it:

> "...if I ever need any help like, dreadful, the menopause I hardly knew a thing about it and in my first well women clinic all these women came up and I thought, 'Oh no'. And she (the GP) gave me a tutorial on the menopause. And then there was a study day she saw, so she said, 'Oh go on that study day', so she's very good". (116)

By comparison, some male GPs appeared to be more reticent or uninterested in the educational needs of the respondents and were sometimes more difficult to approach for help or information:

> "...the three GPs are very, very different. Dr T., she's great. She does the minor surgery...and she's great, she loves demonstrating and loves showing you and all this. She's great in that respect and she's always bringing you books and

information and she's really good...Dr J., he's very good, erm, but he won't offer help, you've got to go and badger him a little bit. And if you do badger him too much I think he, you know, he doesn't really like it that much". (128)

It appears that there may be a level of mutual understanding that comes with being female. For example understanding pressures on women outside the working environment (e.g.children) resulted in one respondent handling the female GP differently:

"...you have to handle them differently. **The lady GP is a mother, so you know she has outside distractions, probably more than the men do. She will always tend to sort of hand a lot more over...I usually take it on** because it's not going to usually take more than 5 minutes to deal with, you know. But I know that there's that element where there will be more put onto you by that particular person..." (116, my emphasis).

This respondent nurse was indeed a mother herself, so she felt she understood why the female GP passed a lot more tasks and responsibilities onto her. She did not mind taking the extra work on because she felt the GP had "outside distractions" i.e. the family. In contrast, one respondent discussed the differences between the male and female GPs in terms of their willingness to pass over unwanted or undesirable tasks to her:

"When I feel that somebody does need a visit, does need a change of medication, he thinks it's too much of a hassle to go out. I think, 'Well that's your job' and I tell him it's his job".

I: "So you mean they would like you to get rid of a lot of that work that they don't want to do?"

"Oh they'd love it, they'd love it. **The male partner especially. The female partner will see anything, anytime. No problem. But**

she gets put upon. Not so much by me but the receptionists and him. Coz they know she'll see anybody and everybody."
(115, my emphasis)

On page 270 the issue of the GP's control over practice nurses' time was discussed. There are indications in the quotation above of a similar situation operating between the male and female GPs in this practice. The respondent described how the female GP was "put upon" by the receptionists and the male GP in terms of unwanted work being passed onto her. The differences between male and female GPs are verified by a study of GPs (Lawrence,1987) which revealed that many women GPs felt dominated and disparaged by the male senior partners in group practices.

It is apparent in this study that some practice nurse respondents felt there was a level of understanding between them and female GPs that was not present in their interactions with male GPs. The reason for this may be due to the fact that, without exception, the female GPs were junior to the male GPs. Therefore, the similar balance of power in evidence between respondents and their employing GPs may also be present between the senior male GPs and the junior female GPs (who, by virtue of being 'junior', are also in a subservient position). This probably enhances the level of understanding that comes from being female.

7.4. CONCLUSION

This chapter has demonstrated that the influence of the field work teachers, health visitor supervisors and health authority policy on student health

visitors serves to contain practice within the boundaries of "traditional" health visiting (i.e. work with the under fives). In the case of practice nurse respondents, it has been shown that the relationship with the GP is of paramount importance in determining the content and boundaries of practice nursing work. A major consequence of the power imbalance in the GP practice is that practice nurses have developed strategies to establish some control over their work and these strategies have been described as "confrontational", "convoluted" or "deferential".

It is evident that, whilst the structural contexts in practice nursing and health visiting are different, the organisational structures of both spheres of work serve to contain practice within boundaries that are acceptable to the most powerful actors in the organisation. Explanation of the structural contexts of these spheres of work facilitates an understanding of the reasons why work with older people is constructed in the way it is, this being the focus of the next chapter.

CHAPTER 8.

HEALTH VISITORS' AND PRACTICE NURSES' CONSTRUCTIONS OF WORK WITH OLDER PEOPLE IN THE COMMUNITY

8.1. INTRODUCTION

This chapter describes data mainly from critical incidents described by practice nurses and experienced health visitors[22] and from interviews with practice nurses, student health visitors and experienced health visitors which provide insight into their constructions of work with older people living in their own homes[23].

The chapter is divided into three sections. The first section covers health visitors' constructions of effective and ineffective work, the second deals with practice nurses' constructions of effective and ineffective work. The third and final section of the chapter discusses the models of practice in evidence in practice nursing and health visiting which were developed analytically from the data.

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[22]It should be noted that the critical incident data from student health visitors are not included in this chapter as it mainly pertained to work with older people in institutional settings (see Chapter 7).

[23] Where critical incident data is described the abbreviation "CI" will follow the respondent number and, similarly, where interview data is described the abbreviation "I" will follow the respondent number,

Whilst there are differences in the structural contexts of practice nursing and health visiting practice (see Chapter 7), this chapter demonstrates that the criteria used by the two groups for constructing work with older people as "effective" or "ineffective" are similar. The data make it evident that both health visitors and practice nurses operate a model of practice with older people which is based on functional deficits, with no focus on the provision of anticipatory/primary preventive health care. Whilst the practice nurses have the **policy remit** for visiting the "well elderly", they appear, in the main, to focus their activity on older people with identifiable problems. Health visitors, by comparison, have a **theoretical remit** for undertaking work with the "well elderly", yet they continue to visit older people with identified problems who have been referred from other agencies.

8.2. HEALTH VISITORS' CONSTRUCTIONS OF WORK WITH OLDER PEOPLE

8.2.1. Identifying older people to visit

In health visiting, the system of identifying older people to visit appeared to be determined by other agencies in that the health visitor respondents in this study only initiated a first-contact visit to an older person when a referral came from another agency. This "crisis" visiting has been identified as a characteristic of most generic health visitors' work with older people (Phillipson and Strang, 1984). Other visits to older people were undertaken because that person was "on the books" i.e. the respondent had visited them previously as a consequence of a referral and the person had become

part of that health visitor's "caseload". These two impetuses for visiting will be considered separately.

8.2.1.1. Referral from another agency

In the interviews the student health visitor respondents demonstrated a degree of confusion about the reasons why some older people were referred to the health visiting service from other agencies. One student health visitor respondent commented on the referrals she had received from practice nurses during supervised practice:

> "I found that when I think back to a lot of those that were referred from the practice nurse **you would go along and visit them** (older people) **and wonder why, what you were doing there and what you could possibly do for them: I don't see much at all...just social things...**" (318 I, my emphasis)

This respondent commented that some practice nurses were doing an assessment of an older person and then referring to the health visitor for "social" visiting. She commented that she didn't know what "you could possibly **do** for them" (318, my emphasis), implying that, unless there was an actual **task** for the health visitor to undertake, there was no point in visiting. With health visitors' work with the under fives, however, it has been suggested that health visitors are unable, with mothers and children, to divorce health and social aspects of their work (Drennan, 1986). The quote also reveals a complete lack, on the respondent's part, of a sense of opportunity for health promotion/anticipatory health care.

There is also an interesting parallel to be drawn here with the idea of "physical" nursing intervention and "psycho-social" intervention which was evident in the data from respondents working in the hospital environment with older people. In chapter 6, the synonymity between "routine" work and tasks to meet physical need in hospital work with older people was highlighted. Psycho-social interaction with older people was sometimes viewed as "extra" to the **essential** work of nurses on long-stay wards, which was to meet the functional deficits of individuals. It appears that, for some health visitors, "social" visiting of older people may also be viewed as non-essential work. In other words, it is legitimate to visit older people for whom there is an **identified functional deficit** and something to be "done", whilst intervention into the "social" aspects of people's lives is not perhaps viewed as a good use of health visiting time and is seldom, if ever, viewed as an opportunity for anticipatory care.

During the interviews with some practice nurse respondents, it was evident that they referred older people to the health visiting service for various different reasons. The types of referrals made appeared to depend upon how the practice nurse constructed the role and function of the health visitor. One respondent, who held an RGN qualification but had had no community nursing experience before becoming a practice nurse, commented on the referrals she made to the health visiting service:

> "well, she always gives me ideas and I tell her and she might say "oh well, I'll see whether I can get her (the older person) into the Thursday luncheon club"...**she's been here much**

longer than I have...there's so many clubs and so on that I don't know about or I don't know who's in charge so it's much easier if A. (the health visitor) just goes to do it and sorts it out."

(119 I, my emphasis).

It is evident that this particular respondent used the health visitor to fill the gaps in her own knowledge of the resources available in the area. The respondent, with no previous experience of work in the community, felt that the health visitor's knowledge of local resources was greater than her own and so it was "easier" for the health visitor to undertake certain activities on her behalf/on her clients' behalf. She clearly did not feel that she needed this knowledge herself, presumably because she did not view this as part of her remit of work.

By comparison, two of the practice nurse respondents, who had both previously worked as health visitors, described the referrals that they made to the health visiting service. One respondent said:

"I have done it (referred older people to the health visitors) on a couple of occasions...**just because I think they needed er..more regular input than I could do. Because my time is prescribed in a very limited way..."**

(116 I, my emphasis)

The other commented:

"I don't have the follow-up...if I find there's anything that needs to be taken further I'll go to the health visitors and say "will you go?" I've had one...(I) notified the health visitor, called in the CPN and he's now been re-housed...".

(115 I, my emphasis).

These two practice nurse respondents had professional experience of working as health visitors and they were very clear about where the boundaries of the two roles lay. One referred to the health visiting service when an older person required "more regular input" (116) than they could give or for "follow-up" (115), given that her own remit was to perform an annual assessment, the other referred for specific reasons such as housing assessments. However, both commented that they had not referred many older people to the health visiting service, as most of the referrals went to the district nurses, chiropody etc.

Most other referrals of older people to the health visitor respondents in this study came from GPs. Questioning one field work teacher respondent about the types of referrals she received from the GP, she said:

> "...somebody whose health is deteriorating or they are not coping as well as they did and they are thinking about going into sheltered accommodation and so I would go out and do an assessment".
>
> (003 I, my emphasis).

Another said:

> "we visit any that, you know, the GPs are a little bit concerned about, you know, they need assessing for home aids or whatever...referrals from the GP they're usually like a bath aid or a commode or zimmers or this sort of thing you know?"
>
> (005 I, my emphasis).

What is apparent in the above quotations is that referrals were made to these health visitor respondents when a need had already been identified by another agency. These respondents visited people "whose health is

deteriorating or they're not coping as well" (003) or people that "the GPs are a little bit concerned about" (005). It can be seen that the very nature of these referrals means that the health visitor visits to assess or meet specific needs of an older person whose health status is already in decline. This finding is consistent with other research which has shown that the aim of health visitors' visits to older people was to assess the degree of deterioration or illness in that person (Fitton, 1990; de la Cuesta, 1992). However this dependency orientation undermines the health visitor's theoretical remit for working with the "well elderly", as intervention appears to operate around the meeting of specific functional needs and deficits. The two models, underpinned by the concepts of dependency versus wellness, appear in health visiting to be in direct opposition to each other. The health visitor respondents in this study did not appear to view visits to "well elderly" people (i.e. those without an acknowledged and recognised degree of dependency) as providing an opportunity for anticipatory health care.

The health visitor's role, therefore, is to assess the person's degree of need (defined as a level of functional deficiency) and, if necessary, refer to another agency. What is interesting here is that there appears to be a two-tier referral in operation. Practice nurses appear to use the health visitor to fill the gaps in their own knowledge base or to reassess the older person. In this way the practice nurse is filtering patients by performing an assessment and then referring those in whom she has identified a "need" to the health visitor for further assessment. This two-tier assessment links with recent

work by Brace and Hunter (1992) which has shown that some older people had up to 12 assessments by various professionals for admission to residential care. Undertaking an assessment of an older person and then referring to another agency for further assessment demonstrates the limitations of the practice nurse's role with regard to the requirements of the GP contract.

8.2.1.2. Visiting people "on the books"

The other impetus for health visitor respondents to visit an older person came from the holding of records on the health visitor's caseload. One student health visitor respondent commented on her view of health visitors' contact with older people:

> "They keep the case-notes on and they visit or they get new patients, new referrals or anything and they go and visit them and **then they just keep hold of the...they deal with the problems as they arise and then they just keep hold of the case-notes then. And they visit occasionally, just occasionally, not in a structured way, no."**
>
> (326 I, my emphasis).

The respondent commented that health visitors "deal with the problems as they arise" (326). This again indicates that, from the moment an older person is referred to a health visitor, they have been defined by the referring agency as "having a problem". Subsequent visits by the health visitor then have the aim of seeing whether the problems have got any worse. Another student health visitor respondent highlighted this:

> "I don't think anybody does elderly visiting, I think, I get the impression that it is sort of a Friday afternoon ritual. That **if you have nothing better to do you take your elderly book out...and see if anybody is in or even see if they're still alive, which sounds awful, but if you haven't visited them for so long you don't know if they are".**
>
> (318 I, my emphasis).

If health visitors do indeed visit older people to "see if they're still alive" (318), as this respondent suggested, it could be suggested that visiting people "on the books" may have little more purpose than "checking-up" on them. An assumption underpinning the "on the books" visit is that the older person will quite possibly have deteriorated since the previous visit.

The respondent also commented that health visitors visit older people if they "have nothing better to do" (318). The issue of fitting visits in to older people when there is time left from the "routine" and, by implication, more important, work (de la Cuesta, 1992) of visiting the under fives is also evident in the following comment by a student health visitor respondent:

> "just the other day I took out fifteen cards and I got I think it was nine no accesses to the under 5's...**you know if I'd got an elderly there and there is time I could go in and out. Kill some time, you know, instead of knocking on doors..."**
>
> (325 I, my emphasis)

This quotation reveals that visits to older people are fitted around the other, higher priority, work with the under fives. The idea that visits to older people can be used to "kill some time" (325) demonstrates the non-essential nature of this work. It also denies the potential (therapeutic) value of the visit. The respondent is clearly implying that health visitors do not have an agenda or

set of aims for each visit to an older person. Instead, the visits are a way of filling the gaps in their working day and being seen to be doing something. This is clearly evident in the following comment made by an experienced health visitor respondent:

> "...I mean if I fancy an easy visit, if I've had a hard week then there's nothing better than going visiting the older ladies that are on my books and having a cup of tea and a natter" (019)

The aim of this respondent's visits to the "old ladies" was clearly to give herself a rest at the end of a "hard week". The visits were a legitimate way to spend working time but she could guarantee that they would be "easy" visits, involving "a cup of tea and a natter" (019). Although there may be therapeutic potential in these visits for the older people themselves, the main therapeutic function was perhaps for the health visitor herself. The description of this "natter" visit could be seen to be supportive of Luker's (1978) conclusion that health visitors lack an appropriate theoretical model for work with older people. It would appear the health visitor respondents (both students and experienced health visitors) lacked a clear direction and purpose for visits to older people unless the person had been referred for a specific need by another agency.

Dingwall (1977) has pointed out that little more is required of the health visitor than actually performing the visit to an older person i.e. they are not required to meet a set of objectives or targets for each visit. This is unlike visiting children, where health visitors often have a purpose (though they

may also have a hidden agenda) for visiting, for example, for an "8 month developmental assessment". The absence of clear guidelines for visiting older people means that this work is relegated to "non-essential" and is fitted in when time permits.

8.2.2. Assessment

It was made apparent by the student health visitor respondents in this study that visits to older people were low priority and that they were given little guidance by their field work teachers as to the purpose and structure of this work (see chapter 7). However, several respondents did comment on the types of assessment they undertook with older people. In the absence of clear theoretical direction from field work teachers, several students had sought guidance from other agencies with regard to structuring their assessments. For example one respondent described the assessment schedule she used:

> "...I went to the social services department with **the home help assistant, you know, who does the assessing as to how much help they actually need, and she gave me a form.** The form she used. **I felt it would be excellent in assessing the elderly,** I've still got one of those forms. And I just used that um..and **it was one of the forms where you just circle any specific area and ranked how much dependence or independence they had. And it pin-pointed the areas that...could be helped in any way"**
> (326 I, my emphasis).

In the absence of guidelines for a health visiting assessment, this respondent used the same assessment as the home helps for determining the areas that "could be helped in any way" (326). Again this demonstrates a lack of

theoretical basis for visits, as the respondent had effectively "borrowed" the assessment from another agency. Given that the aim of the home help service is to assist older people in meeting their functional deficits, this assessment format focuses generally upon physical dependency needs.

Other student health visitor respondents described their approach to assessment as stemming from the activities of daily living model which they were accustomed to using in the hospital setting. One said:

> "...doing the activities of daily living as a model did help...I suppose that knowledge as being a kind of nursing background, I think it really did help and it highlighted problems" (333 I).

This respondent implies that the type of assessment used in general nursing was appropriate for home assessment. However, the model generally used *in general nursing (pre-Project 2000) with older people did* not fully integrate the concepts of anticipatory health care or health promotion. Instead it focussed on ensuring basic minimum standards of care for functionally dependent elders (see chapter 6). Again, we can see the health visiting profession borrowing its approach to assessment from other disciplines or agencies because it lacks a unique philosophy or agenda for work with older people.

8.2.3. Referral

From the incidents described by the 12 (48%) health visitors who completed the critical incident section of the questionnaire, it appears that their success

(or failure) as a referral agent is a key evaluative criterion of their work with older people. Evers, Badger, Cameron and Atkin (1989) have identified the key role of the health visitor in referring older clients to other agencies. This suggestion would also be supported by evidence which demonstrates the key role of the health visitor in referring families with children under 5 to other agencies (Chalmers, 1990).

For example one health visitor respondent described the referrals she had made to assist a brother and sister aged 80:

> "needs included incontinence materials, chiropody, bath nurse. Arranged meals on wheels, chiropody etc...Meals on wheels very much appreciated by brother but refused after day 2 by sister. Arrangements made for brother to socialize - stopped by sister!...**All in all I was unable to make any impact on this lady's lifestyle and was powerless to improve the lot of her brother**".
>
> (006 CI, my emphasis).

This respondent described this incident as an example of "ineffective" health visiting practice. The feelings of powerlessness to improve an older person's *lifestyle* appear to be common to both health visiting and practice nursing. One student health visitor respondent described a visit she had done with her field work teacher to an old lady who had just been discharged from hospital where she had fractured her femur:

> "...we were assessing, supposedly assessing, her situation to see if there was any input we could give. At that time in fact there wasn't an awful lot because she had got pressure sores on her heels from obviously bed rest and traction. She was recovering with the help of district nurses who were visiting three times a week" (325 I).

In the case of this particular lady, her dependency/functional needs were being met by the district nurses and the health visitors did not see they could give any input. This clearly demonstrates the problem when a health visitor visits a person who is already receiving another service. When there is no role for her in referral, the health visitor does not perceive a function for herself. Health visitors are not trained or given sanction by the health authority to provide direct nursing intervention to people in the community, rather this is the role of the district nurse. Where dependency/functional deficits or needs are identified by health visitors, their role ends at referring to another agency for those needs to be met.

8.2.4. The identity crisis in health visiting with older people

The crisis of identity which appears to be a common feature of student and experienced health visitors' work with older people (identified in Chapter 7) is sometimes reinforced by the clients themselves. Unlike district nurses, who are clearly identified by uniform and tend to visit older people for the meeting of a specific need (usually physical), the health visitor's purpose and intention for visiting may be unclear to the older person. This reinforces the health visitor's feelings of a lack of clear role and responsibility with regard to work with older people. For example, one student described an older woman she visited for the purposes of "social support":

> "When I went I explained who I was and what I was each time and in fact **I found out later I was referred to, when the district nurses spoke about anybody she had seen, I was the lady who was looking after incontinence**...really I don't feel that we were

practically of much use, but I feel also Miss J. didn't want any more input than she had...

A: Did you feel you were of use in other ways?

"I don't think so. Socially she had plenty of visitors, people popped in and out while I was there...neighbours were in and out every morning and evening. So I felt not social visiting and not really practical visiting so really I felt it was more an exercise for myself to go in and out" (325, my emphasis)

It is evident that both the lady and the student did not really understand the purpose of the visits. When the student's uncertainty about her role is reinforced by the clients themselves the only outcome measure by which the visit is evaluated is successful access and recording that the visit took place. This lends support to the findings of Dingwall's (1977) study. Lacking a clear motive for visiting and a clear agenda within the visit, it merely becomes a pen and paper exercise. It could be argued that student health visitors leave the training period with a crisis of identity and with unclear guidelines with which to undertake work with older people once qualified (see Chapter 7). This could also explain why the service continues to be led by ad-hoc referrals from agencies who may also be unclear about the role and identity of the health visitor.

Due to the paucity of data from the field work teacher/experienced health visitor respondents regarding their work with older people, it is difficult to be more than speculative about their constructions of work. Piecing together the evidence from student and experienced health visitors, however, it is clear that the service remains referral-led, ad-hoc and lacks a clear

theoretical basis. Therefore the health visitor appears to rely on the model of work with older people that she/he has from experience of work in the hospital setting which is oriented around the meeting of dependency needs. None of the respondents in this study perceived a role for themselves in the provision of anticipatory health care for older people.

In spite of the rhetoric of the professional bodies within nursing and health visiting which have attempted to re-orientate practice to focus on groups other than the under 5s (BGS & HVA; Goodwin, 1988), there is some evidence in this study that nothing much has changed in health visiting since Dingwall's (1977) and Luker's (1979) work in the late seventies. Whilst it is difficult to be more than speculative about the reasons for experienced health visitors lack of involvement with older people, there is evidence from the student respondents in this study that the only true evaluative criteria for visits is that the visit has been completed.

8.3. PRACTICE NURSES' CONSTRUCTIONS OF WORK WITH OLDER PEOPLE

8.3.1. Identifying older people to visit

Of the practice nurse respondents (n = 49), 29 (59%) were responsible for visiting people aged 75 and over in their own homes for the purposes of assessment. All 29 identified people aged 75 and over from the age-sex register. The policy agenda, outlined in the GP contract (Health Departments

of Great Britain, 1989) dictates that the assessment of the over 75s in general practice is **universal**, in that each person above that age is to be offered a home visit by the GP or a member of the practice team. There is an interesting parallel to be drawn here with the policy agenda for health visitors' work with the under fives, which gives health visitors the remit for **universal** visiting of families with children of that age.

Of the 29 practice nurses involved in assessment of the over 75s, only 10 (34.5%) were **solely** responsible for undertaking the assessment. Of the remaining 19, 17 (58.6%) shared responsibility with their employing GP (see chapter 6). This generally meant that, if a GP was visiting an older person at home for any reason, and they were "due" an assessment, the GP would undertake to complete the assessment form. It is difficult to be more than speculative about possible differences in the **content and focus** of GP assessments as opposed to those undertaken by practice nurses, as GPs were not interviewed in this study. However, it would be reasonable to suggest that the interchangeable nature of those responsible for undertaking the assessment demonstrates the nature of the role of many practice nurses in acting as surrogate GPs. The fact that the assessments could be performed by either the GP or the practice nurse would also disregard any notions of a "unique" role for the practice nurse in assessment of the over 75s. The remaining two (6.9%) respondents shared responsibility for undertaking the assessment with other practice nurses working in the practice.

8.3.2. Constructions of effective and ineffective practice

It is evident from the data that, for practice nurse respondents, the major indicator of effective and ineffective practice with older people was referral following assessment.

In 20 of the 24 (81%) critical incidents described by practice nurse respondents as examples of "effective" practice in visiting the over 75s at home, successful referral to another agency following assessment was the key evaluative criterion. As the main purpose of the assessment of the over 75s can be presumed to be to detect unmet need (as this is the purpose of most "screening programmes" (Freer, 1988)), it seems reasonable to suggest that, where a need is identified, a referral to an agency to meet that need should be made. Indeed, the GP contract places GPs and their practice teams

> "under an obligation to refer on patients where there are problems needing specialist services" (Health Departments of Great Britain, 1989).

It is interesting to note, however, that only one (3.5%) of the 29 practice nurse respondents involved in assessment of the over 75s described incidents where they had **personally** met a patient's needs as "effective". The role of this particular respondent in meeting the needs of older people is discussed in detail on page 332.

The data make it evident that successful referral is dependent on the following factors;

a) assessment by the practice nurse and correct identification of the problem/need,

b) co-operation/persuasion of the patient/client and an acceptance by the client that the referral/intervention will have desirable consequences for them, and

c) appropriate referral by the practice nurse to the agency who can best meet the need/find solutions to the problem and acceptance of the referral by the other agency.

It appears that if one, or more than one, of these conditions cannot be met the referral will be unsuccessful. Unsuccessful referral was considered, by the practice nurse respondents, to be an indicator of ineffective practice.

8.3.2.1. Assessment and identification of need

8.3.2.1.1. Contacting clients and gaining access

The first part of the assessment stage required successful access to the patient/client. In the case of interactions/assessments which take place in the clinic setting, access to the client did not appear to be a problem, as the clients had volunteered to attend the clinic. During home visits, however,

negotiating access to undertake assessment of an older person appeared to be problematic for some practice nurse respondents.

The lack of coherent guidance within the GP contract with regard to the **approach to** and **content of** the assessment results in different strategies for contacting older people being used by different GP practices. 26 (89.7%) of the total of 29 practice nurse respondents responsible for visiting the over 75s for the purposes of assessment contacted each individual by letter offering them either a home visit or the opportunity to visit the clinic for the assessment. The older people were asked to contact the surgery to arrange a home visit or a clinic appointment. Of the remaining three respondents, two (6.9%) used a system of "cold-calling" (i.e. just turning up at the person's house) and one (3.4%) wrote to each person giving them a time that she would be calling to undertake the assessment.

One practice nurse respondent, who sent a written "invitation" to older people offering an assessment, followed non-respondents up with an opportunistic visit. She described the consequences of visiting someone who had not replied to the invitation:

> "Elderly screening visit to lady over 75 years. Not on telephone. **Sent a letter inviting lady to either be seen at clinic or in the home. Had no reply. Not seen by GP since 1982 and I was visiting someone in the next road so I called just to make sure all was well. The lady was quite irate about the letter, and my visit.** She did have problems but would not discuss..."
>
> (108 CI, my emphasis).

This example demonstrates the problems that can arise when "cold-calling", especially when the client had already been given the option to have an assessment. Not surprisingly the client was quite irate about the impromptu visit. There is perhaps a level of deception evident in "inviting" a person for an assessment and then visiting them uninvited.

The feelings of professional incompetence or ineffectiveness at failure to get access to a home are not exclusive to practice nurses (see Evers et al. (1989) on health visitor's work with older people & Chalmers (1990) on health visiting with under fives). Certainly there is common ground with hospital nursing work with older people and the frustration and impotence nurses feel when a patient rejects a service being offered (see section 6.3.2). The expectation that the service being offered should be accepted by the older person reveals an underlying assumption that the service will be of benefit to the person. Evers et al (1989) have also pointed out that, in health visiting, a client's refusal of a service offered may be problematic as it makes health visitors question their very function and purpose for visiting.

Giving patients the option to visit the clinic or to have a home visit for the purposes of assessment had benefits for some practice nurses in terms of access to some patients. One respondent described how she had used the over 75 assessment as an excuse to gain access:

> "Gentleman aged 79 years....the daughter had contacted me without her father's knowledge. **She knew her father would not attend the surgery himself and would never allow her to call the doctor out. To be able to assess the gentleman properly I decided to use the over 75 check up as an excuse to get him to the surgery.** He responded to my 2nd letter....".
> (136 CI, my emphasis).

The non-threatening nature of the universal assessment of over 75s appeared to work to this respondent's advantage in terms of gaining access to the patient. There is an interesting parallel here with recent work on gaining access to families with children under 5 in health visiting, where the policy of universal contact for developmental assessments legitimizes the health visitor's presence in the home (Chalmers, 1990).

8.3.2.1.2. Approaches to assessment

Although practice nurse respondents were not asked specifically what techniques/assessment schedules they used to assess people aged 75 and over, it appeared that there were several different methods employed.

It is apparent that the assessment was, in the main, designed to meet the terms of the GP contract rather than to ensure accurate and detailed assessment of the patient themselves. Given the influence of the GP in defining the content and boundaries of practice nursing work identified in chapter 7, it would seem reasonable to suggest that the type of assessment undertaken by most practice nurse respondents was determined by the employing GP rather than by the practice nurse herself.

The most commonly employed technique for assessment by practice nurses was a check-list approach which was then supplemented by an ad-hoc series of questions which the nurse felt were appropriate to the individual patient. One practice nurse described her assessment procedure in the following way:

> "...the format follows the form that's been devised by the FPC. So that sort of gives you the starting point, you work through the form erm using the form as sort of guidelines and pointers so that guides you through the interview and that's about it.
>
> Interviewer: "Right, and so do you, I mean, do you try and stick to quite a rigid schedule when you do the assessment?
>
> "I do because I find if I don't you may well miss something. You know you often get side-tracked by these people. You often get side-tracked into other medical problems and you often get side-tracked into just conversation...it's easy to forget to test somebody's urine if you're not concentrating and obviously you've missed half of what you've gone for if you do that..."
>
> (153 I, my emphasis).

Sticking to a pre-determined format had advantages for this respondent in that it ensured that her agenda was successfully completed and prevented her from being "side-tracked". The possibility of being side-tracked into "other medical problems" suggests that there are some medical problems that were the legitimate concern of her assessment and others which were not. The primary purpose of the visit, then, is to ensure successful completion of the practice nurse's agenda which is to cover all the relevant areas of the assessment format without distraction. This rigid approach has the consequence of preventing the older person from identifying their own needs. It could therefore be seen as a strategy which actively militates

against empowerment of the older person and acknowledgement of consumer-defined needs.

Conversational approaches to assessment have problems in terms of the limited time that practice nurses sometimes have allocated for assessment. One practice nurse respondent described the problems of doing assessments in the clinic setting:

> **"Some elderly patients invited for screening think they have come for the afternoon and are completely oblivious to time! They get annoyed if hurried and I sometimes feel rushed....** In the middle of a busy clinic perhaps a drug addict will arrive with some injury or some crisis...."
>
> (113 I, my emphasis).

The annoyance of patients who feel rushed by the practice nurse during their visit to the clinic for assessment has interesting parallels with studies which have investigated patients' dissatisfaction with GPs. For example, in a study by Arber and Sawyer ((1979) cited in Frankenburg (1992)), "rushing patients or being abrupt" were seen by the patient respondents as the most unsatisfactory characteristics of the GPs. In Chapter 8, the issues of control of practice nurses' time by the GP were mentioned. In this quotation, however, it appears that the respondent may have felt **patients'** expectations of her available time for them were unrealistic.

Another practice nurse respondent, who had previously been a health visitor, commented:

> "Screening the elderly is very time consuming. For the average patient who has lots of history to be told **one has to allow plenty of time for the story of their lives to unfold and a true assessment of their situation to be made. It is therefore very difficult to stick to a rigid time schedule:** to get through a set number per year or per month".
>
> (116 CI, my emphasis)

This respondent had previously been a health visitor and her main responsibility within the GP practice was visiting older people at home. She felt that assessment visits should not be strictly regulated by time, as this undermined the opportunity for a "true assessment" (116) to be made. The approach to assessment of this particular respondent is discussed in detail on page 332.

Other practice nurses appeared aware of the limitations of sticking to a check-list. One practice nurse respondent used a check-list but finished the visit with a more client-directed conversation. She said:

> "I visited an elderly lady well into her 70s...Mrs X said she hadn't any problems but as the conversation progressed and I feel she felt comfortable with me she began to explain her daily routines, it came to light that she cooked at night because she couldn't see the gas flame during the day....she had been to the local hospital and was on the waiting list for treatment for her condition (cataracts) but it had deteriorated...she was like many her age, reluctant to contact the consultant's secretary to enquire how long she would be waiting to be admitted or reviewed." (157 CI)

This respondent encouraged the woman to contact the hospital and she got an appointment to see the consultant again. However, the issue here is that the respondent suggested that Mrs X. said "she hadn't any problems" (157)

until the conversation progressed and she began to feel more comfortable. This demonstrates that informal conversational approaches to interactions with older people may often yield more relevant information from clients about their needs. This aspect of work could be seen as an attempt to establish a relationship with the client in order to gain their cooperation (see Chapter 7) and has interesting parallels with health visitors' work in establishing relationships with clients in order to gain their trust and cooperation (Chalmers, 1990; de la Cuesta, 1992).

8.3.2.2. Co-operation/persuasion of the patient/client

If a problem is identified during the course of an assessment, it is probable that the practice nurse may have to employ techniques to persuade the patient that referral and/or further intervention is required. Chalmers (1990) has described this process in health visiting as "working up" the referral.

In other cases, however, respondents described situations where the patient's cooperation was difficult or sometimes impossible to obtain. Lack of cooperation from a patient appears to engender feelings of impotence on the part of the practice nurse. These feelings of inadequacy in failing to persuade patients to accept services offered in the hospital setting were identified in Chapter 6.

The desire to refer a patient on to another service means that the practice nurse may try to "persuade" that patient to accept help from another

agency. If the patient refuses, the practice nurse will evaluate her practice as "ineffective". Although some of the respondents identified a professional obligation not to "impose your standards onto somebody else's lifestyle" (135 I, 128 I), that did not really appear to alleviate the feelings of failure, inadequacy or ineffectiveness that they felt from lack of patient cooperation. One practice nurse respondent described a situation which she evaluated as ineffective:

> "I visited a patient who was in his 80s and lived alone...when I visited his house it was in an unhygienic state. There were faeces in the bathroom, the kitchen was in a dreadful state with old rotten food about. He ate his meals off a dirty piece of newspaper used as a table cloth. When asked if anyone came in to help or if any services were being used he said no he didn't need them and managed quite well. **When the dangers were pointed out to him he just laughed and was certain he didn't require any help or change in his life. I was very concerned and discussed the situation with his GP who was aware of the circumstances and said there was nothing we could do because he was quite happy to lead this kind of life."**
>
> (137 CI, my emphasis)

The feelings of "wanting to do something" and of feeling a sense of frustration when failing to persuade people to accept help or to change their lifestyles may be characteristic of caring professions, but perhaps particularly of the nursing profession.

Another practice nurse respondent described that she felt "ineffective" when visiting a recently bereaved man;

> "He had all his medications in a row to show me, then went on to ask me why "they" would not legalise euthanasia. He said

> that he had lost his lifelong partner, he was no use to anybody. He refused encouragement to gradually attend social occasions at the sheltered accommodation. There was no more I could do for him at that time - he had previously been seen by the psychiatric department and no treatment thought necessary."
> (102 CI)

Again the parallels with the feelings expressed by respondents working with older people who were deteriorating in hospital and did not want to live are evident (see Chapter 6). The role for this respondent was to perform the assessment. She did not mention a role for herself in bereavement counselling or social support. Evidently, her failure to "encourage (him) to gradually attend social occasions" (102) and the fact that a referral to the psychiatric department was not an option meant that the respondent did not feel that any other courses of action were open to her. This demonstrates that the core function of some practice nurses is to perform the assessment and to refer on. The only action this respondent could take was to give encouragement during the visit, but not to pursue any long-term therapeutic function herself. This demonstrates the influence of the policy remit on GPs and practice nurses which requires them to perform a one-off annual visit but not to set long-term goals or to have any therapeutic function for older people, unless of course the needs identified are medical in nature. In this way the policy agenda restricts the practice of nurses and GPs and denies them the opportunity to become involved with individual older people on a regular basis. Therefore it is inevitable that practice nurses will pass on responsibility for the provision of services to other agencies through the process of referral.

Referral to another agency creates the illusion of a successful assessment visit, indeed in one study of health visiting (Williams, 1975) referrals were counted as positive outcomes of screening older people. However, it would be reasonable to suggest that this demonstrates that practice nurses (and health visitors) evaluate their work in terms of the **process** of assessment and referral irrespective of true patient **outcome** as a result of referral. The practice nurse respondents demonstrated in this study that, once a referral had been made, their responsibility ended. This undermines the evaluative potential of discovering whether, once the referral has been made, the agency referred to successfully met the needs identified.

8.3.2.3. Appropriate referral and acceptance of the referral by the other agency

A large degree of frustration with the lack of available resources in the community for older people was expressed by the questionnaire and interview respondents. The practice nurse respondents in this study had the same direct referral rights as other community nurses. Referral of clients for services such as chiropody and community physiotherapy presented problems, mainly because waiting lists for services were so long. Several practice nurse respondents evaluated their work as ineffective because they were not able to get resources for older people due to long waiting lists. One respondent said;

> "I feel generally ineffective when I come across elderly people who need referral to various agencies knowing that the waiting time is getting longer and longer...". (143 CI).

Another commented;

> "I was asked by the GP to do an elderly assessment on this patient. Following my visit (I decided) the patient needed chiropody, bath aids or help getting into the bath. I made the necessary referrals knowing that the waiting list for chiropody was 6 months and OT assessments were very overworked. **I felt that I had built false hopes for the patient".**
>
> (114 CI, my emphasis)

In the second of these quotations, the respondent said that she felt she "had built false hopes for the patient" (114). The implication of this is that the respondent did not ensure that the patient was fully aware of the waiting times for the services she had referred to. Perhaps this respondent did not feel she was able to be honest with the patient about the probable waiting times.

The issue of long waiting lists certainly presents practice nurses with an ethical dilemma. One respondent questioned the point of performing assessments when the waiting lists were so long;

> "When carrying out over 75 assessments I feel ineffective quite frequently because there are quite often services that would improve the patient's quality of life but they are just not readily available....**consequently there seems no point in making home visits if we are unable to improve things for the patient."**
>
> (125 CI, my emphasis).

Again, this quotation highlights the **key function of the practice nurse in** referral. This respondent questioned the point of doing the visits if she was unable to improve things for patients. She talked about improving quality of life with the provision of services but clearly does not include the practice

nursing service in this, therefore pointing to her role as a referral agent, rather than in serving any therapeutic function. It is interesting to compare this to the potential health visiting function with older people. Health visitors clearly have the potential (as in the "on the books" visit described on page 300) for follow-up and for long-term therapeutic activities with older people, though they do not appear to exploit this potential.

Practice nurse respondents, in the main, saw their key role in visiting older people as acting as a gatekeeper to other services through the activity of referral. The policy agenda determines that the responsibility of GP practice staff who undertake assessments of people aged 75 and over begins and ends with assessment and subsequent referral to another agency if a need arises. The role of the practice nurse is therefore clearly circumscribed by the policy agenda which requires a "one-off" visit on an annual basis and, as discussed in chapter 7, by their GP employers.

8.3.3. Alternative constructions of effective and ineffective work in practice nursing

There were few examples of evaluative criteria other than referral being used within practice nursing work.The policy agenda prescribes the practice nurse's role quite clearly, that is to perform an annual assessment and make referrals where needed. One respondent expressed frustration at the limitations of her role and its clearly prescribed boundaries:

> "I feel like my role is just really like part of the GPs role. **I just go in and then refer. I don't actually do anything nursing-wise at all.** A couple of times I've gone round and patients have said, "Oh I've not had a bath for a month" and **I feel like rolling my sleeves up and saying, "Right, I'll put you in the bath", but I can't.** Maybe the district nurses will cause a stink...I wouldn't blame them coz it's not my job and I'm not qualified to do it. **But I mean the GPs would go mad as well wouldn't they? "We're not paying you to do that".**
>
> (118 I, my emphasis).

This particular respondent had come straight from hospital work into practice nursing. Whilst nurses are encouraged to meet patient's physical needs in the hospital setting, the practice nurse is directed to perform an assessment. She does not have a mandate to directly meet needs herself. As this respondent said her "GPs would go mad" if she bathed someone because that was not what they were paying her for. This reiterates a point made in chapter 8, but it lies at the crux of practice nurses' work, that the GP is the practice nurse's **employer** and therefore has the power to control the boundaries of her role.

There were two notable exceptions to the constructions of effective and ineffective practice demonstrated by the majority of practice nurse respondents in this study. Following analysis of the interview data, it became apparent that these two respondents represented the two "extremes" of practice nursing, in terms of their degree of control over their own work and the way they constructed their individual roles in the assessment of older people at home. Because they appeared to represent the two extremes of a continuum of constructions of practice nursing, they

are considered worthy of individual attention. For the purposes of this discussion these two practice nurses will be considered separately.

8.3.3.1. Practice nurse respondent - Jane (119)

Jane (pseudonym) was in the age-group 20 to 29 and held an RGN qualification. She was paid on an F grade and worked part-time in a practice with three GPs and no other practice nurses. Jane had previously worked on a surgical and high dependency unit and had no post-registration experience (aside from during her general nurse training) of either work with older people or work in the community. Jane gave her reasons for entering practice nursing as "increased job prospects, reasonable hours and increased pay" (questionnaire p5).

Jane was responsible for a whole range of duties within the GP surgery including the running of asthma clinics, hypertension clinics, health promotion clinics, performing immunisations, ear-syringing and assessment of people aged 75 and over at home. She wore a dark-blue nurse's uniform during her work in the surgery and for home visiting. The work of undertaking the assessments was shared between her and the three GPs and she undertook approximately 20 home visits per month.

8.3.3.1.1. Jane - Approach to assessment

Assessment of each person aged 75 and over was undertaken using a check-list approach. Some drug companies print and distribute checklists for

practice nurses to use during over 75 assessments (for an example see Appendix 13). Jane used one of these which was on a tear-off pad provided by a major drug company. Each sheet of the pad had a set of questions with boxes to tick off when the questions had been asked. Jane favoured the pad because it was quick and easy to use and provided structure for the visits.

The assessment process consisted mainly of a problem-solving approach to patient's physical needs. Jane felt that her general nurse training had equipped her adequately to undertake the type of assessment that the practice required.

She said:

> **"...I think well why have we been trained to assess people, you know, in three years training, and can't go out and assess over 75s. I don't think perhaps I'm particularly good at assessing depression in the elderly...but I think our own assessment procedure which we did in hospital anyway must make you aware...and some medical knowledge obviously to be able to advise.** And I always take my oroscope with me coz half of them sound as if they're deaf and I look down their ears and see they've got wax and I say, "Well come up and have them syringed".
>
> (119 I, my emphasis).

It is apparent that the knowledge base for the assessment Jane undertook with older people was fundamentally derived from experience of general nursing work in the institutional setting. However, this knowledge base is built on work with the most dependent of older people who reside in institutional settings. Work with the highly dependent older population often derives its knowledge base from the discipline of geriatric medicine

(Phillipson and Strang, 1986) and does not always encapsulate the broader social issues pertinent to older people living in their own homes.

In addition, the acknowledgement of not being "particularly good" at assessing depression in older people demonstrates the lack of value attached to the psycho-social aspects of health. Acknowledging a knowledge deficit for a particular skill or task but continuing to undertake the work reveals that low priority is attached to that skill/task.

Jane also commented on the necessity for medical knowledge, revealing that the identification of medical problems was a primary focus of the assessment and that she perceived a role for herself in advising on medical problems. She said "half of them sound as if they're deaf" (119) so she took an oroscope with her on her visits. Whilst there is evidence that the prevalence of hearing loss in people aged 75 and over is between 9 and 36% (Lawless, 1992), it is questionable whether a nurse without special training is equipped with the knowledge to diagnose and prescribe treatment for this functional deficit. Given that doctors are trained to advise on medical problems, it could be argued that she was in fact acting as a surrogate doctor in her work.

Jane also talked about continence issues being important in assessing older people. When she was asked to be more specific about this area of work she said:

> "They often talk about the waterworks, but **it's very difficult to deal with older people's waterworks isn't it?** They often say, "Oh I have to get up two or three times a night". Well they will anyway won't they? You can't do anything about that which is a bit sad. **I say, "Well, I'm sorry, as you get a bit older"**..."Oh I see" they all go".
>
> (119 I, my emphasis).

There is evidence that around 10% of older people have problems with incontinence. Lawless (1992) suggests that there is a widespread misapprehension that incontinence is an untreatable consequence of old age, despite evidence that interventions can be effective in curing or substantially ameliorating incontinence (Ouslander, Zavit and Orr, 1990). It would appear that underpinning Jane's comments about old people's "waterworks" is an assumption that the problems some individuals raised were **because** they were old. She did not appear to perceive the need for a thorough continence assessment or for giving any advice/education about improving continence, again demonstrating that her knowledge base for work with older people was limited and perhaps based largely on assumptions rather than facts.

8.3.3.1.2. Jane - Construction of effective and ineffective practice

For Jane, practice was constructed as the undertaking of what could be considered delegated doctor's work. In the case of older people, this meant ensuring a level of physical health that was considered "normal" for any given individual's chronological age. However, her constructions of "normal" for any given age appeared to be based on assumptions which were underpinned by commonly held stereotypes of old age (Gubrium, 1986).

Jane constructed effective practice as successful detection and referral of unmet medical need to the GP. This can be seen clearly in her written description of an incident with an older woman whom she visited for the purposes of assessment:

> "Routine assessment of an over 75 year on my list...diabetes, urine tested, glycosuria. **Told her what I had found, to report to GP. I informed GP. Patient saw GP at the surgery. Left in GPs care. I was worried she could become frightened because I had told her she may be diabetic.** Labelled "diabetic". she wouldn't go to see GP until after her two week holiday - frightened she may collapse in a coma after or during the holiday! A bit put out - care was then taken out of my hands".
> (119 CI, my emphasis).

Jane described this incident as an example of "effective" practice, demonstrating that her overriding aim in the assessment was the successful identification of unmet medical need. By identifying unmet medical need, Jane could gain the approval of her GP, although she was obviously not able to determine appropriate treatment or follow-up of patients. In the follow-up interview Jane expanded her description of the incident by describing a conversation she had with the GP about this particular patient. Jane felt that the patient required some follow-up and that she might be an appropriate agency to undertake that function, but had to gain the GP's approval for this:

> **"well I spoke to the GP and said, 'Do you want me to go back and see her, see how she's getting on?'. "Oh no, no, no the hospital's looking after her, she's alright".** And really I've got enough work to do without going back to see these people but I would have been quite happy to go back and see her. I mean nobody's forbade me to go back but he said, "She's being fully cared for by the hospital, there's no need"."
> (119 I, my emphasis).

In this situation it is apparent that Jane felt a desire to go back and see the patient to follow up the detection of diabetes. However, she felt it was necessary to gain the GP's permission to do this. This demonstrates the singular lack of autonomy and opportunity to make decisions about patient care independently of the GP.

Although it is acknowledged that nobody **forbade** Jane to go back and see the patient, the implication is that she did not feel able to without the GP's prior approval. She deferred the decision to the GP and then acted upon his instructions. The "deferent" approach to interactions with general practitioners was discussed in chapter 8.

The assessment carried out by Jane generally involved referral back to the GP because the questions she asked and the tests she performed were medical in focus. Jane described her pattern of referral in the following way:

> "well generally I assess them and only if I find something that needs dealing with do I refer them, but generally it's only a referral to the GP coz normally it's a medical problem." (119 I).

Although Jane did encounter situations where the problems identified were of a psycho-social nature, her lack of experience in dealing with such problems was often a source of frustration. Jane's description of an incident where she felt ineffective demonstrates the frustration she encountered in dealing with problems of this nature:

> "Over 75 routine assessment. lady very low, no friends, very worried re husband's health, reliant on daughter who lived 10 minutes away. Me to contact daughter, daughter also in bad way = nerves etc. Encouraged to go out of own accord. GP to take care of husband's ill-health. They could get out to W.I. etc, but just wouldn't. Why?? useless - situation not any more improved" (119 CI).

This quotation reveals the frustration Jane felt when dealing with issues other than medical need. Although feelings of frustration when older people do not take up services offered were common to most respondents (see page 313), Jane demonstrates a lack of understanding of the reasons **why** this older person may not have wanted/felt able to "get out to WI" (119).

Questioned further about the value of the assessment visit itself, Jane revealed that, for the well-elderly, she felt that the assessment served a purpose to reassure older people of their physical health status:

> "Well, they're very pleased when you say "oh, your blood pressure's fine" - "Oh good", you know. They're very pleased to know they're alright" (119 I)

The social aspect of visiting, however, whilst recognised as pleasurable for the older person, was not given any therapeutic value. Jane felt that her role was as a representative of the GP surgery and that the social aspects of visiting could be undertaken by anybody:

> Jane: "The highlight of their day isn't it for some of them?"
>
> Interviewer: "And do you think you need to be a nurse to do that or do you think that's just because...?"

> Jane: "What, the social side of it? Oh no, I'm sure if anybody walked in they could chat to them socially" (119 I, my emphasis).

The lack of value Jane attached to skilled therapeutic social interaction with older people reaffirms her medico-physiological approach to constructing and evaluating work.

8.3.3.2. Practice nurse respondent - Maureen (116)

Maureen (pseudonym) was in the 50 to 59 age group, married to a senior lecturer in a Department of Medicine and had two children. She was a qualified midwife and health visitor and worked for several years as a health visitor attached to the GP practice with which she then worked as a practice nurse.

Because of a personal interest in the psycho-social aspects of health, Maureen undertook a certificate in counselling skills and retained an interest in counselling and therapy. She had worked as a practice nurse for just over a year and worked part-time (between 20 and 29 hours per week). She was paid on a G grade for her work in a practice where there were 4 GPs and another practice nurse (Pat) who was responsible for running clinics and other surgery facilities. Maureen had sole responsibility for assessment of the over 75 population, all of which she undertook in the patients' own homes. She did not wear a uniform, instead she adopted what she called "professional" attire - a blue suit on which she pinned her nurse's badge.

She did approximately 40 home visits to patients aged 75 and over per month.

8.3.3.2.1. Maureen - Approach to assessment

Maureen compared her approach to assessment with that of other practice nurses she had been responsible for teaching on an FHSA study day:

> "...I said how long it was taking me personally to get through these visits you see and some girls were putting their hands up and saying "oh we go out with a checklist and get through in twenty minutes" you see...okay, **if you've got a very prescribed set of information that you want to get off a patient maybe you can do it that way, but if you're wanting to go into a full social, emotional, mental assessment then you can't rush in with a checklist** and okay you can get a lot of ticks on it but what extra information are you gaining?" (116, my emphasis)

This quote reveals the difference Maureen saw between an assessment involving a "prescribed set of information" and one involving a "full social, emotional, mental assessment". The difference between a concentration on "physical/functional" aspects of health as opposed to one which incorporates the psycho-social paradigms is clear here. Maureen used a holistic approach to the assessment of older people, incorporating the requirements of the GP contract and an assessment of physical health whilst giving equal weighting to psycho-social aspects of health status. In addition, the assessment itself was viewed as an opportunity for therapeutic intervention.

The level of autonomy Maureen had in deciding the content, timing and focus of her assessment visits stemmed from the relationship she had with the GPs. Maureen described how she had entered into the field of practice nursing:

> "I had worked for the same group of GPs that I went back to for three years or so as a part-time health visitor and was very happy doing that in the essence of working with the GPs. I liked the group I was with, I got on very well **with the GP I was working with...he's very interested in counselling which I'm in, I also am and erm..so we have a lot in common in that respect...then it came up that I met P. (the practice nurse) who said "oh the GPs have been looking for you because they realise that you're not sort of doing anything in particular at the moment, they have a role that they think you would be interested in, d'you want to come and talk to them?"...What they wanted me to do initially was just twelve hours, basically picking up immunisations, the immunisation bit that was coming out, going to come up on the new contract...when I went to have this chat session, it could hardly be called an interview because they all knew me fairly well, erm I said "I would be very interested in doing some work with the elderly, because I feel they don't get enough cover from the health visitors in this area"...and they leapt on it of course because that was a big part of the GP contract" (116 I, my emphasis).**

From the outset Maureen had negotiated her role within the GP practice carefully. Her experience as a health visitor and from being married to a doctor who was a senior lecturer meant that Maureen was very used to dealing with members of the medical profession, both professionally and socially. It appears that there was a level of mutual respect between her and the GPs which was not evident in other respondents' descriptions of the employer-employee relationship (see Chapter 7).

Because the GPs respected Maureen's right to professional autonomy, she was responsible for her own decisions, interpretation of the assessment and for the advice and treatment following the assessment. Maureen explained why she felt autonomous whilst being an employee of the GPs:

> "...I'm quite autonomous in the respect that when I see these over 75s er..that I'm the only one going in and I'm, not coming back to the GP with everything. And they rarely in fact see the results of my assessment..." (116)

This indicates that Maureen had not only the trust and respect of the GP but that she was viewed as having a discrete and important function within the practice which was complimentary to the medical care provided by the GP.

8.3.3.2.2. Maureen - Construction of effective practice

It was described on page 328 how Jane constructed effective practice as the successful meeting and referral of unmet medical need and, in section 8.3., that the majority of practice nurses constructed practice as a successful assessment and, if required, referral to an appropriate agency.

Maureen differed in her view of the aims of her home visits in that she constructed the visit itself as an opportunity for therapeutic intervention for the older person. Whilst referral to appropriate agencies was seen as a valuable end-point of the assessment process for particular individuals, for others she regarded the visit as worthwhile in its own right. Maureen declined to describe any one particular visit in order to explain effective practice. Instead she wrote:

"One of the most effective contacts with the elderly has been, not one of discovering an ailment, or referring to a number of different agencies but, to enable the elderly person to have an available professional to whom to make reference or query as necessary. **Recently I have seen two patients like this - both without relatives, both coping to a point, without involvement with other agencies such as social services, but who needed a person to who they could talk about their needs, worries and concerns and who could give them the confidence they needed to make decisions and of being there when they needed help i.e. a 'reference point' when needed. I feel that this kind of contact is valuable in enabling the patient to cope longer as independent people** and who can 'refer on' when the need arises. I felt I was performing a 'social' role as much as a 'health' role".

(116 CI, my emphasis).

Maureen makes it evident that, for her, effective practice was constructed in terms of the therapeutic intervention during the visit itself. Giving the "well" elderly the opportunity to talk to a professional person "about their needs, worries and concerns" was valued by her and seen as a worthwhile function. She expanded on this aspect of visits to older people in the interview:

Maureen: "... a lot of people have said how useful they've thought it was and how nice it is to have somebody that they can spend a little more time with".

Interviewer: "Do you feel that's a valuable part of the visit, as much as the assessment itself?"

Maureen: "I do, absolutely I do. And it's, if you've got the time to sit down, very much as a sort of mature person, I include myself in that category, to another mature person, you're going to get a lot more feed-back I think and a lot more inside knowledge. And you know you can do a lot of talking, a lot of advising, a lot of counselling. Most of them have been through a recent bereavement of some kind, or even if it's not a family member the fact that they're probably left alone out of an original large circle of friends, so there's a lot you can go through" (116 I).

Maureen's training as a counsellor had led her to value the expertise she had to offer older people, and she saw the assessment as providing an opportunity or reason for visiting clients who would not normally be in receipt of services. These "well-elderly" were often constructed as "well" in the physical/medical sense but Maureen's knowledge about the more psycho-social aspects of old age facilitated the recognition and acknowledgement of issues such as bereavement being important for that population. Maureen saw her experience and expertise as vital components of this therapeutic function. She viewed her experience as a health visitor, her training as a counsellor and her "mature age" (116) as essential factors in providing a quality service for older people:

> "I wouldn't have liked to have taken on this job, in fact I wouldn't have suggested it, had I not had health visitor training..." (116 l).

8.3.2.3. Maureen - Construction of ineffective practice

For Maureen, merely performing and completing the assessment visit was not considered adequate. In the following example, Maureen explained an incident where she felt her practice had been ineffective:

> "I had made an appointment (written) for routine elderly screening at home, giving a time frame for visiting. I was 10 minutes after the appointment time on arrival. The lady was extremely angry at my lateness and despite my apology remained angry but decided to let me in to visit her, rather than make a new appointment. **I screened the patient; all recordings were within normal limits... I tried to engage her in conversation to try and uncover some reasons for the latent anger - which had been triggered by my tardiness.** I heard all

> about her rigidly structured youth and early married life, particularly regarding time...there was resentment going back years. There was unpleasantness - almost hostility - towards me throughout the interview, and the patient was also derogatory regarding her GP. **I began to feel very uncomfortable and wished to take my leave. At this point the patient began to weep about her anger towards me and to apologise. I had to leave to return for clinic appointments but I felt that I was leaving the patient in a very vulnerable state...I felt I had done more harm than good in my visit and inadequate.** (116 CI, my emphasis).

Maureen described having to return to the surgery for appointments, even though she felt she was leaving the client in a vulnerable state. The issue of control of practice nurse's time was discussed in Chapter 8. Because the visit had not come to what Maureen considered a satisfactory conclusion before she left, she felt that the visit had been ineffective and had perhaps even been detrimental to the client ("done more harm than good"). The description of this visit reveals Maureen's belief that the assessment visits were to be therapeutic in themselves. The fact that "all recordings were within normal limits" was not sufficient for Maureen, who felt it necessary to discuss the patient's anger regarding the late appointment. This reveals the aspect of her work that was not merely about satisfying the terms of the GP contract but involved intervention from Maureen herself on issues which appeared particularly important to the patient.

8.4. THE POTENTIAL FOR ANTICIPATORY HEALTH CARE

It appears that underpinning both health visitors' and practice nurses' assessments and work with older people is the notion that old age is a time of deteriorating function. This image of old age in itself undermines any

opportunity for involvement in anticipatory health care or health promotion/education. Indeed it was apparent that many respondents in this study saw older people as incapable of change, therefore they saw little point in attempting to **improve** the lifestyles/health behaviours of older people.

For example one practice nurse respondent wrote:

> "I would say that in my dealing with the elderly hypertensives I am probably ineffective in a lot of cases, as **the majority of these patients are already set in their ways and reluctant to change lifestyle, habits etc."** (105 CI, my emphasis)

The feeling that older people are incapable of change was mentioned by several respondents. A health visitor respondent wrote:

> "my belief is that health education can have little impact on the elderly who are often confirmed in their habits/lifestyles" (005 CI).

This health visitor respondent revealed one of the key issues of work with older people. It is the assumption that older people are "confirmed in their habits" and are therefore reluctant to change that undermines any impetus for health visitors and practice nurses to become involved in the provision of anticipatory health/primary preventive strategies with this age group.

Whilst some older people may be "set in their ways", there is evidence that older people are capable of altering their lifestyle and health behaviour with appropriate facilitation from health care professionals (Higgins, 1989). The

assumptions on which the above examples rest can be seen to be based on little more than a stereotyped image of old age, given the evidence that older people are as knowledgeable as younger cohorts about healthy lifestyle issues and that they tend to live healthier lives than younger people (Vetter, 1990).

8.5. MODELS OF PRACTICE

8.5.1. Health Visiting

It was mentioned in section 8.3. that the paucity of examples of work with older people from experienced health visitors makes it difficult to be more than speculative about the model of health visiting practice in use with older people. The quality of critical incidents described by the 12 experienced health visitor respondents who completed that section of the questionnaire was poor and, even in the interviews, it was difficult to engage respondents in detailed discussion of their work with older people as many of them did not visit older clients. It would appear from the evidence in this study that nothing much has changed since Dingwall (1977) and Luker's (1979a) work on health visiting intervention with older people. The evidence given by student health visitors and experienced health visitors demonstrated that work continues to be focused predominantly on the under 5s (see also chapter 7) and that health visitors merely respond to referrals from other agencies for "crisis intervention" work. It appears that work with older

people at an anticipatory/primary preventive level was not part of the remit of the health visitor respondents in this study.

8.5.2. Practice nursing

In the case of the practice nurse respondents in this study, there was a substantial amount of evidence about their constructions of work with people aged 75 and over, in particular involving the universal assessment demanded by the GP contract. A continuum of models of practice nursing has been developed which reflects the spectrum of models in current use, with the "GP assistant" at one end and the "nurse practitioner" at the other. This continuum is based on data from the respondents who appeared to represent the two poles of practice nursing (see pages 325 - 340), coupled with evidence from the other respondents, and is conceptualised in the diagram below:

GP **Nurse**

<----------><

Assistant **Practitioner**

Figure 1: Continuum of models of practice nursing

Models of practice nursing varied in the degree of control over work and consequent autonomy that practice nurses had, the type of relationship with the employing GP and the focus of the assessment.

Jane apparently functioned as an "assistant" to her employing GPs, in that her role in the detection of unmet medical need was clearly defined and controlled by them and she deferred all decisions about appropriate intervention to them. Her work was characterised by low levels of autonomy and control in terms of its content, by a deferential approach to relationships with the GPs and by a highly medicalised or disease-oriented approach to the assessment of older people. One of the consequences of Jane's deferential approach in her relationships with GPs is that she worked almost exclusively under the remit of a medical definition of health and illness. By adopting the deferential approach she depended heavily on the GP to make decisions for her. It is speculated that this resulted from a lack of confidence in her own decision-making ability.

By comparison, the practice nurse respondents who lay towards the centre of the continuum tended to take a broader approach to assessment, incorporating more fully the concepts of psycho-social health as well as checks on physical function. Whilst not identified as a clearly homogeneous group in the truest sense of the word, these respondents appeared to use a common set of strategies to establish control over the boundaries of their work (see chapter 7). The model of practice of these respondents contained two key functions:

1) Where a "need" or functional deficit was identified from the assessment of an older person, the practice nurse would make a referral to another agency for that need to be met.

2) Where no "need" was identified, the practice nurse would make a record of the assessment and would plan to return a year later to repeat the assessment. This adhered to the requirement of the GP contract for an annual assessment to be undertaken.

It was apparent that these respondents did not view themselves as therapeutic agents for individual older people in any way. The boundaries of their role were clearly drawn by the policy agenda, filtered to them through the GP. They were clearly not autonomous practitioners as they were not in a position to follow-up individuals who may have benefitted from on-going intervention. Rather their key function was to refer individuals to other agencies where a need was identified.

It was also clear that the major concern of these particular practice nurse respondents was with the **process** of intervention rather than on patient **outcome** i.e. the role and responsibility of the practice nurse ended with the referral being made. Whilst they demonstrated a concern that waiting lists for particular services such as chiropody and physiotherapy were long, they did not perceive a role for themselves in ensuring that referrals were appropriate or that the agency referred to had been successful in meeting a patient's needs.

Maureen, on the other hand, articulated her role in a way which was very reminiscent of the definition of a "nurse practitioner" (see chapter 3) in that

she considered herself to be autonomous in her decision-making and practice and had relationships with her employing GPs which were characterised by negotiation and mutual respect. She adopted an approach to assessment which integrated the concepts of physical, psychological and social health and perceived her function in providing direct therapeutic intervention for older individuals as an important part of her visits.

Maureen considered herself an expert in her own right when it came to visiting the over 75s. She was confident in her dealings with GPs and patients and set her own goals and work boundaries. Her interactions with the GPs operated on a collegial basis in spite of the employer-employee relationship. This resulted in the foundation of the relationship being one of negotiation rather than deference.

In terms of assessing the over 75s, Maureen ensured that the terms of the GP contract were met whilst also following her own agenda and priorities for visiting. This involved undertaking a comprehensive, holistic assessment of the older person and making decisions about care and referral independently of the GP. She was confident in her dealings with older people and used her communications and social skills to build up relationships with patients. She considered the assessment visit provided her with an opportunity to provide some therapeutic intervention for the client when necessary, for example bereavement counselling, advice, and social

contact. This aspect of the visits was allocated high value and Maureen viewed herself as skilled, competent and appropriate to undertake this work.

The characteristics of the GP assistant and the "nurse practitioner" model (the two poles of practice nursing) are summarised in the table below.

	GP Assistant	"Nurse Practitioner"
Experience of community nursing	none	extensive
Interaction model with GP	deferential	negotiation
Level of assertiveness	+	+ + +
Level of autonomy	+	+ + +
Approach to assessment	medical focus	psycho-social and physical combined
Aims of assessment visit	detection of un-met medical need	visit of therapeutic value in itself

Table 8. Summary of the poles of the continuum of models of practice nursing

There is some evidence from the data in this study that the continuum is dynamic, in that there were indications that different models of practice nursing were used by individual respondents for different activities. For example Maureen, who appeared to function as a "nurse practitioner" when she visited older people, pointed out:

> **"...at the other end of the scale I'm a GP assistant as far as the immunisations are concerned. I mean I don't give vaccinations without the GP being present because I don't want to,** I fully comply with the advice that's given on that, **because if there's a crisis, I don't feel competent to deal with that crisis..."**
> (116 I, my emphasis).

This quote reveals that Maureen apparently selected the issues/client group with which to fight for her professional autonomy. In the case of work with older people she negotiated her role and apparently operated independently from the GPs. In the case of immunisation work, however, she obviously felt that she wanted to "comply with the advice" that the GPs gave because she lacked confidence in her own decision-making ability and her competence in crisis situations. Whilst this is the only clear example of different models being used by practice nurses in different contexts, it does draw attention to the context-specific nature of practice nursing work. Given that practice nurses are expected to undertake a whole range of functions and tasks within the GP practice (Reedy et al, 1980; Greenfield et al, 1987) it would appear reasonable to suggest that their levels of autonomy and responsibility would vary according to their level of expertise, competence and professional interests. As practice nurses come from a whole range of nursing backgrounds, it is apparent that any individual practice nurse's competence may be of varying levels in different fields of work.

8.6. CONCLUSION

This chapter has drawn on data from critical incidents and interviews which provide evidence for the constructions of health visiting and practice nursing

work in the assessment of older people at home. The paucity of data from experienced health visitors regarding work with older people has meant that it is difficult to be more than speculative about the models of practice in current use. However, evidence has been presented in this chapter (and also in chapter 7) which suggests that health visitors continue to provide a reactive, referral-led and needs-based service for older people which focuses on deteriorating functional capacity.

In the case of practice nurses it has been demonstrated that, for most, the main aim of the assessment visit was to perform the assessment and to refer on to other agencies when a need is identified. This adheres to the purpose of the assessment of people aged 75 and over outlined in the GP contract. It has been suggested that models of practice nursing with regard to assessment of people aged 75 and over at home operate along a continuum from GP assistant to "nurse practitioner". This continuum was developed from analysis of critical incidents from and interviews with eight respondents, therefore it requires further rigorous research testing. In spite of the small sample size, however, there was clear evidence of differences in the models of practice between these eight respondents and it is speculated that the continuum may be dynamic (i.e. that individual practice nurses may use different models in different spheres of work).

CHAPTER 9.

DISCUSSION, CONCLUSION AND RECOMMENDATIONS.

9.1. INTRODUCTION

The overall aim of this study was to gain insight into health visitors' and practice nurses' constructions of work with older people in the community, in particular their roles in the provision of anticipatory health care.

The central finding is that the main goal of the nursing care of older people, both in hospital and in the community, is the meeting of functional deficits or physical (and sometimes psychosocial) needs. Underpinning this is the assumption that older age is a time of deterioration and increasing levels of dependency. It is argued that it is this focus, coupled with the structural contexts of work and training of nurses, practice nurses and health visitors, that militates against their involvement in the provision of anticipatory health care for older people.

The first section of this chapter (9.2) consists of a brief overview of some of the methodological issues which should be considered when undertaking a study of this type. The chapter continues with a discussion of the significance of the study within the current policy context, focusing attention particularly on the changes in primary health care.

9.2. METHODOLOGICAL CONSIDERATIONS.

Several issues regarding the methods used in this study are worthy of consideration. It is apparent that researchers who utilise the Critical Incident Technique (Flanagan, 1954) need to carefully consider the validity of retrospective accounts of events, especially when this data is being used to interpret their current constructions and/or practice. With regard to this study, the question of whether respondents' descriptions of past events whilst working with older people are necessarily representative of their current attitudes towards older people needs to be addressed. The question is not one of whether the respondents' descriptions are "truthful", but rather to what extent retrospective accounts are influenced by respondents' current views, so that pervious incidents are "reinterpreted". The retrospective nature of the technique may deny the dynamic and changing nature of experience, beliefs and attitudes. Whilst the Phase II interviews went some way towards rectifying this issue by attempting to reflect the relevance of individual's past experience on current practice, the sample sizes were limited and therefore it would be beyond the scope of this study to claim a direct link.

Whilst the Critical Incident Technique (Flanagan, 1954) proved to be useful in eliciting case-specific data regarding health visitors' and practice nurses' constructions of practice, the mode of analysis selected by the researcher saw a departure from Flanagan's suggested mode of analysis. The question should be asked as to whether this departure was so radical that it was no longer Flanagan's Critical Incident Technique that was being used. Whilst Norman et al (1992) have accepted that the "positivist" or quantitative mode of analysis was not appropriate in their study, it would appear that the philosophical underpinning of the technique remains seated within the positivist tradition. In view of the current revival of the

technique and its popularity in nursing research at the present time, the assumptions underpinning the technique need to be realised by any researcher considering its use.

A short mention should be given to the sampling techniques used for selecting the Phase II respondents for interviews. Whilst the sampling technique used was, in essence, a theoretical sampling technique it was also stratified so that respondents with particular characteristics (in particular, their previous experience) were represented in the sample. Naturally, this type of theoretical sampling is not identical to that used in "grounded theory" studies, where conceptual phenomena are the basis of sampling. In this study a theoretical sampling technique which was stratified to ensure inclusion of respondents with differing "key" characteristics was seen to be the most effective way of selecting those respondents most likely to shed light on the "key" issues.

9.3. THE INFLUENCE OF POLICY AND STRUCTURE ON PRACTICE

There are clear indications that practice nursing and health visiting practice are directed by the policy agendas set at both government and local level and also by the structural contexts of work and training.

In the case of health visiting, the policy agenda clearly demarcates the health visitor's responsibility for offering a universal service to families with children under five. Many health authorities issue guidelines for visiting this group to which health visitors are expected to adhere. Coupled with health visitors' own concerns about children at risk and the defensive model of practice stemming from those fears, it

is apparent that they have very little time left from "routine visiting" to take a pro-active role in the provision of anticipatory health care with older people. Instead, visits to older people have to fit in around the work with young families, as and when possible.

From 1988/1989 prospective student health visitors were no longer required to have a midwifery/12 week obstetric qualification. In spite of this, it is evident from the data presented in Chapter 5 of this thesis that student health visitors are more likely to have previous post-basic experience of work with children than they are to have experience of work with older people. In addition, a significant proportion of the students held a formal qualification in midwifery or sick children's nursing, none holding post-basic qualifications specific to the care of older people. Higher levels of satisfaction with work with children were expressed by the students than were expressed about work with older people. The previous work histories of these students indicate that, before entry to training, student health visitors are more likely to be oriented towards issues of child health than to the care of older people.

The recently issued document "The scope of professional practice" (UKCC, 1992) acknowledges the concentration of the health visitor's role towards the under five population which, it states, is;

> "at the expense of other groups in the community who need, and would benefit from, the special preparation and skills of health visitors" (UKCC, 1992).

However, during health visitor training, the evidence is that student health visitors gain very little opportunity to develop "special preparation and skills" for work with the well older population. The assumption that health visitors have a unique body

of knowledge for work with older people is a dubious one, given the evidence that, even in the academic segment, health visitor training continues to be oriented around medical definitions of "normal" ageing (Phillipson and Strang, 1984).

The structure of the practice segment of health visitor training serves to contain the boundaries of practice within the model acceptable to field work teachers, health visitor supervisors and the health authority i.e. work with the under fives. Rather than encouraging innovation and change, health visitor training serves to perpetuate the same ways of practice, leaving students with very little opportunity to set their own priorities or explore new and perhaps more constructive ways of working.

It will be interesting to see the developments in health visiting that arise from fund-holding GP practices "buying in" community nursing services for patients registered with the practice. Already there is evidence that GPs are contracting with district health authorities in purchasing health visitor services for the assessment of people aged 75 and over. In this case it can clearly be seen that the dictum of the policy-makers is going to force a change of orientation in health visiting practice away from the under fives. Within this policy shift, it can reasonably be presumed that most GPs will require health visitors to perform the "one-off" assessment outlined in the GP contract. If that is the case, it may undermine any opportunity for health visitors to pursue long-term goals with older clients, or for follow-up visits where health visitors consider them appropriate. The issue of control over work content and conditions is an important one, though it could hardly be claimed that health visitors have ever been truly autonomous practitioners. Within the current situation, pressure is put on student and experienced health visitors alike to conform to ways of working expected by the district health authority. The question is, with the new

policy arrangements, how much control will GPs have over health visitors' work, given that they will be paying for the service?

As the GPs will be paying for the health visitor's time they will inevitably want value for money. Given the comments of practice nurses in this study about the GP's interest lying with income generating activities, it is probable that GPs will not want to pay health visitors to do work for which they get no reimbursement. There is neither professional kudos nor financial incentive for the GP to offer services not required by the contract. If this is to be the scenario, then health visitors will probably continue to overlook their theoretical, but never *exploited*, *role* in anticipatory health care with the well older population. However, as individual health authorities will be responsible for negotiating the nature of the contract for selling community nursing services to GPs, it is inevitable that there will be a wide variation in the terms of the contracts and the activities which health visitors and district nurses are required to undertake.

In practice nursing, the policy agenda (filtered through the GP) has given responsibility for universal assessment of people aged 75 and over to the GP and his/her practice staff. Whilst this policy of visiting all people aged 75 and over has been welcomed by some (UKCC, 1990), it actually results in a real service only to the few older people who have unmet medical need or are in need of services such as chiropody or physiotherapy. The lack of government commitment to ring-fencing money for specific groups has resulted in a situation where there are no extra finances for the resources needed specifically by older people. Although the precise pattern of referrals by practice nurses has not yet been the subject of research scrutiny, this study has identified referral as the main evaluative criterion used for

evaluating practice as "effective". Given this finding, and the fact that the GPs are obliged to refer to other agencies where needs have been identified (Health departments of Great Britain, 1989) it could reasonably be assumed that there has been an increase in the numbers of older people being referred to other community agencies. In the absence of more resources to meet this increase, a scenario of steadily expanding waiting lists and over-stretched services can be envisaged.

The policy agenda dictates that the relationship between GPs and practice nurses operates on the basis of employer-employee. Although most nurses are accustomed to working with members of the medical profession (either in hospital or in the community), they are generally not directly employed by them. The situational power which employer status gives to the GP results in a situation in which practice nurses feel that sanctions could be taken against them if they do not ensure that the relationship runs smoothly. As the majority of practice nurses work part-time (Selby et al, 1992), they express grave concerns over job-security. Whilst many FHSAs are now improving their contractual advice to GPs, holiday entitlements and incremental pay-rises often need to be negotiated by practice nurses with their individual employers. This study has clearly shown that the power of the GP as employer results in practice nurses using a variety of strategies in order to preserve and maintain the relationship.

The terms and requirements of the GP contract are frequently filtered by the employing GP to the practice nurse employee. In this way the policy is interpreted through the frame of reference of the medical profession, which is essentially oriented to the detection and treatment of illness and disease (often called the "medical model"). whilst there is no evidence in this study of GPs delegating tasks

to practice nurses which are central to the GPs work, they do appear to alleviate the GP of some of the more "peripheral" tasks which were traditionally part of the GP's remit. In this way practice nurses could perhaps be seen as satellite workers who revolve around the GP's core medical function.

9.4. THE CONSTRUCTION OF OLD AGE WITHIN NURSING AND HEALTH VISITING

At the onset of nurse training, student nurses have a view of old age which stems from their experience as members of society (Makin-Bounds, 1990). Old age is constructed within society generally as a time of deteriorating function and increasing levels of dependency (Phillipson and Strang, 1984). Through the course of their training and work in the hospital setting, nurses come into contact with members of the older population who are amongst the most dependent of that population (Johnson, 1990), people who require high levels of care to compensate for functional deficits. The images of old age in the hospital setting consequently reinforce the generally held societal stereotype.

This study has identified work with old people in the hospital setting as characteristically fraught with tension. It appears that the recent findings of studies by Waters (1990) and Reed (1989) are supported in this study in that routine methods of organizing care still dominate these settings in spite of the introduction of new concepts such as the nursing process and team nursing. The paradigms of physical and psycho-social care, far from being integrated into an "holistic" model, are instead shown to be in competition. It will be interesting to see whether the introduction of primary nursing, the latest method of organizing nursing care, will effect a change in nursing practice.

Nurses working in hospital come into contact with many dependent older people, some of whom may be dying and some of whom are demonstrating the very characteristics of old age that people in society fear most. Menzies (1960) suggested that nurses have to face some of the more unpleasant facets of life through the course of their work and talked about the defences against anxiety which nurses sometimes have to employ in order to "cope". In this study, the image of their own possible future ageing has been shown to be an influential factor in shaping nurses views about work in general with older people and it is this image which leads some nurses to avoid working with this group.

The structural context of nursing work in hospital does nothing to challenge or reject the stereotype of old age, in fact it reinforces the image of old age as a time of hopelessness, with little prospect of cure (Reed, 1989) or rehabilitation (Waters, 1991). The emphasis, within long-stay and other wards where older people are being cared for, on routines and basic standards of physical care undermines the expectations of nurses who have been educated to believe that issues of psychosocial well-being are part of good nursing care (May, 1992). This conflict between "real" and "ideal" nursing care is another factor which may lead nurses to avoid this area of work.

Previous research studies attempting to uncover nurses' attitudes towards older people have mistakenly combined attitudes to work with attitudes to individuals (Ingham and Fielding, 1985). The use of attitude measurement scales currently available is thought to be unhelpful as they appear to confuse stereotypes of old age with attitude to individuals. This study has identified that there is a difference between nurses' (in particular during student nurse training) negative feelings about

the structural context of work and their more positive feelings about individual older people with whom they work. It is the inherent tension in the difference between these feelings that appears to make work with older people an unpopular choice once qualified.

During health visitor training, students are expected to re-orientate their mind-set from the model of nursing espoused in the hospital which focuses on concepts such as care, to one which incorporates the concepts of health promotion, searching out of health needs and work at a community level (CETHV, 1977). Whilst this may be a successful reorientation with regards to work with children (though it has been suggested that health visiting work with children is also problem-led (de la Cuesta, 1992)), in work with older people the re-orientation appears to have been unsuccessful. Instead, student health visitors gain little or no experience of work with well older people during field work and supervised practice. This is due to the fact that they only visit older people who have been referred to the health visiting services, people who have already been defined as having a problem or a functional deficit by the referring agency.

In spite of the attempts of the academic segment of health visitor training and professional bodies of health visiting to encourage students to take a more pro-active role with the well older population, the realities of practice are such that they tend to visit more dependent older people. Dingwall (1977) suggested that "health visitor students learn to operate with a set of "normal clients"", however this would not appear to be the case with the older population. Health visitors appear to have constructed "normal" old age as a time of dependency and deteriorating function in common with their medical and paramedical colleagues (French, 1990)

and many segments of society (Townsend, 1981). In fact dependency is not a normal characteristic of reality for most older people (Johnson, 1990), therefore the health visitor's construction of "normal" is based on experience of work with the "abnormal".

The case of practice nursing is slightly different, although the results of the practice orientation appear to be the same. Practice nurses have the policy remit to visit the "well elderly" population through the guidelines for over 75 assessments within the GP contract. However, the evidence from this study shows that, in the main, practice nurses do not take a pro-active role in work with this group, rather they focus their attentions on referring individuals in need of other services. Rather than focus on **patient outcome** as an evaluative criterion for their practice they appear more concerned with the **process** of assessment and referral. Given that most practice nurses do not have any training for work with older people other than the first level nurse qualification, they depend on their previous experience of work with older people (in the hospital setting) to inform and guide their practice.

The nature of employment of practice nurses by GPs can also be seen to have a profound effect on their work practices. Given that the orientation of GPs is towards the detection and treatment of illness and disease, this compounds the practice nurses' focus on older people in need of services or treatment for medical conditions. In the most extreme cases (defined in this study as the GP assistant), the assessment of people aged 75 and over is translated directly into a search for unmet medical need.

The types of dependency needs focused upon during assessments varied between individual respondents in this study. The "GP assistant" took a highly medical approach to assessment whilst other practice nurses gave priority to physical/functional deficits with peripheral attention to psychosocial health issues. The health visitors continued to provide a reactive, needs-based, referral-led service. The "nurse practitioner", on the other hand acknowledged and exploited her own therapeutic value as well as undertaking the assessment procedure.

What is of interest here is that the practice nurse who worked within the "nurse practitioner" model was trained as a health visitor. She had, theoretically, the training and experience with which to undertake anticipatory health activities with older people and she was not constrained (unlike her health visitor colleagues) by work with children under five. Rather she had the support of the policy agenda for visiting well older people yet continued to focus on functional deficit needs with little attention to anticipatory health care. Given this evidence, it seem reasonable to postulate that nurses, practice nurses and health visitors are not trained and have not developed an epistemological basis for providing anticipatory health care for older people.

It would appear that health visitors and practice nurses have been unable to change their focus of attention from the model of dependency which is inherent in nursing work in the hospital setting to a model which facilitates productive work with members of the older population who are well. Although practice nurses have been accused by other community nurses of not being qualified to undertake assessment of people aged 75 and over at home (Nursing Times News, 1990) it would be

reasonable to suggest that health visitor training does not facilitate adequate experience and knowledge with which to undertake this work either.

The greatest potential for a nurse who could take a pro-active role in the provision of anticipatory health care to older people appears to lie within the nurse practitioner concept: an independent, autonomous nurse (employed perhaps by the health authority) who could specialise in work with older people and who could work alongside, rather than for, general practitioners. However it may be that nurses, who have undergone training in the hospital setting where older people have high levels of dependency, are not able to re-orientate their mind-sets to incorporate the concepts that are required to work pro-actively with the well older population (Garrett, 1984). In this study, even the respondent who demonstrated several characteristics reminiscent of the nurse practitioner did not perceive the potential for exploiting this area of work.

The question that remains to be asked is whether professions such as nursing have a responsibility to challenge the stereotypes and biases held by the rest of society. Dingwall and Robinson (1985) have made claims that health visitors have a "social policing" function when it comes to surveillance of families with children under five years through the policy of universal visiting. In this way, they suggest, health visitors act as instruments or guardians of the state by ensuring that children are protected and the status quo is maintained. Several social gerontologists have suggested that health care professionals, rather than being guardians of the state, should in fact take responsibility for questioning and challenging public policies and governmental decisions (Townsend, 1981; Walker, 1986). However, the risks that individual practitioners take when they become involved in challenging policy (at a

governmental or more local level) have been highlighted by the recent sanctions taken against so-called "whistle-blowers" (Nursing Times News, 1992). What is apparent from this study is that health visitors and practice nurses currently serve to perpetuate the image of ageing which, as defined by the medical profession, ensures that old age continues to be considered a time of dependency and deteriorating function.

9.5. CONCLUSION

It is suggested that it is the combination of society's construction of ageing and the experience of nurses working in hospital for the dependent older population which militates against the potential for practice nurses and health visitors to view older people as having anything but a downward curve of well-being. Even in the case of practice nurses qualified as health visitors who visit the "well elderly" in addition to those in perceived need of intervention from another agency, the respondents in this study adhered to the societal image of older people as being too old to benefit from anticipatory health care strategies. Due to their nurse training background, dominated as it is by meeting the needs of the most dependent older people, the images of old age which respondents had were essentially oriented around a model of dependency and declining capacity. When nurses encounter the "well elderly", they do not appear to feel that input on an anticipatory level is valuable or purposeful. The "well elderly" are therefore perceived as not being "in need" and are rarely (if ever) empowered to improve their lifestyles or health status. Far from facilitating the government's stated policy of providing health promotion/education for members of vulnerable groups, concentration on an annual assessment of people aged 75 and over in general practice has again left ignored the needs of well older people.

9.6. RECOMMENDATIONS.

Whilst this research study has made a contribution to the body of knowledge regarding nurses' work with older people, it is acknowledged that there are many areas which remain unexplored. The following recommendations are made:

1. The role and potential function of a specialist nurse for older people operating within the nurse practitioner framework clearly requires further exploration. Whilst this study has identified the key attributes of the "nurse practitioner" style of practice nursing, it appears that anticipatory health care activities with older people are not integrated into the remit for practice nurses. The issue of training needs for practice nurses and nurse practitioners working with older people should therefore be addressed by both the practice and education segments of the profession.

2. In the light of the forthcoming Community Care Act, due to be implemented from April 1993, serious consideration must be given by policy-makers and planners to the interplay between the assessments of people aged 75 and over outlined within the GP contract and the assessments to be performed by social services. The differences between health and social need remain unclear in definition and it is likely that assessment of these areas can not easily be separated. In order to avoid unnecessary duplication and repeated assessment of people aged 75 and over, a strategy should be developed which would facilitate easier exchange

of information between agencies and collaborative assessment/planning of care.

3. The effect of universal annual assessment of people aged 75 and over clearly requires evaluation. In particular patient/client outcomes following assessment and referral have not, to date, been the object of rigorous scientific scrutiny. The work presented in this thesis should be extended to include measures of positive (or negative) health gain of individual clients following assessment and referral. This would give some indication of whether the policy of universal assessment reduces the need for in-patient services and effects a change in levels of morbidity. It would be useful not only as a measurement of cost-effectiveness but as an indicator of the quality of different types of assessment and assessors.

4. This study has shown that student health visitors' attitudes towards work with older people are largely influenced by their experiences of the care of older people in institutional settings. Managers should therefore bear in mind nurses' attitudes and experience of work in this setting when appointing new staff to positions which involve work with older people.

5. Finally the issue of nurses' attitudes towards work with older people still requires serious consideration by the profession. Until society as a whole changes its attitude towards old age perhaps one cannot expect the nursing profession to adopt a more pro-active role with older people. The evidence

from this study suggests that nursing work with older people continues to be an unpopular choice and is allocated low priority within the health visiting profession compared to work with children. It would appear that the nursing profession may have the potential to be instrumental in challenging widely held stereotypes about people from many so-called "vulnerable" groups. By acting as role-models for the rest of society, the nursing profession could then make a serious claim for its place as an advocate of patient rights and entitlements. The nurse's role in empowerment of marginalised and under-valued groups requires further consideration. Nurse managers and educators clearly have a responsibility to raise the profile and status of nursing work with older people, so that it becomes a valued area of work. Perhaps a move in this direction would ultimately benefit the position of older people in society generally.

REFERENCES.

Abel-Smith, B. (1976) Value for money in health services. London, Heinemann.

Adams, G. (1977) Essentials of geriatric medicine. London, Oxford University Press.

Age Concern (1977) Profiles of the Elderly. Standards of Living and Aspects of Life Satisfaction. Mitcham, Age Concern England.

Allen, M. (1983) Primary Care Nursing: research in action. IN Hockey, L. (Ed) Primary Care Nursing. Edinburgh, Churchill Livingstone.

Altheide, D.L. (1987) Ethnographic content analysis. Qualitative Sociology **10** (1) pages 65-77

Altschul, A. (1972) Nurse-patient Interaction. Edinburgh, Churchill Livingstone.

Andersson, B.& Nilsson, S. (1964) Studies in the Reliability and Validity of the Critical Incident Technique. Journal of Applied Psychology **48** pages 398-403

Andrews (1985) Demographic changes and resources for the elderly (Editorial) British Medical Journal **6** (290) pages 1023-1024

Antle May, K. (1989) Interview techniques in qualitative research: concerns and challenges. IN Morse, J.M. (Ed.) Qualitative Nursing Research. A contemporary dialogue. Rockville, Aspen Publishers Inc.

Arie, J (Ed) (1981) Health Care of the Elderly. London, Croom Helm.

Armstrong, D. (1983) The political anatomy of the body. Cambridge. Cambridge University Press.

Audit Commission (1986) Making a Reality of Community Care. London, Audit commission.

Bailey, T.J. (1956) The critical incident technique in identifying behavioral criteria of professional nursing effectiveness. Nursing Research. **5** (2) pages 52-56

Baker, D.E. (1978) Attitude of Nurses to the Care of the Elderly. Unpublished PhD thesis, University of Manchester.

Baldwin, J.T. (1967) The use of a nurse in general practice. Journal of the Royal College of General Practitioners. **13** pages 364-367

Barbato, C.A. and Feezel, J.D.(1987) The language of ageing in different age groups. The Gerontologist. **27** pages 527-531

Barber, J.H. (1984) Screening and surveillance of the elderly at risk. Practitioner 228 (1389) pages 269-273.

Barrow, G.M. (1986) Ageing, the Individual and Society. 3rd Ed. New York, West Publishing Co.

Beardshaw, V. (1990) Squaring the circle: the implementation of "Caring for People". Kings Fund News **13** (1) page 1

Beechey, V. and Perkins, T. (1987) A Matter of Hours: Women, Part-time Work and the Labour Market. Cambridge, Polity.

Bellack,A.S. (1983) Recurrent problems in the behavioural assessment of social skill. Behavioural Residential Therapy **21** (1) pages 29-41

Benjamin, A. (1981) The Helping Interview. Boston, Houghton Mifflin Company.

Benner, P. (1984) From novice to expert: excellence and power in clinical nursing practice. California, Addison-Wesley

Bergstrand, G.P. (1985) Health visiting and the Elderly. A study of Professional Socialisation. Unpublished MSc thesis, University of Surrey.

Biggs, S. (1989) Professional Helpers and Resistances to Work with Older People. Ageing and Society **9** pages 43-60

Black, S. (1987) The needs of the well elderly. Health Visitor **60** (8) pages 266-267

Bland, R.E. (1992) The pursuit of excellence? The relationship between quality, cost and dependency in residential homes. Paper presented at British Society of Gerontology conference, September 1992, University of Kent at Canterbury.

Bliss, A. and Cohen, E. (Eds) (1977) The New Health Professionals: Nurse Practitioners and Physician Assistants. Rockville, Aspen Publications.

Bond, J. and Carstairs, V. (1982) Services for the elderly: A survey of the characteristics and needs of a population of 5,000 old people. Edinburgh, Scottish Home and Health Department.

Bond, J. and Coleman, P. (Eds) (1990) Ageing and Society. An Introduction to Social Gerontology. London, Sage Publications.

Booth, T. (1985) Home Truths: Old People's Homes and the Outcome of Care. Aldershot, Gower.

Borgen, W. and Amundson, N. (1984) The experience of unemployment. Ontario, Nelson.

Bowl, R. (1986) Social work with old people IN Phillipson C. and Walker A. (Eds) Ageing and Social Policy: A Critical Assessment. Aldershot, Gower.

Bowles, A. (1992) What is a nurse practitioner? 3 Practice Nurse March pages 598-599

Bowling, A. (1981) Delegation in General Practice - A Study of Doctors and Nurses. London, Tavistock Publications.

Bowling, A. (1985) Doctors and Nurses. IN Harrison, A & Gretton, J. (Eds) Health Care U.K. 1985 London, CIPFA

Bowling, A. (1987a) Practice nurses and nurse practitioners. The Practitioner 231 pages 631-633

Bowling, A. (1987b) Practice nurses-the future role. Nursing Times 83 (17) pages 31-33.

Bowling, A. (1988) The Changing Role of the Practice Nurse in the UK. IN Bowling, A. & Stilwell, B. (Eds) The Nurse in Family Practice. Harrow, Scutari Press.

Bowling, A. (1989) The White Paper and the Elderly. 233 pages 998-1003

Bowling, A. and Stilwell, B. (Eds) (1988) The Nurse in Family Practice. Harrow, Scutari Press.

Bozet, F. (1980) Practical suggestions for the use of the audio cassette tape recorder in nursing research. Western Journal of Nursing Research. 2 (3) pages 602-605

Brace, S. and Hunter, S. (1992) Multidisciplinary assessments of older people. Paper presented at the British Society of Gerontology Conference. September, University of Kent.

Bradley, J. (1991) Personal Communication.

Briggs, C. (1986) Learning how to ask: A sociolinguistic appraisal of the role of the interview in social science research. Cambridge, Cambridge University Press.

British Medical Association (1990) Personal Communication

British Geriatric Society and Health Visitors Association (1986) Health visiting for the health of the aged. A joint policy statement. London, BGS & HVA.

British Medical Association (1990) Personal communication.

Brubaker, T. and Powers, E.A. (1976) The stereotype of "old": A review and alternative approach. Journal of Gerontology. 31 pages 441-447

Burge, J.M. (1978) Stereotyped attitudes toward the aged in nursing homes. Issues in Mental Health Nursing 1 pages 53-61

Burgess, R.G. (1984) In the Field: An Introduction to Field Research. London, George, Allen and Unwin.

Burns, T.R. and Flam , H. (1987) The Shaping of Social Organization. London, Sage.

Burridge, R. (1988) The role of the health visitor with the elderly. Health Visitor **61** (1) pages 20-21

Butler, R.N. (1975) Why survive? Being old in America. New York, Harper and Row.

Callery, P. (1988) A study of role negotiation between nurses and the parents of hospitalised children. Unpublished MSc thesis, University of Manchester.

Callery, P. (1992) Personal communication.

Campbell, M.E. (1971) Study of the attitudes of nursing personnel toward the geriatric patient. Nursing Research **20** pages 147-151

Carr, A.J. (1988) The Implications of the Cumberledge Report for the Development of a Nurse Practitioner Role. IN Bowling, A. & Stilwell, B. (Eds) The Nurse in Family Practice. London, Scutari Press.

Cartwright, A. and Smith, C. (1988) Elderly People, their Medicines and their Doctors. London, ISSM.

Cater, L. & Hawthorne, P. (1988) A survey of Practice Nurses in the U.K. IN Bowling, A & Stilwell, B. (Eds) The Nurse in Family Practice. Harrow, Scutari Press.

Caves, R. (1988) Consultative methods for Extracting Expert Knowledge about Professional Competence. IN Ellis, R. (Ed) Professional Competence and Quality Assurance in the Caring Professions. London, Chapman & Hall.

Chalmers, K.I. (1990) Preventative work with families in the community: a qualitative study of health visiting practice. Unpublished PhD thesis, University of Manchester

Chalmers, K.I. and Luker, K.A. (1991) The development of the Health visitor-client relationship. Scandinavian Journal of Caring Science. **5** (1) pages 33-41

Cheah, L. (1992) Nursing Care for Elderly People: Gerontological work as a nursing specialism. Paper presented to the International Conference on the Marginalisation of Elderly People. Liverpool University, May 1992.

Chenitz, W.C. and Swanson, J.M. (Eds) (1986) From Practice to Grounded Theory. Qualitative Research in Nursing. Wokingham, Addison-Wesley Publishing Company.

Chernik, K. (1992) Personal Communication.

Clamp C. (1980) Learning through incidents. Nursing Times. **40** pages 1755-1758

Clark, M. (1978) Getting Through the Work. IN Dingwall, R. & MacIntosh, J. (Eds) Readings in the Sociology of Nursing. Edinburgh, Churchill Livingstone.

Clark, J.M. and Hockey, L. (1987) A Guide for the Enquiring Nurse. Norwich, John Wiley and Sons Ltd.

Clarke, M., Clarke, S., Odell, A. and Jagger, C. (1984) The elderly at home: health status and social status. Health Trends **16** pages 3-7

Clay, T. (1988) Community service left to struggle on. Nursing Times **84** (6) page 6

Concise Oxford English Dictionary (1964) 3rd edition.

Connolly, J. (1983) Improving the balance - part 1. Nursing Times **79** (37) pages 51-53

Cook, T.D. & Campbell, D.T. (1979) Quasi-experimentation: Design and Analysis Issues for Field Settings. Chicago, Rand.

Cormack, D.F.S. (1983) Psychiatric nursing described. Edinburgh, Churchill Livingstone.

Cormack, D.F.S. (1984) Flanagan's Critical Incident Technique. IN Cormack, D.F.S. (Ed). The Research Process in Nursing. London, Blackwell Scientific Publications.

Corner, J. (1991) In search of more complete answers to research questions. Quantitative versus qualitative research methods: is there a way forward? Journal of Advanced Nursing. **16** pages 718-727

Cornwell, J. (1986) Health beliefs in old age: the theoretical ground for conceptualising old people,as a group. IN Glendenning F. (Ed) Working together for health: older people and their carers. Stoke-on-Trent, Beth Johnson Foundation.

Coulter, A. and Schofield, T. (1991) Prevention in general practice: the views of doctors in the Oxford region. British Journal of General Practice. **41** (4) pages 140-143

Council for the Education and Training of Health Visitors (1977) An Investigation into the Principles of Health Visiting. London, CETHV.

Covell, B. and Angus, M.M. (1980) A comparison of the characteristics of elderly patients admitted to acute medical and geriatric wards. Health Bulletin **38** pages 64-70

Curran, J.P. (1979) Pandora's box re-opened? The assessment of social skills. Journal of Behavioural Assessment 1 (1) pages 55-71

Currie, C.T., Smith, R.G. and Williamson, J. (1979) Medical and nursing needs of elderly patients admitted to acute medical beds. Age and Ageing 8 pages 149-151.

Dant, T. (1988) Dependency and old age: theoretical accounts and practical understandings. Ageing and Society. 8 pages 171-188

Davies, B. (1986) New managerialist arguments and the supply and financing of care. IN di Gregorio, S. (Ed) Social gerontology: new directions. London, Croom Helm.

Davies, M. (1988) The role of general practitioners in supporting carers of the elderly in the community. Journal of the Royal College of General Practitioners. May pages 194-5

de la Cuesta, C. (1992) Marketing the service: basic social process in health visiting. Unpublished PhD thesis, University of Liverpool.

Department of Health (1988) Health Statistics. London, HMSO

Department of Health (1989a) Working for Patients. London, HMSO.

Department of Health (1989b) Caring for People. London, HMSO.

Department of Health (1991) Practice Nurse Workforce Statistics. London, HMSO.

Department of Health and Social Security (1977) The Extending Role of the Clinical Nurse. Health Circular (77) 22. London, DHSS.

Department of Health and Social Security (1980) Inequalities in Health (also known as The Black Report) London, HMSO.

Department of Health and Social Security (1981a) Care in Action. A Handbook of policies and priorities for the Health and Personal Social Services in England. London, HMSO

Department of Health and Social Security (1981b) Growing Older. London, HMSO.

Department of Health and Social Security (1982) Health Statistics. London, HMSO.

Department of Health and Social Security (1986) Neighbourhood Nursing - A focus for care (The Cumberledge Report) London, HMSO.

Department of Health and Social Security (1987) Promoting Better Health. London, HMSO.

Department of Health and Social Security & Welsh Office (1978) A Happier Old Age. London, HMSO

Diers, D. and Molde, S. (1983) Nurses in primary care: the new gatekeepers? American Journal of Nursing **83** pages 742-745

Dingwall, R. (1977) The Social Organisation of Health Visitor Training. London, Croom Helm.

Dingwall, R., Rafferty, A. and Webster, C. (1988) An Introduction to the Social History of Nursing. London, Routledge.

Donaldson, R.J. and Donaldson, L.J. (1983) Essential Community Medicine. Lancaster, MTP press Ltd.

Dougherty, S.A. (1981) A descriptive study of student nurses' feelings about nursing elderly patients in hospital. Unpublished MSc Thesis, University of Manchester.

Drennan, V. (1986) Talking to health visitors - perceptions of their work. IN While, A. (Ed) Research in Preventive Community Nursing Care. Chichester, John Wiley and sons.

Duffy, M.E. (1985) Designing nursing research: the qualitative-quantitative debate. Journal of Advanced Nursing. **10** pages 225-232

Dunn, W.R., Hamilton, D.D. & Harden, R.M. (1985) Techniques of identifying competencies needed of doctors. Medical Teacher. **7** (1) pages 15-25

Dunn W.R. & Hamilton, D.D. (1986) The critical incident technique - a brief guide. Medical Teacher. **8** (3) pages 207-215

Dunnel, K. and Dobbs, J. (1982) Nurses Working in the Community. London, HMSO.

Dye, C.A. (1979) Attitude change among health professionals. Journal of Gerontological Nursing. **5** pages 31-35

Ebrahim, S., Hedley, R. & Sheldon, M. (1984) Low levels of ill-health among elderly non-consulters in general practice. British Medical Journal **289** pages 1273-4

Edmunds, M.N. (1979) Junior Doctoring. Nurse Practitioner **38** pages 40-41, 46

Ellis, R. (Ed) (1988) Professional Competence and Quality Assurance in the Caring Professions. London, Chapman & Hall.

English National Board (1988) Health Visitor and Related Courses: Rules, Regulations, Notes of Guidance and Syllabus. London, ENB.

English National Board (1989) Practice Nurse Training. Outline Curriculum. London, ENB.

Eraut, M.(1985) Knowledge creation and knowledge-use in professional contexts. Studies in Higher Education **10** (2) pages 117-133

Estes, C. (1992) Plenary speech. Delivered at British Society of Gerontology Conference held in Canterbury in September 1992.

Evans, J. Grimley (1984) Prevention of age-associated loss of autonomy: epidemiological approaches. Journal of Chronic Diseases. **37** (5) pages 353-63

Evans, J. Grimley (1986) The health of an ageing population. IN Bittles, A.H. and Collins, K.J. (Eds) The Biology of Human Ageing. Cambridge, Cambridge University Press.

Evers, H.K. (1981a) The creation of patient careers in geriatric wards: aspects of policy and practice. Social Science and Medicine. **15a** pages 581-588

Evers, H. (1981b) Old women's self-perceptions of dependency and some implications for service provision. Journal of Epidemiology and Community Health 38 pages 306-309

Evers, H. (1981c) Tender Loving Care? Patients and nurses in geriatric wards. IN Copp, L.A. (Ed) Care of the Elderly. Edinburgh, Churchill Livingstone.

Evers, H. K. (1984) Patients' experiences and social relations in geriatric wards. Unpublished PhD thesis, University of Warwick.

Evers, H., Badger, F., Cameron, E. and Atkin, K. (1989) Elderly care visiting service: a profile of clients and work of health visitors. Community Care Project Working Paper No 18. Birmingham, Community Care Project.

Farquhar, M. and Bowling, A. (1990) Preventive Activity - part two. Nursing Standard **4** (38) page 50

Farquar, M. and Bowling, A. (1992) Older People and their GPs. Journal of the British Society of Gerontology. **2** (2) pages 7-10

Fatchett, A.B. (1990) Health visiting: a withering profession? Journal of Advanced Nursing. **15** pages 216-222

Fawcett-Hennessy, A. (1989) Partners in Time? Nursing Times **87** (45) page 33.

Featherstone, M. and Hepworth, M. (1990) Images of Ageing IN Bond, J. and Coleman, P. (Eds) Ageing In Society. London, Sage.

Fennel, G., Phillipson, C. and Evers, H. (1988) The sociology of old age. Milton Keynes, OUP

Field, D. (1984) "We didn't want him to die on his own" - Nurse's accounts of nursing dying patients. Journal of Advanced Nursing **9** pages 59-70

Field, P.A. and Morse, J.M. (1985) Qualitative Nursing Research: The application of qualitative approaches. Rockville, Aspen.

Fielding, P. (1986) Attitudes Revisited. London, RCN

Fielding, N.G. and Lee, R.M. (1991) Using Computers in Qualitative Research. London, Sage Publications.

Fitton, J. (1990) Health visiting and the aged. Health Visitor **53** (10) pages 521-523

Fivars, G. & Gosnell, D. (1975) Nursing Evaluation: the problem and the process. Pittsburgh, Westinghouse Learning Corp.

Flanagan, J.C. (1954) The critical incident technique. Psychological Bulletin. **51** pages 327-358

Flatley, M. (1992) In-Depth Interviewing: A Discussion of the Ethical Issues. Paper presented at Royal College of Nursing Research Advisory Group Conference. April, University of Birmingham.

Fowler, G., Fullard, E. & Muir Gray, J.A. (1988) The Extended Role of Practice Nurses in Preventive Health Care. IN Bowling, A. & Stilwell, B. (Eds). The Nurse in Family Practice. London, Scutari Press.

Fox, D.J. (1976) Fundamentals of Research in Nursing. New York, Appleton-Century-Crofts.

Freer, C. (1988) Old Myths: Frequent Misconceptions about the Elderly. IN Wells, N. & Freer, C. (Eds) The Ageing Population. Burden or Challenge? Basingstoke, Macmillan Press.

French, S. (1990) Ageism. Physiotherapy **76** (3) pages 178-182

Garrett, G. (1984) Caught and not taught? Nursing Times **80** (43) pages 48-51

George, V. and Wilding, P. (1984) The impact of social policy. London, Routledge and Kegan Paul.

Georgian Research Society (1991) The attitude of general practitioners towards practice nurses: a pilot study. British Journal of General Practice. **41** (1) page 19-22

Gillis, S.M. (1973) Attitudes of nursing personnel towards the aged. Nursing Research **22** pages 517-520

Glaser, B.G. and Strauss, A.L. (1965) Awareness of Dying. Chicago, Aldine Publishing Company.

Glaser, B.G. and Strauss, A.L. (1967) The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago, Aldine.

Goffman, E. (1961) Asylums: Essay upon the Social Situation of Mental Patients and Other Inmates. New York, Anchor.

Goffman, E. (1974) Frame Analysis: An Essay on the Organization of Experience. Cambridge, Harvard University Press.

Goldman, L. (1976) A revolution in counselling research. Journal of Counselling Psychology. **23** (6) pages 543-552

Goodwin, S. (1988) Whither Health Visiting? Keynote Speech delivered at Health Visitor's Association Annual Conference, Bournemouth.

Goodwin, S. (1991) Commentary. IN Salvage, J. (Ed) (1991) Nurse Practitioners. Working for change in primary health care nursing. London, King's Fund Centre.

Graham, H. and Livesley, B. (1983) Can re-admission to a geriatric medical unit be prevented? Lancet i pp404-406

Greenfield, S. (1992) Nurse Practitioners and the Changing Face of General Practice. IN Loveridge, R. and Starkey, K. (Eds) (1992) Continuity and Crisis in the NHS. Buckingham, OUP.

Greenfield, S., Stilwell, B. and Drury, M. (1987) Practice nurses: social and occupational characteristics. Journal of the Royal College of General Practitioners 37 pages 341-345

Griffiths, Sir R. (1992) Plenary (round table) speech Delivered at the British Society of Gerontology Conference. September 1992, University of Kent.

Gubrium, J.F. (1986) Oldtimers and Altzheimer's: the Descriptive Organization of Senility. London, JAI Press.

Gunter, L.M. (1971) Students' attitudes towards geriatric nursing. Nursing Outlook 19 pages 466-469

Haase J.E. & Myers S.T. (1988) Reconciling paradigm assumptions of qualitative and quantitative research. Western Journal of Nursing Research. **10** pages 128-137

Haber, C. (1983) Beyond sixty-five: The Dilemma of Old Age in America's Past. Cambridge, Cambridge University Press.

Hardie, M.W. (1975) Geriatric patient care, opinions of a sample of nurses. Nursing Times 71 pages 61-64

Health Departments of Great Britain (1989) General practice in the National Health Service. The 1990 Contract. London, HMSO.

Health Visitor Editorial (1990) Market forces the pace. Health Visitor. 63 (1) page 1.

Hendy, A. (1988) The future development of the roles of the health visitor and district nurse. Unpublished MPhil thesis, University of Manchester.

Her Majesty's Stationery Office (1988-) Social Trends. London, HMSO.

Her Majesty's Stationery Office (1989-) Social Trends. London, HMSO.

Higgins, P. (1989) Short term changes in health behaviours of older adults. The Canadian Journal of Nursing Research. 21 (1) pages 19-30

Hogg, A. (1990) Personal communication.

Holsti, O.R. (1969) Content Analysis for the Social Sciences and Humanities. Reading, Addison-Welsley.

Hooper, J. (1979) An exploratory study of student and pupil nurses' attitudes towards and expectations of nursing geriatric patients in hospital. Unpublished MSc thesis, University of Surrey.

Hultsch, D.F. and Deutsch, F. (1981) Adult development and aging: A life-span perspective. New York, Mc-Graw-Hill.

Hunt, A. (1978) The elderly at home: a study of people aged sixty-five and over living in the community in England in 1976. London, HMSO.

Hunt, M. (1972) The Dilemma of Identity in Health Visiting 1 Nursing Times Occasional Papers 68 (5) pages 17-20.

Hunt, M. (1982) Caseload Profiles - Their Implications for Evaluating Health Visitor Practice. Health Visitor 55 (12) pages 662-665

Huntington, J. (1981) Social Work and General Medical Practice: Collaboration or Conflict? London, George Allen and Unwin.

Illich, I. (1977) Limits to Medicine. Harmonsworth, Penguin.

Ingham, R. and Fielding, P. (1985) A review of the nursing literature on attitudes towards old people. International Journal of Nursing Studies. **22** (3) pages 171-181

James, N. (1987) Care and Work in Nursing the Dying. Unpublished PhD thesis, University of Sheffield.

Jesop, M. (1986) Most practice nurses are not nurse practitioners. General Practitioner **31** (10) page 20

Johnson, M.L. (1972) Self perception of need amongst the elderly: an analysis of illness behaviour. Sociological Review **20** pages 521-531.

Johnson, M.L. (1986) Ageing as a labelling phenomenon. IN Dean, K., Hickey, T. and Holstein, B.E. (Eds) Self-care and Health in Old Age. Health Behaviour; Implications for Policy and Practice. London, Croom Helm.

Johnson, M. (1990) Dependency and Interdependency. IN Bond, J.and Coleman, P. (Eds) Ageing in Society. London, Sage.

Johnson, P. (1987) Structured Dependency of the Elderly: A Critical Note. London, Centre for Economic Policy Research.

Jones, S. (1986) The elders: a new generation. Ageing and Society **6** pages 312-331

Kafer, R.A., Rakowski, W. and Hickey, T. (1980) Ageing opinion survey. A report on instrument development. International Journal of Ageing and Human Development. **10** pages 99-119

Kalish, R.A. (1979) The New Ageism and the Failure Models: A Polemic. The Gerontologist **19** (4) pages 298-402

Kant, I. (1951) The moral law. London, Hutchinson.

Katz, D. (1960) The functional approach to the study of attitudes. Public Opinion Quarterly. **24** pages 163-204

Kirchner, W.K. & Dunnette, M.D. (1967) Using Critical Incidents to Measure Job Proficiency Factors. IN Fleishman, E.A. (Ed) Studies in Personnel and Industrial Psychology. Illinois, Dorsey Press.

Kitson, A.L. (1987) A comparative analysis of lay-caring and professional (nursing) caring relationships. International Journal of Nursing Studies. **24** (2) pages 155-165

Krippendorf,K. (1980) Content Analysis: An Introduction to its Methodology. Sage, California.

Kubler-Ross, E. (1970) On Death and Dying. London, Tavistock Pubs. Ltd.

Labour Party News (1990) September edition.

Laidman, P. (1987) Health Visiting and Preventing Accidents to Children. Child Accident Prevention Trust Research Report No. 12. London, Child Accident Prevention Trust.

Lamerton, R. (1973) Care of the dying. London, Priory Press Ltd.

Laslett, P. (1987) The emergence of the third age. Ageing and Society 7 pages 133-160

Lawless, M. (1992) Health for Elderly People in the Oxford Region. Oxford, Oxford Regional Health Authority.

Lawrence, B. (1987) The Fifth Dimension - Gender and General Practice. In Spencer, A. and Podmore, D. (Eds) In a Man's World. London, Tavistock.

Liverpool Family Health Services Authority (1991) Personal Communication.

Liverpool Primary Care News (1992) Newsletter, June. Liverpool, Liverpool Family Health Services Authority.

Livesley, B. (1989) Running out of staff for the NHS. British Medical Journal 299 pages 1-2

Lofland, J. (1971) Analysing social settings. Belmont, Wadsworth.

Lofland, J and Lofland, L. (1984) Analyzing Social Settings: A Guide to Qualitative Observation and Analysis. Belmont Ca., Wadsworth Publishing Co.

Long, P. (1976) Judging and reporting on student nurse clinical performance: some problems for the ward sister International Journal of Nursing Studies 12 page 2.

Luker, K.A. (1978) Goal attainment: A possible model for assessing the role of the health visitor. Nursing Times 74 (30) pages 1257-1259

Luker, K.A. (1979) Health visiting and the elderly. Midwife, Health Visitor and Community Nurse. 15 (11) page 457

Luker, K.A. (1982) Evaluating health visiting practice. London, RCN

Luker, K.A. (1988) The Nurses Role in Health Promotion and Preventive Health Care. IN Wells, N. & Freer, C. The Ageing Population:Burden or Challenge? Basingstoke, Macmillan Press.

Luker, K.A. & Perkins, E. (1987) The elderly at home: service needs and provisions. Journal of the Royal College of General Practitioners **27** pages 248-249

Maclean, U. (1989) Dependent Territories. London, Nuffield Provincial Hospitals Trust.

Makin-Bounds, K. (1990) Predictors of ageism and accuracy of beliefs about elderly people in samples of general public and nursing staff. Unpublished MSc, University of Surrey.

Marks, L. (1987) Primary Health Care on the Agenda? A discussion document. London, King's Fund Centre.

Marsh, G.N. (1967) Group practice nurse: an analysis and comment on six months' work. British Medical Journal **1** pages 489-491

Marsh, G.N. (1976) Further nursing care in general practice. British Medical Journal **2** pages 626-627.

Marsh, G.N. & Chew, C. (1984) Well man clinic in general practice. British Medical Journal **288** pages 200-201.

Martin, C. (1987) Practice makes perfect. Nursing Times **83** (17) pages 28-30

May, D. and Kelly, M. (1982) Chauncers, Pests and Poor Wee Things: Problems of Legitimation in Psychiatric Nursing. Sociology of Health and Illness **4** (3) pages 203-379

May, C. (1992) Individual Care? Power and Subjectivity in Therapeutic Relationships. Accepted for publication In Sociology.

McCabe, B. Wharton (1989) Ego Defensiveness and its relationship to attitudes of registered nurses toward older people. Research in Nursing and Health **12** pages 85-91

McCrowan, K.F. and Lowe, L.S. (1981) Cost Benefit Approach to Postage Used in Mail Questionnaires. Journal of Marketing Research. **47** pages 335-339

McKeown, T. (1979) The Role of Medicine: Dream, Mirage or Nemesis? Oxford, Basil Blackwell.

McClymont, M., Thomas, S. and Denham, J. (1986) Health Visiting and the Elderly. London, Churchill Livingstone.

Melia, K. (1981) Student Nurses' Accounts of Their Work and Training: A Qualitative Analysis. Unpublished PhD Thesis, University of Edinburgh.

Melia, K.M. (1982) Tell it as it is - Qualitative methodology and nursing research: understanding the student nurses' world. Journal of Advanced Nursing. **7** pages 327-335

Melia, K. (1987) Learning and Working: The Occupational Socialisation of Nurses. London, Tavistock.

Menzies, I.E.P. (1960) A case study of the functioning of social systems as a defence against anxiety. A report on the study of a nursing service of a general hospital. Human Relations **13** pages 95-121

Miller, L. (1987) The Professional Construction of Aging. Journal of Gerontological Social Work. **10** (3/4) pages 141-153

Morgan,N. (1991) Personal Correspondence.

Morse, J.M. (Ed.) (1989) Qualitative Nursing Research. A contemporary dialogue. Rockville, Aspen Publishers Inc.

Mossey, J.M. & Shapiro, E. (1982) Self-rated health: A predictor of mortality among the elderly. American Journal of Public Health **72** pages 800-806

National Association of Health Authorities (1988) Action not Words. Birmingham, National Association of Health Authorities.

Norman, A. (1981) Rights and risk: a discussion document on civil liberty in old age. London, Centre for Policy on Ageing.

Norman, A. (1987) Aspects of Ageism: A Discussion Paper. London, Centre for Policy on Ageing.

Norman I.J., Redfern, S.J., Tomalin, D. and Oliver, S. (1991) Developing Flanagan's Critical incident Technique to Elicit Indicators of High and Low Quality Nursing Care from Patients and their Nurses. Journal of Advanced Nursing. **22** (5) pages 590-600

Nuessel, F. (1982) The language of ageism. The Gerontologist **22** pages 272-276

Nursing Standard News (1990) **4** (31) page 5

Nursing Times Editorial (1990) **86** (9) page 8

Oakley, A. (1981) Interviewing women: a contradiction in terms IN Roberts, H. (Ed) Doing Feminist Research. Boston, Routledge and Kegan Paul.

Oakley, A. (1984) The importance of being a nurse. Nursing Times **80** (50) pages 24-27

Office of Population, Censuses and Surveys (1984) General Household Survey. London, HMSO.

Office of Population, Censuses and Surveys (1990) General Household Survey. London, HMSO.

Oppenhiem, A.N. (1966) Questionnaire Design and Attitude Measurement. London, Heinemann.

Ouslander, J.G., Zavit, S.H. and Orr, N.K. (1990) Incontinence among elderly community-dwelling dementia patients: characteristics, measurement and impact on care-givers. Journal of the American Geriatric Society. **38** (4) pages 440-445

Parker, S. (1980) Older Workers and Retirement. London, HMSO.

Parkes. K.R. (1985) Stressful episodes reported by first year student nurses: a descriptive account. Social Science and Medicine. **20** (9) pages 945-953

Phillips, S. (1988) Health Visitors and the Priority of the Elderly. Health Visitor **61** pages 341-2

Phillipson, C. (1982) Capitalism and the Construction of Old Age. London, Macmillan.

Phillipson, C. and Strang, P. (1984) Health Education and Older People. The role of paid carers. University of Keele, Health Education Council/ Department of Adult Education.

Phillipson, C.and Strang, P. (1986) Training and Education for an Ageing Society: New perspectives for the Health and Social Services. University of Keele, Health Education Council/Department of Adult Education.

Phillipson, C. and Walker, A. (Eds) (1986) Ageing and Social Policy: a critical assessment. Aldershot, Gower Press.

Phillipson, C., Bernard, M. and Strang, P. (1986) Dependency and interdependency in old age: theoretical perspectives and policy alternatives. London, Croom Helm.

Polit, D. and Hungler, B. (1978) Nursing Research: Principles and Methods. Philadelphia, J.B. Lippincott Company.

Pollitt, C. (1990) Consumers, markets and the NHS. Kings Fund News **13** (2) page 1

Potrykus, C. (1990) A dangerous package. Health Visitor. **63** (1) pages 2-3.

Pritchard, P.M.M. (1981) Manual of Primary Health Care: its nature and organisation. Oxford, OUP.

Pritchard, P. (1992) Doctors, Patients and Time. IN Frankenburg, R. (Ed) Time, Health and Medicine. London, Sage Publications Ltd.

Quint, J.C. (1967) The Nurse and the Dying Patient. New York, Macmillan.

Raymond, E. (1977) The Practice of Health Visiting. IN Owen, G.M. (Ed) Health Visiting. London, Balliere Tindall.

Reed, J. (1989) All dressed up and nowhere to go: nursing assessment in geriatric care. Unpublished PhD thesis, Newcastle Polytechnic.

Reed, J. and Bond, S. (1991) Nurses' assessment of elderly patients in hospital. International Journal of Nursing Studies **28** (1) pages 55-64

Reedy, B.L.E.C., (1972) Organisation and Management: the general practice nurse. Update **5** pages 75-78

Reedy, B.L., Metcalfe, A.V., de Roumaine, M. and Newell, D.J. The social and occupational characteristics of attached and employed nurses in general practice. Journal of the Royal College of General Practitioners **30** pages 477-482

Rimon D. (1979) Nurses' perceptions of their psychological role in treating rehabilitation patients: a study employing the critical incident technique. Journal of Advanced Nursing. **4** pages 403-413

Robb, S.S. (1979) Attitudes and intentions of baccalaureate nursing students toward the elderly. Nursing Research *28* pages 43-50

Robinson, D.(1989) Response rates in questionnaires. Senior Nurse **9** (10) pages 25-26

Robinson, G. (1990) The future for practice nurses. British Journal of General Practice. **40** pages 132-133

Robinson, J. (1985) Health visiting and health. In White, R.(Ed) Political Issues in Nursing: past, Present and Future. Chichester, John Wiley and Sons.

Rosen,A. & Abraham, G. (1963) Evaluation of a procedure for assessing performance of staff nurses. Nursing Research. **12** pages 78-82

Royal College of General Practitioners (1983) Promoting Prevention. Occasional paper 22. London, RCGP.

Royal College of Nursing (1983) Thinking about Health Visiting. London, RCN.

Royal College of Nursing (1984) Training Needs of Practice Nurses. Report of a Steering Group. London, RCN.

Royal College of Nursing (1987) RCN Response to the Consultation on Primary Health Care Initiated by the UK Health Departments. London, RCN.

Royal College of Nursing (1989) The White Paper: Not Working for Elderly People. RCN Newsline **14** (7) pages 1 & 4

Royal College of Nursing (1990) Personal Communication

Royal College of Nursing (1990) Practice Nursing. Your Questions Answered. London, RCN.

Royal College of Physicians of London (1981) Organic mental impairment in the elderly. Implications for research, education and the provision of services. Journal of the Royal College of Physicians of London **15** pages 141-167

Salisbury, C. (1991) Working in partnership with nurses. (Editorial) British Journal of General Practice. **41** (351) pages 398-399

Salisbury, C.J. and Tetterstall, M.J. (1988) Comparison of the work of a nurse practitioner with that of a general practitioner. Journal of the Royal College of General Practitioners. **37** pages 314-316

Salvage, J. (Ed) (1991) Nurse Practitioners. Working for change in primary health care nursing. London, King's Fund Centre.

Schatzman, L. & Strauss, A. (1973) Field Research: Strategies for a natural sociology. New Jersey, Prentice-Hall.

Schonfield, D. (1982) Who is Stereotyping Whom and Why? The Gerontologist **22** (3) pages 267-272

Seidel, J.V. and Clark, J.A. (1984) The Ethnograph: A computer program for the analysis of qualitative data. Qualitative Sociology. **7** (1/2) pages 110-125

Selby, A., Winkler, F. and Brown, P. (1992) More Practice. Health Service Journal. 19 (3) page 31

Selleck, T. (1982) Satisfying and anxiety creating incidents for nursing students. Nursing Times **78** (48) pages 137-140

Sellitz, C., Wrightsman, L.S. and Cook, S.W. (1976) Research methods in social relations. New York, Holt, Reinehart and Winston

Simon, P. (1992) Pioneer Spirit. Nursing Times **88** (30) pages 16-17

Sims, A. (1979) The critical incident technique in evaluating student nurse performance. International Journal of Nursing Studies **13** pages 123-130

Slater, R. and Gearing, B. (1988) Mental Health Problems in Old Age. Oxford, Oxford University Press.

Smail, S. (1990) Health Promotion and the New GP Contract. Practice Nurse. February pages 391-392

Smith, P.A. (1988) Quality of nursing and the ward as a learning environment for student nurses: a multi-method approach. Unpublished PhD thesis, King's College London.

Smith, P. (1992) The Emotional Labour of Nursing. Basingstoke, Macmillan Educational Ltd.

Stein, L.I. (1967) The doctor-nurse game. Archives of General Psychiatry. **16** pages 699-703

Stein, L.I., Watts, D.T. & Howell, T. (1990) The doctor-nurse game revisited. New England Journal of Medicine. **322** (8) pages 546-549

Stilwell, B. (1987) Different expectations. Nursing Times **83** (24) pages 59-61

Stilwell, B. (1990) Partners in practice. Nursing Times **86** (20) pages 32-33

Stilwell, B., Greenfield, S., Drury, M. and Hull, F. (1987) A nurse practitioner in general practice: working style and pattern of consultations. Journal of the Royal College of General Practitioners. **37** pages 154-157

Stocking, B. (1991) Bringing about change. Chapter IN Salvage, J. (Ed) (1991) Nurse Practitioners. Working for change in primary health care nursing. London, King's Fund Centre.

Strauss, A. (1987) Qualitative Analysis for Social Sciences. New York, Cambridge University Press.

Strauss, A. and Corbin, J. (1990) Basics of Qualitative Research - Grounded theory procedures and techniques. Newbury Park CA, Sage.

Sudnow, D. (1967) Passing On - The Social Organisation of Dying. New Jersey, Prentice-Hall.

Swanson, J. The formal qualitative interview for grounded theory. IN Chenitz, W.C. and Swanson, J. (Eds) From Practice to Grounded Theory: Qualitative Research in Nursing. Wokingham, Addison-Wesley.

Sylvester, J. (1992) 'Buy-in nurses?' Nursing Standard **6** (34) pages 20-21

Tajfel, H. (Ed) (1959) The Social Dimension. Cambridge, Cambridge University Press.

Thompson, K. (1988) The challenge of caring for the elderly in the 1990's. Journal of the Royal College of General Practitioners. 38 (315) pages 438-439

Tinker, A. (1984) Staying at Home: Helping Elderly People. London, HMSO.

Tinker, A. (1989) Why the sudden interest in Ageing? Inaugural lecture delivered at King's College London.

Townsend, P. (1962) The Last Refuge - A Survey of Residential Institutions and Homes for the Aged in England and Wales. London, Routledge and Kegan Paul.

Townsend, P. (1965) On the likelihood of admission to an institution. IN Shanas, E. and Streib, G.F. (Eds) Social Structure and the Family Generational Relations. New Jersey, Prentice Hall.

Townsend, P. (1981) The structured dependency of the elderly: creation of social policy in the twentieth century. Ageing and Society 1 page 5-28.

Townsend, P. (1986) Ageism and social policy. IN Phillipson, C. and Walker, A. (eds) Ageing and Social Policy. Aldershot, Gower.

Townsend, P. and Wedderburn, D. (1965) The Aged in the Welfare State. Occasional Papers on Social Administration No 14. London, Bell.

Treacey, M.M. (1987) "In the pipeline": a qualitative study of general nurse training, with special reference to nurses' role in health education. Unpublished PhD thesis, Institute of Education, London.

Treharne, G. (1990) Attitudes towards the care of elderly people: are they getting better? Journal of Advanced Nursing 15 pages 777-781

Tremellen, J. and Jones, D.A. (1989) Attitudes and practices of the primary health care team towards assessing the very elderly. Journal of the Royal College of General Practitioners. 39 pages 142-144

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1990) Statement on Practice Nurses and Aspects of the New GP Contract. London, UKCC.

Vetter, N.J. (1990) Lifestyle and the elderly. Health Education Journal 49 (2) pages 76-79

Vetter, N.J. and Ford, D. (1990) Smoking prevention among people aged 60 and over: a randomised controlled trial. Age and Ageing 19 pages 164-168

Vetter, N.J., Jones, D.E. & Victor, C.R. (1984) Effect of health visitors working with elderly patients: a randomised controlled trial. British Medical Journal 48 (1) pages 44-45

Victor, C.R. (1987) Old Age in Modern Society. London, Croom Helm.

Walker, A. (1981) Towards a political economy of old age. Ageing and Society 1 pages 73-94

Walker, A. (1986) The politics of ageing in Britain. IN Phillipson, C., Bernard, M. and Strang, P. (Eds) Dependency and interdependency in old age: theoretical perspectives and policy alternatives. London, Croom Helm.

Wallace, P. and Young, E. (1992) Health checks for elderly people. Paper presented at the British Society of Gerontology conference. September, University of Kent.

Waters, K. (1991) The nurse's role in the rehabilitation of elderly people in hospital. University of Manchester, Unpublished PhD Study.

Weber, M. (1968) Economy and Society. New York, Bedminster Press

Wells, T.J. (1975) Toward understanding nurses' problems in care of the hospitalised elderly. Unpublished PhD thesis, University of Manchester.

Wells, T.J. (1980) Problems in Geriatric Nursing Care. Edinburgh, Churchill Livingstone.

While, A. (1981) making a nurse into a health visitor. Health Visitor. 54 (4) pages 150-153

Wilde, V. (1988) A Qualitative Analysis of critical incidents associated with difficult, challenging and satisfying experiences in nursing. Unpublished MSc thesis, University of Manchester.

Wilkinson, S.M. (1986) The satisfactions and stresses of nursing patients with cancer. Unpublished MSc thesis, University of Manchester.

Williams, E.I. (1984) Characteristics of patients over 75 not seen during one year in general practice. British Medical Journal 288 pages 119-121

Williams, E.I. (1989 edition) Caring for elderly people in the community. London, Chapman Hall.

Wiiams E.I. & Barley, N.H. (1985) Old people not known to the general practitioner: low risk group. British Medical Journal 291 pages 251-254

Williams, I. (1975) Case for screening the elderly. Update II 12 pages 1275-1276, 1278-1282

Williamson, J. (1981) Screening, surveillance and case finding. IN Arie, J. (Ed) Health Care of the Elderly. London, Croom

Williamson, J., Stokoe, I.H., Gray, S., Fisher, M., Smith, A., McGhee, A. and Stephenson, E. (1964) Old people at home: their unreported needs. Lancet i, pages 117-119

Wilson, D. et al (Eds) (1986) Ageing and Social Policy. Aldershot, Gower publications.

Wilson, G. (1992) Older people's experience of health services: the conflict between gratitude and expectations. Paper presented at the British Society of Gerontology Conference. September, University of Kent.

Wilson-Barnet, J. (1984) Gaining Access to the Research Site. IN Cormack, D.F.S.(Ed) The Research process in Nursing. Oxford, Blackwell Scientific Publications.

Wiseman, J. (1982) Health visiting: what will be its function in the future? Nursing Times **78** (13) pages 49-52

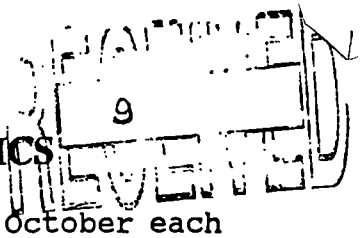
Woolsey,L.K. (1986) The Critical Incident Technique: an innovative qualitative method of research. Canadian Journal of Counselling. **20** (4) pages 242-254

Woolsey, L.K. and Adler, J. (1986) Women's self actualization: The significance of homosociality in career women's development. Cited In Woolsey, L.K. (1986) The Critical Incident Technique: an innovative qualitative method of research. Canadian Journal of Counselling. **20** (4) pages 242-254

APPENDICES

APPENDIX 1.

PRACTICE NURSE WORKFORCE STATISTICS.



PRACTICE NURSE WORKFORCE STATISTICS

The Department collects data on an annual basis at 1 October each year from Family Health Service Authorities in England and Wales. The tables for period 1986 to 1990 indicating trends were:-

REGIONAL STATISTICS
Number of whole time equivalent nurses employed by General Medical Practitioners:

	1986	1987	1988	1989	1990
Northern	150	164	217	282	427
Yorkshire	147	167	213	277	570
Trent	223	258	323	464	767
East Anglia	187	211	235	271	443
North West Thames	249	281	316	389	610
North East Thames	190	273	235	279	536
South East Thames	151	182	227	360	657
South West Thames	154	171	198	276	448
Wessex	204	237	280	330	534
Oxford	177	199	231	339	449
South Western	227	279	326	462	683
West Midlands	302	354	407	487	751
Mersey	57	71	104	166	331
North Western	84	136	166	248	490
TOTAL ENGLAND	**2,502**	**2,983**	**3,478**	**4,630**	**7,696**
Wales	140	167	194	268	459
TOTAL ENGLAND & WALES	**2,642**	**3,150**	**3,672**	**4,898**	**8,155**

414
821

(Regional figures for 1991 not yet available)

APPENDIX 2.

INTERVIEW GUIDE - EXPLORATORY WORK (PRACTICE NURSES).

Specific questions:

1. Age
2. How long practice nurse
3. Professional background
4. Why entered practice nursing?
5. How would describe role?
6. Ask about structure of area (demography)
7. Client groups

General areas for discussion:

1. Organisation of work - who are the clients, who decides the structure etc.
2. Role with older people - over 75 assessments: how find them, how organised, where take place etc.
3. Feelings about role, experience and expectations of employers
4. Contact with other community nurses.

APPENDIX 3.

INTERVIEW GUIDE - EXPLORATORY WORK (HEALTH VISITORS).

Specific questions:

1. Age

2. How long health visitor

3. Professional background

4. Why entered health visiting?

5. How would describe role?

6. Ask about structure of area (demography)

7. Client groups

General areas for discussion:

1. Guidlines for visiting older people in the area, do management set priorities/specific policies?

2. Organisation of caseloads, how set priorities within caseloads, what criteria are used to decide how often to visit?

3. Role of health visitor with older people e.g.

-do you visit the elderly?
-how are people included on the caseload?
-what is main focus of health visiting intervention?
-how do you feel about visiting older people?
-do you feel health visitor has a role?

4. Feelings about roles of other nurses e.g. district nurses and practice

APPENDIX 4.

QUESTIONNAIRE - EXPERIENCED HEALTH VISITORS

Respondent number ☐☐☐

CARD 3

QUESTIONNAIRE - EXPERIENCED HEALTH VISITORS

This aim of this questionnaire is to find out something about health visitors' work with elderly people. If there are any questions you do not wish to answer, please leave the space blank. All information is totally confidential and your names will not be used in any discussion of the findings of the research. However, in order to be able to identify you for possible follow-up interviews, it would be helpful if you would write your name, contact address and telephone number in the space below;

NAME.....

ADDRESS.....

.....

TELEPHONE NUMBER.....

Following collection of the questionnaire, the front page will be detached and you will be identifiable by a respondent number only. Your name and address will be stored in a locked filing cabinet, to which only the researcher will have access.

Thank you for volunteering to complete the questionnaire.

I would like to begin by asking some questions about yourself and your job (please tick box/boxes).

FOR OFFICE USE ONLY ☐☐☐

Q1. **What is your age?**

20-29	☐	1
30-39	☐	2
40-49	☐	3 ☐
50-59	☐	4
60+	☐	5

Q2. **Which of these professional qualifications do you hold?**

SRN/RGN	☐	☐
SEN	☐	☐
HEALTH VISITORS CERTIFICATE	☐	☐
FIELD WORK TEACHER CERT.	☐	☐
DISTRICT NURSE CERT.	☐	☐
PRACTICAL WORK TEACHER CERT.	☐	☐
FAMILY PLANNING CERT.	☐	☐
REGISTERED MIDWIFE	☐	☐
ENB PRACTICE NURSE COURSE	☐	☐
DEGREE/DIPLOMA	☐	☐
OTHER (PLEASE SPECIFY).....		☐☐☐☐
.....		

103. **If you hold a degree/diploma, please specify which of the following you hold;**

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BACHELOR DEGREE IN NURSING WHICH INCLUDED A COMMUNITY QUALIFICATION	☐	1
BACHELOR DEGREE IN NURSING	☐	2
DIPLOMA IN NURSING	☐	3
OTHER DEGREE/DIPLOMA (please specify).....		4
.....		

☐ (21)

☐☐☐ (22-24)

104. **How would you describe your ethnic origin?**

British	☐	1
Afro-caribbean	☐	2
Asian	☐	3
African	☐	4
Other(please specify)		5
.....		

☐ (25)

105. **How long have you been a health visitor ?**

less than 1 year	☐	1
1-4 years	☐	2
5-9 years	☐	3
10-14 years	☐	4
over 14 years	☐	5

☐ (26)

106. **Do you work full time or part time?**

		FOR OFFICE USE ONLY
Full time	☐	1 ☐ (27)
Part time	☐	2

107. **If you work part time, for how many hours a week are you employed?**

Less than ten hours	☐	1
10 - 19 hours	☐	2 ☐ (28)
20 -29 hours	☐	3
30 - 39 hours	☐	4

108. **How many years have you worked in your current position?**

less than 1 year	☐	1
1 - 4 years	☐	2 ☐ (29)
5 - 9 years	☐	3
over 10 years	☐	4

109. **What job did you do immediately before entering health visiting (e.g. sister on female surgical ward)?**

(please specify).....

.....

☐☐☐☐ (30-33)

110. **Do you have any other responsibilities apart from being a health visitor (e.g. FWT, liaision nurse, clinical specialist)?** (please specify).....

.....

.....

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☐☐☐☐ (34-37)

111. **Which grade applies to your job?**

D	☐	1
E	☐	2
F	☐	3
G	☐	4
H	☐	5
I	☐	6

☐ (38)

112. **Why did you decide to enter health visiting?**

.....

.....

.....

.....

.....

.....

.....

.....

☐☐☐☐ (39-42)

☐☐☐☐ (43-46)

113. **Could you please describe your main responsibilities within your current position:**

.....

.....

.....

.....

.....

.....

.....

.....

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☐☐☐☐ (47-50)

☐☐☐☐ (51-54)

114. **How is your caseload determined?**

GP attached ☐

Geographical area ☐

Other (please specify).....

.....

☐☐ (55-56)

115. **How would you describe the area that you work in (e.g. mixed, middle class etc)?**.....

.....

☐☐☐☐ (57-60)

116. **Approximately how many families with children under 1 year do you have on your caseload?**.....

☐☐☐☐ (61-64)

117. **Approximately how many families with children aged 1-5 do you have on your caseload?**.....

☐☐☐☐ (65-68)

118. **Approximately how many people over 65 years of age do you have on your caseload?**

.....**males** .....**females**

☐☐☐☐ (69-72)

☐☐☐☐ (73-76)

119. **Do you have a policy of assessing all the over 75's in your area?**

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YES	☐	1	Card 4
NO	☐	2	☐ (6)

120. **If yes, who is responsible for performing these assessments?**

You	☐	1	☐☐ (7-8)
The GP/s	☐	2	
Another health visitor	☐	3	
School nurse	☐	4	
Someone else (please specify)			
.....			

121. **Do all the assessments take place in the person's home?**

Yes	☐	1	☐ (9)
No	☐	2	

122. **If no, where else do the assessments take place?**

..... ☐☐☐ (10-12)

.....

123. **Roughly how often are these assessments performed?**

..... ☐☐☐ (13-15)

124. **What form do these assessments take (e.g. Informal, structured questions etc.?** (Please specify).....

..... ☐☐☐ (16-18)

.....

.....

125. **Approximately how many people over 75 are registered with the practice?** .....males .....females

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☐☐☐☐ (19-22)

126. **Approximately how many home visits to people over 75 did you do last month?** .....

☐☐☐☐ (23-26)

127. **Do you have any system for providing preventive health care or assessment for the 65-74 age group?**

Yes ☐ 1 ☐

No ☐ 2 (27)

128. **If yes, could you please describe how this system works**.....

.....

.....

.....

.....

.....

☐☐☐☐ (28-31)

☐☐☐☐ (32-35)

129. **Do <u>you</u> visit any people aged 65-74 at regular intervals?**

Yes ☐ 1 ☐

No ☐ 2 (36)

130. **If you do visit some people aged 65-74 at regular intervals, approximately how many do you visit?**

.....

☐☐☐ (37-39)

131. **Roughly how often do you make these visits?**

.....

☐☐☐

(40-42)

132. **What is the purpose of these visits?.....**

.....

.....

.....

.....

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☐☐☐☐ (43-46)

133. **Approximately how many home visits to people aged 63-74 did you do last month? .....**

☐☐☐ (47-49)

134. **Do you have any other contact with elderly people (apart from home visits)?**

Yes	☐	1 ☐
No	☐	2 (50)

135. **If yes, please describe these contacts and their frequency (e.g. well elderly clinic 1 x per week).**

.....

.....

.....

.....

.....

☐☐☐☐ (51-54)

☐☐☐☐ (55-58)

136. **Do you think that routine assessment is in the best interests of the elderly?**

Yes, it is in their best interests	☐	1 ☐
No, it isn't in their best interests	☐	2 (59)
Don't know	☐	3

137. **Given that assessments of the over 75's have to be done, where should they be done?**

		FOR OFFICE USE ONLY
At home	☐	1
In the clinic	☐	2
Either	☐	3

☐ (60)

138. **In the context of the elderly, how well prepared do you feel for doing home visits?**

Very well prepared	☐	1
Adequately prepared	☐	2
Not adequately prepared	☐	3
Completely unprepared	☐	4

☐ (61)

139. **In the context of the elderly, how well prepared do you feel to perform assessments?**

Very well prepared	☐	1
Adequately prepared	☐	2
Not adequately prepared	☐	3
Completely unprepared	☐	4

☐ (62)

PLEASE TURN OVER

The next part of the questionnaire involves describing, briefly, **2 incidents** in which you were involved with an **elderly person or people,** <u>one</u> in which you felt you were particularly <u>effective</u> and <u>one</u> in which you felt you were particularly <u>ineffective.</u>

Below are some guidelines to help you.

<u>IT IS IMPORTANT THAT YOU READ THESE BEFORE CONTINUING.</u>

A "critical incident" consists of any <u>professional</u> interaction with an elderly person or people in which you were involved.

This may include:

1. A visit at home or in the clinic or an intervention in a hospital setting.
2. A crisis situation which you dealt with
3. Any other professional interaction with an elderly person.

PLEASE INCLUDE IN YOUR DESCRIPTION;

1. **Details of the person you were involved with** such as age, sex, socioeconomic and ethnic group.
2. **The reason why you initially became involved** with the person.
3. Details of the **decisions you made about their care** following the incident.
4. **What you were thinking about** as the incident took place.
5. **How you felt** after the incident.

Please describe one incident in which you felt you were **effective.**

PLEASE TURN OVER.

Please describe one incident in which you felt you were **ineffective.**

Thank you for assisting me with my research.

Finally, if there are any comments you would like to make about the questionnaire or about health visitors' work with elderly people, please write them below.

APPENDIX 5.

QUESTIONNAIRE - PRACTICE NURSES.

Respondent number ☐☐☐

QUESTIONNAIRE - PRACTICE NURSES. **Card 1 (1 - 3)**

The aim of this questionnaire is to find out something about practice nurses' work with elderly people. If there are any questions you do not wish to answer, please leave the space blank. All information is totally confidential and your names will not be used in any discussion of the findings of the research. However, in order to be able to identify you for possible follow-up interviews, it would be helpful if you would write your name, contact address and telephone number in the space below;

NAME.....

ADDRESS.....

.....

Telephone number.....

Following collection of the questionnaire, the front page will be detached and you will be identifiable by a respondent number only. Your name and address will be stored in a locked filing cabinet, to which only the researcher will have access.

Thank you for volunteering to complete the questionnaire.

would like to begin by asking some questions about urself and your job (please tick box/boxes).

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☐☐☐

Q1. **What is your age?**

20-29	☐	1
30-39	☐	2
40-49	☐	3 ☐ (6)
50-59	☐	4
60+	☐	5

Q2. **Which of these professional qualifications do you hold?**

SRN/RGN	☐	☐ (7)
SEN	☐	☐ (8)
HEALTH VISITORS CERTIFICATE	☐	☐ (9)
FIELD WORK TEACHER CERT.	☐	☐ (10)
DISTRICT NURSE CERT.	☐	☐ (11)
PRACTICAL WORK TEACHER CERT	☐	☐ (12)
FAMILY PLANNING CERT.	☐	☐ (13)
REGISTERED MIDWIFE	☐	☐ (14)
ENB PRACTICE NURSE COURSE	☐	☐ (15)
DEGREE/DIPLOMA	☐	☐ (16)
OTHER (PLEASE SPECIFY).....		☐☐☐☐
.....		(17-20)

13. If you hold a degree/diploma, please specify which of the following you hold;

FOR OFFICE USE ONLY

BACHELOR DEGREE IN NURSING WHICH INCLUDED A COMMUNITY QUALIFICATION	☐	1
BACHELOR DEGREE IN NURSING	☐	2
DIPLOMA IN NURSING	☐	3
OTHER DEGREE/DIPLOMA (please specify).....		4
.....	☐☐☐	(22-24)

(21) ☐

14. How would you describe your ethnic origin?

British	☐	1
Afro-caribbean	☐	2
Asian	☐	3
African	☐	4
Other(please specify)		5
.....		

(25) ☐

15. How long have you been a practice nurse?

less than 1 year	☐	1
1-4 years	☐	2
5-9 years	☐	3
10-14 years	☐	4
over 14 years	☐	5

(26) ☐

206. **Do you work full time or part time?**

		FOR OFFICE USE ONLY
Full time	☐	1 ☐ (27)
Part time	☐	2

207. **If you work part time, for how many hours a week are you employed?**

Less than ten hours	☐	1
10 - 19 hours	☐	2 ☐ (28)
20 -29 hours	☐	3
30 - 39 hours	☐	4

208. **How many years have you worked in your current job?**

less than 1 year	☐	1
1 - 4 years	☐	2 ☐ (29)
5 - 9 years	☐	3
over 10 years	☐	4

209. **What job did you do immediately before entering practice nursing (e.g. sister on female surgical ward)?**

(please specify).....

.....

☐☐☐☐ (30-33)

210. **Do you have any other responsibilities apart from being a practice nurse (e.g. practice manager, clinical specialist)?** (please specify).....

.....

.....

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☐☐☐☐
(34-37)

211. **Which grade applies to your job?**

D	☐	1
E	☐	2
F	☐	3
G	☐	4
H	☐	5
I	☐	6

☐
(38)

212. **Why did you decide to enter practice nursing?**

.....

.....

.....

.....

.....

.....

.....

.....

☐☐☐☐
☐☐☐☐
(39-46)

213. **Could you please describe your main responsibilities within your current job:**

.....

.....

.....

.....

.....

.....

.....

.....

FOR OFFICE USE ONLY

☐☐☐☐ (47-54)

214. **How many GP's are there in the practice you work for?** .....

☐☐ (55-56)

215. **Do you work with all these GP's?**

Yes ☐ 1

No ☐ 2

☐ (57)

216. **If not, how many of the GP's do you work with?** .....

☐☐ (58-59)

217. **Are there other practice nurses working in the same practice as you?**

Yes ☐ 1

No ☐ 2

☐ (60)

218. **If there are other practice nurses working in the same practice as you, please describe briefly what their main responsibilities are:**

.....

.....

.....

.....

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☐☐☐☐ (61-64)

219. **How would you describe your practice catchment area (e.g. mixed, middle class etc)?**.....

.....

☐☐☐☐ (65-68)

220. **Does your practice have a policy of visiting all the over 75's in your area for the purpose of assessment?**

YES	☐	1	☐
NO	☐	2	(69)

221. **If yes, who is responsible for performing these assessments?**

You	☐	1	☐☐
The GP/s	☐	2	(70-71)
Another practice nurse	☐	3	
Someone else (please specify)			

.....

.....

222. **Do all the assessments take place in the person's home?**

Yes ☐
No ☐

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1 ☐
2 (72)

223. **If no, where else do the assessments take place?**

.....

.....

☐☐☐ (73-75)

224. **Roughly how often are these assessments performed?**

.....

Card 2

☐☐☐ (1-3)

225. **Approximately how many people over 75 are registered with the practice?** .....males .....females

☐☐☐☐ (4-7)

226. **Approximately how many home visits to people over 75 did you do last month?** .....

☐☐☐☐ (8-11)

227. **Does your practice have any system for providing preventive health care or assessment for the 65-74 age group?**

Yes ☐
No ☐

1 ☐
2 (12)

228. **If yes, could you please describe how this system works and what form the assessment takes.....**

.....

.....

.....

.....

.....

☐☐☐☐ ☐☐☐☐ (13-20)

229. Do <u>you</u> visit any people aged 65-74 at regular intervals?

Yes ☐ 1 ☐

No ☐ 2 (21)

230. If you do visit some people aged 65-74 at regular intervals, approximately how many do you visit?

..... ☐☐☐ (22-24)

231. Roughly how often do you make these visits?

..... ☐☐☐ (25-27)

232. What is the purpose of these visits?.....

..... ☐☐☐☐ (28-31)

.....

.....

.....

233. Approximately how many home visits to people aged 65-74 did you do last month? ..... ☐☐☐ (32-34)

234. Do you have any other contact with elderly people (apart from home visits)?

Yes ☐ 1 ☐

No ☐ 2 (35)

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235. **If yes, please describe these contacts and their frequency (e.g. well elderly clinic 1 x per week).**

.....

.....

.....

.....

.....

FOR OFFICE USE ONLY

☐☐☐☐
☐☐☐☐
(36-43)

236. **Do you think that routine assessment is in the best interests of the elderly?**

Yes	☐	1
No	☐	2

☐ (44)

237. **Given that assessments of the over 75's have to be done, where should they be done?**

At home	☐	1
In the clinic	☐	2
Either	☐	3

☐ (45)

238. **In the context of the elderly, how well prepared do you feel for doing home visits?**

Very well prepared	☐	1
Adequately prepared	☐	2
Not adequately prepared	☐	3
Completely unprepared	☐	4

☐ (46)

239. **In the context of the elderly, how well prepared do _____ you feel to perform assessments?**

Very well prepared	☐	1
Adequately prepared	☐	2
Not adequately prepared	☐	3
Completely unprepared	☐	4

☐ (62)

240. **Could you please describe briefly why you came on the practice nurse course.....**

.....

.....

☐☐☐ (47-49)

PLEASE TURN OVER

The next part of the questionnaire involves describing, briefly, **2 incidents** in which you were involved with an **elderly person or people**, one in which you felt you were particularly **effective** and one in which you felt you were particularly **ineffective**.

Below are some guidelines to help you.

IT IS IMPORTANT THAT YOU READ THESE BEFORE CONTINUING.

A "critical incident" consists of any **professional** interaction with an elderly person or people in which you were involved.

This may include:

1. A visit at home or in the clinic or an intervention in a hospital setting.
2. A crisis situation which you dealt with
3. Any other professional interaction with an elderly person.

PLEASE INCLUDE IN YOUR DESCRIPTION;

1. **Details of the person you were involved with** such as age, sex, socioeconomic and ethnic group.
2. **The reason why you initially became involved** with the person.
3. Details of the **decisions you made about their care** following the incident.
4. **What you were thinking about** as the incident took place.
5. **How you felt** after the incident.

Please describe one incident in which you felt you were **effective.**

Please describe one incident in which you felt you were **ineffective.**

Thank you for assisting me with my research.

Finally, if there are any comments you would like to make about the questionnaire or about practice nurses' work with elderly people, please write them below.

APPENDIX 6.

QUESTIONNAIRE - STUDENT HEALTH VISITORS.

Respondent number ☐☐☐

Card 5 (1-3)

QUESTIONNAIRE - STUDENT HEALTH VISITORS

The aim of this questionnaire is to find out something about nurses' work with elderly people in hospital and in the community. If there are any questions you do not wish to answer, please leave the space blank. All information is totally confidential and your names will not be used in any discussion of the findings of the research. However, in order to be able to identify you for possible follow-up interviews, it would be helpful if you would write your name, contact address and telephone number in the space below;

NAME.....

ADDRESS.....

.....

Telephone number.....

Following collection of the questionnaire, the front page will be detached and you will be identifiable by a respondent number only. Your name and address will be stored in a locked filing cabinet, to which only the researcher will have access.

Thank you for volunteering to complete the questionnaire.

I would like to begin by asking some questions about yourself (please tick box/boxes).

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☐☐☐

301. **What is your age?**

20-29	☐	1
30-39	☐	2
40-49	☐	3 ☐ (6)
50-59	☐	4
60+	☐	5

302. **Which of these professional qualifications do you hold?**

SRN/RGN	☐	☐ (7)
SEN	☐	☐ (8)
HEALTH VISITORS CERTIFICATE	☐	☐ (9)
FIELD WORK TEACHER CERT.	☐	☐ (10)
DISTRICT NURSE CERT.	☐	☐ (11)
PRACTICAL WORK TEACHER CERT	☐	☐ (12)
FAMILY PLANNING CERT.	☐	☐ (13)
REGISTERED MIDWIFE	☐	☐ (14)
ENB PRACTICE NURSE COURSE	☐	☐ (15)
DEGREE/DIPLOMA	☐	☐ (16)
OTHER (PLEASE SPECIFY).....		☐☐☐☐
.....		(17-20)

303. **If you hold a degree/diploma, please specify which of the following you hold;**

FOR OFFICE USE ONLY

BACHELOR DEGREE IN NURSING WHICH INCLUDED A COMMUNITY QUALIFICATION	☐	1
BACHELOR DEGREE IN NURSING	☐	2
DIPLOMA IN NURSING	☐	3
OTHER DEGREE/DIPLOMA (please specify).....		4
.....		☐☐☐ (22-24)

(21) ☐

304. **How would you describe your ethnic origin?**

British	☐	1
Afro-caribbean	☐	2
Asian	☐	3
African	☐	4
Other(please specify)		5
.....		

(25) ☐

305. **When did you qualify as a nurse?**

1-4 years ago	☐	1
5-9 years ago	☐	2
10-14 years ago	☐	3
over 14 years ago	☐	4

(26) ☐

306. **Could you please describe the two most recent posts you held before entering HV training (e.g. full-time sister, female surgical ward, 1 year).**

MOST RECENT POST.....

.....

POST BEFORE MOST RECENT.....

.....

307. **Could you please describe why you decided to do Health Visitor training?**.....

.....

.....

.....

.....

.....

.....

.....

308. **What do you think the main responsibilities of the health visitor are?**.....

.....

.....

.....

.....

.....

.....

.....

.....

FOR OFFICE USE ONLY

☐☐☐☐ (27-30)

☐☐☐☐ (31-34)

☐☐☐☐ (35-38)

☐☐☐☐ (39-42)

☐☐☐☐ (43-46

☐☐☐ (47-50)

309. **Which client groups do health visitors work with, mainly?**.....

.....

.....

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☐☐☐☐ (51-54)

310. **Do you think health visitors have a role with elderly people?**

YES ☐ 1

NO ☐ 2 ☐ (55)

DON'T KNOW ☐ 3

311. **If yes, could you describe briefly what that role might be?**.....

.....

.....

.....

.....

☐☐☐☐ (56-59)

☐☐☐☐ (60-63)

312. **Most nurses have some experience of working with elderly people during their nurse training, but have you any post-basic nursing experience of working with elderly people?**

YES ☐ 1

NO ☐ 2 ☐ (64

313. **If yes, what was that experience?**.....

.....

.....

.....

.....

.....

☐☐☐☐ (65-68)

☐☐☐☐ (69-72)

FOR OFFICE USE ONLY

314. **Most nurses have some experience of working with young children and babies during their nurse training, but have you any post-basic nursing experience of working with these groups?**

YES	☐	1 ☐ (73)
NO	☐	2

315. **If yes, what was that experience?**.....

.....

.....

.....

.....

.....

Card 6

☐☐☐☐ (6-9)

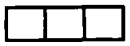
☐☐☐☐ (10-13)

316. **Do you find working with elderly people generally**

very satisfying	☐	1
satisfying	☐	2 ☐ (14)
not satisfying	☐	3
don't know	☐	4

317. **Do you find working with children and babies generally**

very satisfying	☐	1
satisfying	☐	2 ☐ (15)
not satisfying	☐	3
don't know	☐	4



The next part of the questionnaire involves describing, briefly, **2 incidents** in which you were involved with an **elderly person or people, one** in which you felt you were particularly **effective** and **one** in which you felt you were pariculalrly **ineffective**. Incidents should be from previous nursing experience, either as a qualified nurse or as a student.

Below are some guidelines to help you.

IT IS IMPORTANT THAT YOU READ THESE BEFORE CONTINUING.

A "critical incident" consists of any **professional** interaction with an elderly person or people in which you were involved.

This may include:

1. A visit at home or in the clinic or an intervention in a hospital setting.
2. A crisis situation which you dealt with
3. Any other professional interaction with an elderly person.

PLEASE INCLUDE IN YOUR DESCRIPTION;

1. **Details of the person you were involved with** such as age, sex, socioeconomic and ethnic group.
2. **The reason why you initially became involved** with the person.
3. **Details of the decisions you made about their care** following the incident.
4. **What you were thinking about** as the incident took place.
5. **How you felt** after the incident.

Please describe one incident in which you felt you were **effective.**

(PLEASE TURN OVER)

Please describe one incident in which you felt you were **ineffective.**

(PLEASE TURN OVER)

Thank you for assisting me with my research.

Finally, if there are any comments you would like to make about the questionnaire or about nurses' work with elderly people, please write them below.

APPENDIX 7. SAMPLE LETTER FOR NEGOTIATING ACCESS AT INSTITUTES OF HIGHER EDUCATION (MAIN STUDY.

6 June 1990

Dear ********,

I am writing to enquire as to the possibility of conducting part of my doctoral research study at ********** Polytechnic, where I understand you run a health visitor training course.

I am currently in receipt of a Department of Health studentship at the University of Liverpool under the supervision of Professor Karen Luker. The main focus of the study is the construction of effective practice of student health visitors, experienced health visitors and practice nurses with elderly people and involves the completion of a questionnaire and then a follow-up interview of a subsample of the original respondents.

As I am particularly interested in the experiences of working with the elderly that student health visitors bring with them from general nursing to health visiting, I would envisage administering the questionnaire at the very beginning of their training (i.e.September 1990). The questionnaires can be completed either as a group in a class-room setting, which would require about half an hour, or alternatively they could take them home to complete, whichever you feel would be most appropriate. Obviously, completion of the questionnaire would not be mandatory but the students would be asked to volunteer.

I am also interested in giving the questionnaire to experienced health visitors and it has been suggested that you may run a course for trainee field work teachers. If that is so, perhaps it would be possible for me to have access to that group as well.

I enclose a copy of the first draft questionnaire for your reference.

Please could you let me know your decision on access at your earliest convenience.

Yours sincerely,

Ms A.C. Pursey.

APPENDIX 8. EXAMPLE OF LOTUS SYMPHONY SPREADSHEET.

resp	group	age	degdip	p-basic	hvcert	dncert	midwife
312	3	1	2	1	99	2	
311	3	1	2	1	99	2	
310	3	1	2	1	99	2	
309	3	1	2	1	99	2	
308	3	1	2	1	99	2	
307	3	2	2	1	99	2	
306	3	1	1	2	99	2	
305	3	1	2	1	99	2	
304	3	2	2	1	99	2	
303	3	1	2	1	99	2	
302	3	3	2	1	99	2	
310	3	3	2	2	99	2	
352	3	1	2	1	99	2	
353	3	1	2	1	99	2	
354	3	1	2	2	99	2	
332	3	2	2	1	99	2	
347	3	2	1	1	99	2	
357	3	2	2	1	99	2	
340	3	1	2	2	99	2	
358	3	2	2	2	99	2	
320	3	3	2	1	99	2	
362	3	2	2	1	99	2	
361	3	1	2	1	99	2	
360	3	1	2	1	99	2	
349	3	3	2	1	99	2	
350	3	3	2	2	99	2	
351	3	1	1	1	99	2	
355	3	1	2	1	99	2	

X-axis = respondent number Y-axis = variable names

APPENDIX 9.

STATISTICAL APPENDIX.

STATISTICAL APPENDIX.

This appendix provides a brief overview of the statistical tests used in the study.

1. Statement of Hypotheses.

The null hypothesis (H_0) is a statement of no difference. It is generally used in order to be rejected in favour of an alternative hypothesis (H_1), which is a statement of the research hypothesis. In order to set a probability level at which H_0 is to be rejected, the researcher must state a value of x (level of significance) in advance. The value of x chosen for the purposes of this study is .05.

In this study, the researcher has reported the actual probability associated with the findings in order that the reader may determine for him/herself whether or not the null hypothesis should be rejected (Siegel & Castellan Jr., 1988). However, it should be noted that decisions about rejection/acceptance of the null hypothesis are subject to two types of error, which can affect the statistical inferences made:

Type 1 errors involve rejecting the null hypothesis when it is actually true.
Type 2 errors involve accepting the null hypothesis when it is actually false.

The researcher should attempt to minimise the probability of making these errors by consideration of the power function of the test statistic, which Siegel (1956) states is the probability of rejecting the H_0 when it is false.

2. Description of statistical tests.

It should be noted that all statistics used in this study were calculated using a statistics computer package, SPSS (Statistical Package for the Social Sciences)/PC+ Version 2.0. The description of the calculation of statistical tests is given here for purely illuminative purposes.

2.1. The chi-square test for two independent samples.

The chi-square test may be used to determine the significance of differences between two independent groups which are of nominal of categorical scaling. The hypothesis being tested is whether the two groups differ with respect to some characteristic; the number of cases from each group which fall in the various categories are counted and the proportion of cases from one group in the carious categories are compared with the proportion of cases from the other group.

The data are arranged into a contingency table in which the columns represent groups and each row represents a category of the measured variable. The statistical calculation of the chi-square value is as follows:

$$X^2 = \sum_{i=1}^{r} \sum_{j=1}^{c} \frac{(n_{ij} - E_{ij})^2}{E_{ij}}$$

where n_{ij} = the number of cases categorized in the ith row of the jth column and E_{ij} = the number of cases expected in the ith row of the jth column when H_0 is true (Siegel and Castellan Jr., 1988).

2.2. The McNemar test

The McNemar test is used for two correlated dichotomous variables. It can also be used in analysis of a 'before and after' study when the researcher wishes to have a measure of the significance of change (Siegel and Castellan Jr., 1988). A fourfold table of frequencies is used to represent the first and second sets of responses from the same individuals. The general features of the table are shown below in table 2.2, in which + and - are used to denote different responses.

	+	-
+	A	B
-	C	D

Table 2.2. Fourfold table for use in testing the relationship between two correlated dichotomous variables.

The entries in the table (A to D) are the frequencies of occurrence of the associated responses. In the McNemar test, we are interested only in cells in which changes occur. Therefore calculation of the chi-square is performed

as follows:

$$X^2 = \frac{(A - D)^2}{A + D} \qquad \text{with df} = 1$$

The sampling distribution of X^2 calculated from the above equation when H_0 is true is asymptotically distributed as chi square with df = 1.

2.3. The Wilcoxon Rank sum test

The Wilcoxon Rank sum test is used to test whether two independent groups have been drawn from the same population. The two populations are X and Y and the null hypothesis is that X and Y have the same distribution. The equation for calculating the Wilcoxon Rank sum test (for large samples) is as follows:

$$z = \frac{W_x \pm .5 - \mu_{Wx}}{\sigma_{Wx}} = \frac{W_x \pm .5 - m(N + 1)/2}{\sqrt{mn(N + 1)/12}}$$

where m is the number of cases in the sample from Group X,

n is the number of cases in the sample from Group Y

and W_x is the sum of ranks for group X.

It should be noted that the Wilcoxon test assumes that the scores are sampled from a distribution which is continuous. However, with the measures commonly used in the behavioural sciences, ties may well occur. For details of how the z is corrected for ties see Siegel and Castellan Jr

(1988), pages 135-136.

2.4. The Two-sample T test.

The T test statistic is used to determine whether the mean values of two populations are the same. To test the hypothesis that the two means are equal the following statistic is calculated:

$$t = \frac{\bar{X}_1 - \bar{X}_2}{S_1^2/N_1 + S_2^2/N_2}$$

where $\bar{X}$ is the sample mean of Group 1, S_1^2 is the variance, and N_1 is the sample size. Based on the sampling distribution of the above statistic one can calculate the probability that a difference at least as large as the one observed would occur of the two population means (μ_1 and μ_2) are equal. This probability is called the *observed significance level* (SPSS, 1988). If the observed significance level is small enough, usually less than 0.05 or 0.01, the hypothesis that the population means are equal is rejected.

2.5. Summary.

The description of the statistical tests used in this study has been brief. For further details of the tests and their suitability for certain types of data refer to Siegel and Castellan Jr. (1988).

APPENDIX 10.

RAW DATA AND ETHNOGRAPH PRINT-OUTS - CRITICAL INCIDENTS.

APPENDIX 10A. EXAMPLE OF RAW DATA: CRITICAL INCIDENTS.

EFFECTIVE 116
One of my most effective contacts with the elderly has been, not one of discovering an ailment or referring on to a number of different agencies, but to enable the elderly person to have an available professional contact to whom to make reference or query as necessary. Recently, I have seen 2 patients like this - both without relatives, both coping to a point, without involvement of other agencies such as social services, but who needed a person to whom they could talk about their needs their worries and concerns and someone who could give them the confidence they needed to make decisions to 'be there' when they needed help ie. a reference point when needed.I feel this kind of contact is valuable in enabling people to cope longer as independent people and who can refer on when the need arises. I felt I was performing a social role as much as a health role.

INEFFECTIVE 116
Middle class lady aged 85 years: 4th visit of the morning. I had made an appointment (written) for elderly screening at home, giving a time frame for visiting. I was 10 minutes late when I arrived. The lady was extremely angry at my lateness and despite my apology remained angry, but decided to let me in to visit her rather than wait for another appointment.I screened the patient : all recordings were within the normal limits (she had a degree of O.A.) I tried to engage her in conversation to try to uncover the reasons for her latent anger - which had been triggered by my tardiness.I heard all about her rigidly structured youth and early married life, particularly regarding time (she was thumping the table with her fist at one point.) She also railed against the government for not giving her a pension despite her having paid into a scheme before N.I. began. There was resentment going back for years. There was unpleasantness even hostility towards me throughout the interview and the patient was derogatory towards her G.P. I began to feel uncomfortable and wished to take my leave. at this point the patient began to weep at her anger towards me and to apologise. I had to leave to return to the clinic for appointments but I felt that I was leaving the patient in a particularly vulnerable state. I reported the situation to the G.P. I felt that I had done more harm than good and that my visit was inadequate.

RESPONDENT 116

EFFECTIVE 116

One of my most effective contacts with the elderly has been, not one of discovering an ailment or referring on to a number of different agencies, but to enable the elderly person to have an available professional contact to whom to make reference or query as necessary.

Recently, I have seen 2 patients like this - both without relatives, both coping to a point, without involvement of other agencies such as social services, but who needed a person to whom they could talk about their needs their worries and concerns and someone who could give them the confidence they needed to make decisions to 'be there' when they needed help ie. a reference point when needed.

I feel this kind of contact is valuable in enabling people to cope longer as independent people and who can refer on when the need arises. I felt I was performing a social role as much as a health role.

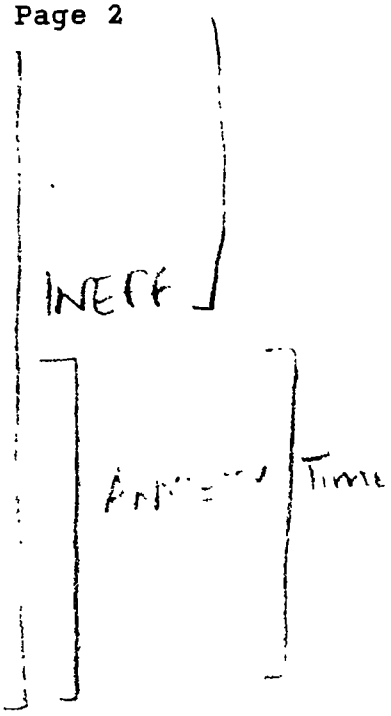
INEFFECTIVE 116

Middle class lady aged 85 years: 4th visit of the morning. I had made an appointment (written) for elderly screening at home, giving a time frame for visiting. I was 10 minutes late when I arrived. The lady was extremely angry at my lateness and despite my apology remained angry, but decided to let me in to visit her rather than wait for another appointment.

I screened the patient : all recordings were within the normal limits (she had a degree of O.A.) I tried to engage her in conversation to try to uncover the reasons for her latent anger - which had been triggered by my tardiness.

I heard all about her rigidly structured youth and early married life, particularly regarding time (she was thumping the table with her fist at one point.) She also railed

against the government for not
giving her a pension despite her
having paid into a scheme before
N.I. began. There was resentment
going back for years.
There was unpleasantness even hostility
towards me throughout the interview
and the patient was derogatory
towards her G.P.
I began to feel uncomfortable and wished
to take my leave. t this point
the patient began to weep at her
anger towards me and to apologise.
I had to leave to return to the
clinic for appointments but I felt
that I was leaving the patient in a
particularly vulnerable state.
I reported the situation to the G.P. I
felt that I had done more harm than
good and that my visit was
inadequate.



APPENDIX 11. INTERVIEW GUIDE (MAIN STUDY).

PRACTICE NURSES:

1. Structure of work - who, why and how?
2. Relationship with GP
3. Previous experience and effects on current work
4. Autonomy and control

HEALTH VISITORS:

1. Role with student health visitors with regard to visiting older people.
2. Own visits and responsibilities wrt visiting older people.
3. Influence of management on work priorities
4. Anticipatory health care (Health promotion and health education) with older people.

STUDENT HEALTH VISITORS:

1. How FWT influences work with older people
2. Setting priorities with under 5s and older people.
3. Guidance/Education wrt work with older people.
4. Visits to older people - why, what and how?

As the series of interviews progressed the schedules changed, becoming more focussed on issues raised in the early interviews by respondents.

APPENDIX 12.

RAW DATA AND ETHNOGRAPH PRINT-OUTS - INTERVIEWS.

APPENDIX 12A. EXAMPLES OF RAW DATA: INTERVIEWS.

Excerpt from interview with respondent 125:

I: So, urm, if you go and do a home visit on an over 75, how do you prepare yourself, how do you decide who you're going to visit and when you're going to visit them?

Pn125: Urm I've got a book made out, d'you want to see it? (I:No, it's alright), and it's urm... I've split it up into 12 months and they're sort of filed, I have white cards as well, and they're all filed when their birthday is, January, February, March, you know whenever. And what I do is, at the beginning of the month I send, this is what I'm doing this year, I send letters out to all the people whose birthday falls in that month (I: Right). It they then ring the surgery, I offer a visit or a health check here, if they want one (I: Right). A lot of them have actually preferred to come here but I would say I probably go out and see about...maybe between 6 and 10 a week in their own home. And i was a district nurse before so um... and it's just sort of, having said that it's totally different though because these are well people, supposedly, that you're going to see. Other than that we've had sort of patients that the hospital have referred because the district nurse, you know it wasn't a district nurse referral and the health visitor said it wasn't really for a health visitor. So they just ring up and say well will you go because we don't know who else to refer them to and

the patients are well but they're being discharged from hospital and we just really want somebody to follow it through. Urm, so that's the way I sort out who and when I'm going to visit.

Excerpt from interview with respondent 116:

I: Right. You said there were a couple of occasions when you had referred to health visitors, could you tell me a bit more about why you felt the health visitor was the appropriate person?

Pn116: Just because I think they needed er...more regular input than I could er...than I could do. Because my time is prescribed in a very limited way, I have two sessions only per week to do this kind of visiting. I started with a group of 750 over 75's to do in a year and the maximum, I started from the bottom up so I started with the 100 pluses and moved through. A lot of these people were living alone, er with no resources, inputs at all apart from p'raps a bit of home help service. Erm...most of them of course elderly women with sort of terrible security problems and all this sort of thing, erm and an amazing number with very little family support. So I found that during the first months I was seeing three or four in a day, if I was lucky really. So I got off to a terribly slow, cumbersome start. Which is inevitable in your first year of doing something like that, I mean I can return to those people now in their second year knowing that all

their structures are in place because I did it last year as it were. And with an inside knowledge of what's going on in that household and knowing the person face-way and they know me. And so I know it'll be quicker this year but for the first year it was pretty desperate you know I was thinking "how do I get through all these people?". In fact I didn't, so I got to about 1910 and then all the others had a questionnaire saying "would you like a home visit?" because what I'd done before that stage was not send out any preliminary stuff, I just sent out a thing, a letter saying this programme is now in place we're visiting, er...we're wanting to visit all our more mature patients, you know, I will call on such and such a date. And I had one person refuse. I mean everybody welcomed it. It was amazing how everybody welcomed it. Or at least didn't deny that they wanted the opportunity. I mean some people found it more helpful than others. But the vast majority said "yes, come along, great" you know. And a lot of people have said how useful they've thought it was and how nice it is to have somebody that they can spend a little more time with.

I: Do you feel that's a valuable part of the visit as much as the assessment itself?

Pn116: I do, absolutely I do. And it's, if you've got the time to sit down, very much as a sort of mature person, I include myself in that category, to another mature

person, you're going to get a lot more feed-back I think and a lot more inside knowledge. And you know you can do a lot of talking, a lot of advising , a lot of counselling. Most of them have been through a recent bereavement of some kind, or even if it's not a family member the fact that they're probably left alone out of a original large circle of friends so there's a lot to go through. And you can't do that in less than an hour. No.

I: Do you think that, perhaps reflecting back on your previous health visiting work, how much sort of health visiting knowledge d'you think you've carried with you into practice nursing?

Pn116: I think it's absolutely integral to the whole thing. I wouldn't have liked to have taken on this job, in fact I wouldn't have suggested it, had I not had health visitor training, because I think the work you do with the elderly as a health visitor is basic to the work I'm doing as a practice nurse.

APPENDIX 12B. NUMBERED VERSION OF ETHNOGRAPH FILE (INTERVIEW)

Excerpt from interview with respondent 125:

I:So, urm, if you go and do a home visit on an over 75, how do you prepare yourself, how do you decide who you're going to visit and when you're going to visit them?

Pn125:Urm I've got a book made out, d'you want to see it? (I:No, it's alright), and it's urm... I've split it up into 12 months and they're sort of filed, I have white cards as well, and they're all filed when their birthday is, January, February, March, you know whenever. And what I do is, at the beginning of the month I send, this is what I'm doing this year, I send letters out to all the people whose birthday falls in that month (I: Right). If they then ring the surgery, I offer a visit or a health check here, if they want one (I: Right). A lot of them have actually preferred to come here but I would say I probably go out and see about...maybe between 6 and 10 a week in their own home. And i was a district nurse before so um... and it's just sort of, having said that it's totally different though because these are well people, supposedly, that

BIRTHVIS

APPROACH

LETTER

OFFCLIN

PREV EXP

APPENDIX 13. EXAMPLES OF ASSESSMENT CARDS (PRACTICE NURSES)

APPENDIX 13 A. ASSESSMENT CARD (PROVIDED FREE WITH ZANTAC)

OVER-75 SCREENING CARD

Date

Surname _____ First name(s) _____

Address _____

_____

Tel. no. _____ Date of birth _____

Sex _____ Marital status _____

Next of kin _____

PLEASE CIRCLE WHEN OPTIONS GIVEN

	COMMENTS
ACCOMMODATION	
TYPE House / Bungalow / Flat / Home / Other	
CONDITION Good / Average / Inadequate	
HEATING Central / Fire / Gas / Electric / Solid / Other	
TOILET Inside / Outside Upstairs / Downstairs	
BATHROOM FACILITIES None / Bath / Shower	
SOCIAL ASSESSMENT	
RELATIVES _____	
DEPENDANTS _____	
OTHER RELATIONSHIPS _____	
SOCIAL SERVICES Home Help / Day Centre / Social Worker / District Nurse	
MEALS Self / Meals on Wheels / Other Help	
CLEANING Self / Help	
PERSONAL	
HYGIENE Good / Adequate / Poor	
INCONTINENCE Nil / Occasional / Severe / Urine Faecal / Rx required	
BOWELS Normal B.O. Constipation / Diarrhoea	
APPETITE Good / Fair / Poor	
DENTITION Own / Dentures / Part	
HEARING (R) Good / Poor / Deaf (L) Good / Poor / Deaf H. Aid ☐	
VISION (R) Good / Poor / Blind (L) Good / Poor / Blind Glasses ☐	
FEET Satisfactory / Needs Rx / Has Rx	
OEDEMA Nil / Feet / Ankles / Legs	
V. VEINS Nil / Mild / Severe Skin Changes ☐	
SPEECH Normal / Difficulties / Able to Communicate	
TOBACCO Nil / Cigs / Cigars / Pipe _____ / Day	
ALCOHOL Nil / Moderation / Excess	

MOBILITY

FULLY MOBILE YES ☐ NO ☐

IF NO With Person / With Aid

TREMOR Nil / Slight / Severe

JOINTS Good / Poor / Rx Satisfactory / Rx Unsatisfactory

MENTAL CONDITION

Alert / Orientated – time; person; place / Disorientated / Lapses / Dementing / Confused

Cheerful / Contented / Withdrawn / Anxious / Distressed

ILLNESSES

Present Illnesses _____

Medication _____

Compliance: Good / Poor

Past Illnesses _____

Allergies _____

COMMENTS

DATA

Height		Weight	
Pulse		Urine	
BP		PEFR	

COMMENTS

Zantac.

APPENDIX 13 B. ASSESSMENT CARD (PROVIDED FREE WITH FRUSENE).

PATIENT ASSESSMENT CARD

75 YEARS AND OVER

NAME
D.O.B. NHS NO.
ADDRESS TEL NO.
CHANGE OF ADDRESS
CARER
SIGNIFICANT MEDICAL DIAGNOSES/DISABILITIES
TYPE OF HOUSING

DATE									
HOME -Well Kept -Heating									
SOCIAL -Day Centre -Warden -Home Care -M on W -Voluntary									
FUNCTIONAL -Cooking -Dressing -Toiletting -Bathing									
MOBILITY -Indoors -Stairs -Outdoors									
SENSES									
MENTAL STATUS									
CARER									
BLOOD PRESSURE									
CONTINENCE									
URINALYSIS									
MEDICATION REVIEW									
ASSESSOR									
COMMENTS									