UNIVERSITY OF ALBERTA

NURSES' PERCEPTIONS OF THE ELDERLY IN THREE DIFFERENT CARE SETTINGS

BY

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DEDICATION

To my parents who taught me to value education and were always there for me, Thank You.

To Sonya whose love, encouragement, support and never ending patience helped me to achieve my goal.

To Ryan who thought I would never finish so he could use the computer again.

To my sisters Margaret and Mary who were always there to help or just to listen.

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ABSTRACT

Nurses' perceptions of the elderly have been difficult to ascertain, and numerous studies have shown varying findings. Most of the studies have been completed in the United States with only very few measuring the perceptions of Canadian nurses toward the elderly. A survey design was used to describe and compare nurses' perceptions of the elderly in three different care settings in a Western Canadian city. Two hundred and eighty four nurses who were working in an acute care hospital, a long term care facility or a home care program completed the Kogan Old Peoples Scale and the Tollett - Adamson Attitudes to Aging Scale. Both the Kogan Old Peoples Scale and the Tollett - Adamson Attitudes to Aging Scale had a positive and negative sub-scale. Reliability analysis indicated high internal consistency for the two attitude questionnaires. Analysis of variance revealed that the nurses involved in the study had an overall positive perception of the elderly. Nurses who were working in home care scored more positively than the nurses in the other two settings. The mean score for the long term care nurses was the least positive on both scales of the two instruments. Education level and job category did not have a consistent influence on nurses' perceptions toward the elderly. Other variables were analyzed in a multiple regression equation and it was determined that none of them contributed to the nurses' perceptions of the elderly in this study. Implication for nursing practice, education, administration and research were discussed. Information generated from this study will assist in developing nursing knowledge and guide nursing research in the area of nurses' perceptions of aging.

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INTRODUCTION AND STATEMENT OF THE PROBLEM

Background of the Problem

In Canada, as in other advantaged nations, the size of the elderly population is rapidly expanding, largely due to a decrease in infant mortality and an increase in longevity. With the "baby - boomers" progressing through middle age an even more rapid increase in the elderly population is imminent. In 1931, seniors comprised only 6 percent of the population but by 1986, there were 2.7 million Canadians over 65 years of age, 11 percent of the total population. It is projected by 2031 that there will be 7.5 million elderly people in Canada (Institutes, 1988).

The Alberta Bureau of Statistics reported 207,230 seniors in Alberta in 1986; this represented 8.1 percent of Alberta's total population. By the year 2016 the population over 65 is expected to increase to over 478,800 persons, double the 1986 figure. The increase in the number of seniors is also a projected increase in the proportion of seniors to other age groups. By 1996, the expected percentage of seniors in Alberta is 9.6% with another increase to 13.5% by 2016 (Seniors Advisory Council for Alberta, 1991). In the next 20 years, the senior population will progressively occupy a larger proportion of the total population. By 2031, it is projected that 22% of the Canadian population will be over the age of 65 (Institutes, 1988).

Problem

With the steady increase in the senior population comes an increasing demand on existing health care resources in a time when health care costs are already a concern. The Mirosh Report (Alberta, 1988) stated that there were 8,144 long term care beds in Alberta in 1971; 12,051 in 1986. The total of long term care beds increased again to a total of 13,576 by the fall of 1991 (Alberta Health, 1992) even though the targeted per capita ratio of long term care beds for people over the age of 65 has decreased from 70 beds per thousand to 60 beds per thousand.

Acute care hospitals have found a steady increase in the proportion of seniors in their patient population, requiring both medical and surgical care. This is not unexpected, as there are more elderly people there will continue to be an increase in the number of people with chronic diseases and other illnesses more common in later life such as cardiovascular diseases and cancers.

The Coordinated Home Care Program in Alberta began in 1979 and by September, 1992 had 22,500 clients, 89% of whom were over the age of 65 (Home Care Information System, 1992). Home Care had steadily expanded their services since 1979 allowing more seniors to receive long term care and acute, short stay care in their own homes. Many of these people would have previously required institutionalization. The shift in care setting helped to relieve some of the pressure on the institutional health care system, but placed an increased burden on health care services delivered in the community. Besides relieving the institutional system, this shift to the community

complied with the wishes of the majority of seniors who wanted to remain in their own homes, thereby maintaining their independence as long as possible (Alberta, 1988, February).

In order to meet the health care needs of the rapidly increasing elderly population, there must be a greater number of nurses prepared to care for the elderly in all three health care settings, acute care, long term care and home care. But more important, nursing personnel currently caring for the elderly must realize the potential and ability of most seniors to remain independent. They must also be aware that illness and infirmity are not a natural consequence of the aging process. It is not sufficient for nurses to merely complete the routine tasks associated with caregiving; there is a demand by the elderly to receive individualized care that will assist them to reach and maintain their maximum potential (Alberta, 1988, February). Alford (1983) in an article about nurses with advanced education in gerontology stated that nurses who have an adequate understanding of the aged can give the elderly the opportunity to take advantage of their unlimited potential.

In order to provide the best of care for the elderly in all health care settings, more Registered Nurses (R.N.) with advanced education and clinical expertise in gerontological nursing are required. Besides sufficiently prepared R.N.s, there needs to be well prepared Licensed Practical Nurses (L.P.N.s), Personal Care Aides (P.C.A.s), Nursing Assistants (N.A.s) and, Home Support Aides (H.S.A.s) in the field of gerontology. Research in the United States indicates the most rigid stereotyping of the elderly is by the non-professional care giver (Gillis, 1973). At the present time the majority of the

care in the institutional long term care sector and the home care sector in Canada is delivered by the non-professional. In 1986, there were 1,935 R.N.s, 3,571 P.C.A.s/N.A.s and 1,305 L.P.N.s employed in long term care institutions in Alberta (Alberta, 1988, pp. 101-102). In home care, a client may be visited several times a week by a H.S.A. but only occasionally see an R.N., this is especially true of the long term care client in the community. Because of the large proportion of non-professional care givers in the institutional and community long term care sector, it is necessary that all nursing personnel who work with the elderly have a basic understanding of healthy aging so that they can better understand the potential of the elderly. It is not enough to just possess the skills to provide the required physical care. The changes associated with the normal aging process and the ability to differentiate between aging and illness is essential to the care of the elderly both in the institution and the community.

Nursing personnel provide the majority of care to the elderly in both institutional long term care and community long term care. It is the nurse who can create the environment for patients to make their own decisions and take an active role in their own care thereby fostering independence. In order for the elderly to receive care that is positive and directed toward rehabilitation or maintenance, nurses must be knowledgeable about the process of aging and not regard it as a time of deterioration and progressive helplessness. If a nurse's perceptions of the elderly are stereotyped and negative it may be difficult to provide the quality of care which is a necessary for an elderly client/patient to maintain the autonomy they so strongly desire and which is believed to be a vital component in their health. If the nursing personnel work with elderly people who have

complex physical and cognitive problems, there may be a tendency to believe that there is nothing but this to look forward to in old age. For a nurse to encourage independence and to promote a positive outlook on the future, positive feelings about the potential of that individual are required. The alternative is to accept the deterioration as a natural consequence of aging which may lead to fostering dependence; this is supported by Lowenthal (1958) who reported that incontinence in the elderly improved when the nursing staff verbalized an expectation of improvement.

Heller, Bausell & Ninos (1984) reported a significant relationship between attitudes and perceptions of care: "negative attitudes toward the aged were found to be more often associated with perceptions of custodial care while positive attitudes were found to be associated with a rehabilitative orientation" (p. 25). Interestingly in a study reported in 1989 by Harris, a weak relationship was found between more positive attitudes and higher incidence of falls on the unit. Harris postulates that the increase in falls is due to the nurses being more inclined to encourage their patients to be more independent, thus increasing the risk of falling. Hatton (1977) in a limited study found that positive scores on the Kogan Old Peoples Scale were significantly related to the quantity of interaction the nurse had with the patient, nurses with negative scores spending more time at the nursing station than nurses with positive scores.

There have been numerous studies undertaken in the United States to determine nurses' attitudes toward the elderly (Campbell, 1971; Chandler, Rachal & Kazelskis, 1986; Gillis, 1973). At the time of this study, there was limited data available on the attitudes of Canadian nurses toward the elderly although two studies carried out in

Canada were reported and the findings indicated positive attitudes toward the elderly (Armstrong-Esther, Sandilands, and Miller, 1989; Downe-Wamboldt & Melanson, 1985).

Generally it was assumed that there is little difference between nurses and their perceptions of aging in the two countries, but this was not necessarily true as the health care systems were completely different. Although there were regional differences in both Canada and the United States, generally people were able to stay at home on home care in Canada until they required more care than the family and home care could provide. In contrast to the U.S., home care in Canada was generally provided for a nominal amount which did not drain the finances of the person.

Because of the high cost of long term care in the United States, many people were not able to afford to go into a long term care facility for an extended period of time; therefore they waited as long as possible before seeking admission to such a facility. Many people stayed home using the services of home care but the cost of home care in the United States could be exorbitantly high as much of the home care was provided by private organizations that operated for profit (C. Burton, personal communication, September 2, 1992). The major difference between the two systems was that in the Canadian system, the client received required services based on need while in the American system many did not receive needed services because of cost.

With the increase in the number of elderly people who were accessing the health care system, it was important to know if the best possible care was being provided to this population group. Part of providing the best care is to be sure that nurses are positive in their approach to the client. A positive approach to the elderly client will project

confidence that elderly people can do many things for themselves and will remain as independent as possible. It is also important to ascertain the best place for the elderly to receive services and care; this decision should be based on the location where the elderly person will have the best opportunity to maximize their potential rather than based on where is the least expensive site to receive services and care. At the time of this study, there was a shift to community care for the elderly but it was not known if there was any difference between how the elderly client/ patient was perceived in the community compared to those who were in an institution. Did nurses see the elderly as more independent because they were able to remain in their own homes even though many of the home care clients required the same level of care as those in an institution?

Because of the differences between the two systems, it could not be assumed that nursing personnel in Canada held similar attitudes toward the elderly and aging than did their counterparts in the United States. Therefore it was necessary to determine the attitudes of nursing personnel toward the elderly in the three care settings in which the elderly received care in the Canadian system.

Statement of Purpose

The purpose of this study was to determine nurses' perceptions of the elderly in three different care settings and to ascertain if these perceptions were differences between the three settings. At the same time this study tried to determine if there were differences in nurses' perceptions of aging based on other factors such as age of the

nurse, job category, educational level, marital status, length of time caring for the elderly, length of time at present job and, previous experience with the elderly.

Research Questions

Based on the purpose described above, this study addressed the following research questions:

1. Is care setting a factor in nurses' perceptions of aging?
2. Does nurses' education and job category influence perceptions of the elderly?
3. Do the following factors influence the nurses' perceptions of the elderly?
    - marital status
    - age
    - personal history with the elderly
    - the amount of time the nurse spent with elderly patients each day
    - the length of time caring for elderly patients
    - preferred age group for giving care

Definition of Terms

Perception

Formal: A concept defined by Allport (1967) as a mixture of feelings, desires, fears, convictions, which provides the framework upon which a person responds and acts toward other people.

Operational: Scores on the negative and positive scale of the Kogan Old Peoples Scale and the Tollett & Adamson Aging Attitude Scale.

Elderly Person

Formal: A person of advanced years with many life experiences to share

Operational: Persons, male or female, 65 years of age or over. The term is used interchangeably with old and aged.

Nurse

Formal: Person who tends or takes care of the young, sick or infirm

Operational: Any person who delivers direct personal care, carries out treatments or administers medication to the patients/clients in the three settings embodied in this study. Nursing personnel will include the following categories of staff:

Registered Nurse (R.N.), Registered Nursing Assistant (R.N.A.), Nursing Assistant (N.A.), Personal Care Aide (P.C.A.) and/or Home Care Aide (H.C.A.). The term "nurse" will also include all of the above categories of nursing personnel, any reference to a specific category of nursing personnel will use the correct designation for their title i.e. R.N.

Acute Care

Formal: A health care setting where patients receive care in an institution from nurses and other health care professionals. Care is directed toward providing short term treatment to patients who require aggressive intervention.

Operational: The general hospital selected for this study

Institutional Long Term Care

Formal: A health care delivery setting where patients receive care in an institution from nurses and other health care professionals. Care is aimed at improving or maintaining present health status, delaying deterioration and/or providing supportive care to patients who can not be maintained in the community and no longer require acute interventions.

Operational: The extended care facility selected for this study where the

patient's need for care is determined prior to approval of admission by a home care assessor who conducts a needs assessment based on the Alberta Assessment and Placement Instrument (A.A.P.I.) (Alberta Health, 1985).

Community Long Term Care

Formal: A health care delivery system where patients receive care in the home from nurses and other health professionals who are employed by an agency external to a facility, hospital or institution. Care is either aimed at improving current health status or, maintaining the patient at the present level of health by preventing or delaying deterioration or, as an alternative to long term institutional care.

Operational: The home care program that delivers community based long term care that was selected for this study where the patient's need for care is determined prior to admission by a home care assessor who conducts a needs assessment based on the Alberta Assessment and Placement Instrument (A.A.P.I.) (Alberta Health, 1985).

CHAPTER II

LITERATURE REVIEW

Introduction

In this chapter, a review of the literature related to nurses' perceptions of the elderly is presented. Since the 1950's a number of research studies have reported attitudes to aging in the general population (Tuckman & Lorge, 1953, Kogan, 1961a). In the 1960s nurses began to research nurses' attitudes toward the elderly. One of the earliest studies dealing with this topic was reported by Brown in a report to the gerontology branch of the United States Public Health Service titled "Nurses' attitudes toward the aged and their care"(cited by Campbell in 1971). Brown reported that "the concept of aged person carried connotations of dependency, inactivity and isolation " (Campbell, 1971, p. 147). Penner, Ludenia and Mead (1983) described the concern of the public to find the reason for the possible negative attitudes toward the elderly because of an increasingly serious shortage of nurses to care for the elderly in the state of Florida.

More studies followed in the 1970s aimed at determining attitudes of nurses toward the elderly and factors that influenced these attitudes (Campbell, 1971; Gillis, 1973; Wolk & Wolk, 1971; Chamberlain, Rawls, Powell & Roberts, 1978; Robb, 1979; Gunter, 1971; Turkoski, 1983; Jorn, 1984). The contribution attributed to various factors varies considerably among studies. Some of the early studies even indicated that nurses had an attitude of rejection and depreciated the value of the elderly (Burnside,

1967; Campbell, 1971; Robb, 1979). Later in the 1970's and throughout the 1980s, nurse researchers seemed to concentrate more on changing or improving attitudes toward the elderly by implementing programs with student nurses (Eddy, 1986; Gomez, Otto, Blattstein & Gomez, 1985; Hannon, 1980; Heller & Walsh, 1976; King & Cobb, 1983; Kayser & Minnigerode, 1975; Tollett & Thornby, 1982; Wilhite & Johnson, 1976; Langland, Raithel, Benjamin, Benson, Crim & Kunz, 1986). Research on the attitudes of nursing students and staff nurses have been reported less frequently since the mid - 1980s (Giardina - Roche & Black, 1990; Harris, 1989; Pietrukowicz & Johnson, 1991). This selected review of the literature encompasses the general findings of the attitude studies focusing upon factors believed to influence nurses' attitudes toward the elderly. The influencing factors discussed in this review include: nurses' work settings, age, education, job category, previous experience working with the elderly, and experience with the elderly as a child. An overview of the more frequently used instruments used to measure nurses' perceptions of the elderly concludes the chapter.

Nurses' Attitudes Toward the Elderly

Although intermittently studied, the results of studies to measure nurses' perceptions of the elderly are contradictory and provide an unclear picture. Until the late 1960's, it was assumed that the attitudes of nurses were negative (Turkoski, 1983) but this has not been borne out by the literature. Turkoski (1983) used the Kogan's Old Peoples Scale in a study of 326 R.N.s in three different care settings. The results

indicate a mean score of 70.21 on the positive scale and 39.55 on the negative scale, both signify a positive attitude toward aging. Brower (1985) used the Kogan Old Peoples' Scale to survey 581 licensed registered nurse subjects from four types of health care organizational settings in Florida. The scores reported reflected a combination of the positive and negative scale and the scoring method is thus difficult to interpret. Brower discussed the results of the study in terms of "more positive" and "less positive"; therefore this researcher interpreted that to mean that the overall mean scores were indicative of a positive attitude. These findings were supported by Chandler, Rachal and Kazelskis (1986) who reported overall positive attitudes in a study of 101 nursing staff in two long term care facilities in Mississippi. Campbell (1971) used the Tuckman-Lorge Questionnaire to investigate the presence of negative stereotypes of the elderly by 147 nursing staff on the medical and surgical units of two teaching institutions in North Carolina. Campbell reports that "not one of the categories of nursing-care personnel included in this study demonstrated a lack of stereotyped attitudes concerning the elderly" (p. 149). It is difficult to compare the results from a study using Kogan Old Peoples' Scale with the results from the Tuckman-Lorge Questionnaire results as Tuckman-Lorge forces a "yes" or "no" answer and the Kogan tool utilizes a Likert like scale that allows partial agreement and disagreement.

A Canadian study reported in 1985 utilized the Opinions about People Questionnaire developed by the Ontario Welfare Council, Section on Ageing (Downe-Wamboldt & Melanson, 1985). The study determines the attitudes toward the elderly of 70 students beginning and 21 students completing a four year baccalaureate nursing

program, and compares them to the attitudes of 31 registered nurses entering a three year university nursing program. Downe-Wamboldt & Melanson reported that the nursing students and the registered nurses were characterized by positive attitudes toward the elderly. Armstrong-Esther et al, another Canadian research team reported that 74 nursing staff and eight volunteers of an acute care hospital held overall positive attitude toward the elderly based on the Kogan Old People's Scale.

Gillis (1973) reported generally positive attitudes toward aging of a sample of 86 nursing personnel employed in five nursing homes and one general hospital. Gillis used a modified Likert 100 -item instrument developed by Lowy in 1968 and revised by Gillis in 1972 to consist of 48 statements about the elderly. In 1978, Taylor & Harned conducted a study to determine the attitudes toward the elderly of 71 Registered Nurses in Oklahoma. They were all participants in a Conference of the Aged who were asked if they would volunteer to complete the Kogan Old People's Scale and return it by mail. The scores on the questionnaire were all within the neutral to positive range.

A study reported in 1990 found the attitudes of 40 first year student nurses and 25 trained staff members of a nursing unit caring for the elderly to be generally neutral overall (Treharne, 1990). The student subjects were more positive than the trained staff. Treharne utilized the Ageing Opinion Survey developed by Kafer in 1980; however very few details were provided about the tool other than the fact it was a Likert type scale.

Jorn (1984) utilized the Tollett-Adamson Attitudes to Aging Scale to determine the attitudes of 28 registered nurses. The findings indicated an overall positive attitude to the elderly. The Tollett-Adamson Attitudes to Aging Scale is composed of 11 positive

and 11 negative statements about the elderly and respondents use a five point Likert like scale to agree or disagree with the statements. McKenny (1984) utilized the same tool and again found that in general, the subjects demonstrated a slightly positive attitude toward the elderly.

Based on the studies, there is little evidence for concluding that nurses' attitudes toward the elderly were primarily negative. They were in fact more commonly reported as more or less positive with the exception of the Campbell (1971) study. Campbell used the Tuckman-Lorge Attitudes to Aging Questionnaire which has a vastly different format than some of the others.

Factors that Influence Nurses' Attitudes Toward the Elderly

As well as determining nurses' attitudes toward the elderly, nurse researchers have attempted to establish the factors that influence these attitudes. The findings of a selected number of researchers regarding these factors follows.

Education Level

The relationship which education bears to attitudes of nurses' shows inconsistency based on the studies reviewed. Jern (1984) reported no significant relationship between education and nurses' attitudes. This finding was supported by McKenney (1984) and, Armstrong-Esther et al (1989). Harrison & Novak (1988) found the contrary; following an eight hour continuing education gerontological nursing program 76 nurses had a

significant positive change in their attitudes toward the elderly based on the Kogan Old Peoples' Scale. Brower (1981a) found that educational levels of R.N.s do have a significant impact on attitudes toward the elderly. Nurses with baccalaureate degrees and nurses with university degrees in fields other than nursing hold more positive attitudes toward the elderly than nurses with diploma educational preparation.

Several studies undertaken with student nurses did report that education in gerontology improved students' attitudes toward the elderly. Wilhite & Johnson (1976), administered a Aging Attitude Questionnaire immediately before and after an eight week geriatric posting to 80 baccalaureate nursing students. The overall score improved following the experience. Another variable that was used was the score of their nursing instructor on the same questionnaire. Students who had an instructor with a higher score on the Aging Attitude Questionnaire scored higher than other participants. King & Cobb (1983) stated that as "students' knowledge levels increased, their negative bias toward the aged decreased, and there was a reduction in the number of misconceptions they had about the aged following a clinical rotation in gerontological nursing" (p. 292). Following a 45 hour teaching unit, 110 senior nursing students showed a highly significant improvement in pre- post-test attitude scores on the Kogan Old Peoples' Scale reported by Heller & Walsh (1976). The above findings were supported by Gomez, Otto, Blattstein & Gomez, 1985; Langland, Raithel, Benjamin, Benson, Crim & Kunz, 1986 and Hart, Freel & Crowell, 1976.

Contrary to the above findings, Tollett & Thornby (1982) reported that "students' attitudes toward the elderly were essentially unrelated to the amount of

geriatric/gerontology content in their curriculum" (p. 21). This was supported by Eddy (1986): Fifty-six baccalaureate nursing students were given the Tuckman-Lorge attitudes to Aging Questionnaire before and after a visitation program with healthy elderly clients. The post test results were not significantly different than pre-test results; however, faculty did note "many positive results relating to this curriculum change" (p. 34). In total contrast, Snape (1986) reported progressively more negative attitudes on the part of students as they progressed through geriatric nursing tuition in England.

Job Category

The variable "job category" was very closely related to education as R.N.s had considerably more education than Nursing Attendants and Licensed Practical Nurses. For the purposes of this literature review they were separated as there are some distinct differences in education with job categories i.e., some R.N.s had university degrees and some were diploma R.N.s. Gillis (1973) reported B.Sc.N.s showed less positive scores than the diploma R.N.s and L.P.N.s but a higher score than the N.A.s. The results of the baccalaureate nurses were surprising but not conclusive as there were only 10 in the sample, by far the smallest in the sample of 83, the other groups had over 20 subjects. Campbell (1971) surveyed 147 R.N.s, L.P.N.,s and N.A.s, from two teaching institutions using the 137 item Tuckman-Lorge questionnaire. The research indicated a difference in job category had an influence on nurses' perceptions of the elderly as the R.N.s were less willing to accept negative stereotypical statements about the elderly.

A small exploratory study (Kosberg, Cohen & Mendlovitz, 1972) of 26 multi-disciplinary supervisors of a large home for the aged was conducted and determined that

the Social Worker supervisory group had the most positive perception of the elderly while the difference between the mean scores for the nursing supervisory group (R.N.s) and those for supervisory group for the non-professionals was not significantly different. The researcher attributed the difference to the lower education of the R.N.s compared with that of the Social Worker supervisory staff. Phillipson and Strang (1985) conducted a larger study of multi-disciplinary care givers located in the community using a sentence completion technique. They reported "only a few responses indicated positive themes to the lives of older people...this result may indicate the existence of stereotyped views about the elderly" (p. 890). They noted a significant difference between the groups studied but found the most stereotypical view of the elderly was held by those employed in home help positions. Chandler, Rachal & Kazelskis (1986) reported that L.P.N.s were significantly more negative than either the R.N.s or the N.A.s as measured by Palmore's Facts on Aging Questionnaire.

Age

The age of the nurse is another variable which may or may not relate to nurses' perceptions of the aging patient. Armstrong-Esther, Sandilands & Miller (1989) found no relationship between age and perception in their study. This finding confirmed the findings of several other studies (Kosberg et al, 1972; Gillis, 1973; Smith, Jepson & Perloff, 1982 and Jorn, 1984). Campbell (1971) reported that older R.N.'s had a more positive perception of the elderly, but this did not hold true for other categories of nursing personnel in her study. Three other studies reported that age was related to a positive perception of the elderly, but it was the younger nurses rather than the older

nurses who were more positive (Wolk & Wolk, 1971; Thorson, Wattey & Hancock, 1974, Taylor & Harned, 1978).

Past Personal History with the Elderly

Another variable which is frequently associated with nurses' perceptions of aging is a personal history with an elderly person. Again the results are not uniform throughout the literature; Meyer, Hassanein & Bahr (1980) reported that a lack of previous experience with the elderly was related to positive perceptions of them. This is supported by other researchers (Chandler et al, 1986; Taylor & Harned, 1978; McKenny, 1984). Armstrong - Esther et al (1989) reported nurses who had contact with their parents at least monthly had a less positive perception of the elderly as measured on the Kogan Old Peoples Scale. Snape (1986) reported previous experience with the elderly had no relationship to perceptions, although rather than personal history with the elderly the findings were related to working with the elderly before nursing them. A group of pre - nursing students were administered the Tuckman - Lorge Attitudes to Aging Questionnaire. The results indicated a more positive perception of the elderly if they had previous living experience with people over 65 years of age. However, if the previous experience with the elderly was as an aide in a nursing home, they had a more negative perception (Hart, Freel & Crowell, 1976). A study of nursing students published in 1976 (Heller & Walsh, 1976) also reported a relationship between a positive perception of the elderly and a close relationships with grandparents.

Length of Time Working with the Elderly

A most discouraging finding is the reported relationship between the number of

years nurses work with the elderly and negative perceptions of the elderly. Campbell (1971) reported that the more time the nurses in her study spent with elderly patients, the more willing they were to accept the stereotypical statements. Hart et al (1976) stated that pre -nursing students had more negative perceptions of aging if they worked in an old age home before entering the program. Using a relatively unknown tool designed by Lowy in 1968 (cited in Gillis, 1973), Sister Gillis reported "the means for each group revealed a U-shaped pattern, depending on the number of employed years in care of the aged... The more positive attitude was evidenced at the beginning and end of the continuum, with the strongest positive attitude at the beginning" (p. 519). However, these finding were not supported in two other studies which found no relationship between nurses' perception of the elderly and the length of experience working with them (Jorn, 1984; Smith et al, 1982).

Setting

Brower (1981) reported significant differences in nurses' attitudes toward the elderly depending on the setting where the nurse worked. Brower's study results indicated significant differences between groups of nurses working in different health care settings. Registered nurses from nursing homes, hospitals and home care agencies completed the Kogan Old Peoples' Scale. The most positive scores were obtained from nurses employed by the Visiting Nurse Agency. They were significantly higher than all the other groups. Results from nurses employed by the Visiting Nurse Agency were significantly higher than those of nurses employed by a privately operated home care agency. Brower related this finding to the differences in philosophy between the two

agencies. Turkoski (1984) conducted a study that compared the results on Kogan's Old Peoples' Scale for 326 Registered Nurses from three different care settings; acute care, long term care and home care. The R.N.s employed by the home care agency reported significantly more disagreement with the negative statements about the elderly than nurses from either the nursing home or the acute care agency. Gillis (1973) reported a difference in results between the nurses employed in a general hospital and those employed by a nursing home. The nursing home staff had a less positive attitude toward the elderly but the differences were not at a significant level. Taylor & Harned (1978) also looked at nurses from more than one care setting and concluded that nurses working for the State Department of Institutions, Social, and Rehabilitative Services had more positive results on the Kogan Old Peoples Scale than nurses who worked in teaching or bedside nursing. Contradictory to the above, Chandler, Rachal & Kazelskis (1986) reported that the attitudes of nursing personnel are not affected by the employing agency. The Chandler et al study was conducted in two long term care institutions of different levels (skilled and intermediate). It is possible that there are more similarities than differences between these two facilities.

Instruments

The majority of studies reporting on nurses' attitudes toward the elderly have used one of three instruments; the Tuckman-Lorge Attitude to Aging Questionnaire, the Kogan's Old Peoples Scale and the Palmore's Facts on Aging Quiz. Although there is

no consensus as to which tool is preferable, there has been enough usage of each to allow for comparison of results. Some nurse researchers have chosen to use tools developed by other researchers (Gillis, 1973; Downe-Wamboldt & Melanson, 1985; Nodhturft, Banks & Macmullen, 1986; Treharne, 1990) or develop their own (Kosberg, Cohen & Mendlovitz, 1972; Buschmann, Burns & Jones, 1981; Tollett & Adamson, 1983; Snape, 1986). The following discussion will be limited to the three most widely used instruments as they are listed above and the Tollett - Adamson Attitudes to Aging Scale that was developed by nurse researchers and tested on nurses (Tollett & Adamson, 1983).

Tuckman & Lorge (1953) were the first to develop one of the well known and widely used attitude questionnaires. They developed their tool using 137 stereotypical statements about elderly people that addressed 13 categories. Respondents were asked to agree or disagree with the statement by answering "yes" or "no". There was no possibility of degrees of acceptance or rejection of the statement. There were interpretational problems with this scale because some portions of the scale were more a measure of knowledge than attitudes especially the category "physical" (Kogan, 1979; Palmore, 1977). Axelrod and Eisendorf (1961) suggested that 88 of the 137 statements were appropriate to measure attitude, the others were not useful. They used the questionnaire to measure the attitudes of college students and in the subsequent analysis found that determination of the subject's positivity or negativity was not altered by the responses on the remaining 49 questions. The original method of scoring the Tuckman-Lorge Attitude to Aging Questionnaire did not permit any differentiation between

agreement with a negative stereotypical statement (i.e. They are critical of the younger generation) or a positive stereotypical statement (i.e. They are proud of their grandchildren). Therefore an aggregate score did not indicate whether the subject agreed with all the negative statements, the positive statements or the ones related to knowledge. Several studies have been used to measure nurses' perceptions toward aging using the Tuckman-Lorge Attitude Questionnaire (Campbell, 1971; Hart, Freel & Crowell, 1976; Wilhite & Johnson, 1976; Eddy, 1986; Tollett & Thornby, 1982; Tollett & Adamson, 1982).

Palmore (1977) designed a quiz to evaluate knowledge of aging with 25 factual statements supported by research. Palmore stated that there was a clear distinction made between attitudinal and factual statements. The tool has been repeatedly criticized by other researchers as a poor measure of stereotypical beliefs about the elderly (Klemmack, 1978). While it does not appear that the original author intended the quiz to be totally a measure of attitude, its use by some nurse researchers has been a bit confusing as to whether it was intended for knowledge or attitudinal measurement or a combination of both (King & Cobb, 1983). Huckstadt (1983) used it to assess student nurses' knowledge about the elderly and Hannon (1980) used it in combination with the Kogan Old Peoples' Scale to avoid the confusion.

Kogan's Old Peoples Scale (K.O.P.S.)(1961a) has been widely used in nursing research (Dye, 1978; Hannon, 1980; Penner, Ludenia & Mead, 1983). The Kogan scale was developed with 17 paired statements, one negatively worded and the other positively worded. The respondents were requested to give their initial reaction to the statement

on a Likert type response scale. Kogan tested his tool at two different universities and reported Odd-Even reliability coefficients for the scales of the negatively and positively worded statements of from 0.66 to 0.85. There was a trend toward greater reliability for the negative scale than the positive scale. Content validity was tested with the same two groups of students; Kogan calculated correlations between scales measuring attitudes toward minority groups and physically disabled persons and between scales of authoritarianism and anomie with the Kogan's Old Peoples Scale. Anomie is the persons sense of alienation from others in their social environment. The results of the correlations were from .21 to .50 with the attitude scale toward disabled people and from .17 to .45 with the anomie scale.

The score can be computed in one of two ways; an aggregate score of the negative and positive scales combined or, a negative scale score and a positive scale score. However, defining positive or negative as a combined aggregate score is misleading as even a great deal of negative opinion can result in overall positive score. Turkoski (1983) stated that "two subjects could have identical scores and the investigator would have no way of knowing if one was more positive or more negative than the other" (p. 44). Consequently, Turkoski reported the results from the negative scale and the positive scale and compared group means on the two scales rather than one. Interestingly, there were no significant differences identified between the three groups on the positive statements but there was a significant difference on the negative statements.

Lyons (1983) acknowledged that the summary score did not indicate a true picture

of the subjects' responses but, nevertheless, based the overall conclusion on the summary score although the results of each question was reported separately. It is impossible to compare the results of studies using Kogan's Old Peoples Scale if alternate methods of scoring are used.

A more recently developed tool is the Tollett-Adamson Attitudes to Aging Scale (1983). Tollett and Adamson, both nurse researchers, had used the Tuckman-Lorge in their own research (1982) but found it was not completely satisfactory so they designed a new measurement tool. The Tollett -Adamson Aging Attitude Scale is a five point Likert-type scale with 11 positive and 11 negative statements that were not paired. Responses to an item may be scored from one to five, a higher score indicating a positive attitude toward the elderly. Tollett and Adamson ended up developing two instruments (Form A and Form B) of 30 items each. The testing of the two instruments on a group of student nurses yielded point biserial coefficients from $r = -.03$ to $r = .68$ for Form A and $r = .77$ to $r = .71$ for Form B. Alpha reliability coefficients were $r = .87$ for Form A and $r = .91$ for Form B. Items explaining less than 5% of the variance were dropped from each Form; therefore Form A ended up with 28 items and Form B ended up with 22 items.

Jorn (1984) and McKenny (1984) both made use of the Tollett-Adamson Attitudes to Aging Scale in their research. Jorn determined that her sample of 28 R.N.s from a large acute care hospital in the United States had a mean score of 80.42, and a standard deviation of 1.44. A score of 66 falls mid-point between the lowest and highest obtainable scores, Jorn classified all scores of 66 and above as indicative of a positive

perception and all scores below 66 as indicative of a negative perception. McKenny reported a mean score of 66.50 indicating only a slightly positive attitude toward the elderly in her study of 22 senior level baccalaureate students in the United States.

Summary

Since the purpose of this study was to determine the attitudes toward the elderly of nurses in three different care settings and to ascertain whether or not certain factors contributed to these attitudes, a review of the literature reporting nurses' attitudes to aging was reviewed. It was concluded that generally nurses' attitudes to aging are more or less positive. The findings regarding the factors that influence these findings were not as clear. Results with all factors that were reviewed were somewhat mixed and contradictory.

The more common tools in the determination of nurses' attitudes, as well as one less commonly used tool developed for and by nurses, were also reviewed. These tools all have some weaknesses but the Tuckman-Lorge Attitudes to Aging Questionnaire, the Palmore's Facts on Aging Quiz and Kogan's Old Peoples Scale have been widely used in the nursing research literature; therefore these measures can be frequently used for comparing results among different studies. A fourth tool was reviewed, the Tollett-Adamson Attitudes to Aging Scale; developed by nurse researchers for determining nurses' attitudes toward the elderly. This tool has not been widely used to this point.

CHAPTER III

METHODS AND PROCEDURES

Introduction

A survey design was used in this study to describe and compare nurses' perceptions of the elderly in three care settings. It was conducted utilizing nursing personnel in three varied field settings. Nurses' refers to all staff who are providing "hands on" nursing care to patients/clients in these settings. The settings are: a long term care facility; medical units within an acute care facility and; a home care program. The three sites are all situated in or close to an urban centre in Alberta, Canada. Data was gathered over a two week period at each facility during a three month interval in the spring and summer of 1990. Each participant was asked to complete two questionnaires, the Tollett-Adamson Attitudes to Aging Scale (Appendix A) and the Kogan's Old Peoples Scale (Appendix B). At the same time, participants were asked to complete an Information Sheet (Appendix C) containing questions regarding socio-demographic variables.

Settings

Long Term Care

The long term care facility was a 312 bed multi-level institution that provided for residents who required varying levels of residential care. Residents in the long term care system in Alberta were classified from A to G on a yearly basis; residents classified as

A's were relatively self-sufficient and only require minimal assistance while those classified as G's required extensive assistance in all areas. Classification was done in the fall of each year by assessors not affiliated with that facility, and the results used to determine the level of funding of nursing care hours in the following year for that particular facility. This particular long term care institution was publicly owned and operated and funding was provided by the provincial government.

At the time of data collection, the classification categories for the residents were: 9 A's; 54 B's; 28 C's; 23 D's; 55 E's; 124 F's and; 19 G's (Alberta Health, 1991). This mix placed the facility six percent above the average for long term care facilities in the province of Alberta. The mean age of the residents was 79.10 years with standard deviation of 13.90. The age range was from 19 - 105 years with only 37 residents under 65 years.

At the time of the study, there were 193 part time and full time nursing personnel employed at the long term care facility. The nursing personnel belonged to one of three categories: Registered Nurses, Licensed Practical Nurses and Nursing Attendants. In this group, 47 were Registered Nurses (R.N.), 57 were Licensed Practical Nurses (L.P.N.) and 89 were Nursing Attendants (N.A.).

Registered Nurses in Alberta had completed a minimum of two years nursing education in a community college, hospital or university school of nursing. The college programs were two years in length, the hospital based ranging from two-and-a-half to three years in length and basic university program requiring four years for completion. Registered nurses graduating from university programs held both an R.N. diploma and

a B.Sc.N. degree, R.N.s from the hospital-based and college programs could go to university and obtain a B.Sc.N. degree at a later date if desired.

Licensed Practical Nurses also came from varied educational backgrounds. Some took their training many years ago in a hospital-based setting for approximately ten months as predominately on-the-job experience with some lectures. At the time of the study the program was still ten months long but completed in a vocational college with practical experience in different hospitals in the region of the college.

Nursing Assistants were most often hired with little or no previous healthcare experience; they received on-the-job training to fulfil their job description. Their job involved providing basic nursing care and assistance in the activities of daily living to residents under the supervision of a Registered Nurse. There was a program available for Nursing Assistants delivered by the facility, but centrally developed by a vocational college. It was a competency based program, the length being dependent upon both the learner and the facility delivering the program. Upon completion of the program, the nursing assistant was classified as a Personal Care Aide (P.C.A.). The Nursing Assistant and Personal Care Aide results were not separated for this study.

Acute Care

The acute care facility was a 932 bed hospital situated in the same urban centre as the long term care facility. Only the staff on the medical units were invited to take part in the study as there were generally more elderly patients on medical units than on the other services. There were 207 medical patients evenly distributed on seven units at the time of the study; four units admitted patients under the care of internists; the other

three units predominately admitted patients under the care of general practitioners. One of the units that was used was under the services of general practitioners and was divided into programs; ten beds for Acute Geriatric Assessment and Rehabilitation and; twenty beds for patients approved for admission to a long term care facility but waiting for a bed to become available. Half of the ten Acute Geriatric Assessment and Rehabilitation beds were under the services of a gerontologist, the other half were under a general practitioner with a special interest in gerontology. The average age of patients on the seven medical floors fluctuated on a daily basis but, on an arbitrarily selected day, the average age of patients was 75.4 years of age. From discussion with the hospital staff this was considered to be typical for the area (F.Nalawajek, personal communication, December 30, 1991).

The medical units of the acute care facility employed 71 percent R.N.s and 29 percent L.P.N.s; on six of the units both categories of staff were used but the Cardiology unit employed only R.N.s. There were 124 R.N.s and 54 L.P.N.s employed to fill 115.5 R.N. and 49.7 L.P.N full time equivalent positions.

Home Care

The Coordinated Home Care Program was a provincially funded program administered by 27 boards in 27 health unit areas throughout the province of Alberta. The health units administered many public health programs such as Immunization, Dental, Speech, Public Health Inspection and, Home Care to name a few. The Coordinated Home Care Program selected was adjacent to the urban area where the two study facilities were located. The health unit area included one city of approximately

45,000 and a large rural component including five significantly sized towns of several thousand people. The caseload for the health unit where the study was conducted was 861 during the time the questionnaires were being completed (Home Care Information System, 1990). The health unit was made up of five sub-offices throughout the area; nursing personnel from all the areas were invited to take part in the study.

In four of the health unit sub-offices, Home Support Aides (H.S.A.) were employed by the health unit and were part of the home care staff, except in one sub-office area where H.S.A. services were contracted from the local Family and Community Support Services (F.C.S.S.). F.C.S.S. was funded jointly by the province and the municipal district where it was located and was administered by an appointed board of elected officials from the local governments. In order to include all the staff who provide direct care to home care clients, approval was obtained from the local F.C.S.S. to invite H.S.A.s who worked with clients of the local home care program to take part in the study. Including the H.S.A.s from the one F.C.S.S. program, there were 39 R.N.s and 40 H.S.A.s. working with the Home Care clients at the time of the study.

The Home Support Aides were hired and trained on-the-job to fulfil their duties. There was also a continuing education program developed by the vocational college for H.S.A.s while employed; all H.S.A.s in this health unit had not completed this course at the time of the study. Again as with the P.C.A.s and the N.A.s in the long term care facility, for the purposes of this study no distinction was made between the two categories of support worker in the home care program.

Sample

The target population for this study was nursing personnel providing direct nursing care in any of the three settings (long term care, acute care or home care). All full time and part time nursing personnel from the three settings working during the data collection period were invited to fill out the questionnaires.

Random selection of respondents was rejected in favour of using the entire population for the study as it was accessible and available and it was possible for the researcher to manage the number of subjects involved. In addition, the use of random selection may have limited the size of the groups. Similar studies reported 37% (Jorn, 1984) and 54% (Turkoski, 1983) return rates respectively. The number of possible respondents was the lowest at the health unit with 79 nursing personnel available. The use of random selection in this group with a low return rate might have seriously biased the results. Kirk (1982) stated that based on a power of .95 with a three group design, minimum sample size is 32 at the .05 significance level (p. 841). Kirk refers to analysis of variance which is the method of analysis that was employed to ascertain if there was a difference between the means of the three groups of nurses. The accessible population included all the nursing population from the three sites who were working during the time of the study. If a staff member was ill, on leave of absence or vacation and was not expected back within the time frame of the study, a questionnaire was not left for the individual.

During the initial data analysis, the researcher decided to exclude male nursing

personnel from the study as their numbers were so small; there were only nine from acute care, four from long term care and one from home care for a total of fourteen. Results from fourteen subjects would not have been enough to do an analysis of the male nursing personnel as a separate group and their responses might have been sufficiently different to confound the results.

Sample Profile

The sample consisted of 284 female respondents between the ages of 20 and 64 years of age, although it is noted that 22 subjects did not report their age on the Information Sheet. The mean age for the entire sample was 39.54 years. Most of the respondents were married (67.3 %). with only 15.8% single, 2.1% widowed, 12% divorced and 2.5% with "other" status. With regard to job category, 141 were R.N.s, 75 were L.P.N.s and 67 were either N.A.s, H.S.A.s or P.C.A.s (this group will be referred to only as P.C.A.s in the following paper). The subjects had worked with the elderly from as little as 0.5 hours to 17 hours each working day. Three respondents had just started at the job while all the others had been in the job for varying lengths of time up to 31 years. Sixty-six point two percent of the respondents had a close continued relationship with an elderly person as a child or teenager. Of the 284 nursing personnel involved in the study, one had no previous experience working with the elderly while the others ranged from 0.1 years to 35 years experience; the mean was 9.37 years with a standard deviation of 6.99. Seventy seven nursing personnel had a Grade 6 - 12

education; 107 were graduates of a basic R.N. Program; 25 held a B.Sc.N.; 32 had Community College education; 35 had attended a Technical Institute; one respondent reported having a Masters degree in Nursing or another discipline and; three people did not complete this portion of the questionnaire. One hundred of the respondents stated they preferred to work with the elderly, 11 preferred to work with infants; 12 preferred to work with children; 35 with young adults; 64 with middle aged adults and; 19 either did not list a preference or listed more than three age groups as their preference. Several respondents listed two groups as their preference, in these cases the first or second response was alternately selected.

To evaluate the similarity between groups, a chi square test was done on the categorical variables of marital status, age of preferred client group; level of education of subject; subject contact with elderly as a child and; job category of subjects. The chi square values along with degrees of freedom and probability are reported in the respective frequency tables for each of the categorical variables.

Results indicated there were significant differences between the three groups on marital status, educational level, preference of client and, job category of nursing personnel. The first variable, marital status, indicated a considerable difference in the number of single or unmarried nursing personnel between the three groups (Table 3.1). This can be explained in a three of ways. R.N.s often preferred to work in an acute care setting to increase their general knowledge

Table 3.1

Marital Status by Care Setting

MARITAL STATUS	ACUTE CARE	LONG TERM CARE	HOME CARE	TOTAL
MARRIED	64	76	51	191
SINGLE	35	9	1	45
WIDOWED	1	3	2	6
DIVORCED	13	17	4	34
OTHER	5	2	0	7
TOTAL	118	107	58	283
$\chi^2 = 39.41$ df=8 P(.05				

following graduation. Traditionally most have been single, although this was changing as more mature students were entering nursing programs at the time of this study. The home care group came from a rural-urban mix; many single nursing personnel did not return to work in a rural setting as they preferred to remain in the city where there was more professional and social activity. This situation may change as jobs become more difficult to obtain in urban settings.

A third reason to explain the presence of a higher number of single nurses in acute care agencies is that most hospitals tended to hire new graduates from their school program in preference to nurses from elsewhere. Because this hospital had provided an educational program known and understood by its staff, the background as well as the performance of new graduates were known quantities. Because hiring programs and orientation programs were costly, many institutions have felt that hiring their own graduates represented substantial cost saving. Some may also have felt an obligation to hire their own students.

There were more than the expected number of married people in the home care group and less than the expected number of married people in the acute care group. A factor contributing to this was significantly lower wages in the homecare setting as single people are usually self supporting and would choose the highest salaried position.

There was no significant difference noted between groups for the variable "close contact with elderly as a child" (Table 3.2). Although there was no significant difference it was noted that 30.5% of acute care stated they had close contact with an elderly person as a child while 36.1% of long term care and 34.5% of home care respondents reported

Table 3.2

Close Contact with the Elderly as a Child by Setting

CLOSE CONTACT	ACUTE CARE	LONG TERM CARE	HOME CARE	TOTAL
YES	82	68	38	188
NO	36	39	20	95
TOTAL	118	108	58	284
$\chi^2 = 2.55$ df=4 p = 0.64				

having the same experience, this is likely due to chance. Because the three care settings selected for the study all served a large elderly population, different results on this variable might be found in other health care settings where a major focus of care is other than the elderly. Nursing personnel who do not want to work with the elderly client or have limited experience with the elderly may choose one of the other care settings to practice.

The chi square for the variable "education level" indicates a discrepancy between groups (Table 3.3). The $\chi^2 = 42.25$; df = 6. This discrepancy was not surprising as there was a considerable difference in the overall education level between settings. Long term care and homecare settings were able to employ people with no previous education in healthcare and then provide on-the-job training. This practice no longer existed in the acute care sector although there were still L.P.N.s employed in acute care facilities and other healthcare settings who received on - the - job training many years ago before Grade Twelve was a requirement. At the time of this study, this group received their education through a vocational college. L.P.N. respondents who stated they had a Grade 6 - 12 education generally fit into the group of L.P.N.s who received their education on - the -job.

The difference between care settings on the variable "age of preferred client group" was quite remarkable. The majority of nursing personnel in the acute care sector preferred to work with young or middle - aged adults, while nursing personnel in the other two care settings much preferred the elderly client group (Table 3.4). In acute care 22.03% preferred the elderly as client; 74.1% preferred the elderly in long term care and

Table 3.3

Educational Level By Setting

EDUCATION LEVEL	ACUTE CARE	LONG TERM CARE	HOME CARE	TOTAL
GRADE 12 or less	14	39	28	81
B.Sc.N or other	9	8	9	26
Technical School	18	16	1	35
Community College or Hospital based R.N. program	77	42	20	139
TOTAL	118	105	58	281
$\chi^2 = 42.25$ df = 6 p(.05				

Table 3.4

Age Group Nurses Preferred to Work with by Setting

PREFERRED AGE OF CLIENT	ACUTE CARE	LONG TERM CARE	HOME CARE	TOTAL
INFANTS	6	5	0	11
CHILDREN	6	4	2	12
YOUNG ADULTS	29	4	2	35
MIDDLE AGED ADULTS	51	4	9	64
ELDERLY	26	80	37	143
MISSING VALUES	0	11	8	19
TOTAL	118	108	58	284
$\chi^2 = 115.66$ df = 10 $p < .05$				

63.8% preferred the elderly in homecare.

Job category of staff was the final ordinal variable included on the Information Sheet. The most notable discrepancy was the unequal representation of the job categories in the acute care group (Table 3.5). This was an expected finding as there are differences in hiring patterns between the settings. In acute care there were many more duties that required the expertise of a R.N. as opposed to the long term care and the home care setting. Many of the nursing tasks associated with the long term care and the home care setting were assistance with personal care and did not specifically require the services of an R.N. In the acute care setting there were no members of the N.A./P.C.A./H.S.A. group hired by the hospital because they were not able to perform the more complex nursing tasks that the R.N. and the L.P.N. were able to perform. The acute care settings in the area of this study discontinued the hiring of the N.A./P.C.A./H.S.A. group because of their lack of flexibility to perform these more complex tasks. In Table 3.5, the long term care group has the least discrepancy reported, however the N.A./P.C.A./H.S.A. group did not respond in the same proportion as the other two groups as there were only 24.4% R.N.s and 46.1% at the time of the study but 32.7% R.N.S and 36.5% N.A.s responded.

Since "age of the nurse", "hours a day working with the elderly", "length of time at the job" and, "years caring for the elderly" was treated as interval data, an analysis of variance (ANOVA) was used to determine if there was a significant difference between the three settings on these variables. Tables 3.6 to 3.9 provides a summary of the ANOVA results.

Table 3.5

Job Category by Care Setting

JOB CATEGORY	ACUTE CARE	LONG TERM CARE	HOME CARE	TOTAL
R.N.	77	35	29	141
L.P.N.	41	33	1	75
N.A./P.C.A./ H.S.A.	0	39	28	67
TOTAL	118	107	58	283
$\chi^2 = 79.29$ df = 4 $p < .05$				

The average age of the respondents was 39.54 years of age. There was an appreciable difference between the age of the respondents in the acute care setting and the respondents from the other two sites (Table 3.6, Table 3.7). Nursing personnel from the acute care setting had an average age of 34.76 years; a sharp contrast from respondents in long term care with an average age of 43.23 years and home care with an average age of 43.04 years. The differences might be attributed to many of the same factors discussed above regarding differences in marital status between sites. Generally it could be assumed that single nursing personnel were younger than the married respondents. Younger staff appeared to show a preference for working with more acute patients in the acute care; the findings were consistent with this tendency. Also, as there was more shift work required of nursing personnel in an acute care setting, often young mothers found night and evening shifts easier to manage as husbands were usually home in the evening and/or night to assume responsibility for the children. As mentioned previously, many new diploma nursing graduates were hired to fill vacancies in the organization upon graduation. Long term care and home care did not have schools of nursing and would not draw from this pool of primarily young newly-qualified nurses.

It was not common for new graduates of R.N. and L.P.N. programs to seek employment in long term care facilities immediately following graduation. They were often more interested in gaining experience in general hospitals, as many new graduates believed that going to work in a long term care facility caused them to "lose their nursing skills". Unfortunately there was a perception in the past that nurses working in long term care agencies did so because they were unable to manage in an acute care facility.

Table 3.6

Age of Nurses By Care Setting

CATEGORY	ACUTE CARE	LONG TERM CARE	HOME CARE	TOTAL RESPONDENTS
MEAN AGE	34.76	43.23	43.04	39.54
STAND. DEV.	10.23	7.68	8.42	9.89
RANGE	20 - 59	25 - 60	28 - 64	20 - 64

Table 3.7

Analysis of Variance for Age of Nurses by Care Setting

SOURCE	DF	SUM OF SQ.	MEAN SQ.	F RATIO	PROB.
Between groups	2	4535.74	2267.87	27.96	0.00
Within groups	259	21007.38	81.11		
Total	261	25543.12			
Scheffé Contrasts - Significant differences between Group I (AC) and Group II (LTC) and between Group I and Group III (HC)					

There might still be remnants of that disparaging view of long term care nurses. If that was true, it might have been another reason for young, less experienced nurses to shy away from the long term care experience.

Home care nurses practised quite autonomously; consequently they required experience and confidence in their nursing skills, especially related to client assessment. Thus, less experienced nurses also did not receive encouragement to work in the home care setting. Many of the nurses who were recruited to work in home care moved from fairly recent hospital experience into the home care field as they had the necessary skills.

The variable "hours a day working with the elderly" was significantly different between groups (Table 3.8, Table 3.9). The mean for home care mean was 5.60, a figure that was considerably lower than in the other two settings. The reason for this was likely the structure of work in home care as opposed to the other two settings. Nursing staff from home care spent a considerable amount of time on the road travelling between clients; therefore their contact hours with the clients were less than those of nurses in other types of settings. Nursing personnel who were employed in either an acute care hospital or a long term care facility found all their patients/residents in the same area and therefore were able to spend the whole working day with clients. Travel time between clients might have offered home care nursing personnel an opportunity to evaluate interactions with clients, assess client problems, plan for the next client, as well as an opportunity to relax and change focus.

In the acute care setting, "mean hours working with the elderly" was the highest

Table 3.8

Mean Number of Hours a Day Working with the Elderly by Group

	ACUTE CARE	LONG TERM CARE	HOME CARE	TOTAL RESPONDENTS
MEAN HOURS	8.66	7.25	5.60	7.50
STAND. DEV.	2.87	2.02	2.28	2.71
RANGE	0.5 - 16	3 - 16	2 - 17	0.5 - 17

Table 3.9

Analysis of Variance of Mean Number of Hours Working with the Elderly by Group

SOURCE	DF	SUM OF SQ.	MEAN SQ.	F RATIO	PROB.
Between groups	2	371.85	185.93	30.81	.00
Within groups	276	1665.44	6.03		
Total	278	2037.29			
Scheffé Contrasts - Significant differences between Group III (HC) and Group I (AC) and between Group III and Group II (LTC) Scheffé Contrasts - Significant difference between Group II and Group I					

of all three groups at 8.66 hours. This probably reflected the use of twelve hour shifts in the facility. Both eight and twelve hour shifts were used on the medical floors of the acute care facility. The mean for the long term care facility was 7.25 hours and fairly closely reflected the time nursing personnel spent with residents in an eight hour working day.

"Mean length of time at present job" again was significantly different between groups (Table 3.10, Table 3.11). At 3.89 years, nurses in home care had spent the least amount of time working in their positions in the three settings. Nurses working in long term care had been in their positions an average of 8.72 years and those in acute care, 6.77 years; the overall mean for all groups was 6.83 years. The Coordinated Home Care Program in Alberta came into existence in 1979. While the program was very small in the beginning, there has been continued expansion over the years. Fairly substantial changes to the program occurred in the two to three years prior to this study. This was probably reflected in "mean length of time at present job" since there was gradual growth of the program since 1979 included taking on of new staff. With increased funding of the program in the past five years, many new positions were created. Those were undoubtedly all factors of some importance here. After the home care program has been in existence for a greater length of time, there might be some changes in this variable.

A Scheffé contrast was completed following the analysis of variance (Table 3.8), the results reported a significant differences between group one (AC) and group three (HC) and between group two (LTC) and group three (HC). The difference between

Table 3.10

Nurses Length of Time in Present Job by Group

CATEGORY	ACUTE CARE	LONG TERM CARE	HOME CARE	TOTAL RESPONDENTS
MEAN TIME IN YRS	6.77	8.72	3.89	6.92
STD. DEV.	6.82	6.22	3.33	6.26
RANGE	0 - 31	.25 - 30	0 - 12	0 - 31

Table 3.11

Analysis of Variance of Length of Time in Present Job by Group

SOURCE	DF	SUM OF SQ.	MEAN SQ.	F RATIO	PROB.
Between groups	2	881.92	440.96	12.15	0.00
Within groups	279	10122.53	36.28		
Total	281	11004.46			
Scheffé Contrasts - Significant differences between Group III (HC) and Group I (AC) and between Group III and Group II (LTC)					

"length of time at present job" in acute care and long term care was not unexpected. The increased movement within the acute care sector may have been partially due to the composition of the staff with a greater proportion of younger nursing personnel. The staff in long term care was older on average and most were likely working in their position of choice. However due to the diversity of services within the acute care sector, staff may not necessarily have been working on the service of their first choice and may have been waiting to transfer to a service of their choice. This was supported by the findings reported in Table 3.4 where significantly lower numbers of nursing personnel in the acute care sector selected the elderly as their "preferred group".

The final variable from the Information Sheet was "mean years caring for the elderly". Again there were significant differences (see Table 3.12, Table 3.13) where the mean for home care staff was 8.00 years, for long term care staff, 11.27 years and for acute care staff, 8.30 years. The considerable difference between the three sites likely reflected some of the factors previously discussed. Nursing personnel were younger in the acute care setting than those in long term care and therefore did not have as much nursing experience; as well, they were more mobile as evidenced in Table 3.8.

Nursing personnel in the home care setting had the most experience working with the elderly previous to their present employment (Table 3.8 and Table 3.9). They had been in their present job for an average of 3.89 years but they had been working with the elderly an average of 8.00 years. Thus, they had worked with the elderly an average of 4.11 years prior to assuming their present position in the home care program. Nursing personnel in long term care had worked at their present job longer, but they did

Table 3.12

Mean Number of Years Caring for the Elderly by Group

CATEGORY	ACUTE CARE	LONG TERM CARE	HOME CARE	TOTAL RESPONDENTS
MEAN YEARS	8.30	11.27	8.00	9.37
STD. DEV.	6.87	6.61	7.10	6.96
RANGE	.5 - 35	0 - 30	.1 - 30	0 - 35

Table 3.13

Analysis of Variance of Mean Number of Years Caring for the Elderly by Group

SOURCE	DF	SUM OF SQ.	MEAN SQ.	F RATIO	PROB.
Between groups	2	623.54	311.77	6.7	0.00
Within groups	276	12838.55	46.52		
Total	278	13462.09			
Scheffé Contrasts - Significant differences between Group II (LTC) and Group III (HC) and between Group II and Group I (AC)					

not have as much previous experience with the elderly before taking the position in long term care. Long term care nursing personnel had worked with he elderly 11.27 years and had been in their present job for 8.72 years, indicating that they had worked with the elderly an average of 2.55 years before beginning their present job.

Acute care nursing personnel had spent the least time working with the elderly prior to their present job. The mean length of time working with the elderly for this group was 8.30 years while their mean length at their present job was 6.77 years; thus they had worked with the elderly an average of 1.53 years before taking their present position.

Instruments

Two questionnaires were used in this study to measure attitudes towards aging in nursing staff: Kogan's Old People Scale (K.O.P.S.)(Appendix B) and the Tollett - Adamson Attitudes to Aging Scale (T.A.A.A.S.)(Appendix A). A demographic Information Sheet (Appendix C) developed by the researcher was also completed by all the respondents. The K.O.P.S. was developed in the late 1950s and was first published in 1961 (Kogan, 1961a). It was developed to assess attitudes toward elderly people with respect to norms and individual differences, stereotypes of the elderly and, misconceptions about the elderly. Kogan produced the tool based on his belief that the elderly occupied a minority group status in the United States, and therefore were stereotyped in much the same way as ethnic, religious and racial minorities. Because

of his belief that the elderly were another minority, Kogan developed many of the statements contained in K.O.P.S. from other tools used to measure stereotypical attitudes toward other minority groups such as the mentally ill, Black-Americans, the deaf and the disabled. Kogan and others added statements they had developed because of their intuitions regarding stereotypes and feelings about elderly people in society. Besides the minority group model, Kogan incorporated questions which reflected such personality dimensions as autonomy, achievement, nurturance, self-esteem and misanthropy; "subjects more favourably disposed toward old people were expected to exhibit stronger tendencies toward self-esteem and nurturance, while subjects more unfavourably disposed were expected to have stronger needs with respect to misanthropy, autonomy and achievement" (Kogan, 1961a, pp. 44-45).

The K.O.P.S. instrument is a Likert scale of 34 short statements (17 positive - negative paired questions where the positive statement and the negative statement are opposites). The pairs deal with the following: residential patterns, discomfort in the company of the elderly, differences amongst elderly people, cross-generational relationships, dependence, cognitive style and capacity and, appearance and personality of elderly people.

There are six response categories in the original tool: strongly disagree (scored one), disagree (scored two), slightly disagree (scored three), slightly agree (scored five), agree (scored six) and, strongly agree (scored seven); failure to respond was scored a four. The scale is a self-administered pencil and paper test with no suggested time limit. The negative and positive statements are scored separately, although some researchers

have chosen to use a combined score rather than the two separate ones (McTavish, 1982). McTavish reports that some researchers have used only one of the sets of statements, rather than using both the negative and the positive set. The researcher used the K.O.P.S. as recommended by Dr. Kogan as no articles were located that used only the positive or negative scale.

Kogan originally tested his instrument on three samples of psychology students at two separate universities: (1) 128 males, (2) 186 males and, (3) 87 males and 81 females. Following this testing, Kogan (1961b) used another sample of 89 males and 115 females from the Age Centre of New England in Boston. The mean age of the respondents was 71 for males and 68 for females. Since this early testing by the developer of the instrument, K.O.P.S. has been used extensively with college students and in the healthcare field (McTavish, 1982).

In this early testing of the instrument, Kogan (1961a) stated that the subjects more strongly disagreed with the negative statements than they agreed with the positively worded statements. A t-test for the statistical significance of the overall mean differences yielded t values which were significant at the .01 level in each of the three original samples. The students also tended to be more positive than negative in their attitudes toward the elderly.

In Kogan's original three samples, the Odd - even Spearman - Brown reliability coefficients for the negative scales were 0.76, 0.73 and, 0.83 while the reliability coefficient for the positive scales were 0.77, 0.66 and 0.73 (Kogan, 1961a). Higher reliability was demonstrated for the negative scale than for the positive scale in this early

testing. Kogan also reported interscale correlations for the three groups at 0.51, 0.52 and, 0.46 respectively.

Two forms of validity were established by Kogan. The first was a correlation of the scales with other variables and the second, correlation of scales with later behaviours. Kogan (1961a) explained his results as follows:

> A number of statistically significant relationships that were observed between attitudes toward older people and other attitudinal and personality variables are partially attributed to response set effects. We were forced to conclude on this basis that no clear consistent relationship obtained between authoritarianism as measured by the F scale and attitudes toward old people. On the other hand, unfavourable attitudes toward old people were associated with feelings of anomie, and negative dispositions toward ethnic minorities and a variety of physically disabled groups. A nurturance factor derived from a brief personality inventory given to the subjects was significantly correlated with the K.O.P.S. scores; the more nurturant subjects being more positively disposed toward old people (pp. 53-54).

Permission was received from Dr. Nathan Kogan to use the K.O.P.S. in this study (Appendix D). Due to this author's opinion that the term "old" would elicit a rebound positive reaction to the questions based on terminology rather than the subject's response to the statement, the term "elderly" was substituted for the term "old" throughout K.O.P.S. with the permission of Dr. Kogan (Appendix E). Dr. Kogan wrote to the author with his permission and also commented that it was a change that he

thought should be made in order to update the instrument. He also suggested there were other changes that should be made although he did not volunteer what these should be.

The scoring of the K.O.P.S. for this study was adjusted as the author did not believe that the "no response" category would ensure that the respondent would be neutral toward the statement. In this study, a "no response" was treated as a missing value. Responses were scored as: strongly disagree (one); disagree (two); slightly disagree (three); slightly agree (four); agree (five and; strongly agree (six). In this study 3.5 was the mid-point on the scale and was considered to be neither negative nor positive. Thus, persons who identified with positive statements and reported a high positive score should theoretically report low scores on the negative scale, indicating disagreement with negative stereotyping.

Two scoring methods were suggested by Kogan; one was to obtain one sum score including both the positive and the negative statements. The second method treated the negative and positive statements separately or, as sub-scales of the tool. The first method did not indicate the strength of the positiveness or negativeness of the attitude. Turkoski (1985) chose the second scoring method and justified her choice with the following discussion:

> With a single determinant a subject could have a score of 119 derived from 19 positively rated positive questions (6 x 17) and 17 negatively rated negative questions (17 x 1), indicating a very positive attitude toward the elderly. The same 119 could, however, also be derived from 17 positive scores of 4 (17 x 4) indicating marginal agreement with positive statements, and 17 negative scores

> of 3 (17 x 3) indicating very slight disagreement with the negative stereotypes of elderly persons. Thus, two subjects could have identical scores and the investigator would have no way of knowing if one was more positive or negative than other. It can be easily understood that using a single summed score really does not tell the researcher anything explicit about the subject's attitude (pp. 43-44).

As Turkoski presented a reasonable case for using the second scoring method, it was selected for use in this current study.

The second instrument (T.A.A.A.S.) used in this study was developed by Tollett and Adamson in 1983 at Texas Women's University, Houston. The scale used for this study (Form B) was made up of 22 statements about elderly people: eleven statements were positively worded and 11 statements were negatively worded. Although there were equal numbers of positive and negative statements, they were not matched pairs. The scale was developed through a process that started with the formation of a panel of experts consisting of experts in gerontology, geriatrics, geriatric nursing and a psychometrician (Tollett & Adamson, 1983). Based on an extensive literature review and the advice of the expert panel, a battery of 250 items was assembled. The 250 statements were divided into two tests of 125 items each. Thirty-five nursing students received Form A and 40 students received the other 125 statements on Form B. The coefficient alpha for reliability was calculated as r= 0.90 for Form A and r= 0.93 for Form B. Point biserial correlation coefficients were used as initial tests of the instrument's validity. Items with a positive point biserial correlation coefficient of 0.5

or more were retained. In the article by Tollett and Adamson describing the construction of the instrument, there was no rationale provided for the use of a positive point biserial correlation coefficient of 0.5 even though the cut-off point of 0.25 and above is normally used in test construction (Tollett & Adamson, 1983). An equal number of positive and negative statements were maintained on each form.

Based on the findings on the first testing, 30 items were used on each form and administered to 28 graduate nursing students. At the same time demographic data was collected on each respondent. Of the 25 demographic variables, only one, political orientation, demonstrated a significant difference in attitudes to the elderly. Respondents with the most liberal political orientation had the highest mean score on the scale indicating a more positive attitude toward the elderly.

Factor analysis was employed using the remaining statements on both Form A and Form B. There were nine factors identified on Form A; eight of the nine factors accounted for 95.5% of the total variance. Factor one and two were constructs relating to interaction with others and isolation; these two constructs accounted for 47.6% of the total variance. The remaining seven factors were entitled sensory loss, relationships with others, generosity, usefulness, egocentricism, dogmatism and physical activity (Tollett & Adamson, 1983).

On Form B, seven of eight factors accounted for 95.9% of the total variance. Factor one was labelled **interaction with others** and accounted for 45.9% of the total variance. The seven other factors were named as follows: **future orientation, conservatism, independence, egocentrism, flexibility, dogmatism** and **sexuality.**

Factors with less than five percent explained variance were dropped from the tools in their final form. The finalized Form A contained 28 items and Form B contained 22 items. Form B was used in this study (Appendix A).

In 1984, McKenney reported that following the administration of Form B of the T.A.A.A.S. to 22 nursing students at the university, Cronbach's Coefficient Alpha was 0.22, far below the original results described by the authors of the tool. McKenney used the T.A.A.A.S. and Aging Semantic Differential developed by Rosencranz and McNevins in 1969 in order to establish the concurrent validity of the T.A.A.A.S. The original authors of the Aging Semantic Differential did not address either reliability or validity in their article describing the tool (McKenney, 1984). The correlation coefficient between the two instruments in the McKenney study was 0.44. The study concluded that the T.A.A.A.S. needed to be further tested on groups to establish satisfactory levels of reliability. This researcher decided to use Form B as both McKenny (1984 and Jorn (1984) had done in order to compare the results. There were no studies located that had used Form A. Permission to use Form B of T.A.A.A.S. was obtained from the first author, Dr. Susan Tollett (Appendix F). This researcher did obtain the unpublished manuscript describing the development of this instrument from Dr. C. Adamson at a later date (Tollett & Adamson, 1983).

The scoring of T.A.A.A.S. is carried out using a five point Likert Scale. The scoring for the statements is as follows: strongly Disagree (one); disagree (two); neutral (three); agree (four) and strongly agree (five). In this study 3.0 was the mid-point on the scale and was considered neutral. The highest score achievable on each sub-scale

was 55 and the lowest was 11. Thus, persons who identified with positive statements and reported a high positive score should theoretically report low scores on the negative scale, indicating disagreement with negative statements. Persons who disagreed with the positive statements would achieve a low score on the positive sub-scale and likely have a higher score on the negative sub-scale.

It was not entirely clear what method of scoring was preferred by the authors of the tool. However, Jorn (1984) stated the positive statements should be scored in a similar fashion to the K.O.P.S. with the highest score being assigned to strongly disagree and that negative statements should be scored in the opposite order. Thus, scoring would be carried out as follows: strongly agree (one); agree (two); neutral (three); disagree (four) and; strongly disagree (five). It was assumed that this was the manner the original authors preferred, as one of them (Adamson) was on Jorn's thesis committee. In this study, the researcher used the same scoring system for both the positive and negative statements of T.A.A.A.S. Comparisons could thus be made more easily as the scoring system was similar to the K.O.P.S.

If the scoring was done as Jorn (1984) suggested, the score on the positive scale would be high for a person who generally agreed with the positive statements; however the score would be low for someone who generally agreed with the negative statements. Jorn (1984) analyzed the negative and positive statements together as one scale; however, this researcher separated the two sub-scales for the same reasons as were described earlier by Turkoski (1983) relative to the discussion of the use of the K.O.P.S. This same reasoning is applicable to the T.A.A.A.S.; therefore it makes more sense to have

the scoring done on the two tools in a similar manner to eliminate any confusion that might occur in using two scoring methods.

For this study, this author decided to use both K.O.P.S. and T.A.A.A.S. even though they were both developed to measure attitudes toward the elderly. T.A.A.A.S. was developed for and tested on nurses but had limited documentation of use. The K.O.P.S., on the other hand, had been used extensively. Many published studies document findings acquired through use of this instrument. For these reasons, it seemed appropriate to use the two instruments in the study.

Procedure

Ethical approval was obtained from the Faculty of Nursing of the University of Alberta (Appendix G). Following initial approval from the Faculty of Nursing, approval was obtained from the acute care hospital, the long term care facility, home care and the F.C.S.S. Program involved. Data collection was carried out from the middle of May until the end of June 1990 at the acute care facility; from middle of July until the end of August 1990 at the long term care facility and, mid-June to mid-July at the home care program.

After approval by the individual organizations, each was contacted and a meeting set up with the administrative staff to discuss the study. A second meeting was arranged for the researcher to discuss and explain the study with the unit/area supervisors and to gain their support. Beginning with the acute care facility, a time was arranged for the

researcher to go to each unit and explain the study to the nursing staff on duty that day. The session held to give the explanation took approximately fifteen minutes and was held on the unit. After the explanation, the unit supervisor informed the researcher of the number of questionnaires to be left on each unit; the only staff not counted were those on holidays, off ill or on Worker's Compensation. A pre-arranged place for the questionnaires to be left after their completion was decided upon by each unit supervisor. The researcher picked up the questionnaires two weeks following their distribution. All completed and non-completed forms were returned to the researcher. The procedure was the same for the acute care and long term care facilities.

Due to the geographical location of the five sub-offices of the health unit, a different procedure was followed. All the R.N.s were to be in one sub-office for an all day inservice session at which the manager of the home care program invited the researcher to attend and explain the study. Following the explanation the questionnaires were left with the nurses and collected at the end of their session that same day.

The H.S.A.s were not at the inservice session therefore their questionnaires were distributed at a later date. The H.S.A.s were located throughout the health unit area and it would have been very difficult to meet with them during the data collection period. Their supervisors were R.N.s who took part in the orientation to the study at the inservice session. Because they are the only people in the system who meet with all the H.S.A.s, they were asked to explain the study and distribute the questionnaires. The H.S.A.s took their questionnaires home and brought them in the next time they were to be in the office.

The final group were the H.S.A.s employed by F.C.S.S. who cared for clients in the home care program selected for this study. The researcher went to the small town where the program was situated and met with the "homemaker supervisor". Following the explanation of the study the supervisor took the questionnaires and distributed them to the H.S.A.s. Because of problems with distance, the H.S.A.s were all given the forms; if they did not want to participate in the study, the questionnaires were not returned to their supervisor.

All the questionnaires were put in a brown envelope along with the Information Sheet and the Explanation of the Study (Appendix H). The Explanation of the Study provided nursing personnel who had not been able to attend the orientation sessions with basic information about the study, the name and phone number of the researcher and the name and phone number of the thesis supervisor.

The two questionnaires were copied on different coloured paper to assist the researcher to distinguish them at a glance. Half of the respondents received the K.O.P.S. before the T.A.A.A.S.; the other half of the respondents received the questionnaires in reverse order. This was done to try and get the same return on both questionnaires. It was thought possible that the respondents might get tired of filling out the forms and quit after one. This method would also eliminate the constant influence of the questions from the first form influencing the response to the second form.

The respondents could not be identified after the return of the questionnaires. In order to identify the field setting from which each questionnaire came, the envelopes and questionnaires were numbered thus:

1. AC 000 - AC 200 For nurses in the acute care setting;
2. LT 201 - LT 400 For nurses in the institutional long term care setting and;
3. HC 401 - HC 500 For nurses in the community long term care setting.

Protection of Human Rights

This project received ethical clearance from the Ethics Review Committee, Faculty of Nursing of the University of Alberta (Appendix G). Participation in this study was voluntary. There were no ramifications for the staff based on participation or non-participation in the research. The questionnaires were left on the unit or centre where the staff were located except for the H.S.A.s who were all given a questionnaire. In all circumstances the researcher was unaware of who completed and returned the forms. In all cases the respondents were in an orientation session and/or provided with a copy of the Explanation of Study which outlined the purpose and the content of the study.

Individual consents were not obtained from each respondent, and the return of the completed questionnaire was considered as consent to take part in the study. No coercion or soliciting of responses took place. This method of obtaining consent was chosen because there is no way of identifying respondents from their response sheets. All individual questionnaires were to be destroyed at the completion of the defense of this

thesis, but copies of the raw date were to be retained on disk for the possibility of further work in this area at a later date. Before the completion of secondary analysis of the data in further research, ethical clearance would need to be obtained from the University of Alberta.

It was specified in the beginning that only collective findings would be used in presentations, discussions and publications. No individual information would be revealed at any time from this study. In addition no indication of the location of the sites of the study was to be revealed in presentations or publication. Because of this the name of the city and rural-urban area used in this study was not included.

Data Analysis

Data from the Information Sheet (socio-demographic variables), and the responses to K.O.P.S. and the T.A.A.A.S. were entered into SPSS 4.0 using Data Entry II. The data was then analyzed using the SPSS 4.0 software package. Descriptive statistics such as the means, ranges, frequencies and standard deviations for each of the three groups and for the total sample were summarized and presented in tables in Chapter III under Sample Profile. Differences between the groups were identified through an analysis using chi-square or ANOVA depending on the level of the data. A discussion of the findings was also included under that same section.

In an effort to answer the research questions the following analyses were conducted to ascertain the shared contribution of the interval data scores on the dependent

variables (score on the positive and the negative scales on K.O.P.S. and T.A.A.A.S.). Analysis of variance was done on the mean score of the negative and positive statements of the K.O.P.S. the T.A.A.A.S. by group setting. This was executed to determine if there was a difference between the three groups on their aggregate scores. As there were significant differences determined, Scheffé Contrasts was carried out to ascertain where these differences were located. Analysis of variance was also done on the mean scores of the negative and positive scales for K.O.P.S. and T.A.A.A.S. by job category and education level to determine if there were differences in the perception of aging based on these two variables. Following the analysis of variance, a stepwise regression was carried out to ascertain whether scores on the negative and positive scales of the two instruments could be predicted by the scores on the following four variables: "Preferred age of client", "length of time at present job", "hours a day working with the elderly" and, "years caring for the elderly". A one way analysis of variance was carried out to determine if there were differences in perceptions of aging based on the variables "marital status", "age of the nurse" and "previous experience with the elderly as a child".

Reliability was calculated for the negative and positive scales for both instruments. Cronbach's alpha coefficient was used to establish internal consistency between statements and the attribute measured on the negative and positive scales of the two instruments. Reliability was also calculated for the T.A.A.A.S. as a single scale instrument as it has always been used in this manner in previous studies. K.O.P.S. was not analyzed as a single scale as it was designed by the authors to be used as two scales. Following this, correlations between the matched pairs of statements on K.O.P.S. were

calculated. A correlation was also calculated between the positive and negative scales of the same instrument and, between the two positive scales and the two negative scales on the two instruments used. Finally, a correlation was performed on the paired statements in K.O.P.S. The results of the statistical analysis are presented in the next chapter.

CHAPTER IV

RESULTS AND INTERPRETATION

Introduction

In this chapter the response rate for the study is reported followed by a brief discussion on the technique used to encourage responses. Establishing the reliability of the two questionnaires used in this survey was important to the integrity of the study and is presented prior to the results of the analysis. A discussion of each instrument is presented in Chapter Three as two separate scales, one positive and one negative; the reliability coefficients are reported in this manner as well. Following this, a discussion of the results of data analysis is presented in relation to the research questions as in Chapter One. At the conclusion of this chapter, a discussion of the relationship between the scores on the negative and positive K.O.P.S. and T.A.A.A.S. as well as the relationship between the two negative scales and the two positive scales is put forward. A brief discussion regarding the use of T.A.A.A.S. as encompassing both a positive and negative scale as compared with its use as a solitary scale is presented.

Response Rate

For all variables a "missing value" was incorporated during the coding to allow for accurate analysis. There were 39 "missing values" on the Information Sheet out of a possible 2,840 responses (1.37%); on the K.O.P.S. there was a possible 9,656

responses with 136 "missing values" (1.41%) and; on the T.A.A.A.S. there was a possible 6,248 responses with 104 "missing values" (1.66%). The completion rates were quite uniform, probably due to the alternating order of the questionnaires in the package. Each respondent was presented first with the Information Sheet, but following that, half of the questionnaires had the K.O.P.S. questionnaire first and the T.A.A.A.S. questionnaire second; the other half of the packages used the reverse order for the questionnaires. Some respondents did not complete the second questionnaire; thus, ordering the questionnaires in this manner controlled for the possible effects of extraneous variables that might be introduced by presenting the questionnaires to all respondents in a fixed order. The overall response rate on the questionnaires was 76.74%.

The procedure used to present the study and ask for the cooperation of the staff is described as follows. The researcher went to each nursing unit at the two facilities and gave a short explanation to the staff who were on duty. This process was further enhanced by the researcher spending some time with the nursing unit supervisors/home care manager to give them an opportunity to ask questions, express any concerns and to gain their support before the study was explained to the staff. All supervisory staff were extremely supportive and introduced the researcher in very positive manner to the nursing personnel who were then invited to fill out the questionnaires. It would have been difficult for the staff to complete the questionnaires if the supervisors were not supportive of the study. Only those providing direct nursing care were included in the study. The process was slightly different in the home care setting as some sub-offices were a

considerable distance from the city. A personal explanation was given to the R.N. participants as they gathered for an inservice education session at one of the sub-offices close to the city. The researcher was unable to meet with the other respondents from the home care program personally but offered to be available by telephone for anyone choosing to phone. The researcher's phone number was provided in each package for any respondents who wanted further explanation (Appendix H).

The positive environment the researcher encountered in the three settings was reflected in the excellent response rate obtained which was considerably higher than in two similar studies by Jorn (1984) at 21.5% and Turkoski (1983) at 54% . The Jorn project studied one acute care facility while Turkoski sampled three different settings of the same type as selected for this study. The details of the distribution and response rate for this study are summarized in Table 4.1.

Both acute care and the home care group had a ratio of respondents in each category that was relatively equivalent to the staff mix in the facility; this is not the case for group two. There is a staff mix of approximately 24.4% R.N.s; 29.5% L.P.N.s and 46.1% N.A.s in the long term care facility but the respondents were 32.7% R.N.s, 30.8% L.P.N.s and 36.5% N.A.s. This meant that R.N.s had a higher response rate

Table 4.1

Response Rate By Group

CATEGORY	QUESTIONNAIRES DISTRIBUTED	COMPLETED QUESTIONNAIRES RETURNED	PERCENTAGE RETURN
ACUTE CARE	171	127	74.26
LONG TERM CARE	146	111	76.02
HOME CARE	70	59	84.29
TOTAL	387	297	76.74

than the other two groups; the L.P.N.s responded in approximately the same proportion as their staffing pattern, but the N.A.s under responded. This may be due to the R.N.s higher interest and knowledge about research or, the N.A.s might have felt they had nothing to contribute to the research. The P.C.A./N.A. group also might not have been as oriented to pencil and paper tests as the R.N. group. Because of the over representation of R.N.s in group three, an attempt was made to determine if the overall group three score was affected by this uneven representation.

Of the 297 questionnaires returned, 13 were unusable because they were from male respondents and did not comprise a sufficiently large comparison group. Also, male respondents were not evenly distributed across the three settings; the largest number (9) were from acute care. If the responses were different than those of female respondents, it might have influenced the overall acute care response although not those of the other groups. Because of these reasons, it was decided to drop them from the study.

Reliability of the K.O.P.S. and the T.A.A.A.S.

In this study, the K.O.P.S. reliability coefficient (Cronbach's alpha) for the positive scale was 0.71; the negative scale indicated higher internal consistency with a Cronbach's alpha of 0.87. In three initial studies by Kogan using his own tool, the Odd-Even Spearman-Brown reliability coefficients for the positive scale were 0.77, 0.66 and 0.73 and those of the negative scale 0.76, 0.73 and, 0.83 (Mangen & Petersen, 1982).

In this study, the reliability coefficient (Cronbach's alpha) for the positive scale T.A.A.A.S. was 0.73 and 0.75 on the negative scale. The original authors did not separate the tool into a positive and negative scale; their initial testing yielded an alpha reliability coefficient of 0.93 for Form B; the form used for this study (Tollett & Adamson, 1983). The reliability coefficient (Cronbach's alpha) for the T.A.A.A.S. as a single scale instrument was $\alpha = .83$ however the results on the T.A.A.A.S. for this study were reported as two separate scales to aid comparison with the K.O.P.S.

Findings and Discussion

Nurses' Perceptions of the Elderly Based on Care Setting

On the positive scale K.O.P.S., the highest possible score was 102 while the lowest possible score was 17. On the negative scale K.O.P.S., the highest possible score was again 102 and the lowest possible score, 17. If a group mean score was high or over 59.5 on the positive scale, it indicated an overall positive perception of the elderly based on the respondent's responses to the positively worded statements. Conversely, if the group mean score was under 59.5 it indicated a negative perception toward the elderly, in other words, disagreement with the positively worded statements. On the negative scale, the reverse was true; if the overall mean score on the negative scale was above 59.5, this indicated a negative perception of the elderly; however, if the group mean was under 59.5 a positive perception toward the elderly was demonstrated.

The mean scores, standard deviations and frequencies for each of the two scales

were analyzed first by care setting then by total group. All three group scores indicated a positive perception of the elderly on both the positive and negative scales of the K.O.P.S. This meant that the mean score for the positive scale on the K.O.P.S. for all three groups was over 59.5: Group I (AC) 72.92, Group II (LTC) 71.76 and, Group III (HC) 72.95. The overall mean was 72.49. An analysis of variance generated a F ratio of .67, df=2, 269 and p=.51.

On the negative scale K.O.P.S., all three groups scored below 59.5; this indicated a positive perception because of disagreement with the negatively worded statements. The mean scores for the three groups were group I (AC) 42.28, Group II (LTC) 45.71 and, Group III (HC) 39.69. The overall mean for the negative scale was 43.06. In an analysis of variance there was a significant difference between groups at the 0.05 level on the negative scale with an F ratio of 5.97, df=2, 266 and p=.01

For ease of interpretation the mean scores were divided by the number of questions in the subscale to derive a number (Mean Item Score) that could easily be interpreted using the Likert type scale (Table 4.2). Based on the M.I.S., the mean scores on the negative scale K.O.P.S. were all between "disagree" and "slightly disagree".

It was noted that there was a considerable difference in the standard deviation on the two scales. Standard deviations on the positive scale were as follows: Group I (AC) 7.47, Group II (LTC) 8.61 and, Group III (HC) 7.77. The standard deviation for the total respondent group on the positive scale was 7.97. The standard deviation for the whole group on the negative scale was noticeably higher: Group I (AC) 9.56, Group II

Table 4.2

Perceptions of the Elderly on K.O.P.S. By Care Setting

	POSITIVE SCALE			NEGATIVE SCALE		
GROUP	**MEAN**	**STD. DEV.**	**M.I.S.***	**MEAN**	**STD. DEV.**	**M.I.S.***
ACUTE CARE	72.92	7.47	4.29	42.28	9.56	2.49
LONG TERM CARE	71.76	8.61	4.22	45.71	12.92	2.69
HOME CARE	72.95	7.77	4.29	39.69	9.10	2.33
TOTAL	72.49	7.97	4.26	43.06	11.09	2.53

* M.I.S. Mean Item Score = Mean subscale score ÷ 17

(LTC) 12.92 and, Group III (HC) 9.10. The standard deviation for the overall group on the negative scale was 11.09. The means and standard deviations for the three groups on K.O.P.S. are presented in Table 4.2. Using a one - way analysis of variance, significant differences between groups were found at the 0.05 level of significance on the negative scale of the K.O.P.S. Following the one way analysis, Scheffé Contrasts were used to identify which groups were significantly different. There was a significant difference between Group II (LTC) and Group III (HC) on the negative scale. Group II (LTC) had a higher overall mean score than Group III (HC) indicating that Group II respondents tended to disagree with the negatively worded statements less strongly than Group III. The positive scale indicated no significant differences between groups. The results of the analysis of variance are found in Table 4.3.

A significant difference was not found between groups on the positive scale K.O.P.S. Group means were as follows: Group I (AC) 72.92, Group II (LTC) 71.76 and, Group III (HC) 72.954. While there was not a significant difference between groups, the pattern of means on the negative K.O.P.S. was the same as for the positive K.O.P.S. Group III (HC) had the highest or most positive score, followed by Group I (AC); the least positive score was demonstrated by the respondents from the long term care facility (Group II). The converted M.I.S. scores for the positive scale K.O.P.S. were all between "slightly agree" and "agree" including the total score for all respondents (Table 4.2).

The second scale used in this study, the T.A.A.A.S. was scored similarity to the K.O.P.S. The highest possible score for the positively worded statements was 55 and

Table 4.3

Analysis of Variance Negative and Positive K.O.P.S. by Care Setting

NEGATIVE SCALE					
SOURCE	**D.F.**	**SUM OF SQ.**	**MEAN SQ.**	**F RATIO**	**PROB.**
Between groups	2	1415.63	707.81	5.97	.003
Within groups	267	31643.43	118.52		
TOTAL	269	33059.05			
Scheffé Contrasts - Significant differences between Group II (LTC) and III (HC)					
POSITIVE SCALE					
SOURCE	**D.F.**	**SUM OF SQ.**	**MEAN SQ.**	**F RATIO**	**PROB.**
Between groups	2	85.30	42.65	.67	.51
Within groups	264	16817.40	63.70		
TOTAL	266	16902.70			

the lowest score or the score was 11, a neutral score was 33. Therefore any score above 33 was considered a positive response to the positively worded statements. In the negatively worded statements, a score over 33 indicated agreement with the negatively worded statements and any score under 33 indicated disagreement with the negatively worded statements. Thirty-three is again the neutral point for the score.

On T.A.A.A.S. there was a significant difference between groups on both the negatively worded and positively worded statements. Positive T.A.A.A.S. scores for the three groups were, Group I (AC) 39.14, Group II (LTC) 36.54 and, Group III (HC) 38.33. The mean for all respondents was 38.00. The results on the negatively worded statements were Group I (AC) 26.64, group II (LTC) 28.76 and, Group III (HC) 26.35 with the overall mean for all respondents at 27.38. On the positive T.A.A.A.S. the M.I.S. places the group means and the aggregate mean between "agree" and "strongly agree". The M.I.S. for the negative T.A.A.A.S. places all groups and the overall mean between "disagree" and "neutral" (Table 4.4).

The standard deviations for the positive statements T.A.A.A.S. were Group I (AC) 3.68, Group II (LTC) 5.51 and, Group III (HC) 3.80. The overall standard deviation was 4.61. The standard deviation for the negative statements T.A.A.A.S. were Group I (AC) 5.08, Group II (LTC) 5.80 and, Group III (HC) 4.03. The standard deviation for the total respondents on the negative T.A.A.A.S. was 5.28. Again, as in K.O.P.S., there was more variability in the responses to the negative statements than to the positive. The mean scores and standard deviations for the three groups are shown in Table 4.4.

Table 4.4

Perceptions of the Elderly on T.A.A.A.S. by Care Setting

	POSITIVE SCALE			NEGATIVE SCALE		
GROUP	**MEAN**	**STD. DEV.**	**M.I.S.***	**MEAN**	**STD. DEV.**	**M.I.S.***
ACUTE CARE	39.14	3.68	3.56	26.64	5.08	2.42
LONG TERM CARE	36.54	5.51	3.33	28.76	5.80	2.61
HOME CARE	38.33	3.80	3.48	26.35	4.03	2.40
TOTAL	38.00	4.61	3.45	27.38	5.28	2.49
Mean Item Scale (M.I.S.) = Mean subscale ÷ 11						

There was a significant difference between groups on the one way analysis of variance on the negative ($F=5.81$, $df=2, 268$, $p<.01$) and the positive scale T.A.A.A.S. ($F=9.12$, $df=2, 264$, $p<.01$). Upon further analysis using Scheffé Contrasts, the significant difference on the negative scale was between Group II (LTC) and both of the other two groups at the 0.05 level of significance. This finding was similar to the results on the K.O.P.S., Group II (LTC) was only significantly different from Group III on the negative scale of the K.O.P.S., rather than for both Group I (AC) and Group III (HC). There was a significant difference between Group I (AC) and Group II (LTC) on the positive scale T.A.A.A.S. The one way analysis results for the T.A.A.A.S. are given in Table 4.5

Because of the similarity of the findings on K.O.P.S. and T.A.A.A.S., the discussion of results was integrated. Respondents in Group II (LTC) worked with the most debilitated and cognitively impaired elderly people of all three groups. When a person is too debilitated and/or too cognitively impaired to remain in their own home or another community placement and receive their care from informal caregivers or from a combination of informal and formal caregivers, they are referred for admission to a long term care facility. In this study, staff working with the facility-based long term care resident on a continuing basis showed a less positive attitude toward aging than did the other two groups of nursing personnel. It was speculated by this researcher that continued exposure to elderly people with such a high level of disability might precipitate a less positive perception of aging and the elderly. This was supported by the findings: Group III (HC) respondents had the most positive response of the three groups on the

Table 4.5

Analysis of Variance - Negative and Positive T.A.A.A.S. By Care Setting

NEGATIVE SCALE					
SOURCE	**D.F.**	**SUM OF SQ.**	**MEAN SQ.**	**F RATIO**	**PROB.**
Between groups	2	312.25	156.13	5.81	.003
Within groups	266	7149.31	26.88		
TOTAL	268	7461.56			
Scheffé Contrasts - Significant differences between Group II (LTC) and III (HC) Significant differences between Group I (AC) and Group II					
POSITIVE SCALE					
SOURCE	**D.F.**	**SUM OF SQ.**	**MEAN SQ.**	**F RATIO**	**PROB.**
Between groups	2	364.66	182.33	9.12	.0001
Within groups	262	5238.34	19.99		
TOTAL	264	5603.00			
Scheffé Contrasts - Significant differences between Groups I (AC) and II (LTC)					

negative scale of the K.O.P.S. and T.A.A.A.S. Group III (HC) respondents cared for clients who are usually in their own home and were able to stay there with the assistance of a combination of informal and formal caregivers. Overall, the home care client was less debilitated and more independent than the institutionalized elderly. This more independent client reinforces the nursing personnel's positive perceptions of aging. Group III (HC) respondents had a mean score indicating the most positive perception of aging on all but the positive scale T.A.A.A.S. Group I (AC) had the highest score on the positive scale T.A.A.A.S. but the Group III (HC) score was very close behind.

In acute care there is was a cross section of elderly patients, some were very dependent and were waiting to go to a long term care facility while others were acutely ill but were otherwise independent and would return home. Based on this, it is this researcher's expectation that the perceptions of aging of the acute care nurses would fall between the other two groups. This was supported by the results on the negative scale K.O.P.S. and T.A.A.A.S. as well as the positive scale K.O.P.S.; Group I (AC) scored between the other two groups.

One both instruments, there was a more uniform response on the positive scale within and between groups based on the standard deviation. Within the groups, the standard deviation was lower on the positive K.O.P.S. and the positive T.A.A.A.S.; therefore, there was more agreement within the group as well as no significant differences between groups on the scale. The groups maintained a positive response to negatively worded statements by disagreeing with them but, they reacted less consistently than to the positively worded statements. This difference between positive and negative

scales might have been due to a "knee jerk" or to a defensive reaction to broad negative statements about the elderly; positive statements did not elicit this same reaction allowing more consistency in response.

Question One

Is care setting a factor in nurses' perceptions of aging?

Based on the data analysis previously described, there were significant differences in nursing personnel's perceptions of aging on the negative scale K.O.P.S. and both the positive and negative scale T.A.A.A.S. related to the care setting where the respondents were employed at the time of this study. Therefore in this study the data indicated that the care setting was a factor in the nursing personnel's perceptions of aging. Mean scores on all scales across the three settings indicated positive responses on both questionnaires; however, the home care respondents were significantly more positive than those of the long term care facility in their reaction to the negatively worded scales. It can perhaps be concluded that home care personnel responded the most positively because they were able to see the positive aspects of aging on a daily basis as they went into the homes of their elderly clients.

Nursing personnel from the long term care facility had the least positive score on all four scales. It is important at this point to state that it is unlikely the results reflected less caring for the elderly on the part of staff of the long term care facility as compared with nursing personnel in other settings. This is supported by the findings on the variable "age of preferred client group" (Table 3.4) as 74.07% of the nurses in long term care stated that they preferred to work with the elderly compared with 63.79% of the home

care nurses and 22.03% of the acute care nurses. The variables "years caring for the elderly" (Table 3.9) and "length of time at present job" (Table 3.8) also added support to this author's conclusion that the nurses in long term care did not care less for the residents because they had a less positive attitude toward the elderly, they appeared to have liked their jobs enough to stay in them and continue to work with the elderly. The nurses from the long term care setting cared for the elderly on an average of three years longer than the other two groups and stayed in their present jobs almost two years longer than the acute care nurses. The residents in the long term care facility used in the study cared for very high level care residents that demanded a lot of physical and emotional energy from the staff. It is unlikely nurses would remain in that working environment if they did not care about the residents. Rather, the long term nurses scores on the K.O.P.S. and the T.A.A.A.S. simply captured the perspective that the care givers had about aging at one point in time. Nursing personnel in the long term care facility viewed aging as a less productive and less positive time in the life span than caregivers in the other two settings. Based on the degree of infirmity of residents in the long term care facility, this was not surprising. This may be much like a nurse who works with terminal cancer patients, who receives a biased perspective of the overall results of cancer treatment. Nursing personnel in long term care might well have felt that residents suffered the natural consequences of aging that await us all.

Nurses' Perceptions of the Elderly Based on Education

To carry out the analysis for the second research question, the educational groups

were collapsed into four educational levels (Table 4.6), rather than the seven educational categories on the Information Sheet (Appendix C). Rather than have two categories, Grade 6 - 9 and Grade 10 - 12, it was decided to have Grade 12 or less. The next category was for respondents whose level of education included technical school. Technical school includes courses of varying length but usually under one year in duration. The community college and hospital based R.N. program were collapsed into one. The majority of respondents in this category were R.N.s but some may be from other fields of education of the same approximate duration. Any person with a university degree, regardless of the area of focus or level of degree, was included in the category "University degree" . Originally the study was designed to separate the baccalaureate and masters prepared university graduates but there was only one masters respondent. In order to maintain confidentiality, the results from the masters respondent are included with results from the baccalaureate respondents.

Results on the K.O.P.S. and the T.A.A.A.S. were somewhat unexpected as the groups achieving the highest score on the two positive scales were not the same as the groups achieving the lowest score on the negative scales. This meant that the group indicating the most positive perception of aging on the positive scales did not indicate the most positive perception on the negative scales, that could have been due to a social desirability effect. Although there was little consistency in responses within the two scales of the same tools, there was some consistency between like scales on the different instruments. This was not surprising as there was a higher correlation between the positive scales on the two tools and the negatives scales on the two tools than between

Table 4.6

Mean Scores on K.O.P.S. and T.A.A.A.S. by Educational Level

	TOLLETT - ADAMSON SCALE		KOGAN OLD PEOPLES SCALE	
EDUCATION	**POSITIVE**	**NEGATIVE**	**POSITIVE**	**NEGATIVE**
Grade 12 or less	36.44 (n=73)	28.33 (n=76)	72.17 (n=72)	44.31 (n=74)
Technical School	38.63 (n=32)	26.91 (n=34)	72.58 (n=33)	42.00 (n=34)
Community College or Hospital Based R.N. Program	38.80 (n=132)	27.25 (n=131)	72.71 (n=134)	42.75 (n=134)
University Degree	37.56 (n=25)	25.96 (n=25)	71.60 (n=25)	42.96 (n=25)
Total	38.00 (n=262)	27.39 (n=266)	72.44 (n=264)	43.11 (n=267)

the two scales on the same tools. This is discussed further later.

On the positive scale K.O.P.S., the Community College or hospital-based R.N. program group obtained the highest or most positive score; the same group obtained the highest score on the positive scale T.A.A.A.S. as well. The lowest or most positive score on the negative scale K.O.P.S. was the group that attended a technical school and the group that scored the lowest score on the T.A.A.A.S. was the group with university degrees. It is noted that the differences between scores were very small.

The lowest or most negative scores on the positive scale K.O.P.S. was the group with university education rather than the Grade 12 or less group that achieved the lowest scale on the positive scale T.A.A.A.S. The group with the highest or most negative score on the negative scale K.O.P.S. was the Grade 12 or less group, and on the negative scale T.A.A.A.S., the Grade 12 or less group also scored the highest. While there were definite differences between groups on their mean score as discussed above, the only significant difference between any of the educational groups was found between the Grade 12 or less group and the community college/hospital-based R.N. program on the positive scale of the T.A.A.A.S. at the 0.05 level ($F=4.52$, $df=3, 261$, $p).01$) using a one way analysis of variance followed by Scheffé Contrasts (Table 4.7).

The results for each educational group on the positive and negative scale for K.O.P.S. and T.A.A.A.S. are given in Table 4.6. When reviewing the results it is important to remember a high score on either of the positive scales indicates a positive perception by agreeing with the positive statements; a low score on the negative statements on either scale indicates a positive perception by disagreeing with the negative

Table 4.7

Analysis of Variance of Positive Scale T.A.A.A.S. by Education Level

SOURCE	DF	SUM OF SQ.	MEAN SQ.	F RATIO	PROB.
Between groups	3	278.89	92.96	4.52	.00
Within groups	258	5303.11	20.56		
TOTAL	261	5582.00			
Scheffé Contrasts - Significant difference between the "Grade 12 or less" Level and the "R.N. and Community College Level					

statements.

There was a significant difference at the 0.05 level of significance between the educational category "Grade 12 or less" and the "Community college or hospital-based R.N. Program" on the positive scale T.A.A.A.S.. The Community college or hospital-based R.N. Program scored significantly higher or more positively than did the other group. There were no other significant differences between the educational levels on the negative scale T.A.A.A.S. or the positive and negative scale K.O.P.S.

Nurses' Perceptions of the Elderly Based on Job Category

The highest or most positive score for the K.O.P.S. on the positive scale was the N.A./P.C.A./H.S.A./ group while the R.N. group was the lowest on that scale (Table 4.8). What was surprising is that the N.A./P.C.A./H.S.A group had the highest score or, in other words, most strongly agreed with statements on the K.O.P.S. negative scale. The L.P.N. group was the most positive, and therefore disagreed the most strongly with the negative statements. None of the findings on the positive or negative scale K.O.P.S. were significant.

On the T.A.A.A.S., the R.N. group had the highest score on the positive scale and the lowest on the negative scale meaning they had the most positive response on both scales. The lowest score on the positive scale and the highest score on the negative scale was found in the N.A./P.C.A./H.S.A. group, this meant they had the most negative response on both scales. The analysis of variance findings on the negative scale ($F=2.72$, $df=2, 267$, $p=.07$) (Table 4.9) were not significant, however the difference between the R.N. group and the P.C.A. was significant on the positive scale ($F=4.15$,

Table 4.8

Mean Scores on K.O.P.S. and T.A.A.A.S. By Job Category

	TOLLETT - ADAMSON SCALE		KOGAN OLD PEOPLES SCALE	
JOB CATEGORY	POSITIVE	NEGATIVE	POSITIVE	NEGATIVE
N.A./P.C.A./H.S.A.	37.00	28.69	73.03	45.67
L.P.N.	37.49	27.33	72.58	42.21
R.N.	38.82	26.81	72.28	42.25
TOTAL	38.06	27.39	72.53	43.02

df=2, 263, p).05).

Question Two

Does nurse's education and job category influence perceptions of the elderly?

Within the variable "job category", the R.N. group response was consistently the most positive on both the negative and the positive T.A.A.A.S. On the education variable the group "community college or hospital-based R.N. Program" scored the most positively on the positive scale while on the negative scale the "university degree" group had the most positive response. The "university degree" group were almost all in the R.N. category of the variable job category. This might account for some of the difference between the two variables. When the university degree nurses were removed from the R.N. group, their score declined somewhat. The difference between the P.C.A. and the R.N. job category group might have been due to the difference in education. The R.N. group received their initial education regarding the elderly over a couple of years within varied settings, they may have experienced working with the elderly in numerous settings and have had the experience to know that the majority of the elderly do not end up in a position requiring a great deal of care either in a long term care facility or in the community. The category "university degree" within the variable education had even more exposure to the well elderly through the group's exposure to public health and the well elderly person living in the community and not requiring long term care services, either institutional or home care based.

Table 4.9

Analysis of Variance of Score on Positive T.A.A.A.S. by Job Category

SOURCE	DF	SUM OF SQ.	MEAN SQ.	F RATIO	PROB
Between groups	2	166.53	83.27	4.15	.02
Within groups	261	5239.62	20.08		
TOTAL	263	5406.15			
Scheffé Contrasts - Significant difference between the "N.A/P.C.A./H.S.A." Category and the "R.N." Category					

Nurses' Perceptions of the Elderly Based on Other Variables

Four of the variables from the Information Sheet that yielded interval data were entered into a multiple regression equation to determine if there was any relationship to the score on the positive and negative scales on K.O.P.S. and T.A.A.A.S. The variables used were "hours caring for the elderly each day", "length of time at job", "years caring for the elderly", preferred age group to look after", "age of the nurse". The multiple correlation for the positive and negative scale on the two instruments was as follows: Negative scale K.O.P.S. = 0.04, positive scale K.O.P.S. = 0.03, negative scale T.A.A.A.S. = 0.01 and, positive scale T.A.A.A.S. = 0.02. For example, on the negative scale K.O.P.S., 4.3% of the variability in the mean scores can be explained by the above variables. Because the amount of variability on K.O.P.S. and T.A.A.A.S. that was explained by the four mentioned variables , there was little or no predictive value.

Each of the following variables were entered into a one way analysis of variance using as the independent variable the K.O.P.S. and T.A.A.A.S measures.: "marital status" (negative T.A.A.A.S. $F=.60$, $df=4, 267$, $p>.05$) (positive T.A.A.A.S. $F=2.01$, $df=4, 263$, $p>.05$) (positive K.O.P.S. $F=1.6$, $df=4, 265$, $p>.05$) (negative K.O.P.S. $F=.82$ $df=4, 268$ $p>.05$); "close contact with elderly as a child" (negative T.A.A.A.S. $F=2.91$, $df=1, 267$, $p>.05$) (positive T.A.A.A.S. $F=2.46$, $df=1, 263$ $p>.05$) (positive K.O.P.S. $F=1.33$, $df=1, 265$, $p>.05$) (negative K.O.P.S. $F=1.51$, $df=1,268$, $p>.05$) and "age of nurse" (negative T.A.A.A.S. $F=.60$, $df=41,247$, $p>.05$) (positive T.A.A.A.S. $F=.92$, $df=41,243$, $p>.05$) (positive K.O.P.S. $F=.98$, $df=41, 246$ $p>05$) and (negative K.O.P.S. $F= .67$, $df=42, 249$ $p>.05$). The results showed no significant differences

on the negative or positive scale K.O.P.S. and T.A.A.A.S.

Question Three

Do the following factors influence nurses' perceptions of the elderly?

- **marital status**
- **age**
- **past history with the elderly**
- **the amount of time spent with elderly patients each day**
- **the length of time caring for elderly patients**
- **preferred age group for giving care**

To summarize, the variables referred to in the third research question had little or no effect on nursing personnel's perceptions of aging as determined. When the variables "hours caring for the elderly each day", "length of time at job", years caring for the elderly", "preferred age group to look after", "age of the nurse" were entered into a multiple regression equation there was 4.3% or less of the variance in the responses explained by these four variables. The variables "marital status", "close contact with elderly as a child" and "age of nurse" appeared to have no significant relationship to the scores obtained on the instruments used to measure perceptions of aging.

Correlations Between Scales

Following analysis of the data in order to answer the research questions, a

correlation of the scales was completed. The correlation between the negative and positive scale K.O.P.S. = - 0.61. Kogan reported that "the correlations between the OP+ (positive scale K.O.P.S.) and OP- (negative scale K.O.P.S.) ranged from .46 to .52 in all three samples, all significant beyond the .01 level" (Kogan, 1961a, pp.48).

The correlation between the positive and negative scale T.A.A.A.S. was - 0.57. Because previous documentation of the use of these tools did not separate them into a positive and negative scale there were no previous reported correlations. It was not unexpected to have found the correlation for the K.O.P.S. higher than T.A.A.A.S. because the K.O.P.S. was 17 matched pairs and respondents likely remembered their answer for the other question. There was likely some attempt by the respondents to try and be consistent.

The correlation between the two negative scales was higher than the two positive scales. The negative scales correlated at 0.75 while the two positive scales correlated at 0.62 (Table 4.10). This may have been due to less variance in the negative scales than on the positive scales as discussed earlier. Kogan referred to this when he stated that "subjects disagree more with statements commenting adversely on old people than they agree with statements praising old people" (Kogan, 1961a, pp. 48).

Discussion

This study was undertaken to gain more knowledge about nurses' attitudes toward aging and to determine any factors that may contribute to these attitudes. It was a

Table 4.10

Correlation of Scores Between K.O.P.S. and T.A.A.A.S. Scales

	POSITIVE K.O.P.S.	NEGATIVE K.O.P.S.	POSITIVE T.A.A.S	NEGATIVE T.A.A.S
POSITIVE K.O.P.S.	1.00*	-.61*	+.62*	-.48*
NEGATIVE K.O.P.S.	-.61*	1.00*	-.54*	.75*
POSITIVE T.A.A.S.	+.62*	-.54*	1.00*	-.57*
NEGATIVE T.A.A.S.	-.48*	+.75*	-.57*	1.00*
* p = 0.05				

pleasurable experience to obtain the data from the three care settings used in this study. The administrative staff in all three settings were extremely cooperative, in fact eager to assist in any way. The staff freely gave of their time and did not seem to resent the time taken away from their busy work schedule. It is exceptional to achieve such a high response rate in all the sites. It would suggest that there is a curiosity to learn amongst the staff of the three sites and that they are willing to cooperate in research in nursing in order to learn more. The results of this study did provide some insight into the research questions proposed in this study; however there is still much to know and new directions to pursue.

Question One

Is care setting a factor in nurses' perceptions of aging?

The relationship between nurses' attitudes toward the elderly determined by the scores on the K.O.P.S. indicated there were significant differences between groups on three of the four sub-scales. Overall the nurses who were working in a long term care facility scored consistently less positively than nurses employed in the other three settings.

The negative scale K.O.P.S. scores were significantly less negative for nurses' working in the home care setting than the long term care setting; on the positive scale K.O.P.S. the long term care nurses scored less positively than the other two groups but not significantly so. On the positive scale T.A.A.A.S. the long term care nurses were significantly less positive than the acute care group; on the negative scale T.A.A.A.S. the long term care nurses scored more negatively than both of the other two groups.

These findings were consistent with findings reported by Turkoski (1983) in a similar study. Turkoski used the K.O.P.S. to measure nurses' attitudes toward the elderly in the three settings similar to the ones utilized in this study. Turkoski found no significant differences on the positive sub-scale K.O.P.S. but did find significant differences between groups on the negative sub-scale; the nurses from the home care agency disagreed more strongly with the negative statements about the elderly than the group from the acute care setting and the nursing home. The significant difference between groups were between the home care nurses and the long term care nurse in this study; there were not significant differences between the acute care nurses and the home care nurses.

Results from two other studies support the findings of this study. Brower (1981b) found nurses from the Visiting Nurse Agency scored more positively on the K.O.P.S. than nurses from nursing homes and hospitals, although a privately owned home care agency scored the lowest of the groups. Brower stated that the difference may be that the nurses working for the privately owned home care agency may not have subscribed to the philosophy of home care but were in it for the higher wages paid. Gillis (1973) also found that nurses from a nursing home scored lower than nurses from acute care, although the differences were not significant. The aggregate group M.I.S. for Turkoski's sample was slightly less positive at 4.13 than the overall group score for this study at 4.26. All groups in this study also scored slightly more positively than the groups in the Turkoski study.

Question Two

"Does the nurse's education and job category influence perceptions of the elderly?"

The differences on the K.O.P.S. and the T.A.A.A.S. by education alone were generally inconclusive although there was some weak relationships present. There was a significant difference between the "Grade 12 or less" group and the "Community college/hospital based R.N. program" group on the positive scale T.A.A.A.S only. The "Grade 12 or less" group obtained the most negative score on the negative scale K.O.P.S. and the negative scale T.A.A.A.S. as well as obtaining the least positive score on the positive scale T.A.A.A.S. This was generally the same nursing staff as in the "job category" group for N.A.s/P.C.A.s/H.S.A.s. This was supported by the results of the K.O.P.S. and the T.A.A.A.S. by job category: the N.A.s/P.C.A.s/H.S.A.s group scored the least positively on the negative and positive scale T.A.A.A.S. and the negative scale K.O.P.S. This finding was supported in the literature by Gillis (1973) who reported that N.A.s obtained the least positive attitude score and by Campbell (1971) who reported N.A.s to be more willing to accept negative stereotypical statements about the elderly. Generally the findings of this study and the literature were inconclusive as no one job category was consistently more negative in all instances. There may have been differences within institutions based on the positive example set by the administrative staff. Inservice education sessions and informal learning experiences may be a confounding variable influencing the results.

Because education is so hard to separate from job category, it may have been better to determine people who had taken extra studies in gerontology and compared their

scores with people in the same job category who had not, in order to ascertain the influence of education. Several studies reported improved attitude scores for student nurses following a gerontology course or experience (Wilhite & Johnson, 1976; Chamberland, Rawls, Powell & Roberts, 1978; King & Cobb, 1983; Heller & Walsh, 1976). Generally research has not determined a relationship between education and nurses' attitudes to aging (McKenny, 1984; Armstrong-Esther et al, 1989). Brower (1981a) found that baccalaureate degree R.N.s had more positive scores on the K.O.P.S. than nurses with basic education. This finding does not confirm the findings of this study as the baccalaureate prepared nurses' scores were lower than the diploma R.N.s on the positive scales. Gillis (1973) also reported baccalaureate prepared nurses scored lower than diploma R.N.s and L.P.N.s but higher than the N.A.s. Perhaps the baccalaureate prepared R.N.s did not overreact to the negative statements about the elderly because they are more experienced in responding to questionnaires and may answer more candidly.

Although there is some evidence of education and job category having some influence on the nurses' attitude to aging, it is not substantial. While there are some differences which were significant, the mean score between the job category groups and the education levels were quite small. Significant results were obtained on these small differences due to the large groups.

Question Three

Do the following factors influence nurses' perceptions of the elderly?

- **marital status**
- **age**
- **past history with the elderly**
- **the amount of time spent with elderly patients each day**
- **the length of time caring for elderly patients**
- **preferred age group for giving care**

Based on the results, age appeared to have had little effect on the attitude scores obtained by the nurses surveyed for this study. These findings were supported by the literature. Jorn, 1984; Kosberg et al, 1972; Gillis, 1973; Smith, Jepson, & Perloff, 1982 and Armstrong-Esther, Sandilands & Miller, 1989 all concluded that age did not appear to relate to nurses' attitudes toward the elderly. Marital status was not mentioned as an influencing factor in any of the articles on nurses' attitudes that were reviewed.

A past personal history with the elderly is frequently associated as a positive influence on nurses' attitudes toward the elderly but this has had no support in the literature. The results of this study did not demonstrate that "past experience" with the elderly had an influence on the attitude scores of the nurses although 66% of the respondents claimed close contact. Further study of different care settings where nurses do not work with the elderly (i.e. Obstetrics or Paediatrics) might indicate a lesser number of the nurses had close contact with the elderly as a child, thus indicating nurses with close contact with the elderly chose to work in settings where the focus of care was the elderly. The literature did not support this finding as past studies have indicated a negative effect of experience with the elderly on nurses' attitudes (Meyer, Hassanein & Bahr 1980; Chandler et al, 1986; Taylor & Harned, 1978; McKenny, 1984; Armstrong -

Esther et al, 1989). This author did not locate any studies that made an attempt to evaluate the quality of respondents experience with the elderly as a child. There could be a difference based on whether the experience was positive or negative.

Length of time working with the elderly did not have a significant upon the nurses' attitudes in this study. This finding is supported by the findings of Jorn, 1984 and Smith et al, 1982. Hart et al (1976). There was no appreciable influence of "age of preferred patient" on the nurses' attitudes toward the elderly but there were significant differences between groups on this variable. Nurses from long term care consistently scored slightly less positively then the other two groups but still stated they preferred to work with the elderly 74% of the time. This was not supported as such in the literature. This is an area of concern, however, that the nurses who want to work with the elderly and do work the most consistently with them have the most stereotypical attitudes. This finding was likely due to the number of very ill, and debilitated elderly located in long term care institutions. The nurse working in long term care would rarely have had opportunity to see the well elderly or, people returning home to function independently in their own homes as did nurses in both of the other settings. This would be consistent with Gillis' findings (1973); she reported that nurses attitudes toward the elderly become more negative after a couple of years of working with them.

In conclusion, based on the findings of this study, the only variable that appeared to have a definite influence on nurses' attitudes toward the elderly was work setting. Nurses who cared for with the most debilitated and dependent elderly expressed the least positive attitudes while the nurses who cared for the elderly in the community and saw

them still maintaining their independence demonstrated the most positive attitudes.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The objective of this study was to describe the attitudes of nurses in three different care settings and then to compare the mean attitude scores from the three settings to ascertain whether there was a difference between them. Following this, several variables were analyzed to determine if they influenced the nurses' attitude scores. The three settings used for this study were long term care, acute care and home care. The mean scores for the nurses in the three settings indicated a positive attitude toward the elderly on all four sub-scales.

While all mean scores indicated a positive perception toward the elderly, nurses in the long term care did tend to score less positively on all four scales; the difference was significant on three of the scales. Home care nurses tended to score the most positively on three of the four scales; the differences were significant on two of the scales. At all times, the Mean Item Score (M.I.S.) for the three groups were within the same category on the Likert type scale; all groups were between "slightly agree" and "agree" on the positive scale K.O.P.S. On the negative scale K.O.P.S. for all the groups the M.I.S. score fell between the "disagree" and the "slightly disagree" score. On the positive scale T.A.A.A.S. the M.I.S. was between "neutral" and "agree" and on the negative scale between "neutral" and "disagree". Small differences were significant because of the fairly large numbers of respondents in each group rather than because of large difference in the scores between groups.

There was very little influence by either education or job category on nurses' attitudes toward the elderly in this study. There did seems to be a tendency for R.N.s from either a Community College or hospital based program to score more positively on the positive scales. The respondents who had a Grade 12 or less education did have the least positive score on three of the four scales. None of the other educational categories scored consistently enough for a pattern to emerge. There was a significant difference between the Community College/Hospital based R.N.s and the group with less than Grade 12 on only one scale.

Analysis was done to determine if there was a difference in attitude scores between different job categories of the nurses involved in the study. The P.C.A./N.A./H.S.A. group obtained the least positive score on both the T.A.A.A.S. positive and negative scales. This same group had the least positive score on the negative scale K.O.P.S. also. The group that had the most positive score on the negative and the positive scale T.A.A.A.S. was the R.N.s; on the positive scale K.O.P.S. it was the P.C..A./N.A./H.S.A. group and on the negative scale K.O.P.S. it was the L.P.N. group. The findings on the T.A.A.A.S. were consistent between the positive and the negative scale but the findings on the K.O.P.S. were not. Only the positive T.A.A.A.S. had significant findings and that was between the R.N. and the N.A./P.C.A./H.S.A. groups. The M.I.S. for the R.N. group was 3.5 and for the N.A./P.C.A./H.S.A. group it was 3.34 on the positive scale T.A.A.A.S. which was the only scale with significant findings.

None of the other variables had a meaningful influence on the attitudes of the

nurses toward the elderly. The variables examined were : "hours caring for the elderly each day", length of time at the present job", "years caring for the elderly", "preferred age group to look after", "age of the nurse", "marital status" and "close contact with the elderly as a child".

In summary, the job settings in this study did have a small but consistent influence on the mean attitude scores of the nurses who worked there. There was some difference in the attitude scores based on education and job category groups.

Limitations of the Study

1. Because convenience sampling was used for this study, any generalization outside of the study population should be made cautiously as this sample may not be representative of the population from which it was drawn.
2. Although effort was used to try and strengthen the internal validity through the study design to make the groups as comparable as possible, it was difficult to control for the effects of other variables in the three settings; therefore threats to internal validity may have occurred.
3. A threat to the external validity of this study may have been the Hawthorn effect, as subjects may have responded to the questionnaire in a certain way because they were being studied. If this occurred, it is likely that the effect would have existed across all groups.

Implications for Nursing

The findings of this study have implications for nursing practice, research, education and administration. There is still very little known about attitudes toward the elderly. The results of this study indicated that nurses working with the elderly in these settings, held generally positive attitudes toward the elderly. Research is required to establish nurses attitudes toward the elderly in other settings to try and determine if the nurses attitudes are different in these areas. In doing this research nurses can develop a beginning understanding of how much work setting affects attitudes toward aging. If nurses who work in other areas hold a more positive attitudes toward the elderly, then it may be that working with the elderly does have a negative impact on nurses attitudes. Research into the impact of nursing leadership and how it influences nurses' attitudes should be considered in the future. It may well be that leadership is a critical variable in the setting.

In order to determine if there is a change in nurses' attitudes toward the elderly after working with the elderly over a period of time, research to establish attitudes upon employment and then a couple of years later is required. This is the only way to establish if there is a change over time.

Research is required to discover if male nurses attitudes toward the elderly are the same as female nurses, if they are different then it is important to establish how the attitudes are different between the two groups. As more and more men are entering the nursing workforce it is important to understand the implications of this shift in the

characteristics of nurses.

Before there is a considerably more research into the attitudes of nurses toward the elderly, research to establish if attitude makes a difference in the delivery of care is required. If long term care nurses have a less positive attitude toward the elderly, how is this translated into the delivery of care. Is the care delivered more custodial than rehabilitative? If there is no difference in the type of care delivered than it may not be important that nurses in one care setting are more positive toward the elderly than in another care setting.

A large majority of nurses on the medical units used for this study stated that they preferred to work with those in other age groups than the elderly even though they had positive attitudes toward the elderly. More research is required to ascertain what is the influencing factor that motivates a nurse to elect to work with one age group over another. If nurses go to an area with a preference to work with the elderly and then change their preference, research should determine if this is so and if so what factors cause this to happen.

The implications for nursing practice relate to the type of care delivered to the elderly. It is necessary that the elderly have care with a rehabilitative focus. This does not just apply to long term care but also home care and acute care. The elderly person is at the highest risk for long term care institutionalization when they are in acute care. Acute care nurses often "do for" their elderly patients rather than spend the time to encourage them to do things for themselves. This practice leads to dependency and lack of confidence to care for themselves. Nurses in acute care as well as the other two

settings must practice with rehabilitation and independence as a primary focus of care. While this is especially important in acute care it is equally necessary in long term care institutions. Many elderly people can return to the community following a rehabilitative period in long term care. Nurses must focus their care in long term care, when ever possible, on helping the resident become independent enough to return home. The tendency to perceive long term care as a temporary location should be encouraged by the nursing staff but first they must believe it themselves.

Findings in this study may have implications for nursing education. Nursing students should have the experience during their nursing education with all types of elderly people. They must learn the problems of old age, but they should also be given the opportunity to meet and associate with the well elderly. If students only have an opportunity to associate with the elderly who are ill and hospitalized, they may not see many positive aspects of the aging process. It is also important that student nurses be instructed in the rehabilitative models of care which will foster independence in their elderly patients. If they begin to learn this manner of fostering independence from the beginning, they will undoubtedly continue to practice in this way in their later professional careers.

The most important implication of this study for nursing administration is that a positive attitude toward the elderly can be reinforced by example. Nurse administrators can try and reinforce the worth of the elderly by encouraging their staff to take the time to let the patients "do" for themselves. Encouraging the use of seniors as volunteers affords the staff more opportunity to work with the well elderly. This practice will

remind the staff that there are, in fact, elderly people in the community who are independent and healthy.

Recommendations for Study

Because this study was limited to one of each of the three setting types, further study is necessary to determine if the findings are peculiar to these sites. A larger study of several sites of each type would give a clearer picture of nurses attitudes. This should be done before any conclusions are drawn about the ramifications of the attitude scores.

Further research into the quality of nurses' previous experience with the elderly to ascertain if the experience had an influence on attitudes toward the elderly. A comparison study of nurses' attitudes toward the elderly who had a previous positive experience as compared to nurses with a previous negative experience would give an indication of the influence of this variable.

Summary

Two hundred and eighty four female nursing staff from three care settings completed two attitude questionnaires to determine their attitudes toward the elderly. Nurses' attitudes toward the elderly were generally positive in the three care settings used in this study. The setting where the nurses are employed had an influence on their attitudes. Generally nurses who worked in a home care setting had slightly more positive

attitudes than nurses in acute care or long term care settings. Nurses who were employed in long term care consistently scored less positively then the other two groups. Other factors were studied to determine if they had an influence on nurses' attitudes toward the elderly. While education and job category had a slight influence, all the other factors showed no appreciable influence.

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APPENDIX A

TOLLETT and ADAMSON
AGING ATTITUDE SCALE

INSTRUCTIONS: Each of the following is a statement about people who are 65 years of age or older. Please place an "X" in the space below each statement which best describes your reaction to that particular statement.

1. Elderly people tend to relax previous standards of personal appearance.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

2. Elderly people should not hold positions of authority in Canadian society.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

3. Elderly people are more resistant to new ideas and new ways of doing things than young and middle-aged people.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

4. Elderly people possess fewer prejudices against ethnic and minority groups than middle-aged people.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

5. Elderly people enjoy sexual activity.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

6. Most elderly people expect their children to take care of them.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

7. Elderly people enjoy helping each other.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

8. Elderly people are interested in the future.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

9. Living together without marriage is acceptable for young males and females but taboo for elderly males and females.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

10. Elderly people are too conservative and traditional to hold positions of authority in business.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

11. Elderly people can take care of their physical needs without assistance.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

12. Most elderly people are very stoic and set in their ways?

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

13. Federally subsidized payments of heating costs for the elderly would be unfair.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

14. Most elderly people behave as mature adults.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

15. Most elderly people are capable of functioning within Canadian society.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

16. Elderly people are optimistic toward the future.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

17. Elderly people tend to lose faith in their religious beliefs.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

18. Elderly people prefer to be left alone.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

19. Elderly people enjoy new experiences and travelling.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

20. Elderly people tend to be equally concerned about themselves and others.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

21. Elderly people are more concerned with dying than they are with living.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

22. Elderly people enjoy the company of both males and females of all age groups.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
[ ]	[ ]	[ ]	[ ]	[ ]

Note: Cited in Attitudes of Registered Nurses Toward the Elderly (p. 46-47) by D.L. Jorn, 1984, Unpublished masters' thesis, Texas Women's University, Denton, Tx.

APPENDIX B

ELDERLY PEOPLE SCALE

DIRECTIONS: On the following questionnaire, you will find a number of statements with which you may or may not agree. Following each statement are six boxes labelled as follows:

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

You are to indicate the degree to which you agree or disagree with each statement by checking the appropriate box.

Please consider each statement carefully, but do not spend too much time on any one statement. PLEASE DO NOT SKIP ANY ITEMS.

There are no "right" or "wrong" answers -- the only correct responses are those that are true for you.

1. It would probably be better if most old people lived in residential units with people their own age.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

2. Most old people respect others privacy and give advice only when asked.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

3. If most old people expect to be liked, their first step is to try to get rid of their irritating faults.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

4. It would probably be better if most old people lived in residential units that also housed younger people.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

5. There is something different about most old people: its hard to figure out what makes them tick.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

6. When you think about it, old people have the same faults as anybody else.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

7. In order to maintain a nice residential neighbourhood, it would be nice if too many old people did not live in it.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

8. Most old people are really no different from anybody else: they're as easy to understand any younger people.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

9. Most old people get set in their ways and are unable to change.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

10. You can count on finding a nice residential neighbourhood when there is a sizeable number of old people living in it.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

11. There are a few exceptions, but in general most old people are pretty much alike.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

12. Most old people are capable of new adjustments when the situation demands it.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

13. Most old people would prefer to quit work as soon as pensions or their children can support them.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

14. It is evident that most old people are very different from one another.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

15. Most old people should be concerned with their personal appearance; they're too untidy.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

16. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

17. Most old people tend to let their homes become shabby and unattractive.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

18. Most old people seem to be quite clean and neat in their personal appearance.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

19. Most old people are irritable, grouchy, and unpleasant.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

20. Most old people can generally be counted on to maintain a clean, attractive home.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

21. It is foolish to claim that wisdom comes with old age.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

22. Most old people are cheerful, agreeable, and good humoured.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

23. Most old people are constantly complaining about the behaviour of the younger generation.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

24. People grow wiser with the coming of old age.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

25. Old people have too much power in business and politics.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

26. One seldom hears old people complaining about the behaviour of the younger generation.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

27. Old people make excessive demands for love and reassurance.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

28. Old people have too little power in business and politics.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

29. Most old people make one feel ill-at-ease.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

30. Most old people need no more love and reassurance than anybody else.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

31. Most old people are relaxing to be with.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

32. Most old people bore others by their insistence on talking about the "good old days."

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

33. One of the most interesting qualities of old people is their accounts of their past experiences.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

34. Most old people spend too much time prying into the affairs of others and giving unsought advice.

STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
[ ]	[ ]				

APPENDIX C

INFORMATION SHEET

PLEASE COMPLETE THE FOLLOWING QUESTIONS. THERE IS NO WAY TO IDENTIFY YOU FROM YOU ANSWERS AS YOUR NAME IS NOT ON THIS SHEET. THE ONLY IDENTIFICATION WILL BE A CODE ON THE TOP CORNER WHICH WILL LET THE RESEARCHER KNOW WHICH QUESTIONNAIRES ALL CAME FROM THE SAME PERSON.

1. AGE _____

2. Place an "X" beside appropriate answers

   GENDER Male _____ Female_____

   (Please fill in the blanks)

3. MARITAL STATUS

   1. Married ___
   2. Single ___
   3. Widowed ___
   4. Divorced ___
   5. Other (Please specify)
      _____

4. JOB CATEGORY: (Circle appropriate answer)

   1. R.N.
   2. L.P.N.
   3. N.A.
   4. Personal Care Aide (P.C.A.)
   5. Home Support Aide (H.S.A.)

5. On the average, how many hours each working day do you spend working with elderly people?

(Fill in the blank)

_____hrs

6. How long have you worked at this job?

(Fill in the blank)

_____

7. Did you ever have close continued contact with an elderly person when you were a child or teenager?

(Check the appropriate answer)

Yes ____ No ____

8. How many years have you been caring for elderly patients?

(Fill in the Blank)

_____years

9. Highest level of education: (Circle appropriate answer)

1. Grade 6 - 9
2. Grade 10 - 12
3. B.Sc.N or other bachelor's degree
4. Technical Institute Program
5. Community College Program
6. M.N. or other Master's degree

10. What age group do you prefer to look after?

(Please circle your choice)

1. Infants (0-1 years of age)
2. Children (2 - 12 years of age)
3. Teenagers (13 - 19 years of age)
4. Young adults (20 - 45 years of age)
5. Middle aged adults (46 - 64 years of age)
6. Elderly adults (65 and older)

THANK YOU FOR FILLING OUT THIS QUESTIONNAIRE.

APPENDIX D

NEW SCHOOL FOR SOCIAL RESEARCH
GRADUATE FACULTY OF POLITICAL
AND SOCIAL SCIENCE
65 FIFTH AVENUE
NEW YORK, N.Y. 10003
(212) 741-5727

DEPARTMENT OF PSYCHOLOGY

September 8, 1989

Elizabeth L. Broad RN BA BScN
9701-157 Street
Edmonton, Alberta, CANADA T5P 2T4

Dear Elizabeth Broad:

In response to your recent request, I hereby grant you permission to use my OP Scale in your proposed research project. My supply of copies of the Scale is exhausted, but please note that it has been reproduced in the following volume: Shaw, M., & Wright, J. (1967) Scales for the Measurement of Attitudes, McGraw-Hill, pp. 468-471.

If you are interested in more current reliability and validity information concerning the OP Scale, I would recommend the following source: Mangen, D.J., & Peterson, W.A. (Eds.) (1982) Research Instruments in Social Gerontology, Vol. 1, Clinical and Social Psychology. University of Minnesota Press, pp. 549-556.

You have my best wishes for the success of your project. I should be pleased to learn about the outcomes of your research.

Sincerely,

Nathan Kogan
Professor

NK:jb

APPENDIX E

NEW SCHOOL FOR SOCIAL RESEARCH
GRADUATE FACULTY OF POLITICAL
AND SOCIAL SCIENCE
65 FIFTH AVENUE
NEW YORK, N.Y. 10003
(212) 741-5727

DEPARTMENT OF PSYCHOLOGY

February 28, 1990

Ms. Elizabeth L. Broad
2 Geneva Crescent
St. Albert, Alberta
Canada T7N 0Z4

Dear Ms. Broad:

In reference to your letter of February 5, I have no objection to the substitution of the word "elderly" for "old" in the items of the Kogan OP Scale.

It is possible, in fact, that you may have pinpointed a problem that extends beyond Canada. The OP Scale was constructed quite a long time ago, and it is quite conceivable that some revision of the items (along the lines you suggest among other things) would be desirable. Of course, that is a matter for future consideration, and you need not concern yourself with it for your particular project.

You have my best wishes for the success of your efforts.

Sincerely,

N. Kogan

NATHAN KOGAN
Professor

NK:bb

APPENDIX F

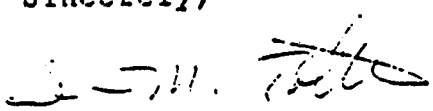
S.M. Tollett R.N., Ph.D.
3730 Kirby,
Suite 150,
Houston, Tx.,
U.S.A.
77098

Elizabeth L. Broad,
2 Geneva Crescent,
St. Albert, Alberta,
Canada
T8N 0Z4

Dear Elizabeth,

In response to your recent request, I hereby grant you permision to use the Tollett-Adamson Aging Attitude Scale in your research.

Sincerely,



Susan M. Tollett, R.N., Ph.D.

APPENDIX G

University of Alberta
Edmonton
Canada T6G 2G3

Faculty of Nursing
3-120 Clinical Sciences Building

Certification of Ethical Acceptability for Research Involving Human Subjects

NAME OF APPLICANT: Elizabeth Broad

TITLE OF PROJECT: Nurses' Perceptions of the Elderly in Three Different Care Settings: A Thesis Proposal

The members of the review committee, having examined the application for the above-named project, consider the procedures, as outlined by the applicant, to be acceptable on ethical grounds for research involving human subjects.

Jan. 12/89
Date

T. Davis, RN, PhD
Chair
Ethics Review Committee
Faculty of Nursing

APPENDIX H

EXPLANATION OF STUDY

TITLE OF THE PROJECT:

Nurses' perceptions of the elderly in three care settings.

RESEARCHER DOING THE STUDY:

ELIZABETH BROAD
MASTERS OF NURSING STUDENT
FACULTY OF NURSING
UNIVERSITY OF ALBERTA
PHONE 458-1915

THESIS SUPERVISOR:

DR. JANET KERR
PROFESSOR
FACULTY OF NURSING
UNIVERSITY OF ALBERTA
PHONE 492-6253

PURPOSE OF THE STUDY:

Over the last ten years, the type of patients cared for in the health care system has changed. The patients are more acute and there are more elderly patients than there ever has been before. There is an indication that this trend will increase even more in the future. Many studies have been done to learn how nurses feel about the elderly in the United States and Britain but not much is known about how Canadian nurses feel about the elderly. This study is designed to measure nurses perceptions of the elderly in three different care settings; acute care, auxiliary care and home care. A comparison will be done of the results between the three facilities. The information I obtain about each of you who answer the questionnaire will be used to try and determine what factors are related to perceptions toward the elderly.

Three questionnaires are enclosed in this envelope. If you chose to take part in the study, please complete all the questions. The first questionnaire requests information about you which will help me learn more about the nurses who care for elderly patients. The other two questionnaires are designed to measure nurses' perceptions of the elderly. The questions may seem repetitive at times but it is important to answer all of them. The questionnaire takes approximately 20 minutes to answer.
The hospital administration has given permission for this study to be done, but they will not see any individual responses.

After you have completed the questionnaires, seal them in this envelope and leave them in the box provided on your nursing unit. I will pick them up from there.

VOLUNTARY PARTICIPATION:

You do not have to participate in this study if you do not want to. If you decide to be in the study, you may drop out at any time. There will be no consequences if you do not take part in the study.

CONFIDENTIALITY:

Your name is unknown to me and there is no way of identifying you from the questionnaires. Any articles or presentations resulting from the study will not report individual results but rather the collective findings. The information I obtain from the questionnaires will be saved, if it is ever used for another study, permission will be obtained from the Faculty of Nursing Ethical Review Committee beforehand.

The questionnaires do not have a name on them, there is a number on them which corresponds to a number on the envelope. The number is used by me to keep questionnaires from each respondent all together and, also, to identify the facility where the nurse is employed.

I will be happy to answer any questions you have. You may contact me at the number given on the front page of this explanation paper.

If you decide to participate, I would like to thank you very much for your help. After the study is completed I will present my findings at your hospital or health unit. THANK YOU!!