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**Quality in Dementia Care:
Evaluating Staff Attitudes and Behaviour.**

Tracey Carol Lintern

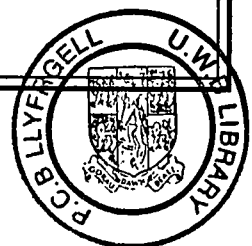
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SUMMARY

Research suggests that for many older people with dementia living in residential care, communication with staff often provides the most significant element of their day. It seems likely that the quality of the interactions provided by staff during their care of people with dementia will be an essential factor in affecting the person's quality of life. Research also suggests that the attitudes of nursing and care staff towards people with dementia is a central component in the quality of care they deliver, however, to date, there has been no empirically established evidence that staff attitudes have a direct effect on the quality of life of the people cared for.

This study aims to examine the impact of staff attitudes on both the quality of care delivered and on the quality of life of residents and to examine whether there are any changes in any of these areas as a result of training and development interventions. The research includes a review of existing attitude measurements and the development of a new attitude scale for use with dementia care professionals, offering evidence for its reliability and validity. In order to evaluate quality of care, a new observational technique is developed, which draws on previous observational methodologies, with a focus on the behaviour of staff during their care of people with dementia.

Results suggest that staff with more 'hopeful' attitudes about people with dementia are more likely to engage in social interactions and activities with residents and use more quality indicators (such as giving choice and information) during physical care tasks. The study also showed improvements in staff attitudes, the quality of care provided and in resident well-being following a number of training and development inputs. The implications of the results are discussed in relation to the limitations of the research.

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CHAPTER ONE

1.0 Introduction

The number of people in the population affected by dementia has been steadily rising for several decades and current demographic predictions indicate that this increase is likely to continue for many years to come. The prevalence of dementia increases with age and improved healthcare over the years has allowed people to achieve longer and longer life spans. Therefore, there are growing numbers of people living with dementia, and requiring specialised care, often provided in residential settings (Woods, 1999).

Medical advances in this area have been slow to bear fruit and little is known about what causes the conditions known as dementia, how to diagnose them or how best to treat people affected by them. Despite the continuing developments in psychopharmacology there still remains no cure for dementia. Some relief from symptoms in the early stages of dementia has been provided by medications such as Aricept, although the long-term benefits of such drugs are not yet clear. Since medication can do little to alleviate the difficulties faced by those with dementia the focus of research and development has increasingly been placed on improving the quality of life of people with dementia by addressing their psychosocial needs. Attention has been given in recent years to the interaction between people with dementia and those who care for them in residential settings (e.g. Dean, Proudfoot & Lindesay, 1993; Kitwood & Bredin, 1993), as often communication with care staff forms the most significant part of the person's day (Campbell, 1971; Bagshaw & Adams, 1986). Accordingly, improving quality of care for people with dementia is increasingly viewed as a crucial element to improving resident's quality of life.

It has been suggested that an important component of quality of care of people with dementia is the attitudes held by nursing and care staff towards their clients and how they should be cared for (Naus, 1973; Weinberger & Millham, 1975; Bagshaw & Adams, 1986). However, the proposition that the attitudes of care staff have a direct effect on the quality of life of people with dementia has not yet been empirically established.

The research presented here aims to examine the impact of staff attitudes on both the quality of care delivered and on the quality of life of residents and to examine whether there are changes in any of these areas as a result of training and development interventions. Specifically the research aims are as follows:

1. To establish a suitable attitude instrument for use with dementia care professionals.
2. To establish a suitable behavioural observational technique for evaluating the quality of care delivered by dementia care professionals.
3. To investigate the relationship between the attitudes and behaviour of dementia care professionals.
4. To enhance our understanding of the psychological processes underlying professionals' attitudes towards older people with dementia.
5. To enhance our understanding of the role of attitudes in influencing quality of care.
6. To examine the responsiveness to change among the attitudes and behaviour of care staff following training and development interventions, and to monitor any subsequent impact on the well-being of residents with dementia.

1.1 Attitude Research

Before the 1960's, the investigation of attitudes and factors influencing their change was a popular topic for research in social psychology (Eagly & Himmelfarb, 1978). By the late 1960's interest in the topic had undergone a marked decline, probably because many studies found a low correlation between attitudes and behaviour and this was highlighted in an influential review by Wicker (1969). However, in the 1980's, studies more frequently began to show that under certain conditions people's attitudes and behaviour were closely associated. This led to a renewed interest in attitude research, particularly within the field of health psychology where attitude studies gained considerable recognition in predicting health-related behaviours (e.g. Wurtele and Maddux, 1987).

Definitions of what an attitude is have varied considerably, from a predisposition to act in a certain way (Mednick, et al., 1975) to likes and dislikes (Bem, 1979, cited in Gross, 1987, page 262). Eiser & van der Plight (1988), describe attitude as 'a form of experience that (a) refers to specific objects, events, people or issues, and (b) is primarily evaluative' (p 1). They go on to say that attitudes are expressed 'by describing the objects of our experience in evaluative terms' (p 1). Thus attitudes are our subjective evaluations of specific objects, events, people or issues. Although they are subjective, Eiser & van der Plight highlight how:

'We do not typically treat our attitude as 'just a matter of opinion'. We regard our attitude as 'the truth', at least until someone can introduce new facts or arguments to change our mind' (p 1).

This section considers the major theories on attitudes, the attitude-behaviour relationship, and how attitudes might change.

1.1.1 Consistency Theory

The most influential theories on attitudes have focused on the principle of cognitive consistency, whereby human beings are conceptualised as sorting through and modifying large amounts of information in order to achieve some kind of cognitive coherence (Gross, 1987). One of the best known consistency theories is Heider's balance theory (1946), which maintains that people prefer harmony among their various attitudes and beliefs and are likely to evaluate things that are related to each other in similar ways. Heider (1946) suggests that people are motivated to organise their evaluation of objects, people and events into simplified structures containing the least possible likelihood of instability or contradiction. For example, people are thought to like people who they believe share the same attitudes as themselves and are also more likely to adapt their own attitudes so that they are more similar to those of people they like. Heider argues that this is because 'balance' results in intrinsically 'right' feelings.

A second well-known consistency theory is Osgood & Tannenbaum's congruity theory (1955), according to which one attitude will change when another attitude or belief is inconsistent with it. In this situation, it is the attitude that is less firmly held which is thought to change. Congruity theory attempts to formulate predictions about the amount of attitude change likely to occur as a function of a person's initial evaluations. In developing Osgood & Tannenbaum's work Petty & Cacioppo (1985), suggested that the more extremely pro- or anti- your attitude at first, the less likely you are to change it.

1.1.2 The Three Component View Of Attitudes

Many studies have attempted to relate verbal measures of attitude to various forms of actual social behaviour. Thus questions arise as to whether people who express prejudiced attitudes act in ways that display open hostility or discrimination towards the subjects of their prejudice. However, research has shown that this is not necessarily the case. Many studies attempted to test such relationships (e.g. La Piere, 1934) and, in a widely cited and influential review, Wicker (1969) concluded that only a minority of studies were able to find any close relationship between verbally expressed attitudes and overt behaviour. As a result of such work, Abelson (1972) suggested that the concept of attitudes be disregarded entirely. However a number of subsequent studies which have examined attitudes in more detail, have found that the strength of the attitude-behaviour relationship is dependent on the presence or absence of particular criteria in the research. This concept is explored more fully in section 1.1.3.

The theoretical approaches that developed out of this later work recognise that there may be some discrepancies between attitude and behaviour, but without deeming this to be evidence that attitudes are unimportant and attitude research irrelevant. Perhaps the most notable of these is Rosenberg & Hovland's (1960) 'three-component' view of attitudes. As shown in figure 1.1, attitude is viewed as an intervening variable between 'stimuli' that are objects, people and events and 'responses' to these stimuli. Attitudes are thought to contain three 'components', defined as 'affect' concerned with feelings, evaluations and emotions, 'cognition' concerned with beliefs about whether something is true or false and 'behaviour' concerned with intentions or decisions to act. Verbal responses can reflect each or any one of these attitudinal components.

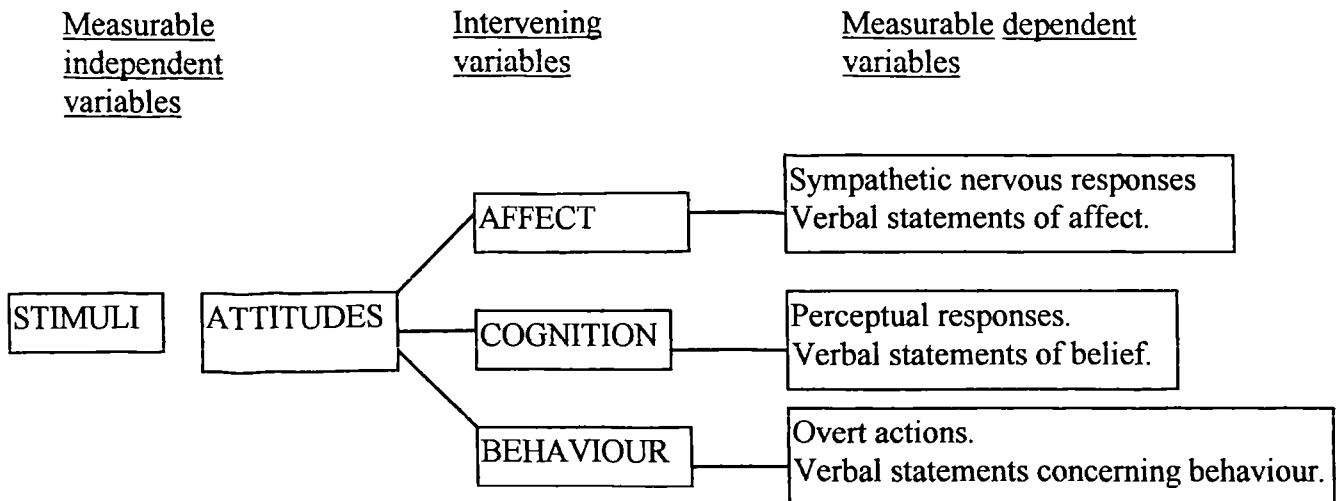


Figure 1.1: The three-component view of attitudes (adapted from Rosenberg & Hovland, 1960).

A number of subsequent studies based on the ‘three component model’ have concluded that affect, cognition and behaviour are interrelated, although still distinguishable from each other (e.g. Ostrom, 1969; Kothandapani, 1971).

Fazio & Zanna (1981) suggest that congruity between behaviour and the affective component of attitudes is likely to be higher for attitudes developed as a result of direct, personal experience. Breckler (1984) however, takes this even further, arguing that the attitude object needs to be present during self-report of attitudes in order for measures to be reliable. For example, in his study he found a stronger relationship between people’s attitudes towards snakes and their behavioural reaction to snakes when a snake was actually in the room during verbal assessment of attitudes. This led Breckler to argue that if the object is not present, verbal reports giving supposedly affective, cognitive or behavioural responses, may be largely moderated by the cognitive system, since respondents are relying on the symbolic representation of the object, rather than the object itself. Whilst this may be true for objects that people rarely come into contact with it is

unclear whether the same would be true if the participant has daily contact with the attitude object.

Despite the influence of the three-component view of attitudes in directing much of the research on the attitude-behaviour relationship during the early eighties, there remained little information about whether verbal measures of any of the three components could accurately predict overt behaviour.

1.1.3 Predictions Of Behaviour From Attitudes

Fishbein (1967) and Fishbein & Ajzen (1975) noticed that, in many of the studies reviewed by Wicker (1969), researchers had used quite general measures of attitudes to predict quite specific types of action. As a result they argue that the lack of relationship detected between attitudes and behaviour may be due to inconsistencies in the generality or specificity of the measures used to assess attitudes and behaviour. Alternatively, when levels of generality or specificity in the attitude and behaviour measures are similar, the correlations are far higher (Ajzen & Fishbein, 1977). For example, Weigel, Vernon & Tognacci (1974), measured the relationship between volunteering to work for an environmental organisation called the Sierra Club and people's attitudes. Attitudes, however, were measured with varying specificity, ranging from attitudes towards environmentalism in general, to attitudes towards pollution, to attitudes towards the Sierra Club itself. Correlations were found to be stronger, the more specific the attitude measurement.

One of the primary principles of the Fishbein & Ajzen position is the distinction between attitudes towards objects or people, and attitudes towards specific actions towards that object or person. It is the latter kind of attitude that is thought to provide the best predictor of behaviour. However, there is also an important mediating factor within the Ajzen & Fishbein (1980) paradigm. In their model the presence of what is termed the ‘subjective norm’ refers to the perception of and value placed on the opinions of other people, regarding the acceptability of a behaviour. The subjective norms interact with an individual’s attitude toward the behaviour in order to determine the intention to perform that behaviour. Behaviour then is determined by this intention. These relationships are presented in what Ajzen & Fishbein (1980) entitle the ‘Theory of Reasoned Action’ (see Figure 1.2).

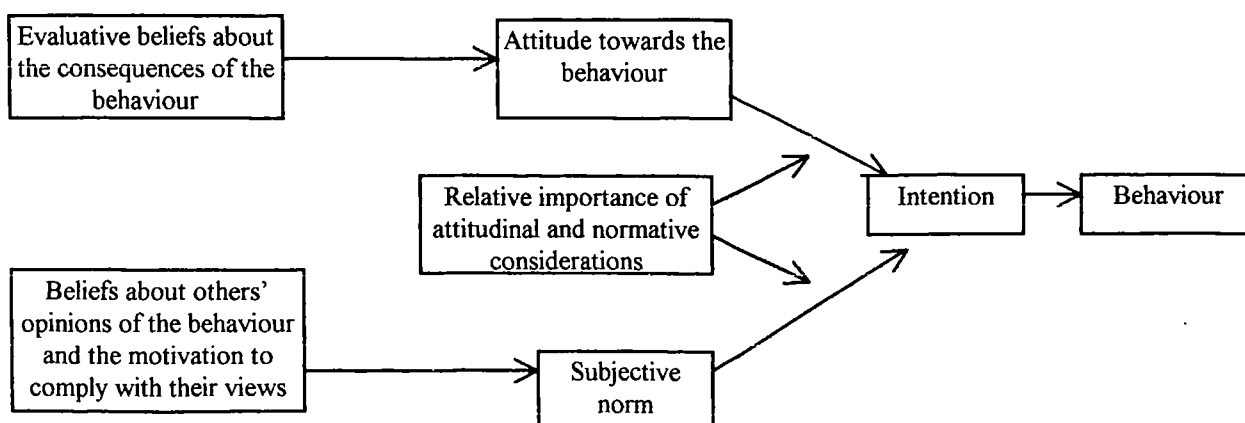


Figure 1.2: The ‘theory of reasoned action’ (adapted from Ajzen & Fishbein, 1980).

Despite some predictive success (Budd & Spencer, 1984, 1985; Davidson & Jaccard, 1975, 1979; Manstead, Proffit & Smart, 1983), there remains some criticism of the theory of reasoned action. One such criticism is that the specificity of attitude and subjective

norm measures have to be so narrow that they end up resembling the measure of intention they predict.

Another problem is the use of the term 'reasoned action' in the title of the model. This title raises the question of whether the model is a list of the variables that should be measured in order to predict behaviour, or as its name implies, it defines the way in which behavioural decisions are made. In addition, the behaviour being considered will often be similar, if not identical, to behaviours carried out many times before, rather than being an evaluation or a decision that is being made for the first time. Thus, not only do models such as these need to explain 'reasoned action' but they also need to explain behavioural habits (Eiser & van der Plight, 1988).

An alternative model incorporating previous behaviour was presented by Bentler & Speckart (1979) from a study on students' self-reported attitudes towards, intentions to use and actual use of drugs. Contrary to the assumptions of the 'theory of reasoned action', their model indicated that attitudes and previous behaviour predicted subsequent behaviour directly, over and above the effects mediated by differences in intention. A response to these findings would be that the theory of reasoned action was never intended to apply to the prediction of behaviours that may be a result of physical addictions. However, Fredricks & Dosset (1983) in comparing the Fishbein & Ajzen and the Bentler & Speckart models, found support for elements of both models with a non-addicted behaviour cohort. In their study on student's classroom attendance, they found that subsequent attendance was predictable from previous attendance, irrespective of intention. On the other hand, the effect of attitude on subsequent behaviour was mediated by intention, as predicted by the Fishbein & Ajzen model. Feasibly, attitudes and beliefs can

be changed to some degree, whereas past experience cannot. Questions do remain however as to whether habitual behaviour can be influenced by persuasive communication and whether it is attitudes or past experience that are more important in predicting people's future actions.

While much of the work within attitude research has focused on predicting people's behaviour from their attitudes, there has also been substantive research to develop theories of attitude change.

1.1.4 Attitude Change

Perhaps the most influential theory in attitude change is Festinger's cognitive dissonance theory (1957). The crux of this theory is that when someone simultaneously holds two or more cognitions, which are inconsistent with each other, they experience tension or 'dissonance'. The more difficult it is to decide on the precedence of cognitions, the stronger the dissonance. Festinger's theory, in line with earlier consistency theories, maintains that, in such a situation individuals will be motivated to reduce this uncomfortable feeling of tension by achieving consonance. This may involve the use of cognitive restructuring, whereby dissonance can be removed by bringing attitudes into line with previous behavioural decisions or by adapting behaviour to align with newly developed attitudes. Attitude change is seen as a major way of reducing dissonance and, inversely, the purposeful creation of dissonance, through challenging pre-existing ideas or beliefs is also a well-used technique in bringing about attitude change.

1.1.5 Section Summary

According to most theorists, attitudes consist of three factors: affective, cognitive and behavioural. In order to fully evaluate or understand a person's attitudes, consideration of each of these factors is required.

In terms of measuring attitudes in a way that accurately predicts behaviour the following issues all need to be considered; generality/specificity, attitudes towards people as opposed to how one intends to behave towards those people, the views and opinions of significant others, and the influence of habit or ritualistic behaviour.

In terms of changing people's attitudes, the creation of dissonance within a person's ideas could potentially motivate them to reassess the situation and change their attitudes or behaviour. However, it is worth remembering that those who hold extremely pro or anti attitudes are less likely to change and certainly within healthcare this could have important implications for staff selection.

Having reviewed some of the major theories within the general literature on attitudes, the next sections more specifically consider attitudes towards older people and people with dementia.

1.2 Attitudes Towards Older People & People With Dementia

Much of the research regarding attitudes towards older people focuses on those pertaining to health care professionals working with older clients, since the attitudes of such personnel are often thought to have a major influence upon the way in which care is delivered (Naus, 1973; Weinberger & Millham, 1975; Bagshaw & Adams, 1986). However, wider societal and cultural factors are also likely to have a significant influence on people's attitudes since these provide the context within which such attitudes are formulated and maintained. Therefore, some appreciation of the attitudes held amongst the general population is required before considering the attitudes of health care staff in more detail.

1.2.1 Societal Attitudes

The attitudes of the general population towards older adults have received relatively little empirical investigation. However, both anecdotal evidence and a growing literature on the subject seem to support the concept that ageism is a genuine and widespread phenomenon.

Bytheway (1995) draws together a number of examples of the way in which ageist attitudes and practices are ingrained in our society. For example, newspaper articles which reinforce negative stereotypes; attitudes of employers and employment agencies towards older people; language such as 'silly old fool' which implies an association between being 'silly' or 'stupid' and being old (Nuessel, 1984); humour such as that seen in birthday

cards which ridicule the fact that someone is getting older; advertisements such as those for 'age-defying' treatments and creams; and the ever increasing cosmetic surgery industry, which clearly express the undesirability of getting older. Furthermore, Bytheway also identifies evidence of ageism within the Health System where he points out that there are a number of ageist policies implied by The Health of the Nation White Paper (Department of Health, 1992). Many of the targets set for improving the health of the nation exclude people over a certain age, typically 65 or 75 years. Implicit within this is the suggestion that the health of people over this age is not a priority and Bytheway argues that 'in seeking to reach these targets, an under-resourced National Health Service (NHS) will give even less attention to older people than previously' (page 57). More recently, the government's National Service Framework (2001) has set out policies aiming to root out age-discrimination in the NHS, thus giving an important acknowledgment that such practices do currently exist and need to be addressed.

The concept of ageism was first coined by Butler in 1963 (cited in Biggs, 1993). He describes ageism as:

a process of systematic stereotyping and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender.....Ageism allows the younger generation to see older people as different from themselves: thus, they suddenly cease to identify with their elders as human beings and thereby reduce their own fear and dread of ageing.....At times ageism becomes an expedient method by which society promotes viewpoints about the aged in order to relieve itself from responsibility towards them

(Butler, 1987)

This representation of ageism is exemplified by Biggs (1993) who draws on an example from Social Trends (HMSO, 1988), which says:

Although the size of the dependent population in 2025 will not be much higher than it was in 1971, it's composition will be different in that there will be far less children and many more elderly people, so reducing the demand for education but increasing the burden on health services.

(HMSO, 1988)

Thus where children are perceived as producing demands on resources, older people produce a burden. Furthermore, Biggs (1993) argues that the literature in the UK regarding the structural inequality evoked by retirement (Laczko & Phillipson, 1991) and the unequal distribution of resources based on age (Townsend, 1986; Walker, 1986) point to an artificially constructed dependency by older people on the state, whereby the skills of older adults are undervalued and unused and they are therefore forced to become dependent on others.

Phrases which frequently appear in the popular media, such as the 'sense of impending crisis', 'the burden of the aged' and a 'demographic time bomb' (The Guardian, 2nd January, 1989) are now being challenged as alarmist descriptions of the changes in the age distribution of the UK population (Walker, 1990). It is true that the proportion of young people is declining in relation to older adults, but statements such as these reflect powerful cultural biases and serve to preserve the social inequalities and restrictions experienced by older individuals by maintaining ageist attitudes, encouraging the concept that older people are a drain on resources, and thereby heightening dread and fear.

Another description of ageism is given by Bytheway & Johnson (1990) who produced the following 'working definition':

1. Ageism is a set of beliefs originating in the biological variation between people and relating to the ageing process.
2. It is in the actions of corporate bodies, what is said and done by their representatives, and the resulting views that are held by ordinary ageing people, that ageism is made manifest.

In consequence it follows that:

- (a) Ageism generates and reinforces a fear and denigration of the ageing process, and stereotyping presumptions regarding the competence and the need for protection.
- (b) In particular, ageism legitimates the use of chronological age to mark out classes of people who are systematically denied resources and opportunities that others enjoy, and who suffer the consequences of such denigration, ranging from well-meaning patronage to unambiguous vilification.

(Bytheway & Johnson, 1990)

This definition effectively highlights the power of prejudicial attitudes, discriminatory practices and institutional policies, which Butler (1980) argues have transformed ageing 'from a natural process into a social problem in which the elderly individual bears the detrimental consequences.'

Many of the ideas, which have developed, on ageism emanate from the propositions of Goffman (1961) who, from his qualitative research of strangers' social interactions maintained that people are likely to be discredited by social characteristics that set them apart from the 'normal' world. Such discrediting characteristics, suggests Martin (1986) are likely to elicit negative evaluations, emotional responses and avoidance behaviours by others (as cited in Kahana, et al., 1996).

According to Goffman (1961) we can expect the level of stigma associated with individuals to be dependent on the number and type of 'blemishes' a person is perceived as having. Blemishes that are seen as non-correctable are anticipated to hold the greatest degree of stigma. Moreover, symptoms of mental rather than physical illness are associated with particular stigma, as these are perceived as potentially disruptive and threatening to 'normal' individuals.

Goffman's theories have been supported in research by Austin (1985) in a succession of studies aimed at investigating attitudes of students, professionals and the general public toward various types of disability. Findings demonstrated that people with mental illness are viewed less positively than those with physical illness. As Bytheway (1995) asserts, it seems that we live in a society that 'values above all else the independence, competence and capacity associated with mature adulthood, and which deplors dependence, incompetence and incapacity'.

Clearly, older people with dementia embody a number of stigmatising conditions. Not only are they older and therefore subject to ageism, but they also experience mental health problems and therefore have what is perceived by others as a terminal condition characterised by disruptive and threatening tendencies. Given this combination of factors, it could be anticipated that prejudice and stigma towards older people with dementia is likely to be exceptionally high.

In more recent years, Goffman's claims have been affirmed by Stirling (1996) in her work on Social Role Valorisation and its relevance for older people and people with dementia. Stirling (1996) compares attitudes towards and services for older people with those for other disabled groups such as people with learning difficulties. Stirling states that while efforts to build more positive philosophies and models to replace stereotypes and prejudicial thinking about some groups have had a degree of success, efforts to do the same for older people have been less of a focus. This is because they are seen in terms of 'models of pathology, non-productivity and social burden' (Stirling 1996) and they are not perceived as a minority group.

Stirling comments on the way in which the negative attitudes of society are embedded in the provision of services for older people and lists a number of ways in which the lives of older people are predominantly affected by such systems. First rejection and segregation from society promotes feelings of insecurity in the wider community and contributes to a diminished experience of the world. Second, people are congregated on the basis of their disability by which they then become defined in other aspects of their life. Third they experience a discontinuity of their physical environment, in particular having to give up their home and a discontinuity in relationships and social connections. Fourth, they experience a loss of control, autonomy and individuality and a loss of citizenship as they are no longer encouraged to use public facilities. Fifth they become caught in a poverty trap and are perceived as an economic burden due to the low value placed on their lives. Finally they are denied their true feelings as it is assumed that people with dementia don't feel as we do; thus they are dehumanised by others and blamed for problems arising from the effects of isolation and internalisation of negative stereotypes, which thus become a 'self-fulfilling prophecy'. As an alternative to these degenerative features of growing older, a model of development based on promoting positive ways in which older people can be viewed by their community and so come to view themselves is strongly advocated, whereby their lifestyles could and should be valued and their sense of personhood maintained.

If negative and stigmatising attitudes are ingrained in society and within service providers as suggested above, it is particularly important to consider whether the attitudes of health and social service workers are consistent with such prejudice, since these are the people who work most closely with older and disabled people in ensuring their needs are met with adequate provisions and services.

1.2.2. Attitudes Within Health Care

Those working with disadvantaged groups might be expected to have more positive attitudes towards their clients due to greater knowledge and increased contact with them. Thus one might assume that they would have increased sympathy for them and their situation as they are not as detached from them as the general population. Unfortunately, evidence suggests that this has not been the case and much of the research on the attitudes of health care workers indicates that they are unable to disengage from the negative stereotypical thinking of society and may indeed have exaggeratedly negative attitudes because of their prolonged contact with those who (according to Goffman's theory) are thought of as most 'blemished'.

Some studies have found the attitudes of health care professionals to be similar to those of the general population (Solomon & Vickers, 1979; Tornstam, 1985, cited in Saarela & Viukari, 1995). However, in a summary of the evidence reported in the 1960's and 1970's, Adelson et al. (1982) report widespread findings of negative attitudes and stereotypical thinking towards the aged among professionals and ancillary staff in nursing homes and other institutional settings (Coe, 1967; Kahana & Coe, 1969; Kosberg & Gorman, 1975; Kosberg & Harris, 1976 cited in Adelson et al., 1982). Green (1981) also notes frequent references to the negative attitudes of service providers and paid caregivers in the gerontological literature. Indeed, Ciliberto, Levin & Arluke (1981) and Revenson (1989), demonstrate increased negative attitudes of workers who had greater contact with older people with physical illness, dementia, or both.

In a review of the literature on the attitudes of American nurses, Martin & Buckwalter (1984) draw similar conclusions about the negativity of nurses towards older people and

say that further support for this negative bias is evident in the lack of geriatric nursing in nursing education and the preference of most nurses to work with younger age groups (Burnside, 1981). Likewise, Gomez, Young & Gomez (1991) have related negative attitudes to the tendencies of nursing staff to avoid working with older populations. Indeed Smith et al. (1982) found that nursing personnel at all levels demonstrate a lack of interest in geriatrics and usually have little knowledge about the geriatric patient. Williams (1982, cited in Chandler, Rachal & Kazelskis, 1986), using the Palmore Facts on Ageing Quiz #1 (Palmore, 1977) found that 75% of nurses studied demonstrated negative attitudes towards older people and little understanding of the normal ageing process.

Owing to the frequency of such high levels of negative attitudes amongst health care providers, Kosberg (1983) termed the phenomenon 'professional ageism', suggesting that for those working in the field, ageism is not just a part of their society but is just as insidiously ingrained into their profession. However, although the evidence suggestive of generally negative attitudes has been strong, these findings do not go unchallenged and more recently, several authors have found more positive or neutral attitudes. For example, Chandler et al., (1986) found neutral attitudes towards older people among nursing staff of two long term care facilities in Mississippi, by using both the Kogan Old People scale (Kogan, 1961) and the Palmore Facts on Ageing Quiz #2 (Palmore, 1981). Even more encouragingly, in a study on rural American home health-care workers, Weiler & Sarvela (1991), using their own evaluation tool, found that respondents had an overall positive attitude towards their clients and towards the elderly population in general. In Robinson's (1993) study, a self-developed attitude scale was used which incorporated statements from the Kogan Old People scale, the Palmore Facts on Ageing Quiz and the Tuckman-Lorge questionnaire (Tuckman & Lorge, 1953). This study reports that the responses of nursing

home aides were generally positive with most respondents indicating that they viewed old people as wise, giving good advice, loving children, being friendly and being most interesting.

Further evidence for the positive attitudes of nursing home staff has been reported by Kahana et al. (1996), who provide one of the very few studies to specifically investigate attitudes towards older adults with dementia and to compare these with attitudes to other groups of elderly populations. They employed a modified version of a semantic differential scale developed by Rosencranz & McNevin (1969). Results indicated that attitudes held by the American nursing home employees in their study, were generally positive. Kahana et al (1996) point out the surprising scarcity of documentation on health care workers' attitudes towards older persons with different levels of disability or illness. Their study compares attitudes towards well elderly adults with physically ill elderly adults and elderly adults with Alzheimer's disease. Although attitudes were found to be in the generally positive range, less positive evaluations were made of older adults with Alzheimer's disease than of the physically ill or well older adults, confirming Austin's (1985) assertions that people with symptoms reflecting mental illness or mental disability are viewed most negatively and generally more negatively than those who are ill or ageing.

Most of the research cited, tends to have been carried out in the USA and due to the scarcity of research in this area in the UK, it is difficult to know how the attitudes of British populations would compare. No recent research was found either on the attitudes of the general British population and how these compare to those of nursing home staff, or attitudes towards older people with varying degrees of disability. One study was found

which attempts to assess attitudes towards older adults held by care staff in residential homes in Leicester (Baillon Scothern, Neville, & Boyle, 1996). This study employed both the Kogan Old People scale and a self-developed tool designed for the study, assessing staff attitudes towards the residents and the home (called the SARAH). Generally favourable attitudes were indicated by the two scales used, lending support to similar findings in other countries.

Thus there appears to be considerable disagreement in the literature about how positive or negative the attitudes of care staff working with older adults are. Given that it is the more recent research that suggests that attitudes are generally positive, one might be tempted to believe that due to a growing awareness and understanding of the needs of older people and in staff training and development that attitudes of staff are more positive than they used to be in the 1960's and 1970's. While this may be true to an extent, it is also possible that such differences in the literature reflect a growing awareness of staff of the attitudes that are expected of them in questionnaires, but the degree to which they represent actual beliefs or impact upon actual behaviour towards older clients remains unknown. However, even if staff do provide answers which they believe to be socially or politically 'correct', rather than it reflecting how they actually think or act, this at least demonstrates that some level of education has taken place across the decades and that they are at least more aware of what the 'right' answers are, even if they have yet to internalise them.

While it seems likely that the discrepancies in findings discussed above do appear to demonstrate a shift in attitudes since the early 1970s, a number of alternative explanations may also be possible. For example, the attitudes of staff working in domus units, the new generation of nursing homes specifically designed for people with dementia, may be very

different to those of people working in traditional psychogeriatric hospital wards. This is because the physical environment in which they work and the emphasis and requirements placed on them by their employers are likely to be very different. Employers, who only require their staff to provide what is physically necessary to keep a client clean and well nourished and don't provide time and resources to fulfil psychosocial needs, may be teaching their staff to take a dehumanising approach, encouraging negative attitudes and stereotypical thinking. Thus, contradictory findings may represent differences in the type of establishment being studied and further evaluation of the philosophies of care and the culture instituted by the service provider would be needed in order to establish this.

The differences found in studies of attitudes towards older adults might also be as a result of methodological differences in the measurement instruments used and the concepts and assumptions underlying those instruments. For example, the focus of the attitude scales used vary, with some focusing on knowledge of the ageing process and of dementia, others focusing on attitudes towards clients, others focusing on attitudes towards older people in general, and others towards working practices and policies and procedures of the home. Such differences in the way attitudes are measured make it very difficult to compare the findings of studies.

The literature in the area is also characterised by investigations carried out some considerable time ago and the paucity of recent research in this country may be due to the decline in popularity of employing attitude scales. Questions have arisen regarding the level of association between attitudes and actual behaviour and this may in part have contributed to reduced interest in attitude studies, since difficulties have been encountered

in achieving valid and reliable attitude scales that correlate with quantifiable observations of behaviour (e.g. Salmon, 1993).

It is also possible that as expectations of quality of care have changed since the early 1970's what would have been considered acceptable levels of care then, fall very short of the standards of excellence aimed for today. Thus, the ceiling level of some of the measurement instruments used in the past may no longer be high enough to provide a detailed and informative view of attitudes today.

Finally, the discrepancies found in the research regarding how positive or negative the attitudes of health care personnel are may also be a function of individual differences amongst participants and in order to examine this further, much of the research on attitudes towards older people has been concerned with predictors of attitudes amongst health care staff.

1.2.3. Predictors Of Attitudes

The literature regarding the factors that may influence attitudes of health care workers has been somewhat inconsistent (Lutsky, 1980), however, some factors have emerged as potentially important and these include age, level of education, length of employment, closeness of contact, levels of empathy and self-efficacy.

Several studies have demonstrated an association between age and attitudes towards older people, with older respondents tending to demonstrate more positive attitudes (Campbell,

1971; Wolk & Wolk, 1971; Penner, Ludenia & Mead, 1984; Dillard & Feather, 1991; Kahana et al., 1996). Dillard & Feather (1991), suggest that this may be because younger people are less able to communicate and understand older adults and have limited understanding and experience of the ageing process. They also suggest that it may be because younger aides view the job as short term or as a stepping-stone to other jobs.

In studies that have compared the attitudes of registered nurses, practical nurses and nursing assistants, respondents with higher levels of training have consistently been found to give more positive responses towards their older clients (Campbell, 1971; Wolk & Wolk, 1971; Taylor & Harned, 1978; Almquist, Stein, Weiner & Linn, 1981; Smith, Jepson & Perloff, 1982; Rothbaum, 1983; Penner et al., 1984; Chandler, 1986). Martin (1986) also supports this assertion, stating that those who are more educated are less likely to hold stereotypes of others. Unusually, Kahana et al. (1996), report that in evaluations of well elderly people, more educated nursing home staff gave less positive evaluations. They explain this in terms of the more educated staff being less likely to make generalisations about well older adults representing a lack of stereotyping, which resulted in their lower scores.

Some authors have suggested that perhaps it is not surprising that the attitudes of care assistants are generally more negative than those of qualified nurses because they receive no formal training, thus they have only their own perceptions of the needs of clients to rely on. Since this will have been developed from their own particular cultural background, it is likely to reflect the generally negative bias of society (Moss & Halamandaris, 1977, cited in Robinson, 1993), a finding that is particularly important since it is care assistants who spend the most time with clients (Campbell, 1971).

Indeed, the frequency and intensity of contact with older adults has, in itself, emerged as a potentially powerful predictor of attitudes. Research in this area is based on Revenson's (1989) hypothesis, which states that stereotyping will be reduced and recognition of clients' individual differences and diversity will be improved with increasing frequency and intensity of contact. However, other studies that have focused on work-related contact report a generally negative correlation between favourable attitudes towards older people and contact with them (Campbell, 1971; Ciliberto et al., 1981). One possible explanation for this difference of opinion is suggested by Solomon & Vickers (1979) who cite Cook (1962) in making the proposition that close contact in a positive context is likely to result in a reduction of stereotyping and more individualisation, but that close contact in a negative context could be expected to amplify prejudicial stereotyping. Indeed, Dillard & Feather (1991) found an association between more stereotyped attitudes and longer working hours and it may well be that working longer hours results in a working environment that is more negative in context because staff are more likely to become uninterested and tired during long shifts. Dillard & Feather (1991) suggest that this finding may reflect individual differences in staff, as those who work long hours may be more stressed and may have primarily monetary reasons for doing the job. However, the fact that staff are working long hours might also be a reflection of the employing organisation and the negative attitudes and environment created by limited resources and poor working conditions.

Increasingly researchers and practitioners are concluding that certain organisational factors have potentially powerful influences. Many of the factors thought to promote a more positive care environment have been identified by Kitwood (1997), in his work on cultures of care. These include aspects such as the style of management; the type of

training offered to employees; and the practices used to promote an individualised approach to care such as care planning and key worker systems. While there has been no direct evidence to support a link between organisational factors such as these and the attitudes of employees, the implications are clear. For example, an organisation that encourages the involvement of clients' relatives; keeps detailed life history information about clients; and uses a key worker system to help build relationships between staff and residents, could encourage staff to take an individualised approach, deterring the maintenance of stereotypical attitudes. On the other hand, in an organisation where resources are minimal, where staff are unsupported and the management style is harsh and authoritarian, the negative feelings developed within staff could be projected onto clients, influencing both the way members of staff view clients and the way in which they behave towards them. Thus the environment within which care takes place forms its own 'internal' culture, having the potential to influence the attitudes and behaviour of staff in the same way as wider societal norms.

The influence of a positive context on attitudes has been evidenced by Hatton (1977) who reported that an increased number of positive interactions between nurses and patients were related to positive attitudes. More positive attitudes have also been found to be related to greater job tenure (Campbell, 1971; Atkins, Meyer & Smith, 1982; Penner et al., 1984), thus it might be assumed that those who continue working in the care of older people, over a longer period of time generally find it a more positive experience, hence their decision to remain in this type of employment.

Some authors have argued that health professionals' attitudes towards older clients may be influenced by their feelings about their parents and older relatives (Solomon & Vickers,

1979; Lowy, 1980; Schonfield, 1982). Indeed, research has reported a correlation between positive attitudes and quality of family contact amongst care staff (Knox, Gekoski & Johnson, 1986), with staff who have better relationships with older members of their own family tending to have more favourable attitudes towards their older clients. Thus it seems likely that it is the quality of contact with older people, not the quantity that can potentially pacify effects of social prejudice (Ivester & King, 1977).

In addition to the factors listed above, certain personal characteristics have also been shown to predict attitudes. For example, Solomon & Vickers (1979) found that those with the most negative attitudes towards older people, also scored highly in an 'attitude towards the future' factor which was negatively loaded towards pessimism. The measure used was characterised by phrases such as 'The world is headed towards destruction' and findings represent a generally pessimistic or negative outlook on life, and may perhaps represent more fundamental attributes such as levels of self-esteem or depression.

In investigating this concept further, a recent study by Kahana et al. (1996), employed self-efficacy theory (Bandura, 1986) as a basis for investigating predictors of attitudes. They tested self-efficacy as a schema for understanding the personal characteristics that determine attitudes, since Bandura (1986) claims that self-efficacy is a dominant factor in influencing behaviour. In the context of their study, self-efficacy refers to the feelings of nursing home staff about their own level of skill and competence in carrying out their work. Kahana et al., (1996) state also that 'recent theorising in social psychology has an important influence on attitudes (Langer, 1983) which in turn influence behaviour (Martin, 1986)'. Furthermore, studies that have investigated staff attitudes towards physically handicapped clients (Fichten, Bourdon, Amsel & Fox, 1987) and psychiatric

patients (Margolies, Wachtel & Schmelkin, 1986) report that more positive attitudes were elicited from those with a higher level of self-efficacy in dealing with their clients.

In their own study Kahana et al., (1996) demonstrated that staff who reported greater feelings of self-efficacy also embodied more positive attitudes towards all three groups of older adults in their study (well elderly, physically ill elderly and those with Alzheimer's disease). Additionally, they reported that the 'effect of self-efficacy progressively decreased as the stigma associated with target groups of elderly persons increased'. Kahana et al., (1996) were also able to relate these findings to previous reports regarding closeness of contact. When making evaluations of people with Alzheimer's disease, they found closeness of relationships with parents to be a predictor of self-efficacy that, in turn was a predictor of attitudes.

A further personal characteristic that appears to predict attitudes has also been implicated in research focusing on the role of empathy in nursing homes. Carkhuff (1969) states that the fundamental element of a helping relationship is the interpersonal skill of empathy. A number of studies have investigated its role in quality of care, including Bagshaw & Adams (1986), who found that low levels of empathy were significantly related to negative attitudes and also to a custodial, as opposed to a therapeutic approach to care. Other support for this finding comes from Baker (1984) and Heller, Bausell & Ninos (1984), who demonstrated a relationship between positive attitudes and a rehabilitative, rather than a custodial, approach to care. Subsequently, Åström, (1990, cited in Alfredson & Annerstedt, 1994) found high levels of empathy to be associated with more positive attitudes as well as with higher educational levels. In later papers Åström, Nilsson, Norberg et al. (1990, 1991), also found lower levels of empathy to be correlated with less

positive attitudes and with measures of burnout. Alfredson & Annerstedt (1994) point out that 'the very same factors that we strive for in caring work (being involved, client oriented, well educated) at the same time are the greatest risk factors for well-being'. It is possible that some members of staff do risk their personal well-being by becoming more involved with clients and empathising with their situation. However, the Astrom et al., findings suggest that lower levels of empathy are associated with greater levels of burnout. Their cross-sectional data, however, do not allow identification of the direction of causality. Engaging empathically with clients does require members of staff to acknowledge or experience painful emotions that they might prefer to avoid. It may be that some people are less empathic due to individual personality traits or characteristics, or that when people become burntout their ability to be empathic falls. It could also be that levels of empathy are affected by organisational factors such as levels of support and training, which may strongly influence an individual's ability to either engage empathically with clients or to react defensively towards them and avoid becoming 'too close'. The important question seems to be in finding out how members of staff can be enabled to hold and maintain higher levels of empathy with their clients when this may often be an emotionally painful process.

The broad range of factors identified in the literature as having an influence on the attitudes of health care workers towards older clients and clients with dementia can be conceived of in terms of a systemic model whereby attitudes are maintained or developed through an amalgamation or combination of influential sources. Figure 1.3 offers a visual representation summarising the currently available literature on attitude predictors discussed above.

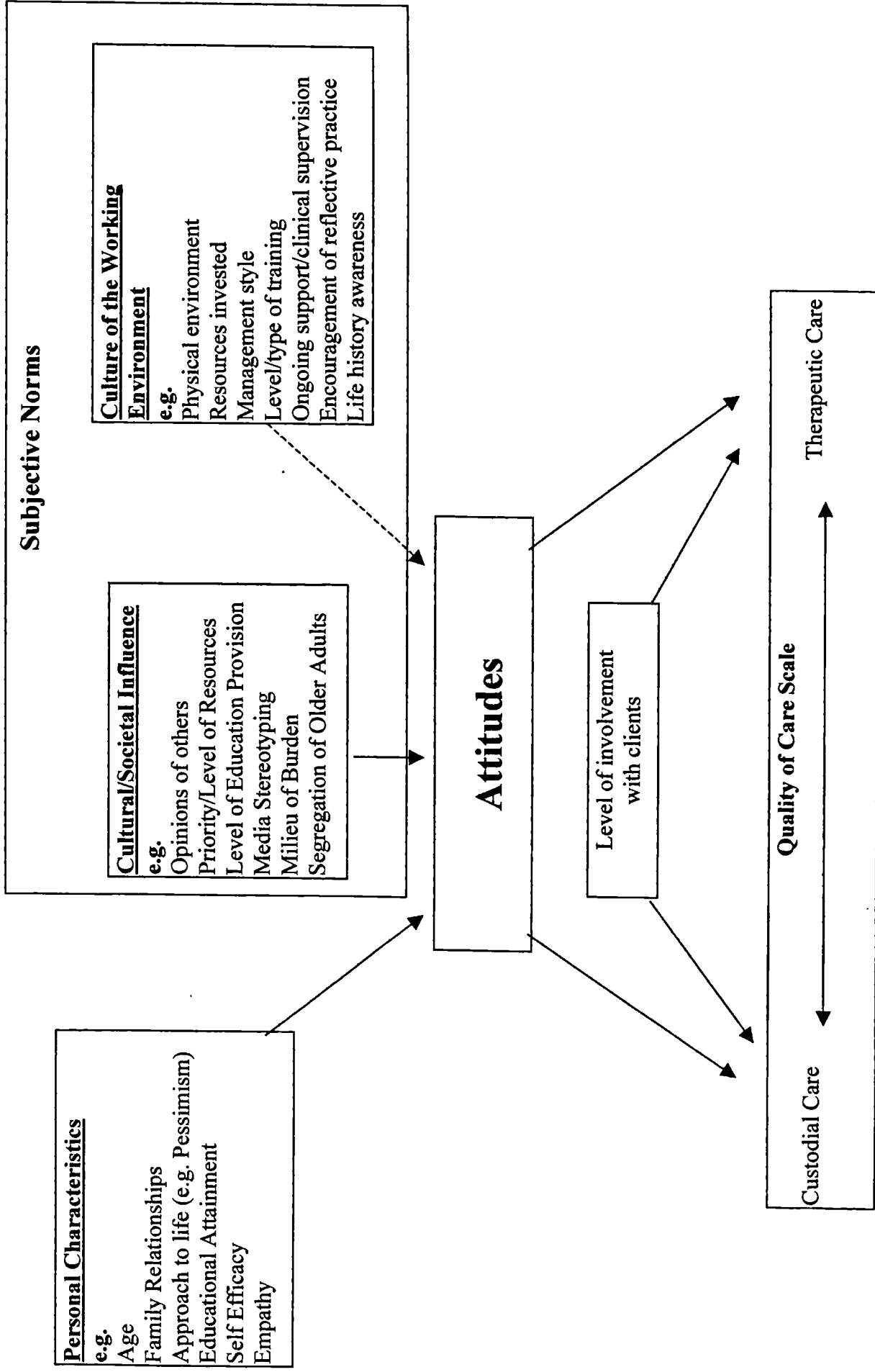


Figure 1.3: Summary of attitude predictors and their potential effects (dotted lines indicate inferred relationships)

Thus it seems that there is a considerable variety of factors that may influence the formation or perpetuation of attitudes towards older clients within the long-term care sector. In relation to the theory of reasoned action, described in section 1.1.3 above, it appears that both societal influences and the working environment could be applied as subjective norms. Personality characteristics on the other hand may be more indicative of one's own attitudes towards a behaviour. According to the theory, a person will weigh up the relative importance of attitudinal and normative considerations and this will determine their behaviour.

1.3 SUMMARY

This chapter has reviewed some of the literature on attitudes and, in particular, attitudes towards older people and people with dementia. Attitude research has prominently been employed to predict health-related behaviours such as smoking or exercise. Its use to examine prejudicial and stereotypical thinking has also been widespread, however there has been little focus on attitudes towards older adults and even less on attitudes towards people with dementia. The research that is available within this field has typically focussed on professional carers of older people, and little is known about how the attitudes of such people compare to those of society at large. It is not within the realms of this study that such a relationship can be examined, however, if similarities could be found between the attitudes of care staff and those of society in general, this might indicate that increased contact with people with dementia, or staff training (if any has been provided) has a limited impact on attitudes. Alternatively, differences could demonstrate the mediating effects of training, or of a positive working environment. It

would also provide persuasive evidence for the benefits of trying to increase awareness amongst wider sections of the community.

Research on the predictors of attitudes in this area has demonstrated that the attitudes held by health care personnel are likely to be dependent both on the nature of the staff with their personal characteristics and cultural background, and on the nature of the employing organisation and its approach to staff training and support. Some of the possible predictors of attitudes are aspects that are fundamental to the person, such as age, which cannot be changed. Nevertheless it may still be important to consider such factors when making recommendations about the selection of appropriate staff in nursing homes. Other factors, however, may be more susceptible to change and it is these factors that may need to become the focus when designing appropriate care environments, strategic policies and procedures, and training strategies and personal development programmes for staff.

Furthermore, people's attitudes may also, to a certain extent, be influenced by the views and opinions of other people whose values they respect. Clearly this has important implications in attempting to change attitudes. For example, it may mean that training which attempts to promote more positive attitudes would be more effective if the whole staff team were involved. However, attempts to change attitudes through the use of intervention programmes could also benefit considerably from having a greater understanding of what exactly it is they are trying to change. There is little current evidence in the literature about the kinds of attitudes held by nursing home staff, with available studies providing somewhat contradictory findings. There does appear to be some evidence that attitudes in the 1990's are more positive than they have been in previous decades, however, since we cannot compare these changes to population norms,

it is difficult to know whether any changes that are present are due to specific improvements in the education of care staff and improved working environments, or reflect a more general development in levels of understanding and acceptance of disadvantaged groups within society.

Further confusion arises over the various methodological techniques applied to measure attitudes of health care staff. Most of the measurements used relate to an American context; are relatively dated; and provide quite general measures of attitudes towards older people, rather than a specific focus on people with dementia. Thus, in order to develop a fuller understanding of attitudes towards people with dementia, their relationships with actual care and a greater understanding of their susceptibility to change, the first requirement is an appropriate form of attitude measurement, against which these relationships can be tested. The following chapter provides a more comprehensive review of attitude measurement and proposes the need for a new attitude scale, based on previous evidence of the elements required for effective attitude evaluation.

CHAPTER TWO

2.0 Development Of A Dementia Specific Attitude Measurement For Use With Health Care Professionals

2.1 Review Of Existing Attitude Measurements

A review of the literature on attitude measurement shows that researchers have been attempting to develop an instrument reflecting attitudes toward older people since at least the early fifties. Less emphasis appears to have been placed on the development of scales specifically to assess attitudes towards older people with dementia, thus, this chapter will review measurements designed to evaluate attitudes towards older people, as well as those designed specifically to address attitudes towards people with dementia.

As suggested in Chapter One, it is difficult to compare some of the studies of attitudes, because of the differences in the attitudes that are measured and the methodology used. Concepts and assumptions underlying the instruments used vary, with some focusing on knowledge of the aging process (and/or of dementia), others on attitudes towards clients, some on attitudes towards older people in general, and yet others towards working practices and policies and procedures of the home. Techniques used to measure attitudes have utilised two main methods. Some studies have used a series of questions or statements to which respondents agree or disagree and others have used a semantic differential scheme whereby respondents make their ratings on a series of adjective scales. As previously suggested, measurement instruments also vary according to the level of specificity aimed for. Most of the currently available attitude scales have elicited attitudes towards older people in general, however, there are a couple that have focused more on

people with dementia. Each of these existing attitudes measurements will be discussed below. The summary tables (Tables 2.1 and 2.2) on pages 40-41 and page 55 also provide an overview of the instruments reviewed and their associated methodological strengths and weaknesses.

2.1.1 Instruments Used To Measure Attitudes Towards Old People

One of the earliest attitude scales to receive frequent use in assessing attitudes towards old people was the Tuckman-Lorge Questionnaire (Tuckman & Lorge, 1953). Designed to reflect stereotypic views towards old people, it consists of a series of 137 short statements about the elderly requiring a yes/no response. The scale was developed from Tuckman and Lorge's series of studies on the acceptance of stereotypes about old people published in the early fifties. The statements are grouped into 13 different factors which include an 'Attitude towards the future' factor, characterised by statements such as 'the world is headed towards destruction', a 'Sex' factor which includes statements about old people such as 'they should not marry' and an 'Assessment of Life' factor incorporating views about whether older people are 'happier that way'. Despite its frequent use during the 1950s, the scale has been criticised for making no use of attitude scaling procedures (Kogan, 1961) and for relying on items that could potentially be objectively realistic rather than stereotypical, since no empirical evidence exists to dispute them (Rosencranz & McNevin, 1969). Other methodological problems include its length (137 items), making it cumbersome to complete; lack of published empirical support for its validity and reliability; and lack of a proven relationship to behaviour.

TABLE 2.1: Summary Table of Studies Reporting Attitude Assessment Measures

Author/s	Year	Title of Measure	Country	Target Group	Participants	Method	Designed to assess:	Item Number	Item selection	Reliability & Validity	Relationship to behaviour
Tuckman & Lorge	1953	Tuckman-Lorge Questionnaire	USA	Older people	147 graduate students (later studied other occupational age groups)	Yes/No statements	Misconceptions and stereotypes	137 in 13 categories	Not stated - classified into categories by authors	Stated by Solomon & Vickers (1979) to be well-validated and reliable, but reports of empirical evidence not found	Not tested
Kogan	1961	Kogan Old People (OP) scale	USA	Older people	482 (mainly male) psychology students	6 point scale: strongly agree to strongly disagree	Attitudes on issues such as intellectual capacity, dependence, personality, and living arrangements	17 matched pairs of positive & negative statements (i.e. 34)	From other minority group attitude scales and from the authors and others' intuition about stereotypes in society	At development odd even reliability reported as .73 to .83 (negative scale) and .66 to .77 (positive scale). Bagshaw & Adams, (1986) question the construct validity of the positive scale. Chandler et al. (1986) report it to be more reliable and valid than the FAQ #2.	Hatton (1977) reports a relationship with nurses' level of positive interactions, but, no statistical significance and sample size of 7
Oberleder	1962	Oberleder Attitude Scale	USA	Older people	40 older people living in residential care (i.e. older peoples' attitudes towards older people)	4 point scale: strongly agree to strongly disagree	If level of adjustment to residential care could be predicted by residents attitudes	25 items using paired opposites	From other questionnaire studies or from studies and theoretical formulations in which discussed prevailing attitudes about old people	Test-retest reliability (1 month) carried out with 36 other residents: values for subscales were between .75 and .88.	Able to predict people who were categorized as adjusted or poorly adjusted by a psychiatrist or social worker
Palmore	1977, 1981	Palmore Facts on Aging Quiz (FAQ) #1 and #2	USA	Older people	87 undergrads, 44 graduate students, and 11 faculty members	True/false statements	Misconceptions about aging	25 items: correct and incorrect	Factual statements based on the empirical documentation of the time	Statistical evidence not reported. Author states that FAQ is only rough indicator, since bias has to be inferred from incorrect answers	Not tested
Dillard & Feather	1989	Adapted version of the Oberleder Attitude scale (see above)	USA	Older people	345 in-home care aides	4 point scale: strongly agree to strongly disagree	Staff attitudes in areas of 'stereotype, potential and limitation'	16 items: positive and negative within 3 dimensions (see left)	Used factor analysis on the 25 item Oberleder Attitude Scale, reducing number of items to 16	Questionnaire originally designed to assess attitudes of older people. Only the 'stereotype' factor (4 items) related to anything. No empirical support given.	Not tested

Author/s	Year	Title of Measure	Country	Target Group	Participants	Method	Designed to assess:	Item Number	Item selection	Reliability & Validity	Relationship to behaviour
Åström et al.	1987a	Attitudes Towards Demented Patients Scale (ADP scale)	Sweden	Older people with dementia	60 health care personnel working in psychogeriatric care	5 point scale: fully agree to fully disagree. (Collapsed to 3)	Staff attitudes towards patients with dementia and their care	30 statements	From 120 items, 30 were selected which best prompted extreme responses (i.e. fully agree or disagree)	Not reported. Validity weakened because 39% of answers were missing, so estimations were made using modes	Not tested
Weiler & Sarvela	1991	Untitled	USA	Older people	548 home health care workers	5 point scale: strongly agree to strongly disagree	Staff attitudes towards the elderly in general and their clients	15 items.	Unable to ascertain	Cronbach Alpha reported as .79. Panel of experts used for validity. Results replicated previous study by Weiler et al., (1988)	Not tested
Robinson	1993	29-item Perceptions of the Elderly Scale (PES)	USA	Older people	246 nursing home aides	5 point scale: strongly agree to strongly disagree. (Collapsed to 3)	Perceptions by staff of the needs, abilities and personality traits of the elderly	29 items.	25 items selected from scales by Kogan & Wallach (1964), Palmore (1974, 1977) and Tuckman & Lorge (1953). Additional 4 - not stated	Report factor analysis indicating 3 factors, one of which (a 'general evaluative factor') explained 54% of the variance. No reliability analysis reported	Not tested
Salmon	1993	Untitled (See item selection)	UK	(1) Physically ill, patients and (2) Older people	27 nurses from psychogeriatric wards	(1) 4 point scale, (2) 5 point scale. Both from strongly agree to strongly disagree	(1) Staff attitudes towards 7 work-related areas (2) Attitudes to nursing the elderly	(1) 41 items (2) 17 items.	Used (1) Philosophy of Treatment Form (POT), Barrell et al. (1965) (2) An attitude scale by Jones & Galliard (1983) - method of item selection unspecified	(1) At development, internal consistency reported as .74 to .93 (Kuder-Richardson). Test-retest with 1 week between testings: values were .51 to .89 (2) Not reported.	Report minimal relationship with observations of behaviour. (More 'recreational activities' related to less sensitivity to patient needs)
Saarela & Viukari	1995	Untitled (See item selection)	Finland	Care of older people	51 physicians, nurses and social workers	Visual analogue scale: strongly agree to strongly disagree	Attitudes to working practices and professional issues	30 items in 5 categories	Used part of an attitude scale developed by Snape (1986), excluding the 'attitude towards old age' category. Original scale based items on previous research and pilot study.	Snape reported scale to have been tested using Likert's criterion on internal consistency.	Not tested
Baillon et al.	1996	Staff Attitudes towards Residents And the Home (SARAH)	UK	Older and confused people	39 care staff and senior staff working in Local Authority Part III homes	7 point scale: strongly agree to strongly disagree	Attitudes towards residents and the home	12 paired statements (i.e. 24 items)	Not reported	Not reported	Not tested

Despite these limitations, Solomon & Vickers (1979) offer support for the measure, stating it to be a reliable and well-validated questionnaire, which allowed them to identify little change in attitudes towards the aged since the tool was developed. However, an alternative explanation of this finding could be that the measure was insensitive to change. The questionnaire has received little attention since the late seventies, and with this in mind, in addition to the methodological problems highlighted above, it could be suggested that this instrument may no longer be suitable for assessing attitudes, particularly given the developments which have occurred in the approach to and care of older people over the last 20 years.

Following Tuckman & Lorge (1953), Kogan, developed his own scale, the Kogan Old People (OP) scale (1961) which was designed to assess attitudes towards old people on issues such as intellectual capacity, dependence, personality, living arrangements, personal appearance and influence on business and industry. The scale consists of 17 matched pairs of positive and negative statements about old people such as 'most old people should be more concerned with their personal appearance; they are too untidy'. Reactions to the statements are obtained on a 6-point likert style scale ranging from 'strongly agree' to 'strongly disagree'. Results can be divided into two scales, one representing positive attitudes and the other negative, or they can be combined into one scale. At the time of its development, odd-even reliability was reported as .73 to .83 for the negative scale and .66 to .77 for the positive scale. Content validity was also reported by Kogan. However, one of the weaknesses of the measure is that it was developed with male undergraduate students, whose views of older people may not be representative of the general population or of people working in the field.

The scale has been used in a number of studies, including Bagshaw & Adams (1985-86) who suggest from the results of the Kogan positive scale (KPS) that either there is little variation in positive attitudes among nursing staff personnel in nursing homes or that KPS does not have construct validity; further investigation would be required to answer this question. Indeed, Kogan himself asserts that the OP scale 'falls somewhat short of an acceptable reliability level'. It is also worth noting that subjects disagree more with negative statements than they agree with positive statements, thus providing an interesting anomaly.

In terms of the instrument's ability to relate to observable behaviour, Hatton (1977) does report some relationship between the Kogan positive scale and positive interactions between staff and older clients. However, this was not a statistically significant relationship and was based on just 7 subjects. Hatton (1977) does however raise the question of why a similar relationship was not found with the negative scale, since the items contained within each are matched pairs.

Palmore (1977) criticises previous measures (including the Kogan OP scale and the Tuckman & Lorge questionnaire) for being long, undocumented and for confusing factual statements with attitudes. The Palmore Facts on Aging Quiz (FAQ) #1 (1977) and #2 (1981) have been used to measure the cognitive component of attitudes by measuring knowledge about old people (Adelson et al., 1982). The quiz includes statements such as 'The majority of old people are seldom irritated or angry' and disagreement with such a statement would contribute towards scoring of negative attitudes. The Palmore FAQ #2 was developed by Palmore as an alternative form of his FAQ #1. Like the FAQ #1, the FAQ #2 is a short, easily administered, easily scored, 25-item true-false quiz that assesses

knowledge of basic physical, mental, and social facts about aging and also identifies widely held misconceptions about aging (Chandler et al, 1986).

Chandler et al. (1986) draw attention to the controversy in the literature regarding the reliability and validity of the FAQ #1 as a measure of bias towards the elderly and suggest the same issues apply to the FAQ #2. The FAQ was designed to consist of only factual statements and was to be used to assess level of information or misconceptions held by groups of people towards the aged. From such misconceptions, bias towards older people is inferred. The adherence to factual statements about the aged drawn from empirical findings is a limitation of the measure, suggests Wright (1988), since stereotypes may not necessary be founded on factual information. It is also possible to imagine that individuals could know the facts about older people, but still have prejudices towards them. Indeed, Palmore himself agreed that the FAQ #2 is only a rough indicator of bias toward the elderly (Palmore, 1981 cited in Chandler et al., 1986). Furthermore, some of the 'facts' incorporated in the scale are based on the available statistics of the time (e.g. Over 15% of the US population are now age 65 or over), which may not be relevant to a UK population and might also be subject to change over time and thus may no longer be accurate.

Chandler et al. (1986) used both the Kogan OP scale and the Palmore Facts On Aging Quiz with a sample of nursing staff from long-term care facilities in Mississippi. As a result of their study, they suggest that the Kogan OP scale is a more reliable and valid measure of attitudes toward the aged than the Palmore scale and reported neutral attitudes on the Kogan scale, but positive attitudes on the Palmore.

Dillard & Feather (1989) adapted a 25-item attitude scale (the Oberleder Attitude Scale, 1962) which included statements representing positive and negative views on aging, where responses to the items are measured on a 4-point scale ranging from 'strongly agree' to 'strongly disagree'. They reduced the number of items to 16 based on a factor analysis identifying three factors relating to the dimensions of 'potential, limitation and stereotype'. The 'stereotype' factor included 4 items which were: 'Old people too often like to meddle in other people's business', 'Older people become grouchy and stubborn with the years', 'Old people like to boss everybody', and 'The older you get, the more set in your ways you become'. When using this scale in a later study, Dillard & Feather (1991) found that younger aides and those working a longer working week had more stereotyped attitudes.

One of the problems with this particular scale is that the adapted version does not appear to have been published. Consequently, no information has been made available regarding its reliability or validity. Furthermore, the original Oberleder (1962) scale was designed for use to assess older people's own attitudes towards old people and it may be less appropriate for use with other groups, since it was not developed with them in mind.

Weiler & Sarvela (1991) developed their own attitude scale, in their study exploring the attitudes of American rural home health care workers towards the elderly and towards elderly clients. The measure was a three-part, fifteen item self-report questionnaire, employing a five-point Likert scale with response options ranging from 'strongly agree' to 'strongly disagree'. Questions concerned perceptions of the elderly in general, elderly clients specifically and also how respondents viewed the quality of care they provided. Statements included 'Most old people are socially active', 'My clients are often irritated'

and 'You treat all your clients the same'. Internal consistency was reported as 0.79 (Cronbach alpha). Opinions of a panel of experts were engaged in order to assure content validity. Results of the study showed that overall, respondents viewed both older people in general and their clients as not having poor memories, being socially active, not often irritated and not all the same, indicating generally positive attitudes.

The attitudes of New York nursing home aides towards the elderly was investigated by Robinson (1993), using a scale developed by adapting previous measures including those created by Kogan & Wallach (1964), Palmore (1977), and Tuckman & Lorge (1953). Items were selected to measure respondents' perceptions of the needs, abilities and characteristic personality traits of the elderly, to form a 29-item scale named the Perceptions of the Elderly Scale (PES). Responses were collected on a five-point Likert-type scale, but for analysis the response options were collapsed to disagree, uncertain and agree. Results showed that the attitudes of aides were generally positive, with most respondents indicating that old people are wise, give good advice, love children, are friendly and are most interesting.

The benefits of this study are that it was carried out with a large sample (237 participants) and it does report the results of a factor analysis which identified three factors (1) Negative evaluation of old people; (2) Old people are bitter complainers; and (3) Recognition of pragmatic concerns. However, Robinson does not report data on the reliability of the measure, nor does she offer empirical support for its validity. Furthermore, the focus of the scale is on people's perceptions of the needs, abilities and characteristics of older people, telling us little about how they might feel towards older

people, what their hopes and beliefs are about them or their futures and how they might interact with them.

In one of the few British studies on attitudes towards older people, Salmon (1993) employed two measurement tools to compare attitudes with the interactions of nursing staff in two psychogeriatric wards. The first of these was an attitude scale developed by Jones & Galliard (1983) where low scores reflect more positive attitudes towards nursing elderly patients. The second assessment used was a philosophy of treatment form (Barrell, DeWolfe, & Cummings, 1965), originally designed for use with physically ill patients. This scale divides into sub-scales on which high scores indicate (a) a desire to inform patients about their condition, (b) sensitivity to the effects of staff behaviour on patients' well-being, (c) sensitivity to patients' need for emotional support, (d) agreement with the need for open and harmonious staff relationships, (e) an unfavourable view of patients' maturity and behaviour, and (f) rejection of the need for staff to be self-critical about their performance. In using the scales, virtually no relationship between attitudes and behaviour were found, the only significant correlation suggesting that nurses who spent more time in recreational activities (i.e. non-patient related) were least sensitive to patient needs. Thus, Salmon (1993) concludes that the attitude assessments were not good predictors of behaviour and that behaviour could not be substantially improved by changing attitudes or by employing staff with more positive attitudes. Alternatively, the results found may represent similar problems in the way data was collected as those identified in the review of attitude studies carried out by Ajzen & Fishbein (1977) (see page 7). In Salmon's study, attitude measurement was quite general (attitudes towards older people), however, behavioural observations were carried out in psychogeriatric wards, presumably with people with dementia. Therefore, the behaviour being observed was more specific than

the attitudes being measured and as predicted by the Ajzen & Fishbein (1977) theory, the relationships between the two were minimal.

Similarly, Saarela & Viukari (1995) studied the effects of a short psychogeriatric training programme on the attitudes of primary health care physicians, nurses and social workers in Helsinki, but measured attitudes towards concepts that were not specifically related to psychogeriatric care. The attitude scale used was a self-administered Likert-type questionnaire developed by Snape (1986), consisting of 30 items in five categories: geriatric nursing as a career; nursing skill; medical management; the multidisciplinary approach; and attitude towards old age. Responses were obtained using visual analogue scales ranging from 'strongly agree' to 'strongly disagree'. Results demonstrated no significant differences in attitudes following training and no significant differences between the respondent groups. However, the 'attitude towards old age' category was not included as it was reported to have low internal consistency, thus results obtained would not have reflected attitudes towards clients, treatment of clients, or the aging process. The focus of training appeared to be on medical issues in lecture format, which may not have been sufficient to change attitudes in the remaining categories, which were mainly towards working practices and professional issues.

In a more recent British study, Baillon et al. (1996) assessed attitudes towards 'the elderly' and the Home among care staff of three local authority residential homes for 'the elderly' in Leicester. Two attitudes scales were utilised, the Kogan OP scale (Kogan, 1961) and a tool specifically designed for the study assessing staff attitudes towards the residents and the home (the SARA). The scale consists of 12 pairs of statements (representing either positive or negative attitudes) to which respondents are required to respond on a seven

point scale ranging from 'strongly agree' to 'strongly disagree'. Results showed significant differences in attitude between GHQ (General Health Questionnaire, Goldberg & Hillier, 1979) cases and non-cases on three of the items, with GHQ cases (i.e. those with poorer psychological well-being) more likely to agree that people living in the home would be better cared for living in a hospital or nursing home, and to disagree that nobody living in the home needed more care in a hospital or nursing home. There was also a significant difference between responses to the statement 'It is easy for residents here to maintain contact with friends and relatives', with GHQ cases less likely to agree. Although the study reports generally favourable attitudes of the staff indicated by the results of the two scales used, little psychometric data is provided on the SARA and the two scales are not compared with each other. Furthermore, no information was reported regarding the reliability of the scale or on its development.

2.1.2 Dementia Specific Attitude Measurements

The only dementia specific attitude measurement found in the literature was from a study to examine the attitudes, empathy and burnout experience of different categories of nursing staff in Sweden. Åström et al. (1990), employed an attitude scale - the Attitudes Towards Demented Patients Scale (ADP scale), developed by them (Åström et al., 1987a) and used in their previous studies (Åström et al., 1987b; Åström et al., 1990). The scale consists of 30 provocative statements concerning the care of elderly patients with dementia. Areas covered include 'how high the level of care given to the demented should be', 'the meaningfulness of their care', 'feelings towards demented patients', and 'care organization'. Possible responses range from 'full agreement' to 'full disagreement' on a

five-point scale, although in analysing the data, Åström et al. (1987a) collapse these to the three categories of 'agree', 'doubtful' and 'disagree' with low scores demonstrating positive attitudes. Results indicated that staff working in somatic long-term care and psychogeriatric care had more positive attitudes towards demented patients than those working in a nursing home and that qualified nurses had more positive attitudes than unqualified staff. In a later study, this scale was also used to demonstrate the relationship of empathy and burnout to attitudes, with greater empathy correlating with more positive attitudes and burnout associated with less positive attitudes (Åström et al., 1990).

The scale does appear to have face validity. It addresses the issues of attitudes directly towards the clients themselves, the way in which they should be cared for and organisational factors influencing their care. However, there does not appear to be any published evidence to support the reliability and validity of the scale and how it relates to actual behaviour. Furthermore, the authors report that as many as 39% of answers were missing and that partly missing data was estimated using mode values. The necessity of this procedure was explained in terms of avoiding underestimation of respondents scores. However, this must surely cast some doubt over the validity of the data obtained since 39% of the answers did not come from participants.

One study (Kahana et al, 1996) was found that explores the attitudes of nursing staff towards different groups of elderly people (well elderly, physically ill elderly and elderly people with dementia). This study uses a modified version of a semantic differential scale developed by Rosencranz and McNevin (1969), which, they state, has been widely used in the literature to evaluate attitudes (Nunnally, 1978; Finnerty-Fried, 1982). However, since the semantic differential method of attitude evaluation uses a completely different method

to the more traditional ones discussed above, the results of this, and other studies that employ the semantic differential method will be reviewed separately.

2.1.3 Semantic Differential Method

The semantic differential method of assessing attitudes was presented and supported by Osgood et al (1967). Participants are presented with a series of adjective scales upon which they make their ratings, for example of a target group (e.g. older adults) or task (e.g. caring for older adults). One early study reporting use of the method using older adults as a target group was that of Rosencranz & McNevin (1969), who asked participants to give judgements about males aged between 20-30 years, 40-55 years, and 70-85 years. Their scale was developed from extensive pre-testing of individual adjective scales with subjects of all ages. The instrument developed from this was a series of 32 bipolar scales that were subsequently tested with a large sample (287 participants) of undergraduate males. Three factors were revealed from the data: (1) the *Instrumental-Ineffective* dimension, representing items such as, productive-unproductive, busy-idle, active-passive, from which older men were judged as being the most 'ineffective' of the three age groups; (2) the *Autonomous-Dependent* dimension, representing items such as independent-dependent, secure-insecure, certain-uncertain, from which older men were judged as being the most 'dependent' of three age groups; and (3) the *Personal Acceptability-Unacceptability* dimension, representing items such as friendly-unfriendly, tolerant-intolerant, happy-sad, from which older men were judged as being the least 'personally acceptable' of the three age groups.

Naus (1973) also employed a semantic differential on older adults, using 15 of the Rosencranz & McNevin (1969) items together with 5 from other studies (Fishbein & Raven, 1962; Jakobovits, 1966), designed to represent an 'evaluative' dimension. Participants were asked to rate target groups of: paternal grandfather; paternal grandmother; maternal grandfather; maternal grandmother; old person I like most; old person I like least; young person I like most; young person I like least; myself; man 70-85 years old; man 20-30 years old, although results of the study focused mainly on the last two target groups. This study also produced three factors from the data that were similar, although not the same as those of the Rosencranz & McNevin (1969) study. The first factor was 'Evaluation', the second was termed 'Decisive-Indecisive' and the third (like Rosencranz & Mc Nevin) was 'Instrumental-Ineffective'. Results showed that older males were rated less positively than younger males, and that older men were rated as less decisive and less instrumental, than younger men.

Ingstad & Götestam (1987) in their study of the attitudes of nursing staff towards patients of a psychogeriatric ward also employed an attitude scale developed from Osgood's (1967) semantic differential scheme. This measure consists of six semantic pairs; (a) positive-negative, (b) valueless-valuable, (c) bad-good, (d) onesided-manysided, (e) unimportant-important, and (f) stupid-smart, where each pair is rated from 1 (bad) to 7 (good). Attitudes towards four activities, cleaning the ward, patients' meals, dressing patients and social interaction with patients, were tested. Findings demonstrated a positive change in attitude on the last three of the four focus activities, following changes in patient behaviour as a result of treatment programmes.

The positive attitudes found initially appear encouraging, however this scale essentially measures attitudes towards particular activities that staff perform in a specific context, rather than to the client group themselves. Thus, it is questionable whether the attitudes represented here are consistent over time or whether they would vary depending on the particular residents being cared for and the associated difficulty of the task in question. Furthermore, staff reporting the attitudes also acted as therapists in the programme to change patient behaviour. Thus, the post intervention attitudes may reflect more about how successful staff wish to appear in their roles as therapists than it does about actual feelings towards the residents.

In the Kahana et al (1996) study mentioned above, responses were obtained from 143 respondents from four nursing homes in Cleveland. Their modified version of the Rosencranz & McNevin (1969) measure consisted of 10 paired attributes such as 'good-bad', 'cooperative-uncooperative'. These required responses on a 4-point scale for each of the target populations. Results demonstrated progressively less positive evaluations of elderly people who were physically ill or had Alzheimer's disease compared with well elderly persons and there were statistically significant differences between each group. However, the modified version of the scale that was used, actually only contained 5 of the original Rosencranz & McNevin (1969) items. The additional 5 appear to have been added by the authors, who report unspecified reliability coefficients of .86 for attitudes towards well elderly people, .81 for attitudes towards physically ill elderly people and .78 for attitudes towards elderly people with dementia. There was no reported evidence to support the relationship of attitude evaluations with the actual behaviour of the nursing staff tested towards their clients.

Rosencranz & McNevin (1969) recommend their instrument for its ability to produce both single and factor scores representing various attitudinal dimensions and suggest that the strength of the semantic differential method lies in its ability to elicit judgments that imply attitudes, rather than relying on fixed lists of statements. They also highlight the non-specific nature of the measure, suggesting its use for self-conception as well as for obtaining views on others. However, one of the difficulties associated with having such a non-specific measure is that in interpreting the data, inferences have to be made regarding the meaning behind a person's use of adjectives. Using semantic differential schemes offers no evidence about how interactions with older people will be effected by the acceptance of certain characteristic traits, thought to be typical of older people. A further methodological problem of the Rosencranz & McNevin (1969) study is the lack of empirical evidence reported to support the reliability and validity of their measure.

Both the Rosencranz and McNevin (1969) and the Naus (1973) studies, compared attitudes towards people of different age groups (20-30 year olds and 70-85 year olds). Similarly, the Kahana et al. (1996) study compared attitudes towards older people of different groups based on their levels of wellness or illness. While the semantic differential method may be a useful way of comparing attitudes towards different groups of people, it is less effective where a specific tool is required to examine attitudes towards one group in more detail.

TABLE 2.2: Summary Table of Studies Reporting Semantic Differential Attitude Assessment

Author/s	Year	Title of Measure	Country	Target Group	Participants	Method	Designed to assess:	Item Number	Item selection	Reliability & Validity	Relationship to behaviour
Rosencranz & McNevin	1969	The Aging Semantic Differential	USA	Males aged: 20-30, 40-55 and 70-85 years old	287 undergraduates	7 point scale between semantic pairs of adjectives	Stereotypic attitudes towards older people	32 paired adjectives	Pre-testing of individual adjective scales derived by Ss of all ages. Ss asked to list bipolar sets of adjectives describing attributes of people of all ages. Factor analysis was then used to refine the scale and reduce items	Report factor analysis indicating 3 factors; Instrumental ineffective, Autonomous-dependent and Personal Acceptability. No further reliability statistics reported	Not tested
Naus	1973	Adapted version Rosencranz & McNevin's semantic differential	Canada	Older men	103 undergraduates	Semantic pairs of adjectives (point scale not reported)	To determine attitudes and stereotypes toward old men	20 paired adjectives	15 paired adjectives selected from The Aging Semantic Differential (Rosencranz & McNevin, 1969). Remaining 5 selected from other studies (Fishbein & Raven, 1962; Jakobovits, 1966)	Report factor analysis indicating 3 factors; Evaluation, Decisive-Indecisive and Instrumental-Ineffective. No further reliability statistics reported	Not tested
Ingstad & Gøtestam	1987	Semantic Differential	Norway	Patients of a psychogeriatric ward	2 nurses and 12 attendants working on the hospital ward	7 point scale between semantic pairs of adjectives	To measure attitudes towards 4 activities: cleaning the ward; patients' meals; dressing patients; and social interaction with patients.	6 paired adjectives	Not stated	Appears to relate to environmental changes on the ward i.e. in patient behaviour	Not tested
Kahana et al.	1996	Adapted version Rosencranz & McNevin's semantic differential	USA	Well & physically ill elderly & elderly with dementia	143 nursing home employees	4 point scale between semantic pairs of adjectives	Well & physically ill elderly & elderly with dementia	10 paired adjectives	5 paired adjectives selected from The Aging Semantic Differential (Rosencranz & McNevin, 1969). Remaining 5 appear to be added by the authors	Reliability coefficients were reported as .86 for well elderly; .81 for physically ill elderly; and .78 for those with dementia. Relate attitudes to self-efficacy.	Not tested.

2.1.4 Summary Of Attitude Measurement Literature

The majority of studies reported do not provide measures that are specific to obtaining attitudes towards people with dementia and have not been developed or validated for use with British populations. Few of them report any empirical support for the reliability or validity associated with their measures and many of them appear somewhat outdated. Furthermore, one of the difficulties with attitudes scales is that it is often unclear how such attitudes actually impact upon behaviour. The extent to which beliefs (such as stereotypical or prejudiced thinking) contributes towards the treatment of older people is generally not made explicit. As shown in tables 2.1 and 2.2, there is virtually no evidence that existing attitude measures are able to predict actual behaviour and this may well be indicative of a tendency to measure attitudes and behaviour at different levels of specificity (as suggested by Ajzen & Fishbein, 1977).

Finally, as detailed in Chapter One, most theoretical frameworks describe attitudes as having affective, cognitive and behavioural components (Halloran, 1967; Lemon, 1973; and Triandis, 1971, cited in Martin & Buckwalter, 1984). Many of the attitude scales described above fail to adhere to this traditional 3-component framework of attitude research. Some are task orientated and therefore only focus on the behaviour aspects of attitudes, others focus on facts, thus encompassing the cognitive component. However, in order to evaluate attitudes, in a way that allows us to appreciate a persons knowledge about people with dementia, their feelings about them and how they intend to behave with them, attitude measurements need to encompass each of these key areas.

Improving the sensitivity, reliability, validity and specificity of attitude measures would be of great benefit in enhancing our understanding of the attitudes held by those likely to have the most significant impact upon the lives of people with dementia living in long term care facilities. Such information could potentially be useful in establishing areas of focus for training interventions and for staff development, in making assessments of the effectiveness of training interventions, as well as having a potential use in staff selection procedures.

2.1.5 Objectives For A New Attitude Scale

In consideration of the various methodological problems associated with previous studies, the following sections present a new instrument for use with care staff, which attempts to fulfil the following criteria:

- is dementia specific
- is standardized and therefore appropriate for use with a UK population
- is standardized and is therefore appropriate for use with health care workers
- has empirical support for its reliability and validity
- can be shown to relate to actual behaviour
- is short and easily completed
- incorporates the three components of cognition, affect and behaviour.

2.2 METHOD

2.2.1 Design Of The Questionnaire

Following a review of the literature on attitude scales, it was evident that existing measures may not represent current concepts regarding the highest quality of care. Thus in order to try and elicit items that would represent aspects of current good practice and that would reflect the way that clients were treated by care staff, it was decided to generate items from consultation with experts in the field and from extensive observations and discussions with care staff during their normal working routine.

The experts consulted included Professor Bob Woods who is Professor of Clinical Psychology of Older Adults at the University of Wales, Bangor. He is an international authority on the clinical psychology of ageing and has published widely on the mental health and psychosocial care of older people (Woods, 1995, 1996, 1989). Also consulted, was Professor T. Kitwood, who, until he died in 1998, was Alios Alzheimer Professor of Psychogerontology. He was also internationally renowned for his work, which focussed on promoting person-centred care for people with dementia, on which he was the author of numerous publications (Kitwood, 1990a, 1990b Kitwood & Bredin, 1991; Kitwood & Benson, 1995). Both experts also had extensive involvement in offering training and consultation to those working in the care of people with dementia and offered advise to both carers and organisations wishing to promote good practice. The researcher also discussed the work at a meeting of the London Centre for Dementia Care, where those involved in training and development of good practice in dementia care in the London area meet to discuss and share ideas and information. Through this, information was

gained about the kind of attitudes and beliefs likely to promote good practice and the types of attitudes that educators in the field are currently attempting to develop.

The researcher also had the opportunity to attend training sessions in person-centred care, which enabled her to talk to care staff about their views on their work and to observe their reactions to some of the ideas suggested during the training sessions. Information from this, together with observations and discussions with care staff during their normal working routine also informed the development of the questionnaires. For example, during training on the social psychology of dementia care (Kitwood, 1996) a care worker asked 'surely it doesn't really matter what you say because they're just going to forget it anyway'. While most people with dementia do exhibit difficulties with short-term memory recall, Kitwood's (1990a) framework suggests that decline in the individual's psychological well-being can be observed where insensitive or demeaning interactions are evident. In conversations with Kitwood, he suggested that people with dementia may have what is best described as an 'emotional memory' about the things that happen to them, but because they will often be unable to explain verbally how they feel about particular interactions that have taken place, it is sometimes assumed that they have not been affected by those interactions. One could surmise that someone who believed that it doesn't matter what you say if people because they will forget it anyway would be more likely to make comments that could negatively impact upon the well-being of someone with dementia than someone who did not believe such a statement. Thus, comments such as these were incorporated into the questionnaire.

A further example of how items were generated can be given through observations that care staff often treated people with dementia in very much the same way as young

children. Residents with dementia were frequently told to sit down, were told not to touch certain items, were told to go out of the kitchen so that staff could get on with what they were doing, were verbally reprimanded for repeatedly asking the same question, and were continually brought back to one communal area where staff could 'keep an eye on them'. In addition, they were often given little choice about things such as what they could do, what they could eat and when things such as bathing or having a cup of tea would happen. Conversations with care staff also revealed that a number of them believed their job to be 'a bit like looking after children really', and had relatively little recognition of the breadth and depth of experience that residents had accomplished during their extensive adult lives. Such observations are consistent with Kitwood's (1990) list of the various types of malignant social psychology that can often be seen in long-term care environments for people with dementia. Within this list he incorporates the 'infantilisation' of people with dementia, which is thought to contribute towards the deskilling of the person concerned through subtle messages implying that they have the subjectivity of a child. Thus, an item reflecting whether respondents viewed people with dementia as being like children was incorporated into the questionnaire.

Based on the consultations and observations described above, items were generated to form into a Likert-type scale, which was named the Approaches to Dementia Questionnaire (ADQ). The aim was to incorporate items that would represent the underlying beliefs that care staff might have about residents with dementia, which could subtly be influencing their interactions with them.

Having considered the number of items used in previous research into attitudes towards older people, it was decided that 20 items would be sufficient to encompass items

covering a range of issues, but would not be so overly long or cumbersome to complete that it became impractical. Previous research aimed to establish scales that encompassed both positive and negative items (Kogan, 1961; Oberleder, 1962; Dillard & Feather, 1989; Baillon et al., 1996) in order to avoid any respondent biases that might occur, for example respondents simply agreeing with every question. Thus in this questionnaire, items were developed to represent ten positive and ten negative statements reflecting attitudes towards older people with dementia and the way they should be treated (see Appendix One). Once the researcher was satisfied with the wording of the 20 items developed, these were placed in random order to form the scale. Respondents are asked to state to what extent they agree with these statements ranging from strongly agree to strongly disagree on a five-point scale. The scale was piloted with 20 respondents working as nurses or care assistants in an NHS unit specializing in the care of elderly people with dementia. Results of the piloting revealed that respondents had no difficulty completing the questionnaire and were able to understand what they were being asked to do.

2.2.2 Participants

The research described in this and subsequent chapters took place primarily within one nursing home (the focus home), which was a charity owned nursing home, based in Surrey and offering specialised care for people with dementia. The nursing home has two dementia care units, accommodating a maximum of 25 residents across the two units at any one time. However, in order to gather enough data to perform a factor analysis on the questionnaire, the data from this one home, was supplemented with data from questionnaires administered to respondents from 4 other nursing homes geographically

dispersed across England and Wales where staff were caring for people with dementia. In total questionnaires were administered to 123 members of staff, comprised of 61 care assistants with no formal training, 26 care assistants with NVQ qualifications, 29 registered nurses and 7 home managers. There were 111 females and 12 males with ages ranging from 17 to 62 (mean age = 37.4; sd = 12.4). Approximately 70% were full-time workers and the rest worked part-time. Length of experience working with older people ranged from 2 months to 28 years (mean years = 8.5; sd = 6.4).

In order to test the validity and reliability of the questionnaire, further analysis was carried out using data from respondents working in the focus home described above. Test-retest analysis was carried out with 23 respondents, who completed the questionnaire on two occasions approximately six months apart. No formal training or development interventions took place with these participants during that time.

For tests of validity 70 respondents from the focus home completed additional questionnaires detailed below and 37 were asked to give their responses to a number of video vignettes, also detailed below.

2.2.3 Ethical Considerations

In order to ensure the ethical standards of the research were satisfactory, approval was sought and obtained from the local health authority's ethics committee (see Appendix Two). Ethical considerations regarding this study included the potential for participants to feel worried about their knowledge levels being judged. Participants were given detailed information about the purpose of the research and how they would be able to participate

so that they could make informed decisions about whether to be involved. They were also assured that material provided would remain confidential and only the researcher would have access to the answers they gave. In addition, they were told that any information they gave would not be associated with their names and that feedback to others would be of a generic and confidential nature and would not identify individuals in describing the kind of responses that were received.

2.2.4 Procedure

In order to evaluate the validity of the questionnaire, results obtained from it were tested against two other questionnaires and against responses to video vignettes. Questionnaires were completed prior to watching the video vignettes. Vignettes were watched within four weeks of completing the questionnaires. Although the questionnaires selected to evaluate the validity of the ADQ are not well validated themselves, they were chosen (1) because there are no existing well-validated questionnaires focussing on the care of people with dementia and (2) because, like the ADQ, they represent constructs that also aim to reflect aspects of good practice in dementia care.

Dementia Care Styles Questionnaire (Brooker, et. al., 1998). This consists of 12 written multiple-choice questions where one of four methods of response to a typical situation is chosen. The responses represent four styles of care: person-centred; behavioural; disease focused; and normalising (i.e. not accounting for the persons disability).

Dementia Knowledge Quiz (Moniz-Cook et al., 2000). This quiz was compiled to evaluate a training programme for staff in residential and nursing homes on challenging behaviour

in people with dementia. It was developed from 'The revised 25 item dementia Quiz' (Gilleard & Groom, 1994) and 'The Alzheimer's disease Knowledge Test' (Deickmann, Zarit, Zarit & Gatz, 1988) and was subsequently revised on the basis of data from almost 600 nurses and care assistants. There are 17 multiple-choice questions/statements, each of which has 5 responses. One is 'don't know' and is not scored. Thus, there are three 'distracter' (i.e. incorrect) answers and one correct answer. In order to allow for guessing, the quiz is scored by calculating the number of correct responses and subtracting the number of incorrect responses divided by three.

Video Vignettes. In order to provide further support for the validity of the measure, 37 participants were asked to give their responses to a number of video vignettes. This method of evaluation is gaining increased popularity and is consistent with the view that the most accurate assessment of behaviour, short of direct observation, involves measurement of behavioural intentions (Crane, 1975; Neff, 1979 cited in Ciliberto et al., 1981; Ajzen & Fishbein, 1980). In this study, vignettes were written to represent 'typical' situations based on the researchers observations in the focus home. The researcher, together with other members of staff from the focus home, including, the manager and deputy manager, secretarial and domestic staff, role-played the vignettes, which were then video-recorded. Role-plays were carried out within the focus home, in order to aid the authenticity of the vignettes by having them take place in a nursing home setting. So that residents and staff were not disrupted or recorded without consent, however, the role-plays were recorded in relatively quiet areas of the home, including a large lounge, used for entertainment events and an unoccupied bedroom.

There were 11 vignettes in total, which were made up of two different types of vignette. The first type of vignettes (type 1 videos) depict scenes where one or more members of staff are interacting with one or more residents. For example, in one scene a resident is sitting alone, looking very bored and rocking slightly. She then begins to pull dried flowers from an arrangement on the table next to her. A member of staff comes along and reprimands her for making such a mess and shouts to another members of staff, drawing attention to what the resident has done. The second member of staff offers the resident some reassurance that no harm has been done and asks the resident if she would like to rearrange the flowers with him, which they then begin to do. There are five type 1 vignettes, which staff were asked to watch once, writing down any positive and negative aspects of care that they notice. Decisions about whether aspects of care are positive or negative are left to the subjective judgement of the participating member of staff. They are then shown the vignette for a second time and are given a few moments to write down any further observations or to amend what they have written previously.

The second type of video vignette (type 2 videos) depicts one or more residents either withdrawn or engaged in behaviours typically seen within the nursing home (again, based on the researchers observations in the focus home). For example, in one scene a resident gets out of her chair and begins to wipe the furniture with her skirt and her cardigan. Staff were asked to watch the vignette once and to write down what they would do if they entered the room at that moment. As with type 1 videos, they are then given the opportunity to re-watch the vignette and to amend their responses as they wish.

For both type 1 and type 2 videos, coding frameworks were devised by using content analysis to categorise the responses generated by care staff. In order to ensure the

reliability of the coding frameworks, two raters coded the data independently. Agreement was achieved on 314 of the 417 units of text categorised (75%), indicating a satisfactory level of inter-rater reliability. The aim of type 1 videos is not to see whether staff members can accurately identify each positive and negative aspect of care according to some pre-defined 'gold standard', but to see the extent to which they can identify the needs of residents according to whether those needs are met or not by the care being offered. Content analysis enabled responses to be categorised in terms of the needs that were either met or unmet, including the need for information, social interaction and privacy. For example, in response to the scene described above, positive aspects of care identified might include 'given something positive to do by re-arranging flowers' (recognising need for stimulation), 'second carer was patient and reassured her' (recognising need for reassurance) and 'instilled confidence in resident by positive attitude' (recognising need for self worth). Negative aspects of care identified included responses such as 'treated resident like a child' (recognising need to be treated as an individual), 'humiliated resident' (recognising need for dignity) and 'shouldn't have put her near the flowers' (identifying a need to maintain a neat environment). The full coding framework for type 1 videos can be found in appendix four.

The aim of the type 2 videos was to see what types of intervention care staff would suggest in response to what residents were doing. Content analysis was used to categorise responses to type 2 videos, which are coded in terms of the style of response that would be taken. Responses to type 2 videos fall under the three major headings of immediate response, problem solving response and preventative response. In response to the example vignette given above, responses might include 'give the resident a duster' (immediate response), 'notice when the resident is bored and ensure she is occupied' (problem solving

response) and ‘supervise her, ensuring there are no cups of hot tea around’ (prevention response). The full coding framework for type 2 videos can be found in appendix four.

2.3 RESULTS

Scores on the Approaches to Dementia Questionnaire were obtained from the 123 participants. Responses to each item were scored from 1 to 5, with items reversed as necessary so that higher scores reflect more positive attitude. Total scores were then obtained by summing the score for each item. Total scores ranged from 50 to 95, with a mean score of 74.65 and a standard deviation of 8.03.

2.3.1 Factor Analysis

Table 2.3 presents the frequency distributions of responses to the 20 ‘Approaches to Dementia Questionnaire’ (ADQ) items.

In order to determine the underlying attitude dimensions reflected in participants’ responses, a factor analysis was performed on the data using principal components analysis. Three factors with eigen values greater than 1.00 were yielded and the scree test suggested that three factors would be worthy of interpretation. Table 2.4 presents the Varimax-rotated factor matrix for this analysis. This table is used to ascertain the nature of the attitude domains measured by the ADQ.

TABLE 2.3: Frequency Distributions of Responses to 20 ADQ Items

ITEM	RESPONSE											
	Strongly Agree		Agree		Unsure		Disagree		Strongly Disagree			
	N	%	N	%	N	%	N	%	N	%		
1. It is important to have a very strict routine when working with dementia sufferers.	3	3	29	24	32	26	52	43	5	4		
2. People with dementia are very much like children.	6	5	33	27	26	22	42	35	12	10		
3. There is no hope for people with dementia.	3	3	10	8	15	12	59	49	34	28		
4. People with dementia are unable to make decisions for themselves.	5	4	20	17	26	22	58	48	12	10		
5. It is important for people with dementia to have stimulating and enjoyable activities to occupy their time.	49	40	67	54	4	3	3	2	0	0		
6. Dementia sufferers are sick and need to be looked after.	17	14	61	50	23	19	19	16	1	1		
7. It is important for people with dementia to be given as much choice as possible in their daily lives.	48	39	58	47	13	11	3	2	1	1		
8. Nothing can be done for people with dementia, except for keeping them clean and comfortable.	7	6	6	5	10	8	69	57	29	24		
9. People with dementia are more likely to be contented when treated with understanding and reassurance.	50	40	61	49	6	5	6	5	0	0		
10. People with dementia should be treated just like any other person.	30	24	59	48	20	16	13	11	0	0		
11. Once dementia develops in a person, it is inevitable that they will go down hill.	4	3	53	44	27	22	32	26	5	4		
12. People with dementia need to feel respected, just like anybody else.	62	50	59	48	0	0	2	2	0	0		
13. Good dementia care involves caring for a person's psychological needs as well as their physical needs.	66	53	55	44	1	1	1	1	0	0		
14. It is important not to become too attached to residents.	9	7	31	26	29	24	40	33	12	10		
15. It doesn't matter what you say to people with dementia because they forget it anyway.	3	2	5	4	5	4	67	54	42	34		
16. People with dementia often have good reasons for behaving as they do.	20	16	79	64	16	13	7	6	0	0		
17. Spending time with people with dementia can be very enjoyable.	34	27	69	56	17	14	3	2	0	0		
18. It is important to respond to people with dementia with empathy and understanding.	52	42	66	53	4	3	1	1	0	0		
19. There are a lot of things that people with dementia can do.	36	29	72	58	10	8	5	4	0	0		
20. People with dementia are just ordinary people who need special understanding to fulfil their needs.	55	44	51	41	8	7	9	7	0	0		

(N = 123)

In addition to the factor matrix, a Kaiser-Meyer-Olkin measure of sampling adequacy was derived indicating that the sample is moderate to high (0.80), so can proceed. The Bartlett test of sphericity was also significant (789.52, $p < 0.0001$), showing that the correlation matrix is not an identity matrix.

TABLE 2.4: Varimax-rotated Factor Matrix for the ADQ

(See Table 2.3 for full statements)	Hope	Personhood	Respect
	Factor 1	Factor 2	Factor 3
4. unable to make decisions for themselves	.70	.28	-.05
2. very much like children	.63	.12	.19
6. sick and need to be looked after	.62	-.30	.08
3. there is no hope for people with dementia	.61	.02	.12
14. it's important not to become too attached to them	.60	.11	.10
8. nothing can be done except keep them clean/tidy	.58	.23	-.08
11. it's inevitable they will go down hill	.57	.05	-.04
1. important to have a very strict routine	.50	.06	-.01
16. they have good reasons for behaving as they do	.10	.75	-.15
18. important to respond with empathy/understanding	-.09	.64	.49
19. lot of things that people with dementia can do	.39	.63	.20
17. spending time with them can be very enjoyable	.24	.61	.38
20. just ordinary people needing special understanding	.13	.56	.27
5. important to have stimulating/enjoyable activities	-.06	.54	.32
9. more content when given understanding/reassurance	.07	.52	.41
7. important to give them as much choice as possible	.28	.42	.40
13. important to care for psychological and physical needs	.03	.27	.77
12. need to feel respected, just like anybody else	.08	.36	.72
15. it doesn't matter what you say as they forget it anyway	.19	-.02	.72
10. should be treated just like any other person	.06	-.11	-.43
Eigenvalue	5.41	2.68	1.29
Variability Explained	27.0	13.4	6.4

(N = 123)

Robinson (1993) describes a loading as the 'correlation between an item and a factor, and items may be considered to represent the factor on which they have their highest loadings'. As indicated in Table 2.4, eight ADQ items had their highest loadings on the first factor, with five items showing values greater than or equal to .60. These were: item 2 'People with dementia are very much like children' (.63); item 3 'There is no hope for people with dementia' (.61); item 4, 'People with dementia are unable to make decisions for themselves' (.70); item 6 'Dementia sufferers are sick and need to be looked after' (.62); and item 14 'It is important not to become too attached to residents' (.60). This factor was termed the '*Hope*' dimension as it appears to reflect a sense of optimism/pessimism towards the abilities and the future of people with dementia. A high score on this dimension would reflect more optimistic perceptions of the abilities of people with dementia and what might be achieved by them.

Factor 2 also had eight items with their highest loadings scoring on this factor, four of which showed values over .60. These were: item 16 'People with dementia often have good reasons for behaving as they do' (.75); item 17 'Spending time with people with dementia can be very enjoyable' (.61); item 18 'It is important to respond to people with dementia with empathy and understanding' (.64); and item 19 'There are a lot of things that people with dementia can do' (.63). This dimension was named the '*Recognition of Personhood*' factor and a person scoring high on this dimension would be considered to recognise people with dementia as sentient beings. The term personhood has received increasing usage in recent years, particularly in relation to improving the quality of care for people with dementia (Kitwood & Bredin, 1992; Kitwood, 1994, 1997a, 1997b). It refers to the way in which people with dementia

should be recognised and responded to as unique individuals and with the same value as any other person.

Factor 3 had four items with their highest loadings on it, three of which showed values of over .70. These were: item 12 'People with dementia need to feel respected, just like anybody else' (.72); item 13 'Good dementia care involves caring for a person's psychological needs as well as their physical needs' (.77); and item 15 'It doesn't matter what you say to people with dementia because they forget it anyway' (.73). This factor was termed the '*Respect of dignity*' dimension a high score on these items would be considered to reflect the value placed on the need for dignity of people with dementia.

Intuitively, one would predict that concepts of personhood, respect and dignity would be closely linked and it is interesting that there appears to be some overlap between factors 2 and 3 of the ADQ, with item 7 'It is important for people with dementia to be given as much choice as possible in their daily lives' loading almost equally on both dimensions. Although this item does not have a strong loading on one factor, it was decided that the item should remain part of the scale, as it does appear to represent elements of both factors.

Thus, the nurses and care assistants responses to the ADQ can be summarised in terms of the extent to which the lives of people with dementia were viewed with hope, recognition and respect.

2.3.2 Refinement Of The Measure

As can be seen from Table 2.4, item 10 'People with dementia should be treated just like any other person' was the only item to score negatively on the factor on which it had it's highest loading. The direction of scoring on this item was '1' for 'strongly agree' to '5' for 'strongly disagree' since it was originally thought that this question might reflect a lack of awareness in care staff of the need for special attention and more creative forms of communication for people with dementia, than would normally be used with other people. However, the interpretation of this question, both by respondents participating in the study and experts when asked their view on this question, have highlighted some ambiguity around this statement. Some people considered that it was important to emphasise that the person with dementia is a person, like any other, i.e. not an object or a vegetable. In addition, Table 2.4 shows that item 10 also fails to load particularly highly on any of the three factors and in tests of internal consistency, it was also found to reduce the reliability of the factor score (from .67 to .22) and the reliability of the measure as a whole (from .84 to .81). On the basis of these considerations, it was decided to refine the measure and exclude item 10. Thus, the analyses shown below are based on the 19 remaining items.

2.3.3 Distribution Of Scores

The frequency distribution of item scores is shown in Table 2.3. It can be seen that on several items distributions appear to be skewed, with responses clustering around the strongly agree and agree options. This is particularly noticeable on items 5, 9, 12, 13, 18, 19 and 20 all of which load onto factors 2 or 3. In order to examine the distributions of factor scores a measure of skewness was calculated for each of the

three factors. Skewness scores were -.29, -.56, and -1.11, for factors 1, 2 and 3 respectively. Heuristically scores greater than plus or minus 1 indicate high levels of skewness, thus factor 3 is particularly negatively skewed.

2.3.4 Internal Consistency

The internal consistency of the questionnaire and its subscales was tested using Cronbach's alpha analysis. Table 2.5 shows the relevant reliability coefficients.

TABLE 2.5: Reliability Coefficients of Internal Consistency

	Cronbach's α
ADQ Total	.8345
ADQ Factor 1 - <i>Hope</i>	.7599
ADQ Factor 2 - <i>Recognition of Personhood</i>	.8209
ADQ Factor 3 - <i>Respect of Dignity</i>	.6720

(N = 123)

Thus, results of internal consistency analysis indicate that the scale has good internal consistency for the total and each of the factor scores, although a lower level of consistency was achieved within factor 3.

2.3.5 Test-retest Reliability

Test-retest reliability was assessed by administering the questionnaire twice to 23 respondents with a six-month interval between. The questionnaire was administered to subjects who did not receive any formal training interventions during this time. Table 2.6 shows the reliability coefficients for this analysis.

TABLE 2.6: Retest Reliability Coefficients

	Reliability coefficient
ADQ Total	.761***
ADQ Factor 1 - <i>Hope</i>	.764***
ADQ Factor 2 - <i>Recognition of Personhood</i>	.770***
ADQ Factor 3 - <i>Respect of Dignity</i>	.338ns

*** indicates $p > .001$; ns = not significant (N = 23).

Table 2.6 shows that levels of test-retest reliability were very good for total scores and factors 1 and 2 scores, particularly since measurements were taken six months apart. However, factor 3 failed to achieve test-retest reliability, indicating that this factor may not be stable over time.

2.3.6 Refinement Of Factor Scoring

Although the factor analysis suggested that there might be three factors worthy of interpretation, the subsequent analysis reported above, indicates that the third factor is

negatively skewed and lacks the reliability of the other two. The Cronbach's alpha of the third factor was slightly below the standard level of .70 (Nunnally, 1978). Similarly, re-test reliability for this factor was low and did not achieve a statistically significant coefficient. The small number of items and the limited variability amongst items on this dimension could explain why there were only modest reliability coefficients on this dimension and it is possible that the addition of further construct-valid items would improve these findings. Tabachnick & Fidell (1989), suggest that the addition of items to a scale typically increases its reliability. However, a longer scale would reduce its practical utility. Consequently, a two-factor solution was also examined, in order to see if this would improve the reliability and validity of the scoring and provide a scale that could be used without a further phase of data collection. The two-factor solution is shown in Table 2.7.

2.3.6.1 Factor Analysis

When a two-factor solution is performed, the 'hope' factor remains the same and the three items constituting the third factor, now become part of the 'recognition of personhood' factor. Overall higher factor loadings are achieved, although slightly less variability is explained (40% compared to 46% previously).

The Kaiser-Meyer-Olkin measure of sampling adequacy remains moderate to high (0.80). The Bartlett test of sphericity was still significant (762.23, $p < 0.0001$), showing that the correlation matrix is not an identity matrix.

The new version of the ADQ, together with its scoring sheet is shown in Appendix Three.

2.3.6.2 Distribution of scores

A measure of skewness was calculated for the two new factors. The skewness score for the ‘hope’ factor was -.29 and for the ‘recognition of personhood’ factor was -.76. This indicates that the ‘recognition of personhood’ factor is more skewed than the hope factor, but that both factors have reasonable distributions.

TABLE 2.7: Varimax-rotated Factor Matrix for the ADQ

(See Table 2.3 for full statements)	Hope	Personhood
	Factor 1	Factor 2
4. unable to make decisions for themselves	.72	.16
2. very much like children	.62	.21
8. nothing can be done except keep them clean/tidy	.60	.11
3. there is no hope for people with dementia	.60	.07
14. it's important not to become too attached to them	.59	.14
6. sick and need to be looked after	.58	-.17
11. it's inevitable they will go down hill	.57	.01
1. important to have a very strict routine	.50	.04
18. important to respond with empathy/understanding	-.08	.80
12. need to feel respected, just like anybody else	.05	.76
13. important to care for psychological and physical needs	-.00	.72
17. spending time with them can be very enjoyable	.25	.70
9. more content when given understanding/reassurance	.08	.66
5. important to have stimulating/enjoyable activities	-.04	.61
20. just ordinary people needing special understanding	.14	.59
19. lot of things that people with dementia can do	.41	.59
7. important to give them as much choice as possible	.28	.59
15. it doesn't matter what you say as they forget it anyway	.14	.49
16. they have good reasons for behaving as they do	.16	.44
Eigenvalue	5.41	2.68
Variability Explained	27.0	13.4

(N = 123)

2.3.6.3 Internal Consistency

Table 2.8 shows the Cronbach's alpha scores for the two new factors.

TABLE 2.8: Reliability Coefficients of Internal Consistency

	Cronbach's α
ADQ Factor 1 - <i>Hope</i>	.7640
ADQ Factor 2 - <i>Recognition of Personhood</i>	.8526

(N = 123)

Thus table 2.8 shows that the two-factor solution yields slightly stronger internal reliability scores for both factors.

2.3.6.4 Correlations between factor scores and summed raw scores

In order for the ADQ to be used by summing the items relating to each factor, correlations were performed between summed scores and factor scores to verify that summed scores would represent a good estimate of the factor scores. Table 2.9 shows the results of these analyses.

TABLE 2.9: Correlations of ADQ summed scores with ADQ factor scores

ADQ summed scores	ADQ factor scores	
	Factor 1 - <i>Hope</i>	Factor 2 - <i>Personhood</i>
Factor 1 - <i>Hope</i>	.98***	
Factor 2 - <i>Recognition of Personhood</i>		.97***

*** indicates $p > .001$ (N = 123).

The results shown in table 2.9 show that there is good correlation between summed and factor scores for both of the ADQ factors, thus summing the items pertaining to each factor will be sufficient for future use of the questionnaire.

2.3.6.5 Test-retest Reliability

Table 2.10 shows the test-retest reliability coefficients for the two new factors.

TABLE 2.10: Retest Reliability Coefficients

	Reliability coefficient
ADQ Factor 1 - <i>Hope</i>	.703***
ADQ Factor 2 - <i>Recognition of Personhood</i>	.689***

*** indicates $p > .001$ (N = 23).

Table 2.10 shows that test-retest coefficients remained reasonable for the two new factors, indicating stability over time.

2.3.7 Cross-Validation Of The Factor Structure

In order to cross-validate the factor structure of the ADQ, responses to the questionnaire amongst a second sample of participants were examined. Participants were 132 members of staff from six residential and nursing homes in different parts of England and Wales. As before, there was a range of ages included, a range of qualifications and the great majority were female. Responses on the ADQ for the 19 remaining items were factor analysed, forcing a two-factor solution and rotating as before. Table 2.11 presents the factor matrix for this analysis.

TABLE 2.11: Varimax-rotated Factor Matrix for the ADQ (Second Sample)

(See Table 2.3 for full statements)	Hope	Personhood
	Factor 1	Factor 2
4. unable to make decisions for themselves	.71	.20
2. very much like children	.79	.00
8. nothing can be done except keep them clean/tidy	.57	.24
3. there is no hope for people with dementia	.57	.34
14. it's important not to become too attached to them	.28	.00
6. sick and need to be looked after	.48	-.20
11. it's inevitable they will go down hill	.62	.14
1. important to have a very strict routine	.48	-.17
18. important to respond with empathy/understanding	.00	.73
12. need to feel respected, just like anybody else	.00	.71
13. important to care for psychological and physical needs	-.00	.79
17. spending time with them can be very enjoyable	.30	.54
9. more content when given understanding/reassurance	.00	.54
5. important to have stimulating/enjoyable activities	.00	.58
20. just ordinary people needing special understanding	.19	.66
19. lot of things that people with dementia can do	.43	.55
7. important to give them as much choice as possible	.22	.59
15. it doesn't matter what you say as they forget it anyway	.42	.44
16. they have good reasons for behaving as they do	.00	.31
Eigenvalue	5.02	2.50
Variability Explained	26.42	13.15

(N = 132)

The resulting factor scores were then correlated with 'Hope' and 'Personhood' scores derived by adding items together, as derived from the previous factor analysis. Table 2.12 shows the results of these correlations.

TABLE 2.12: Correlations of ADQ summed scores with ADQ factor scores (Second Sample)

ADQ summed scores	ADQ factor scores	
	Factor 1 - <i>Hope</i>	Factor 2 - <i>Personhood</i>
Factor 1 - <i>Hope</i>	.97***	
Factor 2 - <i>Recognition of Personhood</i>		.95***

*** indicates $p > .001$ (N = 132).

It can be seen that there are high correlations between summed Hope scores and Factor 1 scores and between summed Personhood scores and Factor 2 scores. In addition, each item loads most highly with the same factor as previously (although item 14 has a fairly low loading in the second sample).

This analysis suggests the derived factor structure is robust across heterogeneous samples, and that the factor scores can be confidently used.

Both factor analyses meet the quality standards laid out by Kline (1994) in that: each factor is designated by at least three variables, heterogeneous samples have been used, the minimum sample size of 100 has been used in both analyses, and the ratio of participants to variables is at least 2:1 (6:1 in this study).

The Kaiser-Meyer-Olkin measure of sampling adequacy for the second sample is moderate to high (0.79). The Bartlett test of sphericity was also significant in this sample (758.16, $p < 0.0001$), showing that the correlation matrix is not an identity matrix.

2.3.8 Validity

In order to evaluate the validity of the ADQ, the relationship between scores on the measure and additional data collected through existing questionnaires and responses to video scenarios were evaluated.

2.3.8.1 Relationship between Attitudes and Dementia Care Styles

Correlations between scores on the Dementia Care Styles Questionnaire (Brooker, et.al., 1998), and ADQ scores are shown in Table 2.13.

TABLE 2.13: Correlations of ADQ with the Dementia Care Styles Questionnaire

ADQ	Dementia Care Styles Questionnaire			
	Behavioral	Person-centred	Medical	Normalising
Total	-.35**	.55***	-.17	-.23
Factor 1 – <i>Hope</i>	-.38**	.48***	-.22	-.12
Factor 2 - <i>Recognition of Personhood</i>	-.19	.43***	-.08	-.27*

* indicates $p > .05$; ** indicates $p > .005$; *** indicates $p > .001$ (N = 70).

Thus, participants with more positive ADQ scores were also more likely to state that they would respond to DCSQ scenarios in a person-centred way. In particular, both factors correlated positively with DCSQ person-centred responses. Weaker, but still significant, negative correlations were also observed between the ‘hope’ factor and a

behavioural style of response to scenarios and the ‘recognition of personhood’ factor and a normalising style of response to scenarios.

2.3.8.2 Relationship between Attitudes and Knowledge

Correlations between scores on DKQ and ADQ scores are shown in Table 2.14.

TABLE 2.14: Correlations between ADQ and the Dementia Knowledge Quiz

ADQ	Dementia Knowledge Quiz
Total	.35***
Factor 1 - <i>Hope</i>	.34**
Factor 2 - <i>Recognition of Personhood</i>	.31**

** indicates $p > .01$; *** indicates $p > .005$ (N = 70).

Thus, ADQ total and each of the factors scores correlated significantly with having increased knowledge about dementia.

2.3.8.3 Relationship between Attitudes and responses to Video Vignettes

The responses to video vignettes given by participants are coded to represent (1) the frequency that each of 15 needs are identified through being asked to point out positive and negative aspects of care; (2) the frequency that each of 18 possible

interventions are suggested, in response to being asked ‘what would you do in this situation’ The coding schedules, giving details of each category can be found in Appendix Four. Tables 2.15 and 2.16, show the results of statistical analyses on this data. Due to the distribution of scores, t-tests were performed on the type 1 video data and Spearman’s correlations between the responses to type 2 video vignettes and ADQ scores. As there were a considerable number of analyses, it is necessary to use a stricter criterion for those that are considered statistically significant. Therefore, only those reaching a significance level of 0.005 are shown (full results of all t-tests and correlations can be seen in Appendix Five).

TABLE 2.15: T-tests of Type 1 Video Responses in relation to ADQ scores

ADQ	Type 1 Videos: Identification of needs			
	Need for Understanding	Need for Self Worth	Need for Privacy and Dignity	Needs of Visitors
Total				
Factor 1 <i>Hope</i>	-4.18**	-3.68**	-3.52**	
Factor 2 <i>Personhood</i>				4.06**

** indicates $p > .005$ (N = 37).

Participants were categorised into two groups: one having ‘no’ recognition of each need and the other having ‘some’ recognition of the particular need and t-tests were performed to look for significant differences in ADQ scores between the two groups. Table 2.15 shows that recognition of a number of needs was significantly related to ADQ score. Specifically, participants who showed some recognition of residents’ needs for ‘Understanding’, for ‘Self Worth’, and for ‘Privacy and Dignity’ had

significantly higher ADQ ‘hope’ scores than those who did not pick up on those needs in the videos.

It is also interesting that participants who indicated some recognition of the needs of visitors of relatives had significantly lower ADQ ‘personhood’ scores than those who did not. This may at first appear to be somewhat anomalous, however, those who did refer to relatives or visitors within the video scenes often failed to notice the needs of the residents in the scenes. For example, typical responses might include ‘someone should have got a chair/cup of tea for the visitor’ with no reference to the fact that the person with dementia in the scene was in distress and that something should be done for them. Thus we might expect that a carer who is more concerned about the welfare of visitors than they are about the welfare of residents in their care, might well express attitudes on the ADQ that reflect a lower understanding of their clients’ sense of personhood.

TABLE 2.16: Spearman’s correlations between ADQ and Type 2 Video Vignettes

ADQ	Type 2 Videos: Intended response	
	Diversion	Total number of Immediate responses
Total		
Factor 1 <i>Hope</i>	.46**	.46**
Factor 2 <i>Personhood</i>		

** indicates $p > .005$ (N = 37).

The ‘Hope’ dimension of ADQ showed significant positive correlations with intending to divert residents to activities that are more constructive and, total number

of immediate responses. Thus, participants with more optimistic attitudes may be more likely to try and engage residents in constructive activities, possibly because they are more hopeful about what people with dementia might achieve given appropriate support.

The ADQ total scores and 'Recognition of Personhood' scores showed no correlations that were significantly correlated at the 0.005 level with any of the type two video response categories.

2.4 DISCUSSION

This chapter described the development of a self-report instrument for use with health care professionals, to validly and reliably measure attitudes towards people with dementia. The scale was intended to be short and easy to complete, to incorporate the three components of cognition, emotion and behaviour and to be specifically tailored to measure attitudes towards people with dementia.

The instrument developed allows computation of both total scores for each respondent and also, more informative factor scores representing each of two attitudinal dimensions. It is this latter process that may help us to gain insights into the way in which attitudes towards older adults with dementia are formed, in addition to understanding the interplay between different attitudinal dimensions. These different dimensions might also be potentially important when comparing groups of

participants or individuals, since total scores might show no significant differences in attitude, but factor scores may differ greatly.

The two-factor solution appears to be much stronger than the three-factor solution initially extracted. Reliability analysis for the two factors, as well as for total scores, indicate that these measures are both internally consistent and stable over time. Stability over time was particularly robust, since a considerable time period elapsed between measurements. The likelihood of scores remaining the same decreases the longer the period between measurements, thus consistency of scores over a duration of approximately six months clearly demonstrates the significance of the reliability coefficients found.

In addition to testing the reliability of the ADQ, measures were also taken to establish its validity. The scale can be said to have some content validity as items were developed by establishing the views of experts in the field, regarding the attitudes they believe influence the behaviour of those caring for people with dementia.

Concurrent validity was studied by comparing scores with a number of external variables believed to measure aspects similar to the attribute under investigation (as advocated by Kerlinger, 1986). Support for the relationship between the ADQ and external criteria was found for total scores and for 'hope' and 'recognition of personhood' factor scores. The external criteria utilised were knowledge regarding dementia, and responses to typical dementia care scenarios, presented both in writing (with multiple-choice response options) and depicted on video (with a free response format).

While the purpose of using the video scenarios was to test the validity of the attitude scale, the order in which these tasks were completed may have been significant. The ADQ was designed to measure participants' attitudes, whereas the videos were designed to measure participants' intention to behave in particular ways (c.f. Ajzen & Fishbein, 1980). In this study, the attitude questionnaires were completed prior to watching the videos and, due to restrictions of time, it was not possible to counterbalance the order in which the tasks were carried out. Such processes would have enabled the researcher to assess whether taking part in one task would affect performance on the other. However, since the vignettes depicted in the videos were of scenes that staff would typically encounter in their day-to-day work and since no feedback was given to staff following their responses to the video vignettes, it seems unlikely that attitude scores would have been affected.

The other type of validity that was evaluated was construct validity and employing a factor analysis tested this. Traditionally, factor analysis involves testing a large number of possible items initially and subsequently selecting or discarding items from these according to the strength of their factor loadings. In this study, however, items were selected on the basis of those thought to be most pertinent to the participant group being studied. It is possible that had the more traditional approach been taken, alternative items with stronger factor loadings, may have replaced some of the items and would have represented the concepts under review more closely. In particular, it is possible that had a greater number of items been included; there may well have been a stronger third factor, which would have contributed to our understanding of attitudes towards people with dementia still further. However, the cross-validation of

the factor structure indicates that the derived factor structure is robust across heterogeneous samples, and that the factor scores can be confidently used.

The factor analysis performed in this study could potentially be criticised for having too few cases. In Comrey's (1973) guide, 123 cases would be considered poor to fair. However, Tabachnick & Fidell (1989) state that other authors view a sample size of 100 to 200 as good enough for most purposes, particularly when the numbers of items are small. As a general rule, they suggest having at least 5 cases for each item. Thus, the sample size in this study was adequate to perform factor analysis, with just over 6 cases per item observed, and this exceeds the criteria offered by Kline (1994) of a sample size of 100 and a ratio of cases to variables of 2:1.

Another possible criticism is the lack of variance amongst scores on some of the items. Seven items were found to have skewed distributions, thus degrading the strength of the factor solution. However, in order to compensate for this lack of normality in the data, appropriate transformations were carried out with skewed variables and the factor analysis re-computed. Results indicated the same factorial dimensions with virtually the same loading values (see Appendix Six). Thus, it appears that distributions of the variables had no significant force on the analysis.

It is also possible that the validity of the ADQ will have been subject to self-selection bias. ADQs were completed and returned on a voluntary basis by the nursing and care staff of a number of different homes. It is not difficult to imagine that those with low morale, little motivation or who are experiencing burnout, may be less likely to engage in activities at work beyond the minimum required of them. It could be argued

that the attitude of these people is particularly important in establishing an understanding of the underlying concepts that influence one's attitudes or behaviour. However, since enforced participation would be both unethical, and likely to produce reactionary responses, the extent to which this factor is influential is likely to remain unknown.

Most techniques for measuring attitudes rely heavily on verbal/written measures in the form of interviews or questionnaires. This is probably because language is the way in which most people express their attitudes. Nevertheless, one of the difficulties with attitude measurement is how people's answers to questions can be converted to a numerical score. The danger is that numerical scores will reduce complex and meaningful concepts to simple scores that are unrepresentative of the way in which such concepts are made manifest. Using multidimensional measures is one way of increasing the likelihood that 'meaning' will be retained. This study indicates that attitudes towards people with dementia are indeed multidimensional and supports previous suggestions (e.g. Rosencranz & McNevin, 1969; McTavish, 1971; Naus, 1973) that the same is true for attitudes towards older people.

Another advantage of the scale is that it is specifically focused on attitudes towards people with dementia. Therefore, according to Ajzen & Fishbein's (1977) proposition, the likelihood of it predicting behaviour towards people with dementia is greater than for more general scales measuring attitudes towards old people.

The two factors discovered, 'hope' and 'recognition of personhood', might provide a useful conceptual framework for understanding attitudes towards people with

dementia. The 'hope' factor is particularly interesting, since it supports Kahana et al's (1996) findings (see page 28) that attitudes are strongly related to self-efficacy. Although this study did not measure participants' self-efficacy, it is possible that the optimism of those who are generally more positive in their outlook, would apply equally to their own sense of efficacy, as well as to that of clients in their care.

In terms of the scale reflecting the three components of affect, behaviour and cognition, it could be said that the 'hope factor' represents the affect element of attitudes, since it contains statements with an emotive component, likely to reflect participants' feelings about the current and future condition of people with dementia. Examples include 'there is no hope for people with dementia' and 'it's important not to become too attached to residents with dementia'. Statements contained within the 'recognition of personhood' factor, on the other hand, come closer to the behaviour and cognition elements of attitude. This is because they focus more on how respondents think about people with dementia, or how they are likely to behave towards them, for example 'spending time with people with dementia can be very enjoyable' or 'it's important to give them as much choice as possible'.

Finally, the grouping of ADQ items into factors also appears to form a positive and negative scale. Although items were not selected to represent matched pairs of positive and negative items, in the same way as the Kogan (1961) scale, it does appear that the positive and negative items of the ADQ have separated into the two factors. The 'hope' factor consists entirely of negative items, to which a 'strongly disagree' response gets the highest score. Alternatively, in the 'recognition of personhood' factor all but one of the items are positive, whereby a 'strongly agree' response

receives the highest score. If one looks at the frequency distribution of the items (shown in table 2.3), it's clear that respondents are far more likely to strongly agree with positive items than they are to strongly disagree with negative items and there may be a number of reasons for this: (1) there may be a cultural bias. British people are well known for their 'politeness' and the lack of strong disagreement with negative items may have been a function of cultural protocols, whereby participants did not want to appear too controversial; (2) It is possible that people generally answer positively worded questions differently to the way they answer negatively phrased ones. That is, there may be different cognitive processes involved in responding to positive and negative statements as these change the context with which one views the attitude target (Schwarz, 1999) - in this case older people with dementia; (3) A bias may have been introduced during creation of the statements, i.e. it may have been that more commonly known positive attitudes were phrased in positive terms and statements reflecting less common positive attitudes within nursing homes were phrased in negative terms, without there being any awareness of this at the time.

The 19 item ADQ scale appears to be a useful measure of care assistant and nursing staff attitudes towards people with dementia. Evidence has been found to support its reliability and validity. However, the only truly reliable way of ensuring that attitude measures validly represent the behaviours they are thought to influence is to actually measure those behaviours and compare the results with attitude scores. In order to see whether the ADQ would relate to actual behaviour, an observational technique was developed so that attitudes and directly observed behaviour could be compared. The

following chapters describe the development of this observational technique and attempt to relate the results from it to self-reported attitudes.

CHAPTER THREE

3.0 Development Of An Observational Technique To Evaluate Quality Of Care For People With Dementia

The numerous studies cited in Chapter One demonstrate that attitude scales have frequently been used as a means of assessing the attitudes of nursing staff working with older adults, often with the implication that negative attitudes result in poorer quality care. However, concern has also been expressed regarding the ability of such measurements to predict actual behaviour in working practice. There are a number of methodological problems associated with attitude scales (as discussed in Chapter Two). It is therefore unsurprising that questions have been asked about both the content validity of attitude scales and, assuming such measurements do give a genuine representation of attitudes, whether these attitudes reflect in the performance of staff or consequently impact upon the quality of experience of older people. What is needed, in order to examine the attitude-behaviour relationship more fully, is an observational technique that would allow comparison of attitudes with directly observed behaviour.

This study aims to examine the use of observational methods in evaluating the delivery of care.

3.1 Review Of Existing Quality Of Care Measurements

Studies attempting to relate attitudes to actual behaviour, particularly concerning health professionals working with older populations, frequently use observational techniques, a method that has been advocated since at least the late seventies. For example, Kogan (1979) advocates the examination of behaviours in a 'naturalistic setting', as does Adelson et al (1982) who state that methods of objectively measuring actual behaviour are required in order to evaluate interventions designed to change

attitudes. However, observational methods are not without their complications and the methodological problems associated with observational techniques, including those of standardising measurements, ensuring reliability and validity and translating observations into behavioural codings, should not be underestimated. Indeed, Adelson et al. (1982) state that Hickey (1975) met with limited success in attempting to use participant observation to evaluate the effects of a training program due to pragmatic problems in collecting data. Specifically, Hickey states that observations were too diffuse to be useful and that observers (who were also participants) tended to ignore guidelines. Despite the problems, Hickey recommended that observational methods be further developed both as a research tool and to evaluate behavioural changes as a consequence of training programs. Findings, however, clearly demonstrate the need for specificity and clarity of behavioural definitions, in order for observational techniques to be usable by anyone other than the person who developed them.

The observational methods used to evaluate quality of care, fall into two main types. In the first type the observational focus is on the residents and how they experience the care environment. For example, some methods focus on quantity or quality of interactions, or on visible indicators of resident well-being as a function of interactions. The second type of observational method focuses directly on members of staff and the way in which care is delivered in order to evaluate quality of care. The following section reviews each of these types of measurement in more detail.

3.1.1 Resident-Based Measures

Observational methods would appear to have a particular advantage in the evaluation of the quality of care for people with mental and physical impairments. Often such clients will have very limited means of expressing their feelings and opinions, they frequently have little control over their environment and may be highly dependent on others for many aspects of their daily life. In this context it is especially important that carers and therapists understand how their interactions impact upon the quality of life

of clients and aim to maintain the highest possible standards. In attempting to evaluate the quality of care for older people with dementia, a number of observational strategies have emerged. Brooker (1995), who highlights the tendency of observational methods to measure quantity rather than quality of resident activity, provides a review of some of these methods. One such technique records the numbers of residents in a particular area who are 'engaged' (i.e. interacting) with their environment in a meaningful way, as opposed to the number of residents who are disengaged (i.e. withdrawn or sleeping) (e.g. McClannahan & Risley, 1975; Jenkins, Felce, Lunt, & Powell, 1977; Felce, Powell, Lunt, Jenkins, & Mansell, 1980). Other techniques have attempted to include information about the type of activity residents are engaged in (e.g. McFayden, 1984; Macdonald, Craig, & Warner, 1985; Bowie & Mountain, 1993). However, these methods tend to use similar gross behavioural categories and record how people with dementia spend their time (Brooker, 1995). Although quantity of activity may be related to quality of care, there may be subtle differences in the quality of experience gained from various activities by each individual resident.

Both the Quality of Interactions Schedule (QUIS, Dean, Proudfoot & Lindsay, 1993) and Dementia Care Mapping (DCM, Kitwood & Bredin, 1992) provide exceptions to the focus on quantity rather than quality, in that ratings do not only record the level of resident interaction or activity, but also the quality of the interaction likely to be experienced by residents.

Several studies (e.g. Davies & Snaith, 1980; MacDonald et al., 1985; Clark & Bowling, 1989; Lindsay, Briggs, Lawes, MacDonald & Herzberg, 1991) have attempted to observe the social interactions between staff and residents, with the view that this is of particular importance for people with advanced dementia, whose quality of life may arise largely from the experience of moment to moment contacts, often during the delivery of physical care. The QUIS allows measurement of the level of interaction received by residents, using a hierarchy of desirable or undesirable

interactions. Social interactions between residents and care staff are coded as positive social; positive care; neutral; negative protective or negative restrictive. Thus recording of positive interactions includes both those that are related to physical care and those that are purely social. Recording of negative interactions includes those that are intended in a protective way (for example 'don't touch that, it's hot') and those that are simply restrictive, which appear to be used for the convenience of members of staff, with no obvious well-intentioned purpose to the resident. Both verbal and nonverbal interactions are recorded. One particular limitation of the method is a potential ceiling effect with regard to its ability to indicate extremely high standards in quality of care. Positive social interactions may vary considerably, however, this category of the QUIS allows no distinction to be made between a short greeting of 'Hello Doris' and a 5 minute conversation. A further limitation is the exclusive focus on interactions, when residents quality of experience may be influenced by many other factors.

Perhaps a more comprehensive method of evaluating quality of care is Dementia Care Mapping (DCM). The method is based on extensive ethological observations of people with dementia in a variety of care settings together with a theory of the process of care. DCM has attracted considerable interest and has been widely used, both as an evaluation tool (Brooker, 1994) and as a means of promoting change (Barnett, 1995). The DCM method is underpinned by Kitwood's model of 'The dialectics of dementia'. Kitwood maintains that the extent of impact made by neurological factors will vary greatly between individuals, but that neurological impairment alone is not wholly responsible for decline in well-being. In addition, the social environment in which people exist is thought to have a profound effect on the psychological and emotional well-being of people with dementia. Thus it is the interplay between neuropathological and social psychological factors that impact simultaneously affecting the course of decline. Kitwood's theoretical standpoint is incorporated into the DCM method by its focus on factors effecting the person's psycho-social environment.

DCM evaluations provide data reflecting five main quality indicators. These indicators are the range of activities residents engage in, the amount of time spent in each activity, levels of resident well- or ill-being, positive event recording and personal detractions i.e. statements or actions made by staff that restrict, devalue or demean residents in some way. The DCM method requires trained observers to record detailed information on each resident for a minimum period of six hours. Every five minutes, one of twenty-four behaviour categories is selected by the observer to indicate the activity each resident is engaged in. A well- or ill-being score is also allocated for each five-minute period reflecting the extent to which each resident is involved or stimulated during that time. This score is based on verbal and non-verbal signs from the resident and on the way in which care is delivered by staff. Positive event recording involves recording episodes of good care practice, which can subsequently be fed back to staff in order to help them build on their strengths. Positive events would include episodes where a deteriorating situation is turned around, where a care worker shows remarkable skill or talent, or where the abilities of a resident are drawn out. In addition, personal detraction coding enables episodes of malignant social psychology (MSP) to be recorded in order to work towards the elimination of bad care practice. Seventeen components of MSP have been identified, which include: infantilization, labelling, objectification and ignoring (see appendix eight for the full list). Observers have to make a judgment regarding the severity of the personal detraction, which may be recorded as mild, moderate, severe, or very severe. From DCM observations, two main types of score are obtained in addition to the qualitative information derived from personal detraction and positive event recording. One is an individual resident score based on the sum of quality ratings and the other relates to the pooled frequency of quality ratings across all residents. The inter-rater reliability of DCM has been shown to be satisfactory, although this is dependent on prior training and experience of the observers. Thus reliability needs to be replicated in each implementation, to ensure that different raters are using the tool in the same way. The DCM method also has good 'face validity' in that those working in the field find that it meets their concept of what quality of life in dementia entails.

Feedback from the observations are subsequently given to the staff group, in order to bring current practices to their attention and enable them to set themselves goals for developing their practice.

The evaluations made in both the QUIS and DCM aim to record behaviour from the perspective of the person with dementia. Recordings are made about individual clients and the way in which they receive care. While this may be effective in evaluating and presenting the experience of the person with dementia, resident-based assessment alone is insufficient in assessing the impact of staff training and supervision or in evaluating the quality of care provided by individual members of staff. Although the quality of care provided by staff may have a substantial impact upon the quality of life experienced by residents, the two are not identical. For example, it is possible to envisage a high quality of care not having a measurable effect on a person whose dementia is so severe that any response to the environment is hardly discernible, or where the person's health is deteriorating rapidly. In addition, since recordings are related to residents and not staff, it is possible that improvements could be observed that are unrelated to individual changes in staff behaviour. For example, the recruitment of new staff with different skills may have an impact on global quality of care scores, yet the behaviour of existing staff has remained the same. Thus the direct effects on staff performance must also be assessed, in order to ensure that each individual member of staff makes appropriate adjustments to the delivery of their care.

3.1.2 Staff-Based Measures

Studies using observational techniques to directly examine the performance of staff include that of Adelson et al. (1982), who recognised the need for methods of objectively measuring actual behaviour in order to determine specifically the effects of attitude on patient care. They designed an instrument to quantify health

professionals' behaviours during interactions with geriatric patients. The method employed was used to observe nurses and nursing assistants mainly during physical care activities. The specific behaviours identified as components of a positive interacting style were; 'uses patient's name', 'banter', 'asks for feedback', 'gives procedural information', 'compensates for disabilities', 'social touches' and 'attends to patient comfort'. Level of appropriate smiling and pacing of both procedure and speech were also recorded. Adelson et al. (1982) recommend the use of such a technique in establishing whether attitude studies can predict behaviour and to examine to what degree and in what ways attitudes are related to behaviour.

In an earlier study, Hatton (1977), attempted to do just that, using observational methods to try and establish a link between nurse's attitudes toward older people and nursing care. Observations focused on the identification of positive and negative nurse-patient interactions. Categories included 'showing respect for the individual', for example, acknowledging a person's presence within a group; 'interacts to engage the patient', for example, engages in conversation or humour; and 'enabling patient to make decisions'. The results of this study provided some support for the idea that nurses with more favourable attitudes exhibit a higher percentage of positive interactions. The study, however, is limited by the small sample size ($N = 7$); the difficulties the author encountered in collecting and categorizing the data; and the lack of a statistically significant correlation between attitude and behaviour measurements. The study also demonstrated that, although positive attitudes (from the Kogan OP scale) did appear to relate to more positive interactions, the same was not true for the relationship between negative attitudes and negative interactions. Thus while the Kogan positive OP scale may predict positive interactions, the negative OP scale does not necessarily predict negative behaviours.

More recently, in a study focusing on attitude-behaviour relationships in relation to dementia care, Salmon (1993) employed observational methods to examine the relationship between nurses' attitudes and the quality of their interactions with clients.

A time-sampling procedure was used where staff members were observed for 5 second periods. Behaviour was categorised into: interaction with patient; conversing with a member of staff about a patient; talking with someone other than a member of staff or patient; writing; and recreational behaviours. Interactions with patients were also subdivided into positive, negative and neutral. Salmon (1993) reports that he found virtually no relationship between attitudes and behaviour, with neither the attitude scale used (Jones & Galliard, 1983), nor the philosophy of treatment form (Barrell, DeWolfe & Cummings, 1965) predicting the proportion of observed interactions that were positive. However, one significant correlation was found which suggested that nurses who were most often observed in 'recreational' behaviour (i.e. not patient directed), were those who were least sensitive to patients' needs for emotional support. Thus it is possible that while the scales used were not able to predict the proportion of positive interactions by staff, they may have been able to identify whether staff were likely to engage in interaction with residents at all. This could well be a reflection of their underlying attitudes towards their clients or their work. One possible explanation for the limited relationship demonstrated by this study can be provided by consideration of Ajzen & Fishbein's (1977) assertion that attitudinal and behavioural criteria must be directed specifically at the same target in order for relationships to be observed. The Jones & Galliard (1983) assessment and the philosophy of treatment form (Barrell et al., 1965), used in this study were designed for use with elderly patients and physically ill patients respectively, but observations were performed on nursing staff caring for people with a diagnosis of dementia. Although one might expect the concepts to be similar, there could equally be something specific about caring for people with dementia that is not captured by evaluations of older people generally.

In addition to studies that attempt to demonstrate a relationship with attitudes, observational methods have also been used in identifying links between quality of care and factors such as staff job satisfaction. One such study, carried out in Scottish psychogeriatric wards is that of Gilloran, McGlew, McKee, Robertson, & Wight

(1993), who identified a number of quality care indicators and constructed these into an observation schedule. They draw on previous discussions of quality of life in institutional settings to emphasise the importance of maintaining autonomy, individuality, choice, respecting dignity and the need for privacy, encouraging independence, and social interaction (Brearley, 1977; Willcocks, Peace & Kellaheer, 1982; Home Life, 1984; Booth, 1985; Hughes & Wilkin, 1987). Gilloran et al. (1993), record the presence or absence of each of these quality indicators during feeding, bathing and toileting activities, arguing that these are the periods when most significant staff-patient interaction takes place. In using this method of inquiry, Robertson et al. (1995), demonstrated that these indicators of patient care are more likely to be present in wards where nursing staff express higher levels of job satisfaction. While the authors of these studies are careful to maintain an ethical stance in relation to observing highly intimate aspects of physical care, it cannot be denied that less intrusive techniques, achieving the same level of appropriate information, would be preferable. It could also be maintained that although it is often during the feeding, toileting and bathing activities when the majority of interactions between staff and patients take place, good quality care during these activities is increasingly becoming a minimal and expected standard. The way in which staff learn to relate to residents during other periods of the day, for example, by providing stimulation or by including residents in purposeful daily tasks, would give a greater indication of the extent to which the goal of truly excellent standards of care are being achieved.

If attitudes are unrelated to behaviour then the attitudes held by nursing personnel working with elderly patients would be irrelevant to their work, given that their attitudes would not effect the way they cared for the residents. Therefore, efforts to change attitudes or employ staff with appropriate attitudes would be obsolete and unnecessary. However, personal experience and common sense tell us that this is not the case, and what is more likely is that the measurement tools used in research, thus

far, have been inadequate in assessing which attitudes are related to which behaviours in caring for elderly people.

The following section presents a new observational method, which draws on some of the existing methods of inquiry detailed above to enable the evaluation of care related behaviours by directly observing care staff in their normal working environment. The technique, designed specifically for use in evaluating the care of people with dementia, attempts to combine some of the key indicators of care quality identified above, and incorporate them into observations of a wide range of care worker activities, that can be carried out in communal areas.

3.1.3 Objective

The objective of this study was to develop a suitably detailed behavioural observation method that could be used to evaluate the behaviour of dementia care professionals and the quality of care they delivered. The observational method developed could then be used to assess the hypothesis that there would be a relationship between the attitudes and behaviour of care staff.

3.2 METHOD

3.2.1 Participants

The observational scale was developed with 52 members of staff, working in the focus nursing home, caring for older people with dementia and older people with physical frailties. Seventeen of these were registered nurses and 35 were care assistants. There were 47 females and 5 males. Participants ranged in age from 18 to 60 (mean = 38.6; sd = 14). Thirty-two worked day shifts and 20 worked night shifts.

Thirty-six participants were employed to work full-time and 16 worked part-time. Experience of working with older people ranged from 2 months to 28 years (mean = 7.4 years; sd = 7.4).

3.2.2 Ethical Considerations

The task of carrying out observations within a care home environment clearly poses some ethical considerations both in relation to residents of the home and staff whose work would be observed. Approval for this study was sought and granted from the local ethics committee (copies of the relevant letters, information sheets and consent forms used can be found in Appendix Two). Every effort was made to minimise the intrusiveness of the observations for the residents. It was decided that observations would only take place within communal areas of the home and as far as possible the observer would remain in one position so that they would 'blend into the background'. The observer also spent some time with residents outside of the observation periods so that residents would be familiar with the observer and be more likely to feel comfortable with her presence. Residents were given a brief description of the purpose of the observations and asked if they minded the observer being there and on no occasion did a resident express dissatisfaction with the observer's presence. Consent for the observations to be carried out was also sought from the resident's next of kin, or advocate as appropriate.

The presence of the observer at times other than observation periods also gave staff the opportunity to get to know and feel more familiar with the observer so that observations would feel less threatening. In order to further minimise the impact of the observations on staff, staff were kept fully informed about the purpose of the research and were assured of the confidentiality of the data that would be collected. Staff members were each given written information about the research project and were subsequently approached individually and invited to ask questions about the

project. Once questions had been answered, consent was sought and granted from each member of staff.

3.2.3 Development Of The Observational Technique

Following a review of the literature, discussions were held with experts in the field in order to establish the elements of an observational technique that needed to be developed. Experts again included Professor Tom Kitwood, who was consulted due to his considerable knowledge and experience in the development of the DCM observational technique. In addition, the development of the technique was discussed with Dr Alex Robertson, Senior Lecturer in Social Policy at the University of Edinburgh. Dr Robertson's areas of expertise include health policy and planning, evaluation of social services and services for mental health. He contributed to the development of the observational technique used by Gilloran et al (1993) and has consulted on policy of central government, local authorities and voluntary agencies. In addition to expert consultation, several weeks of informal observations were carried out on the specialised dementia care units of the focus nursing home. Narrative notes were made of what was happening (and not happening) with regard to the care workers' activity. In particular note was taken of: periods of high activity and inactivity; significant incidents of care and how these were carried out; particularly positive or negative statements or actions made by members of staff; and incidents that could be considered 'missed opportunity' (e.g. where a resident initiated an action or activity but was prevented from completing it by a member of staff).

From these observations categories were constructed by grouping together aspects of the care workers' activities that were similar. Identification then began of what the key elements were for the different groups of categories indicating the quality of the interaction or task that took place. Thus a coding structure (a summary of which can be seen on page 106) was developed which included the following:

Figure 3.1: DCPA OBSERVATIONS KEY (1st Trial)

Code	Behaviour	Style
A	Activities (stimulation)	d - discusses interests i - independent activity encouraged e - engages in activity with resident/s
B	Bathing, washing and shaving	physical care .
C	Conversation	r - with resident c - with colleague v - with visitor
D	Dressing/Undressing	physical care
E	Escorting	l - leading from one area to another s - leading with social element p - socially walking for pleasure
F	Feeding	physical care
G	Grooming (e.g. adjusting hair/clothing)	physical care
H	Housework (e.g. tidying, laying tables)	domestic duties
I	In/out of chair	physical care
K	Kitchen work (e.g. making drinks)	domestic duties
L	Laundry duties	domestic duties
M	Making beds	domestic duties
N	Nursing duties (e.g. changing dressings, giving medication)	physical care
O	Observing	c - colleague r - resident
P	Paperwork (including handover)	
Q	Quiescent (inactive)	
R	Response to challenging behaviours	n - normalising p - person-centred b - behavioural d - distraction m - medical
S	Supervising	c - colleague r - resident
T	Toileting	physical care
U	Unaccountable	
V	Verification	
W	Waiting on (serving food/drinks)	domestic duties
X	eXits (goes for break)	
Z	Zero option (no other category)	

Physical Care Key

- | | |
|-----------------------------|-------------------------------|
| a - attention (individual) | c - choice |
| d - independence encouraged | f - feedback requested |
| i - information given | p - privacy respected |
| s - social interaction | sp - speed (appropriate pace) |

Domestic Duties Key

- | | |
|-----------------------------------|---|
| i - independently | s - while socially engaging with resident |
| e - engaging resident in activity | |

1. Behavioural Category Coding.

The following categories were used to code the types of behaviour care staff engaged in; Activity or Stimulation (performed with residents), Bathing (including washing and shaving), Conversation (with a resident, colleague or visitor), Dressing/Undressing, Escorting, Feeding, Grooming (e.g. combing hair), Housework (e.g. laying tables), In/Out of chair (e.g. moving a resident), Kitchen work (e.g. making drinks), Laundry duties, Making beds, Nursing duties (tasks only carried out by the registered nurse, e.g. giving medication or changing dressings), Observing (of either colleagues or residents), Paperwork, Quiescence (i.e. inactive), Responding to challenging behaviour, Supervising (a colleague or a resident), Toileting, Unaccountable (i.e. unable to locate the person), Verification (consulting colleagues), Waiting on (e.g. serving food or drinks), eXits (i.e. having a break), Zero option (doesn't fit any other category and details are noted separately).

2. Care style coding

For most of the behavioural category codings, it was also possible to record certain quality indicators or 'Key Qualities' of the action being performed. The key quality codes depended upon the type of behaviour that was being carried out. For example, if some form of domestic task was being carried out, note would also be taken of whether this was done independently, whether any of the residents were involved in what was being done, or, if not, whether the member of staff engaged socially with residents while carrying out the task. If some form of physical care task was being performed, the key qualities evaluated were based on the care indicators identified by Gilloran et al (1993) which included the following; degree of choice offered, whether relevant information was given, extent to which independence was encouraged, whether individual attention was given, whether staff conversed with the resident and whether the need for privacy was respected during intimate procedures. In addition, two further quality indicators were used, previously employed by Adelson et al. (1982) in their study of health care professionals behaviour while caring for bedridden geriatric patients. These were whether the member of staff asked for feedback from

the resident, for example asking if something hurts or how it feels and using an appropriate pace (i.e. not too fast or too slow). If a quality indicator was present, the appropriate letter from the Physical care key is circled in the 'KQ' section of the observation form (see Appendix Seven). Further indices of quality were also used for the behaviours of escorting a resident, conversation and providing some form of activities or stimulation for residents (as detailed on observations key above).

3. Response to 'challenging behaviours' coding.

Categories for this part of the observational technique were based on the styles of response used by Brooker (1998) in her Dementia Care Styles Questionnaire. In this questionnaire respondents are asked to say which of four responses they would use if they encountered a number of typical dementia care situations. Responses are categorised as being either: person-centred; behavioural; medical; or normalising. The same categories were used in this study to record the style in which members of staff actually responded to resident behaviour. In addition, on the basis of informal observations carried out in the home a fifth style - using some form of distraction, was also included. Thus, if a member of staff responded to some form of challenging behaviour, the manner in which they did so was recorded in terms of one of these five styles.

4. Personal Detractions (PDs) coding.

Personal detraction coding is used as part of the Dementia Care Mapping (DCM) method (Kitwood & Bredin, 1993) to record any comments or actions that restrict or devalue residents and are likely to reduce well-being. A full list of the various types of personal detraction that it is possible to make is given in the DCM manual (and is reproduced in Appendix Eight). In this study, the type and severity of PD was not recorded as it was thought that the additional information the observer would need to keep in mind in order to accurately record such details would place an excessive demand on the observer's already sizeable task. Rather, a tally was kept of the number of PDs made by each member of staff.

A trial of the coding system then took place using a continuous interval recording method, whereby data was recorded every five minutes over a 90 minute period. A time sampling approach was selected as opposed to a total event recording method, in order to avoid the video equipment and extremely complicated coding system often required by the later to obtain highly detailed information. The time sampling approach used here was based on that used in the DCM method, which is designed to provide rich detailed information, but still be sufficiently accessible for others to learn how to use it.

Each member of staff was observed for four or four and a half hours, using the recording categories above. Staff working day shifts were observed at times during which they would be likely both to perform physical care activities and when there would be time during the day for more recreational type activities with residents. Observations took place on three occasions, once each between the hours of 10.30 a.m. and 12.00 noon; 12.30 p.m. and 2 p.m.; and 2.30 p.m. and 4 p.m.. Night staff were observed at times when they had most contact with residents (i.e. at the beginning and end of their shift). Observations took place on two occasions between the hours of 6 a.m. and 8 a.m. and 9 p.m. and 11 p.m..

Data were recorded on the observation form shown in Appendix Seven. A total of 184 hours of observations were performed.

3.2.4 Refinement Of The Observational Technique

As a result of many hours of observations and joint observations with the project supervisor, it became clear that a number of changes were required in order to improve the reliability of the method and to simplify it's coding system. The new Observations Key can be seen on page 119 and the changes that were made are as follows:

Behavioural category changes:

1. The Activities/Stimulation category was renamed 'Purposeful Activity/Stimulation'. Originally the quality indicators for this category were discussing interests with a resident; encouraging a resident/residents to carry out an activity independently (for example, giving them a book to read alone); and actually engaging in the activity with the resident. Following the observations, it was decided to transfer the 'discusses interests' quality indicator to the behavioural category of 'conversation'. Thus if a member of staff was conversing with a resident about the sort of activity they might like to do, this is coded as 'conversation' rather than as actual 'activity'.
2. As there appeared to be some overlap between some of the non-resident contact categories, and some of these categories were rarely used, these were collapsed under the global heading of 'Administration'. This category then would include paperwork, handovers, supervising colleagues, observing colleagues and verification (consulting with colleagues)
3. The quality indicators used in the Conversation category were originally 'r' for conversation with a resident; 'c' for conversation with a colleague; and 'v' for conversation with a visitor. It was decided that the Conversation category should refer to conversation with a resident only and conversations with colleagues or visitors could be coded elsewhere. Conversations with visitors would be recorded within the 'Administration' category and with colleagues within the 'Administration' or the 'Inactive' category, depending on the content of the conversation. The Conversation (with residents) category, could then be further categorised to indicate the quality of the conversation. One of the criticisms of the QUIS (Dean et al, 1996) was its inability to distinguish between social interactions providing a short greeting of 'hello Doris' and those likely to be more satisfying for residents where the interaction continues long enough for a meaningful conversation to take place. Thus in this study, quality indicators were

introduced as follows: 'bv' indicates a brief verbal interaction of 6 words or less; 'v' indicates a verbal interaction of 7 or more words, but less than two minutes; and 'c' indicates conversation or companionship of longer than two minutes.

4. The Escorting category originally had three quality indicators: 'l' for leading the resident from one place to another; 's' for leading from one place to another with a social element to the interaction; and 'p' for walking with a resident as a sociable or pleasurable activity. Since the first two types of escorting seemed to come under the broader heading of physical care and the third was more of a purposeful activity, it was decided that escorting would be coded with the quality indicators for physical care interactions unless it was walking for pleasure, in which case it would be coded as 'Purposeful Activity/Stimulation'.
5. Some of the domestic duties categories were observed so infrequently that it was decided to collapse a number of categories together under the broader heading of 'Housekeeping'. Thus, this category would then include, making beds and laundry duties.
6. 'Waiting on' category was renamed 'Serving' and the quality indicators key used was changed from the domestic duties key to the physical care key, which appeared to be more appropriate. Initially, it was thought that if someone was merely handing out drinks, this would be classified under the domestic duties quality key. On trial of the observations, however, it became apparent that the physical care quality indicators would be more appropriate here. Even though the member of staff may not have actually engaged in providing direct physical care of the resident, good quality care would still require use of the key qualities of providing choice, information, enabling independence etc., thus use of the physical care key for this behavioural category allows these aspects of care to be registered.

7. The 'response to challenging behaviour' category was renamed 'Response to expression of need' in recognition of the growing body of literature suggesting that much of the behaviour, typically regarded as 'challenging', is now more frequently viewed as an expression of need (e.g. Kitwood, 1997). During trial observations, coding of 'response to expression of need' proved to be particularly difficult. Specifically, coding 'responses to expression of need' as a separate category resulted in the loss of information about what activity the carer was involved in while giving the response to expression of need. For example a carer might be performing some form of physical care with one resident while verbally responding to another resident's repetitive calls. Thus in order to account for this, it was decided that the coding would focus on the member of staff's activity and 'responses to need' would be noted separately. However, difficulty was also encountered in deciding which of the five styles of response were being used. The 'm - medical' response was removed as this would include behaviours such as consulting a Doctor; giving medication; or writing observations in notes, all of which cannot be explicitly observed. Additional response styles were also tried. These included taking 'ro - reality orientation'; 'i - ignoring'; and 'r - reprimanding' response styles. However, even with these changes, classification was difficult and much more work in this area would be needed in order to sufficiently categorise and define each of the response styles. In view of these difficulties, it was decided to remove the 'response to need' coding from the observational method.

Precedence of categories

Trial observations indicated that more than one behaviour could be observed within the same five minute time period. Thus, in order to aid decisions about which code to use, an order of precedence was required. The following order of precedence was developed, to form a hierarchy of behavioural categories, with those thought to be most therapeutic for residents coded first:

1. Any behaviour that provides purposeful activity or substantial conversation (i.e. communication with a 'c' care style coding) for one or more residents, thereby attending to their psychosocial needs. If both purposeful activity and conversation take place during the same five minute period, the observer must make a judgment about which is the most significant for the resident/s concerned. If conversation takes place during a physical care intervention, however, the appropriate physical care code should be used with the presence of social interaction noted amongst the key qualities. (N.B. communication of a shorter length, i.e. less than two minutes, is not included here see point 3 below)
2. Any physical care activity.
3. Communication with a 'v' or 'bv' care style coding.
4. Any domestic or administrative tasks where there is no contact with residents. If residents are involved in performing the task, this is considered purposeful activity - see point 1, above. If the member of staff talks to a resident/s while performing the task, refer to point 1 or point 3 as appropriate.
5. Any other, non-resident related activities.

Definitions of the Physical Care quality indicators.

Using the observational technique, also highlighted difficulties in deciding which quality indicators had been used. For example, if a member of staff was giving individual attention to one resident, but in doing so was ignoring another, would they be coded as having given attention or not? It was also noted that a member of staff could perform two physical care activities (either with the same resident or with different residents) within the same five minute period, so decisions would need to be

made about which interaction should be used to code the key qualities. Thus, the need for specific definitions for the quality indicators became apparent. The following criteria were developed:

1. In order to give the participant the most positive score possible, the quality indicators are allocated whenever they are observed in relation to physical care during a five minute period, i.e. even if the key quality is only used once, despite more than one physical care interaction and even if the key quality is used with one person and not another/others, it is still allocated. For example, if the member of staff is feeding a resident for four minutes without using the key quality of information, but then during the last minute, takes a resident to the toilet and does give information, the behaviour category code would still be 'F' (indicating that most of the five minutes was spent helping a resident to eat), but the key quality of 'i' (giving information) would also be allocated to indicate that the member of staff gave some information to a resident during that five minutes, even though it was unrelated to the feeding behaviour.
2. The remaining criteria refer to each of the key qualities individually:
 - attention (individual) - this key quality is allocated if the attention given to the resident with whom physical care is being undertaken, is focused on that resident and is sufficient to carry out the task. Distraction from the task in order to respond to another resident would not preclude allocation of the indicator, unless it is detrimental to the first resident. For example, this quality indicator would not be allocated, if the member of staff, due to their interactions with another resident, spilled food on a resident while feeding them, or didn't pick up cues that the resident didn't want any more food.
 - choice - this indicator would be allocated if residents are consulted about whether they want the physical care interaction to take place. Offering choice may be verbal or non-verbal, providing the resident appears to understand what they are being offered. For example, if a member of staff is feeding a resident for 20

minutes, it may not be necessary for them to ask if the resident wants to eat, every five minutes. Moving the spoon of food slowly towards the resident's mouth, and waiting to see if the resident opens their mouth to take it, could constitute a non-verbal offering of choice and would therefore be sufficient to warrant allocation of the indicator.

- independence encouraged - this key quality is used to indicate that the resident has been given the opportunity to have some level of independence during the physical care task. For example, being given the opportunity to cut up their own food if they are able, rather than it automatically being done for them.
- feedback requested - this key quality is allocated when the care worker asks for feedback from the resident about the physical care they are receiving, for example, asking if something hurts or if the resident is comfortable once the care intervention is finished.
- information given - a judgment must be made about whether sufficient information has been given for the resident to understand what is happening or about to happen. For example, if a resident still appears puzzled by the information given and no further explanation or repetition of the information is given, this would not be considered sufficient. If food is given with no information about the type of food on the plate, again, this would not be considered sufficient. If a resident is told they are going for a walk and is then taken to the toilet, again this would not be considered sufficient information (and would also be noted as a PD).
- privacy respected - this indicator is allocated in relation to the performing of intimate tasks such as taking the person to the toilet. Clearly if a resident is hard of hearing, it may be difficult to provide both information and discretion. In this case the observer must make a judgment about whether all attempts have been made to perform the care interaction while still respecting the resident's privacy.
- speed (appropriate pace) - here a judgment must be made about whether the care interaction is carried out at an appropriate pace, not too fast and not too slow. Good indicators of whether the pace is appropriate are whether the resident

appears to understand what is happening and appears to be able to cope with the pace of what is happening without distress or agitation.

- social interaction - this key quality is allocated if the care worker engages the resident in some form of social interaction while performing the physical care interaction. This could consist of any form of social interaction from brief comments about the day's weather to a discussion about the resident's childhood experiences.

Reduction of time sampling periods

Periods between mealtimes have previously been identified as times when there is little to occupy residents, who often fall asleep or become withdrawn from their environment (Gilloran et al., 1993). In order to maximise the efficiency of the time-sampling procedure and to see if the number of time sampling periods could be reduced, morning and afternoon observations were compared using paired t-tests (Appendix Nine). Lunchtime observations were not included, as the amount of physical care taking place during this period is likely to be significantly higher. Results indicated that there were virtually no differences between the activities carried out within the 10.30 a.m. to 12 noon and the 2.30 p.m. to 4 p.m. observations. Since equivalent information could be obtained from performing 2 sessions rather than three, it was decided that 2 sessions (including a lunch-time) would be sufficient for future observations.

Observations of night staff

Having attempted to use the same observational method with night staff between the hours of 6 a.m. to 8 a.m. and 9 p.m. to 11 p.m., it was observed that most of the care carried out by night staff during these times took place in the residents' private bedrooms. The ethical boundaries of the study consider observations within resident's bedrooms to be too intrusive. As little information could be gathered on members of staff without going into bedrooms, it was decided that the observational method in its current format might not be suitable for use with night staff.

3.2.5 Final Version of the Observational Technique

Following the refinements of the recording technique detailed above, the final version of the observational technique consisted of the following:

Behavioural Category coding - For the final version of the behavioural category coding, one of nineteen letters is used to represent the activity in which the staff member is engaging. For example 'B' = helping a resident with bathing, washing or shaving, 'H' = engaging in housekeeping duties. The full list of categories is shown in the observation key overleaf. Decisions about which category to code are made using this key and the order of precedence detailed above.

The appropriate letters from the observations key are then recorded on the recording sheet shown in Appendix Seven. This form can be used to observe two people at the same time and it was found that this was the most that could be observed simultaneously, in order to give enough attention to observe each person in detail.

Care Style coding - In order to indicate the quality of activity, a 'care style' code is also attributed during the five minute periods. The Behavioural categories are grouped into three main areas of skill: Physical care; domestic duties; and provision of activities/stimulation. Three care style coding keys are used to represent these areas of skill.

i) Physical care - If the behavioural category that has been coded relates to an aspect of physical care, the appropriate letter from the following list of key qualities (based on the work of Gilloran et al., 1993, 1995; and Adelson et al., 1982), is circled on the observations form (see Appendix Seven):

a - attention (individual)	i - information given
c - choice	p - privacy respected
d - independence encouraged	sp - speed (appropriate pace)

f - feedback requested

s - social interaction.

ii) Administrative & Domestic duties - If the behavioural category coded relates to some aspect of domestic work, the appropriate letter from the following key is recorded in the 'CS' box on the observations form (see Appendix Seven) to indicate the extent to which the residents are included in this activity:

i - independently

s - while socially engaging with resident

e - engaging resident in activity

iii) Purposeful Activities/Stimulation - If the member of staff provides some form of purposeful activity or stimulation for residents, a letter from the following key is recorded in the 'CS' box on the observations form (see Appendix Seven) to indicate their involvement in the activity:

i - encouraging an independent activity

e - engaging in the activity with residents

Note is also taken of the number of 'personal detractors' (i.e. any comment or action that restricts or devalues residents and is likely to reduce well-being) (Kitwood & Bredin, 1993) made by each member of staff. These are tallied in the right hand column of the observations form (see Appendix Seven).

Observations only take place in communal areas, with the aim of being as discreet as possible, i.e. not constantly following or intimidating people by this process. It was found that finding one position within a communal area from which to observe and limiting movement from this point as far as possible, was the most unobtrusive approach. Information is provided to both residents and staff about the process that is taking place and its purpose.

Figure 3.2: DCPA OBSERVATIONS KEY (Final Version)

Code	Behaviour	Care Style
A	Administration (i.e. not directly resident related: e.g. paperwork; handover; talking to colleagues or relatives about a resident; supervision)	admin. duties
B	Bathing, washing and shaving	physical care .
C	Conversation with resident (with colleague = A or I, as appropriate) (with visitor = A)	bv - brief verbal (6 words or less) v - verbal (between 7 words and 2 minutes) c - conversation/companionship (longer than 2 minutes)
D	Dressing/Undressing	physical care
E	Escorting (walking for pleasure = P)	physical care
F	Food - Helping a resident to eat or drink	physical care
G	Grooming (e.g. combing hair, adjusting clothing, wiping hands, etc.)	physical care
H	Housekeeping (e.g. tidying, laying tables, making beds, laundry, etc.)	domestic duties
I	Inactive (not visibly doing anything)	
K	Kitchen work (e.g. making drinks)	domestic duties
M	Moving & Handling	physical care
P	Purposeful activities/stimulation	i - independent activity encouraged e - engages in activity with resident/s
R	Registered nurses specialised care (e.g. changing dressings, giving medication)	physical care
S	Serving (i.e. food and drinks)	domestic duties or physical care if this is part of serving (e.g. placing napkins, cutting up food, etc.)
T	Toilet requirements (N.B. returning from the toilet is coded as 'E')	physical care
U	Unaccountable	
W	Watching (actively observing residents)	
X	eXits (goes for break)	
Z	Zero option (no other category)	

Physical Care Key

- a** - attention (individual)
- c** - choice
- d** - independence encouraged
- f** - feedback requested
- i** - information given
- p** - privacy respected
- sp** - speed (appropriate pace)
- s** - social interaction

Admin. & Domestic Duties Key

- i** - independently
- s** - while socially engaging with resident
- e** - engaging resident in activity

3.2.5 Scoring

Once data has been collected, scores can be calculated for each area of skill. In addition, it is also possible to calculate a score representing the level of social engagement performed by each person observed.

Physical care

Sum the number of times each of the following codes appears during the observation period: B; D; E; F; G; M; R; S (if physical care involved); and T.

Key qualities relating to physical care

Sum the number of key qualities performed and divide by the number of incidents of physical care.

Non-resident contact activities

Sum the number of times each of the following codes appears during the observation period: I; W; and categories A; H; K; and S (if no physical care involved), where 'i' is the recorded care style.

Purposeful activity/stimulation

Sum the number of times each of the following codes appears during the observation period: Categories A; H; K; P; and S (if no physical care involved), where 'e' is the recorded care style.

Level of social engagement

Sum the number of times each of the following codes appears during the observation period: C and categories A; H; K; and S, where 's' is the recorded care style, P where 'e' is the recorded care style and any 's' recorded as part of a Physical Care task.

Number of personal detractions

A tally is also kept of any personal detractions made during the observation period. This provides the personal detractions score.

3.2.6 Data Collection

Once the observational technique had been developed, it could be used to collect data on 36 members of day staff (including 4 new members of staff) from the focus home. These included 6 males and 30 females, 11 of whom were registered nurses and 25 were care assistants. Staff were observed for a period of one and a half hours on two occasions, giving a total of 36, five minute time frames. The results shown below represent the data gathered from this participant group.

3.3 RESULTS

Table 3.1 shows the mean scores for each of the observational measurements. Participants were observed across two time periods (giving a total of 36, 5-minute time frames). Average scores across the two time periods were then calculated for physical care, non-resident contact activities, social engagement and purposeful activity stimulation. For key qualities, scores represent the mean number of key qualities used per physical care interaction and for personal detractions, the score represents the mean number of personal detractions used during the one and a half hour observation period.

TABLE 3.1: Table of Mean Observation Scores

(N = 36)	mean	s.d.
Physical care	7.62	3.25
Key qualities relating to physical care	3.90	1.12
Non-resident contact activities	4.02	1.93
Purposeful activity/stimulation	1.01	1.06
Level of social engagement	3.88	2.67
Number of personal detractions	2.46	1.81

In order to test for convergent and discriminant validity, observational scores were correlated with each other. Table 3.2 shows the correlations between each of the observational scores.

TABLE 3.2: Correlation matrix of observational scores

	Physical care	Key qualities	Non-contact	Activity or stimulation	Social engagement	Personal detractions
Physical care						
Key qualities	.11					
Non-contact	-.19	-.32				
Activity or stimulation	.20	.43**	-.40*			
Social engagement	.12	.59***	-.21	.25		
Personal detractions	.20	-.27	-.21	-.08	-.08	

* indicates $p < .05$; ** indicates $p < .01$; *** indicates $p < .001$. (N = 36)

Table 3.2 shows that significant correlations were found between the number of key qualities used and social engagement, and to a lesser extent to provision of activity or stimulation. Level of activities or stimulation provided also correlated negatively with time spent in non-resident contact activities. Although not significant, a trend could also be observed between key qualities and non-resident contact activities. From table 3.2, it is noticeable that many of the relationships between variables were not

significantly correlated. However, many of the correlations that were not found to be significant were between variables where a relationship would not be expected. For example, it would not be predicted that the amount of physical care undertaken would correlate with the other variables, since this provides a measure of the quantity of time spent in an activity and most of the other variables relate more to the quality of care provided. One might expect personal detractions to correlate negatively with variables such as key qualities, purposeful activity and social engagement. Similarly, social engagement could be expected to relate to purposeful activity, however correlations between these variables were not found to be strong.

3.3.1 Reliability

In order to evaluate the reliability of the observational technique, analyses were carried out to test both inter-rater reliability and test-retest reliability.

3.3.1.1 Inter-rater reliability

In order to test the inter-rater reliability of the technique another observer was trained to use the measure and 3 participants were observed by the 2 raters. Observations took place for an hour and a half on each participant and reliability was calculated separately for behavioural category coding and care style coding.

Reliability for the behavioural category coding was calculated by percentage agreement over the 54 possible time frames. Table 3.3 shows how many times each category was observed by each rater and how many of those were in agreement.

TABLE 3.3: Inter-rater Agreement for Behavioural Categories

Category Code	Rater 1	Rater 2	Agreement
Administration	0	0	
Bathing	0	0	
Conversation	4	4	4
Dressing/Undressing	1	1	1
Escorting	6	6	6
Food	15	14	14
Grooming	3	3	3
Housekeeping	2	3	2
Inactive	0	0	
Kitchen work	5	5	4
Moving & Handling	0	0	
Purposeful activities	4	4	4
Registered nurses care	0	0	
Serving	6	6	5
Toilet requirements	6	6	6
Unaccountable	1	1	1
Watching	0	0	
eXits	0	0	
Zero option	0	0	

Agreement was achieved on 93% of behavioural category codings. In order to account for chance agreement, Cohen's Kappa was calculated. This gave a coefficient of .93 indicating a satisfactory level of agreement. Five of the behavioural categories included in the method, however, were not observed during the inter-rater reliability observations. Given the high level of agreement achieved on the categories that were observed, there is no reason to think this would be different for the remaining five categories, however, since no data is available to support this, it is possible disagreement could occur on those categories not observed.

From those behavioural category codes where agreement was reached, inter-rater reliability was also calculated for the care style coding which accompanies each behavioural category code. Table 3.4 shows the level of agreement between raters on the care style coding.

TABLE 3.4: Inter-rater Agreement for Care Styles & Key Qualities

Key Qualities	Rater 1	Rater 2	Agreement
a - attention (individual)	36	35	35
c - choice	29	32	25
d - independence encouraged	34	32	30
f - feedback requested	33	29	26
i - information given	25	31	20
p - privacy respected	31	36	31
sp - speed (appropriate pace)	34	35	32
s - social interaction	27	33	25
Domestic duties			
i - independently	5	5	5
s - socially engaging with resident	2	2	2
e - engaging resident in activity	5	5	5
Conversation			
bv – brief verbal	0	0	
v - verbal	2	2	2
c - conversation	2	2	2

During the process of care style coding a number of difficult decisions have to be made about which care style codes to apply. For the key qualities codings, qualitative judgements have to be made about whether or not each key quality has been present during each physical care interaction. For example, one may have to decide whether saying ‘OK’ in a questioning tone of voice, is enough to constitute ‘asking for feedback’. Other difficulties encountered included one rater being close enough to hear what a participant said while the other was further away. The detailed guidelines presented in section 3.2 were produced in an attempt to minimise the confusion that may occur around decisions about which codes to apply during each five-minute time frame. Although these guidelines help with the process, it remains that during each five-minute time frame where a physical care interaction is taking place, eight relatively subjective judgements have to be made regarding the quality of the interaction observed.

Given the difficulties outlined above, one might not expect a high level of inter-rater reliability would be achieved. However, agreement occurred on the care style codings on 240 out of the 296 possible opportunities for agreement. Thus an 81% level of agreement was achieved on the care style codes and Cohen's Kappa calculation produced a coefficient of .80.

The level of agreement achieved appears to offer an adequate level of inter-rater reliability for each type of data recording and was particularly high for behavioural codings. These results show that data collected by two different trained observers was sufficiently similar to suggest that had another person collected the data presented in this study, the results would not be significantly different.

3.3.1.2 Test-retest reliability

Test-retest reliability was assessed by observing 23 staff members twice within a period of one month. On one of the occasions staff were observed between the hours of 10.30 am and 12.00 noon and on the other between 2.30pm and 4.00pm. Paired t-tests were performed on the am and pm data and no significant differences were found between the two time periods, thus it was decided that these two time periods were comparable. Table 3.5 shows the reliability coefficients for the retest analysis, which were calculated using rank order correlations.

TABLE 3.5: Retest Reliability Coefficients

	Reliability coefficient
Physical care	.21ns
Key qualities relating to physical care	.19ns
Non-resident contact activities	.08ns
Purposeful activity/stimulation	.44*
Level of social engagement	.29ns
Number of personal detractions	.49*

* indicates $p < .05$; ** indicates $p < .005$; *** indicates $p < .001$; ns = not significant (N = 23)

The observational technique achieved a low, although statistically significant, level of test-retest reliability in measuring staff members ability to provide purposeful activity and use of personal detractions. Coefficients achieved for the other variables, however, were not significant, indicating a lack of consistency on these variables between the two time periods. In order to explain these findings, further examination of the data was carried out by exploring the distributions of each variable. Boxplots were produced which represented scores from Time 1 minus scores from Time 2 so that outliers could be identified (Appendix Ten). Boxplots revealed that some outliers did exist and for three of the variables the same participant appeared as an outlier on each. This indicates that for some individuals scores from the morning observations were not consistent with scores from the afternoon observations. A number of possible reasons for this could exist, for example the participants concerned may have had individual reasons for performing differently such as illness. Particular individuals may prefer working morning shifts to working afternoon shifts and this may consequently have affected their performance. Alternatively it may have been that one of the occasions they were observed was a particularly busy or unusual shift and hence their performance was different. Removal of outliers enables coefficients to be recalculated on the remaining participants without the influence of the more extreme scores.

When outliers are removed, coefficients for purposeful activity and personal detractions move closer to acceptable levels of reliability. In addition a more acceptable reliability coefficient can also be observed on level of social engagement. Table 3.6 shows the coefficients obtained when outliers are removed.

TABLE 3.6: Retest Reliability Coefficients with outliers removed

	Reliability coefficient with outliers removed
Physical care	No outliers
Key qualities relating to physical care	.38ns (N = 21)
Non-resident contact activities	No outliers
Purposeful activity/stimulation	.83*** (N = 19)
Level of social engagement	.65** (N = 20)
Number of personal detractions	.68*** (N = 22)

* indicates $p < .05$; ** indicates $p < .005$; *** indicates $p < .001$; ns = not significant (N = 23)

Although the correlation coefficient is stronger for number of key qualities, once outliers are removed, it remains low. A possible explanation for the low test-retest reliability found on key qualities is that this score is based on the number of key qualities per physical care interaction. However, whereas some participants were observed performing physical care interactions over several different time frames, for others there may have only been one or two physical care interactions recorded. Thus the sample upon which the key qualities score is based may be extremely limited in some cases and in order to try and account for this, the retest analysis was recalculated excluding cases where at least a certain number of physical care interactions had taken place. It was decided that 6 physical care interactions (equalling a total of thirty minutes in time) would be sufficient to establish a representative number of key qualities being used during each physical care interaction. Using six or more physical care interactions as an exclusion criteria, however, resulted in too small a sample from which meaningful analysis could be achieved. Thus, it was decided that cases where 5 or more physical care interactions had taken place would be included. When the analysis was recalculated, a reliability coefficient of .76 was achieved, however, there were still relatively few participants with sufficient number of physical care interactions ($n = 8$).

The exclusion of participants, reducing the sample size to only 8 participants means that there remains a not entirely satisfactory indication of the reliability of the key qualities measure. The initial aim of the test-retest analysis was to examine reliability

in the short-term using the am/pm data. However, the relatively small number of participants with sufficient numbers of physical care observations limits the conclusions that can be drawn from this data. In order to consider the retest reliability of the key qualities measure further, it was decided to examine data that had been collected on two different occasions six months apart. The scores used in this analysis were calculated by combining observation scores from one morning (10.30am – 12 noon) and one lunch-time period (12.30pm – 2pm) in order to maximise the likelihood that a number of physical care interactions would have taken place. Data was available on 16 participants who had performed 5 or more physical care interactions on each occasion and statistical analysis revealed a reliability coefficient of .69.

The two other aspects of the observational technique (physical care and non-resident contact activity) also did not indicate a great deal of consistency over the am and pm observational periods. Data that had been collected on two occasions, six months apart was also examined for these two variables. Coefficients obtained were .34 for physical care and .30 for non-resident contact activities indicating a low level of consistency over time on these two variables. However, given that these two variables measure the amount of time spent engaging in specific activities rather than qualitative aspects of care input, one would not necessarily expect scores on these two variables to remain the same.

3.4 DISCUSSION

This study described the development of an observational method, its subsequent refinement, and offers evidence for its reliability. The technique was intended to be used in communal areas of nursing homes with a focus on staff caring for people with dementia.

The method developed allows calculation of time spent engaged in various types of activity, and also detailed information representing the quality of the interaction or task undertaken. Information about the type of activity in which staff engage, may in itself be useful. For example, the knowledge that particular members of staff engage with residents only when physical care is needed has important implications for the professional development aims of the staff concerned. However, the information gained about the way in which each person carries out their work provides even more detail about which key areas of skill could be developed. For example, it indicates the extent to which members of staff offer residents some level of autonomy or choice about what happens to them.

Inter-rater reliability of the technique was found to be good. However, retest reliability was inconsistent with some scores demonstrating good reliability over time and others not. On closer examination of the data it could be seen that scores with good reliability over time represented the quality of the interaction taking place, whilst those that did not indicated the quantity of the activity measured.

One reason for the lack of reliability in the quantitative measures may relate to the different time periods in which the observations took place. Whilst the t-tests between morning and afternoon observations indicated little difference in scores from one test period to the next, the lack of significant differences is not necessarily evidence that the two test periods are equivalent. It is possible that observations taken at different times of the day are not similar enough to be considered comparable test occasions

because of variations in morning and afternoon routines. For example, during the morning period staff are more likely to be helping residents get out of bed, wash/bath, have breakfast etc. and so one wouldn't necessarily expect consistency between scores representing the quantity of time spent engaged in various activities. This argument is supported by the findings that there were few significant correlations between types of activity carried out between the two periods. Had observations taken place on two morning occasions retest correlations may have been stronger. However, given the amount of variables that will effect staff behaviour, such as the number of staff on duty, the number of residents present, the pressures of time, their mood on the day and the expectations of the nurse in charge, it may be unrealistic to expect high levels of reliability within the short space of time in which staff are observed. Since there are so many variables that may effect staff performance, one could argue that it would be surprising to find any re-test reliability amongst the various sub-scales. However, some level of the reliability was found in the variables of 'activity/stimulation', 'personal detractions', and 'social interaction' and also on the number of 'key qualities' used during physical care, providing sufficient physical care interactions (at least five) had been observed.

Aspects of the technique that relate more to the person's attitudes towards or beliefs about people with dementia, would be expected to remain more constant over time. The number of personal detractions used by staff is likely to reflect more about how they relate to residents in their care, which is a more qualitative measure. Consistency over time was found on number of personal detractions used by staff and on provision of activities or stimulation for residents. Evidence for the retest-reliability of the key qualities used during physical care and time spent socially engaging with residents was not as strong and this may be a result of the way in which these scores are calculated. Although one would imagine that use of key qualities and social interactions represent something about the quality of the care that took place, in fact scores of both are dependent on the number of physical care interactions that take place. Thus it was difficult to demonstrate consistency in these measures when the

sample upon which they are based varies between participants and between time periods.

Test-retest reliability usually requires the comparison of 'like with like' and it is possible that in this study the sampling carried out was not similar enough for this kind of comparison. A possible solution to this would have been to carry out test-retest observations on a reasonable sample of participants, at the same time of day for each sampling period and incorporating at least 5 physical care interactions. Despite this limitation, when 5 or more physical care interactions have taken place a good relationship between different time periods was indicated. Thus, on the basis of these results it would seem wise to recommend that future use of the scale would need to incorporate at least 5 physical care interactions in order to provide a sample of care that is representative enough to calculate a key qualities score.

The scores attained representing the amount of time spent performing physical care tasks or non-resident contact activities are more likely to be influenced by situational factors such as time of day and could therefore be considered state-dependent activities which provide quantitative data about how often these activities were performed. In contrast, scores indicating the quality of the care provided are likely to reflect more about the member of staff's personal beliefs or attitudes. Thus it could be said the different aspects of the observational measurement reflect either situational (state) characteristics or personal (traits) characteristics of the staff members' behaviour and it is on the latter of these that retest-reliability would be predicted and desirable.

The observational method described here has potential use as a research tool that can be used to measure various aspects of staff behaviour. For example, it could be used to assess the impact of training interventions on staff behaviour or it could be used to assess attitude-behaviour relationships. The level of detail recorded during the observational method also gives it the potential to promote individual staff

development using feedback to those observed. This could facilitate awareness of expected standards and encourage goal setting in order to develop areas of weakness in performance.

Such an assessment could certainly be perceived as a threat by staff and thus, great care would need to be taken for its implementation to take place in a sensitive, positive, developmental manner, involving the member of staff fully in the assessment. Feedback would need to emphasise both positive aspects, and any gaps identified should be viewed as training and development needs. DCM is already being widely used in this way. However, feedback from DCM is based on and given back to the care group rather than individuals, thus there is the potential for individuals to overlook the specific changes that they themselves need to make in order to improve their own practice.

Consideration could also be given to in-house awards for those meeting an agreed standard, thus having the potential to improve morale and the sense of achievement experienced by participants. However, observational methods such as this one also have the potential to be misused, for example, to support the dismissal of staff or to 'scapegoat' members of staff whose performance may be less than optimal due to the failings of the organisation as a whole. Thus careful consideration is required regarding how and to whom the observational technique is made available. As a bare minimum, a detailed instruction manual would need to accompany distribution of the method, specifying how and for what purposes the method should and should not be used. While there is the potential for the method to be used for individual staff development, it's likely that such usage of the method would only be advisable within very progressive homes, by someone who had a trusting relationship with the staff and who was highly skilled in carrying out staff development while respecting the member of staff concerned and being sensitive to their needs. The technique may have more practical and widespread use as a research tool, however, clear guidelines would still be required regarding how the method should be used.

CHAPTER FOUR

4.0 Relationship Between The Attitudes And Behaviour Of Health Care Professionals Working With Older Adults With Dementia

4.1 Relationship Between Attitudes & Behaviour

As discussed in Chapter One, there has been conflicting evidence in the literature supporting a relationship between attitudes and behaviour. Congruity between the measurements used to assess attitudes and behaviour appears to be an important factor in predicting such a relationship. This chapter aims to review the evidence for a relationship between the attitudes and behaviour of staff working with people with dementia.

4.1.1 Impact Of Attitudes On Clients

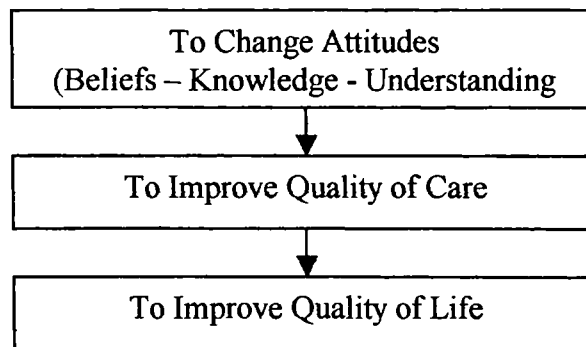
Within studies on healthcare professionals, many authors have written about the effects of attitudes on quality of care and its consequences for older people. Reports generally associate negative attitudes with inferior care for older people. For example, Palmore (1975) states that it is the negative attitudes of staff towards older people that leads to behaviour which, encourages and maintains social atrophy (cited in Bagshaw & Adams, 1986). Bagshaw & Adams (1986) highlight evidence that such an approach may contribute to residents' withdrawal and isolation (Dye, 1979), learned helplessness (Miller & Oertel, 1983), increased physical debility (Palmore, 1975), and deterioration into a severely depressed state mimicking psychosis or organic brain

disease (Tarbox, 1983). Furthermore, they cite a number of studies reporting that nursing personnel encourage the development of atrophy in residents by rewarding dependency behaviour (Baltes & Lascomb, 1975; Barton, Baltes & Orzech, 1980; Birren & Renner, 1980).

Butler (1975) also supports the view that negative attitudes affect care, by stating that the result of negative attitudes for elderly people in institutional care is 'minimal care, inadequate care, or custodial care rather than therapeutic care in a humane environment'. Other researchers have drawn links between the stereotypes held of elderly people and negative attitudes towards them and a failure of nurses to interact with patients in their care (Kahana & Coe, 1969; Hatton, 1977). Similarly, Robinson (1993) claims that 'available research clearly suggests that attitudes toward the elderly influence behaviour (Naus, 1973; Rubin & Brown, 1975; Weinberger & Millham, 1975)'. Inferences about the effects of negative attitudes on behaviour and their impact on the lives of elderly people have also been made by a number of other authors (Burnside, 1981; Alford, 1982; Storlic, 1982; Elliot, 1984). At the other end of the scale, Kahana & Kiyak (1984) state that 'when positive attitudes prevail, they may lead to behaviours that enhance patient satisfaction and promote health and psychosocial well-being'

The problem with much of the literature in this area is that many of these statements about the effects of attitudes on the well-being of residents are made on the basis of little more than supposition and few studies have attempted to illustrate the relationship empirically.

Not only are assumptions made about the impact of staff attitudes on residents, but also about their impact on the delivery of care provided, i.e. the behaviour of staff towards residents. Clearly the assumptions are that staff attitudes will affect the way care is given and this will in turn effect those receiving the care.



Whilst intuitively we might expect these assumptions to be true, in reviewing the literature in this area, it becomes clear that there is little actual evidence to support such links. Indeed, Salmon (1993) draws attention to evidence that suggests attitudes are a poor guide to behaviour in nursing care as well as other fields of research (for example, Sanson-Fisher & Poole, 1980) and consequently guards against the assumption that attitudes reflect behaviour.

4.1.2 Attitude-Behaviour Relations

Attitude scales are generally used on the basis that measuring attitudes will give some insight into predicting and explaining behaviour. However, as discussed in chapter one (section 1.1.3) attitude theory has long questioned the strength of this relationship. In the late 1960's an accumulation of non-significant relationships

between attitudinal and behavioural criteria led to reconsideration of the attitude-behaviour relation. One particularly influential review of the literature (Ajzen & Fishbein, 1977) notes the general consensus amongst authors of the 1960's that measures of attitude had little value in predicting overt behaviour. However, a revival of interest in attitude research in the 1970's led to other conclusions. Studies around this time suggested that attitude is only one of many factors determining behaviour thus a relationship between the two can not always be expected (e.g. Liska, 1975; Brannon, 1976; Schuman & Johnson, 1976).

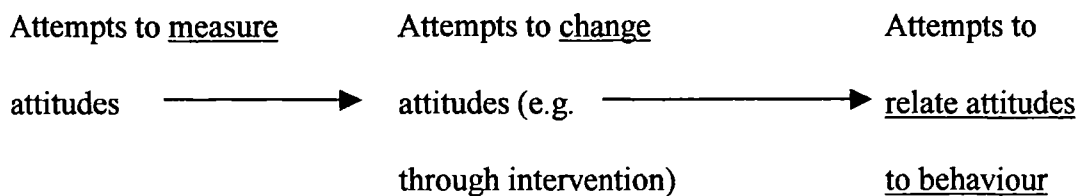
As suggested in Chapters One and Two, Ajzen & Fishbein in a number of papers (Ajzen & Fishbein, 1973; Fishbein, 1967, 1973; Fishbein & Ajzen, 1972, 1974, 1975, 1977) provided a potential explanation for some of the controversy in the literature by emphasising the importance of the extent to which the nature of the attitudinal predictors and behavioural criteria are taken into consideration. The results of their review of the research in this area suggested that there is a relationship between a person's attitude and their behaviour under specific circumstances. When measurement of attitude and behaviour is directed at the same specific target and when it involves the same action, consistently strong relations are observed. Generally low relationships are observed when attitude and behaviour fail to correspond in one or both of these factors.

4.1.3 Methods Of Evaluating The Attitude-Behaviour Relationship

In order to empirically evaluate the relationship between attitudes and behaviour, effective methods are required to assess both attitudes of care staff and the

corresponding actions thought to be related to such attitudes. The various problems associated with attitude measurement have already been discussed in Chapter Two and indeed, measurements of staff behaviour are equally complex.

Chandler et al (1986) suggest that the extent of information provided by research in the area varies in quality. This can be represented on a sliding scale of evidence ranging from studies which aim simply to measure attitudes, to those which attempt to measure change in attitudes (e.g. through some kind of intervention with pre- and post-testing), through to those which attempt to relate attitudes to actual behaviour:



The first two methodologies are useful in establishing the attitudes that are present and the interventions likely to promote their subsequent development. However, merely demonstrating attitude change provides insufficient evidence to establish any changes in actual behaviour.

A few studies have tried to examine the attitude-behaviour relationship in care staff. For example, in attempting to illustrate the relationship between negative attitudes and social atrophy, Bagshaw & Adams (1986) examined the relationship between negative attitudes (as measured by the Kogan Old People Scale) and a custodial orientation toward treatment (using the Gilbert and Levenson Custodial Mental Illness Scale, 1956). They were able to demonstrate a significant correlation between

negative attitudes and a custodial care style. However, custodial orientation toward treatment was based on self-report questionnaire, rather than an actual measurement of overt behaviour.

Studies that have examined the attitude-behaviour relationship using behavioural observations include those of Hatton (1977) and Salmon (1993). Both of these studies were able to show some relationship between the attitudes and behaviour of care staff, although correlations were not strong. In the case of the Hatton (1977) study, correlations were not significant with the small sample size utilised, but there was a trend indicating that nurses with more positive attitudes engaged in more positive interactions with residents. Salmon (1993) on the other hand found that care staff who were least sensitive to patient's needs on attitude measurement, spent most time in activities not involving patient contact. While these studies provide some support for the attitude-behaviour relationship amongst care staff working with older adults, the strength of evidence provided is limited and further exploration of this relationship is required.

4.1.4 Objective

The objective of this chapter is to investigate the relationship between the attitudes and behaviour of staff working in the care of people with dementia using the attitude and observational measurements described in Chapters Two and Three.

It is predicted that positive attitudes will be associated with greater staff involvement in activities and social engagement, a greater number of key qualities during physical care and a lower number of personal detractions.

4.2 METHOD

4.2.1 Participants

Participants were 31 nursing home care staff, working in the care of older people with dementia within the focus nursing home. Nine of these were registered nurses and 22 were care assistants. There were 26 females and 5 males. Participants ranged in age from 18 to 60 (mean = 35.2; sd = 14). All worked day shifts and all but one were employed to work full-time. Experience of working with older people ranged from 2 months to 24 years (mean = 5.7 years; sd = 7.0).

4.2.2 Measurements

The following measurements were employed to assess staff attitudes and behaviour.

4.2.2.1 Staff Attitudes

Attitudes were assessed using the final form of the newly developed attitude scale - the Approaches to Dementia Questionnaire described in Chapter Two.

4.2.2.2 Staff Behaviour

Staff behaviour was assessed using the direct behavioural observation method described in detail in Chapter Three. Each participant was observed on three occasions for one and a half hours, giving a total of 54 five-minute time frames for

each participant. In order to ensure that observations generated data that was representative of participants work across the day, recordings took place between the hours of 10.30am and 12noon, 12.30pm and 2pm and 2.30pm and 4pm for each participant.

4.2.3 Procedure

The measurements detailed above were carried out with participants within one month of ADQ completion.

4.3 RESULTS

4.3.1 Correlation Of Attitude & Behavioural Observation Scores

In order to examine the attitude-behaviour relationship, and to provide support for the predictive validity of the Approaches to Dementia Questionnaire (ADQ) detailed in Chapter Two, scores on the ADQ were compared with scores on the behavioural observation measure detailed in Chapter Three, using Spearman correlation coefficients.

Correlations between scores on the behavioural observations and ADQ scores are shown in Table 4.1.

TABLE 4.1: Correlations between ADQ and Observations

Observations	Approaches to Dementia Questionnaire		
	TOTAL	Factor 1 <i>Hope</i>	Factor 2 <i>Personhood</i>
Physical care	-.14	-.09	-.15
Key qualities relating to physical care	.52**	.43*	.39*
Non-resident contact activities	-.13	-.27	.10
Purposeful activity/stimulation	.37*	.38*	.18
Level of social engagement	.52**	.52**	.29
Number of personal detractions	-.07	.06	-.21

* indicates $p < .05$; ** indicates $p < .005$ (N = 31)

Table 4.1 shows that those with more positive attitudes on the ADQ are also more likely to engage in more activities and social interactions with residents, and also perform more key qualities during physical care tasks. Moderate correlations can be seen between both ‘hope’ and total scores with key qualities and social engagement. Correlations with purposeful activity and between the ‘personhood’ factor and key qualities are fairly small, however. Nevertheless, the relationship between attitudes and behaviour is supported and section 4.4 comments further on the correlations found to be significant as well as exploring possible reasons for non-significant results.

4.4 DISCUSSION

This chapter reviewed the evidence for a relationship between the attitudes and behaviour of care staff working in a nursing home for people with dementia. The results detailed in Table 4.1 show that a relationship was established between

attitudes and behaviour of care staff, using the two measures detailed in Chapters Two and Three. In particular, the *Hope* factor of the attitude scale correlated with three aspects of staff behaviour: social engagement, purposeful activity/stimulation, and number of key qualities used during physical care. In addition, the *Recognition of Personhood* factor of the attitude scale also correlated with number of key qualities, although the correlation was not as strong as that of the *Hope* factor.

The relationship between the *Hope* factor and behavioural observations of social engagement, purposeful activity and key qualities makes intuitive sense. One would expect that those staff who hold more hopeful attitudes about residents and their futures would be more likely to spend time and effort engaging with them and involving them in their own care during physical interventions. Alternatively, those who believe they shouldn't become too attached to residents, that all they can do is keep residents clean and comfortable, and that residents are unable to make any decisions for themselves, might avoid spending time with residents and provide only basic care in an autocratic way.

One might also expect that staff with greater recognition of the personhood of residents would engage in more activities and social interaction with them, however, this was not found to be the case. The lack of correlation between these variables may relate to some of the issues discussed in Chapter Two. Several of the items within the *Recognition of Personhood* factor had relatively skewed distributions, indicating that staff were more likely to agree than disagree with these items. In addition it was suggested in Chapter Two that this factor may represent the behavioural and cognitive aspects of attitude rather than the more affective aspects which are more apparent in

the *Hope* factor. These findings suggest that staff know that they are supposed to think about residents as individuals and treat them in an individualised way. They can therefore give the 'correct' responses to items in the 'personhood' factor, but these responses are only minimally related to how staff will behave towards residents in reality. Conversely, staff may be less clear about what they are supposed to feel about residents and therefore respond to the items in the 'hope' factor in a way that more accurately reflects how they will respond to residents.

The lack of association between the attitude dimensions and the number of personal detractions observed is surprising. However, there were relatively few personal detractions in total (maximum score of 7) and it is possible that a floor effect occurred on this measure, since almost two thirds of the sample had a score of less than 3 personal detractions. Further investigation focussing more explicitly on the relationship between attitudes and personal detractions would help to clarify this relationship.

While no relationship was found between attitudes and amount of physical care or non-contact activity, this would be expected, since these variables are more likely to reflect situational factors as discussed in Chapter Three (see page 131).

The findings presented in this chapter support Ajzen & Fishbein's theory that when attitude and behavioural measurements are sufficiently targeted at the same population a relationship between the two will be found. By using a scale that was specifically designed to evaluate attitudes toward people with dementia and an observational technique designed to evaluate behaviour towards people with

dementia, this study was able to show the particular aspects of each that relate to one another.

The results found also provide empirical support for some of the assumptions made in previous literature about the consequences of staff attitudes on delivery of care. This link between attitudes and behaviour has been applied to research and to training programmes for many years, with little evidence to support its existence. While this research suggests that the assumptions were justified, it also has implications for the focus of future training programmes, which may potentially be more effective at influencing behaviour, if targeted at the 'hopeful' attitudes reflected in the ADQ.

The finding that the attitudes and behaviour of care staff are indeed related, could have important implications for staff education and training. There is evidence to show that attitudes can be changed through training interventions (e.g. Almquist et al., 1981; Ingstad & Göttestam, 1987; Alfredson & Annestedt, 1994), although there has been little research to show whether these changes consequently impact upon behaviour. If, changes in attitude actually resulted in changes in the way that staff deliver care, this is likely to have a major impact upon the experience of people with dementia living in long-term care. However, establishing a link between attitudes and behaviour in itself is not sufficient to suggest that attitudinal changes would result in behavioural changes.

The following chapter examines whether attitudes and behaviour of care staff are subject to change following the introduction of training interventions and whether the measures used to evaluate these factors are sensitive to any changes that occur.

CHAPTER FIVE

5.0 Changes In Staff Attitude And Behaviour Following Intervention

For many years, people have advocated the use of training interventions to improve quality of care. However, few studies have attempted to establish whether such training achieves and maintains these changes. Instead, such interventions have adopted what Matthews (1999) describes as a 'train and hope' approach, rather than empirically testing any changes occurring following training. Amongst those who have evaluated training, the use of attitude scales seems to be a popular choice, with attitude measurements being taken pre- and post- training inputs. The results that have emerged from such studies have produced conflicting findings and this may be because of differences in the quality of the intervention programmes, or the quality of the methods of assessment used to detect change.

Authors who suggest that attitudes are not readily changeable through educational interventions include Dye (1979), Tollet & Thornby (1982), Chandler (1986), Saarela & Viukarin (1995) and Kahana et al (1996). Chandler (1986) found no significant differences in attitudes between respondents who had received an education package and those who did not. Chandler explains that respondents were found to have neutral and/or positive attitudes pre-training, yet the training programme was designed to improve negative attitudes. Chandler herself suggests that the tools used to measure staff attitudes in her study (the Palmore Facts on Aging and the Kogan Old Peoples

scale) may not have been adequately sensitive to change and development of such measures was recommended.

Saarela & Viukarin (1995) also reported no significant modification of attitudes following staff training. However, once again, this might be explained in terms of the suitability of the attitude measurement used, in this case a questionnaire by Snape (1986), which focused on working practices and professional issues. In addition, the type of education programme employed may also have contributed to these findings as it very much followed a 'medical' or disorder-focused model, supplying factual, scientific information, which was not sufficient to change attitudes.

Studies that have reported effective changes in attitudes using educational programmes include Almquist et al. (1981) who measured attitudes using a semantic differential scheme. They employed an education program designed to improve knowledge and attitudes toward elderly people and found it to have a positive effect on both qualified nurses and nursing assistants. Further evidence suggesting that attitudes can change with interventions comes from Alfredson & Anstedt (1994), who demonstrated increased knowledge and new emotional and social attitudes following a staff training program for staff working in group living environments. Their methodology included using interviews to assess staff's attitudes towards forms of care, resident well-being, work and job satisfaction and ways of improving quality of care. The intervention program consisted of both staff training and continued support, and covered areas such as staff-patient relationships, psychodynamic concepts and individual care planning.

Thus it seems that the success of interventions designed to produce change in attitudes amongst staff working with older adults may be dependent both on the nature of the training and development programmes that are implemented and on the nature of measurement used to assess change.

In support of the first point, Chandler (1986) reports a movement in nursing education from providing factual scientific information towards more experiential learning and suggests that it is not sufficient to increase knowledge of elderly people and people with dementia in order to improve attitudes. Alternatively, what is needed is a greater depth of understanding and empathy with elderly people. Experiential methods are becoming increasingly popular in training programmes, with methods such as role-play, games, group discussion and use of films taking a more primary role. Methods such as these may provide a more effective means of improving attitudes, although research has yet to provide empirical evidence for the particular content and techniques likely to be effective. Kahana et al.'s (1996) finding regarding the role of self-efficacy in staff attitudes may also have a bearing here, suggesting that training strategies designed to increase people's confidence in their abilities might also be beneficial.

Training is generally given in the hope that it will improve the way in which care is delivered, with the belief that this will subsequently improve the quality of life of clients. However, although there is some evidence suggesting attitudes can be changed by training, there has been very little investigation of whether there is actually any subsequent change in the delivery of care, or in the experience of those

receiving care. More commonly, training is given, but very little is known about how effective that training will be within the normal working environment.

This chapter aims to try and address some of these concerns, by describing a piece of research which evaluated changes in the attitudes and behaviour of nursing home staff and also evaluated resident well-being, over a two year period during which time a number of training and development interventions were introduced.

5.1 Objective

The aim of this study was to examine the level of change among the attitudes and behaviour of care staff as a result of training and development interventions, and to examine any subsequent impact on the well-being of residents with dementia. It was hypothesised that:

- The ADQ (described in Chapter Two) would be sensitive to the degree of attitude change following training and development interventions.
- The observational technique (described in Chapter Three) would be sensitive to changes in staff behaviour following training and development interventions.
- Positive changes in residents' quality of life would be observed following training and development interventions.

5.2 METHOD

5.2.1 Participants

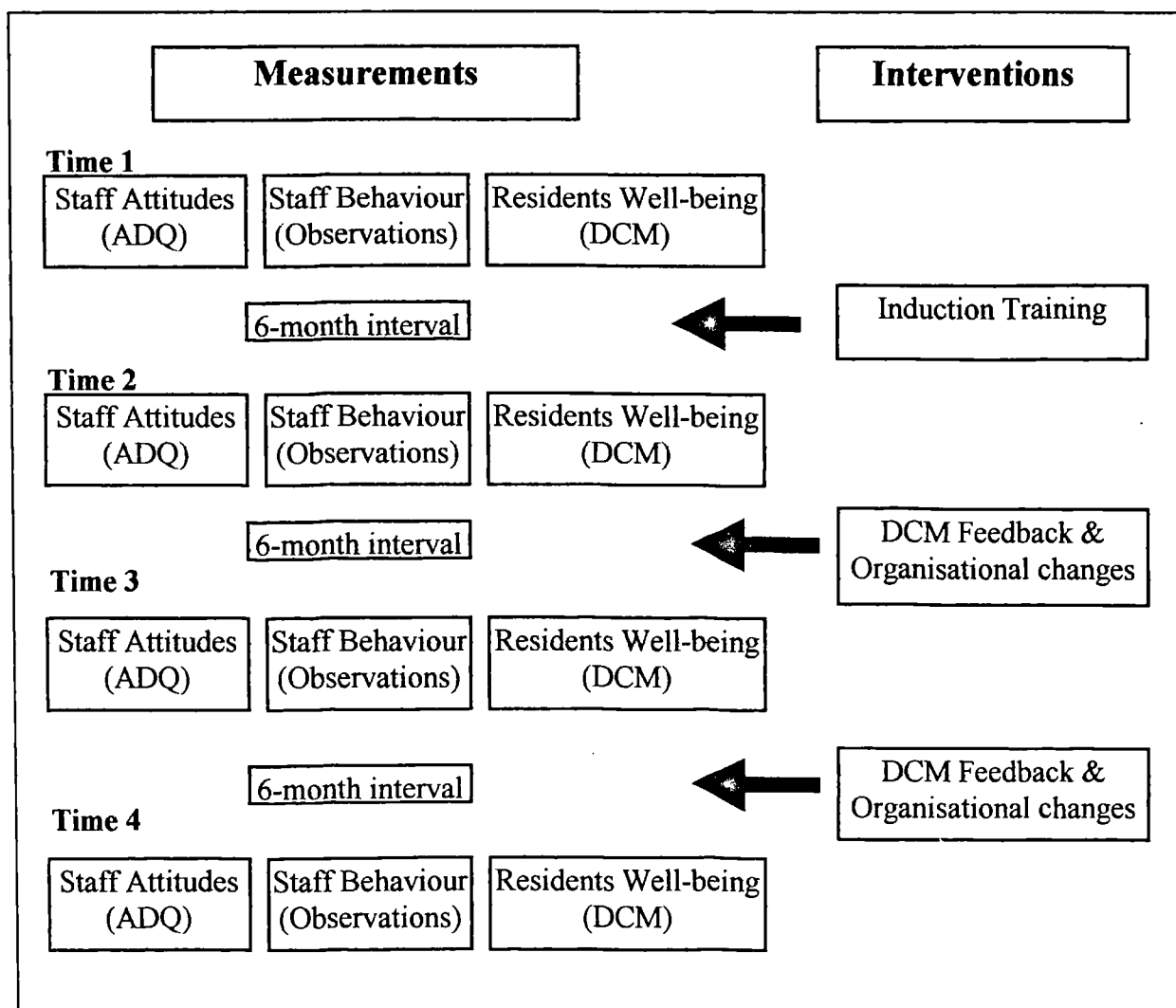
Staff and residents of the focus nursing home were studied. During the 2 year duration of the study there was considerable turn-over of residents with a total of 52 residents included in the study, 37 female and 15 male. Residents ranged in age from 62 to 98 years.

A total of 86 members of staff were included in the study during the duration of the project. Again, this reflected a fair degree of turn-over. Staff were comprised of 60 care assistants (35 working day shifts and 25 working night shifts) and 26 registered nurses (17 working day shifts and 9 working night shifts). The average number of staff at any one time was 50; comprising approximately 14 registered nurses (including 4 night staff) and 36 care assistants (including 14 night staff). 76 members of staff were female and 10 were male with ages ranging from 17 to 62 (mean age = 37.4; sd = 12.4). Sixty-two members of staff worked full-time and 24 worked part-time. At the start of the project none of the care assistants had received any formal training in caring for older people or people with dementia however, approximately 70% of them had some previous experience of working with this client group. Length of experience working with older people ranged from 2 months to 28 years (mean years = 7.4; sd = 7.4).

5.2.2 Procedure

The measures described below were applied before and after each training and development intervention. Measurement of each element took place at four test occasions, with approximately six-month intervals over a two-year period. The various interventions were introduced between each of the test occasions. The diagram below (Figure 5.1) gives a structural outline of the research indicating the relationship between the various measurements and interventions.

Figure 5.1: Structural outline of the research project.



5.2.3 Measurements

5.2.3.1 Staff Attitudes

Attitudes were assessed using a newly developed attitude scale - the Approaches to Dementia Questionnaire (described in detail in Chapter Two).

5.2.3.2 Staff Behaviour

Skills were assessed using a direct behavioural observations method described in detail in Chapter Three. Each member of staff was observed during the normal course of their working day for approximately four hours.

5.2.3.3 Resident Well-being

This was evaluated using Dementia Care Mapping (DCM)(Kitwood & Bredin, 1993), an observational method which provides evidence directly related to the well- or ill-being of residents, the pattern of their daily life and the nature of care interactions (see Chapter Three). Trained observers record the extent to which each person has been, for example, engaged or unstimulated, affirmed or devalued, helped or ignored, as a result of care practice. Two main types of score are obtained. One is an individual resident score based on the sum of quality ratings and the other relates to the pooled frequency of quality ratings across all residents. DCM differs from most other observational techniques in that the quality of interactions experienced by the person with dementia are recorded, as well as actual behaviour. In this project, two trained observers (one of whom was the study researcher) recorded information about

each resident who was present in the nursing home at the time. On each occasion that DCM was carried out, inter-rater reliability was calculated according to the guidelines of the manual. A reliability coefficient greater than .7 was found on each occasion indicating adequate reliability between the raters.

5.2.3.4 Additional Measures

In addition to the measures described above, it was also necessary to monitor changes in resident function and ability, in order to ensure that any changes seen in DCM scores were not merely related to the severity of dementia in residents present at the time of mapping. Consequently, the following questionnaire was administered every 2-3 months throughout the duration of the research project. This questionnaire was selected, since it has been widely used in other studies evaluating environmental changes for people with dementia (e.g. Woods & Britton, 1985; Ward, Murphy & Proctor 1991).

Adaptive Behaviour Rating Scale (ABRS) (Woods & Britton, 1985; Ward, Murphy & Proctor 1991): This measure assesses level of functional ability in areas such as dressing, feeding, toileting and behaviours typically considered problematic such as aggression. A member of staff, who knows the residents well, completed the scale based on their recent observations of the person.

5.2.4 Training And Development Interventions

5.2.4.1 Induction Training

The first intervention consisted of training in person-centred care delivered by Professor Tom Kitwood of the Bradford Dementia Group. Before he died in 1998, professor Kitwood led the field in the development of person-centred care and had extensive experience of providing training to care staff working with people with dementia. Thus the quality of the training provided was of a very high standard.

Firstly, two days were spent with the senior staff of the home, discussing procedures and protocols such as key-worker systems and personal profiling systems for residents, with the aim of developing the culture and philosophy of the systems underpinning the functioning of the home.

Subsequently, two-days induction training was provided to all care staff. Half of the staff attended at a time, with approximately a three-month gap between the first and second groups being trained. All the care staff in the home (52), including those working part-time and/or night shifts were expected to attend, although 3 were unable to do so due to sickness or difficulties with childcare arrangements. A range of techniques were employed during the sessions, including traditional lecturing, interactive discussions, role-play and drama demonstrations and small group work. Specifically, areas of focus included exploring old and new cultures of care and getting staff to reflect upon where they felt their nursing home was in this process. Exploration of the concept of personhood also took place, which included getting people to reflect on experiences where their own personhood had and had not been

respected, and how that felt. There were also demonstrations and a discussion on the Malignant Social Psychology of dementia care and an explanation of dementia care mapping (DCM). A role played drama demonstrating the importance of life history and an exercise in appreciating the uniqueness of individuals was included, together with group exercises exploring the methods of communication used by people with dementia with an emphasis on trying to understand the meaning behind such communication. There were also sessions on understanding the psychological needs of people with dementia and reflecting on one's own practice. At the end of the two days training, staff were given the option of carrying out a short project, focusing on a resident of their choice and developing their knowledge of the resident's life history and current likes and dislikes. All those who attended the training received a certificate and the eight members of staff who completed projects, received certificates of attendance with assessment.

5.2.4.2 Feedback from Dementia Care Mapping

The second type of intervention was the use of DCM as a regular quality of care evaluation and feedback from this to staff. As well as providing a method of monitoring the well being of residents, one of the primary purposes of DCM is as a developmental evaluation. However, in order for any development to take place, staff need to be given information about what has been observed and also need to be able to accept this as a valid representation of the day's activities. The aim is then that they work together with the trained observers in developing an action plan and commit themselves to making the necessary changes to develop their practice. The feedback sessions can also serve as a regular reminder of some aspects of induction training

and also to enable staff to reflect upon individual incidents of care observed or about individual residents requiring particular attention.

5.2.4.3 Organisational Developments

These were instigated in order to develop the philosophy and policies underlying the environment in which care took place and generally were identified in the process of producing action plans from the DCM feedback. They included extending the space available for residents to walk in, the introduction of a handover period in order to improve communication and to provide a forum for continued training and discussion, and introduction of less clinical uniforms in order to create a more relaxed atmosphere. An alarmed door which had created quite a noisy atmosphere on the unit and provoked staff to behave in a way that was not consistent with its intended use, was also removed.

5.3 RESULTS

5.3.1 Staff Attitudes

The first hypothesis of the study was that the ADQ would be sensitive to the degree of attitude change following training and development interventions. It was expected that attitude scores would indicate more positive attitudes following interventions. Table 5.1 shows the mean ADQ scores at each of the four test occasions.

TABLE 5.1: Mean ADQ Scores at Each Test Occasion

ADQ:		T1 (± Nov. 96)	T2 (± July 97)	T3 (± March 98)	T4 (± Sept. 98)
TOTAL	Mean	73.00	74.90	76.70	76.63
	sd	6.66	6.54	7.89	7.28
	n	42	20	30	30
Factor 1: Hope	Mean	24.31	26.40	27.30	27.43
	sd	4.43	3.71	4.84	4.02
	n	42	20	30	30
Factor 2: Recognition of Personhood	Mean	46.55	46.40	47.37	46.97
	sd	4.25	4.69	4.23	4.66
	n	42	20	30	30

A repeated measures ANOVA could not be performed on this data since only 7 participants completed questionnaires at all of the four test occasions. Therefore, paired t-tests were performed on the ADQ total and each of the factor measurements for each pre and post intervention test occasions (i.e. T1-T2; T2-T3; T3-T4). Means and standard deviations for the samples used in each comparison can be found in Appendix Eleven. Paired t-tests were also performed between T1 and T4 in order to examine differences from the beginning to the end of the study. Table 5.2 shows the results of these analyses.

TABLE 5.2: Results of T-Tests on ADQ Scores over Test Occasions

ADQ:		T1-T2	T2-T3	T3-T4	T1-T4
TOTAL	<i>t</i>	-1.08	-2.56*	.58	-2.97**
	<i>df</i>	25	11	18	15
Factor 1: Hope	<i>t</i>	-2.50*	-3.03*	.39	-4.74***
	<i>df</i>	25	11	18	15
Factor 2: Recognition of Personhood	<i>t</i>	.62	-1.30	.50	-1.22
	<i>df</i>	25	11	18	15

* = significant at the 0.05 level; ** = significant at the 0.01 level; *** = significant at the 0.001 level

Significant differences were found on ADQ total scores between T2 and T3 and also between T1 and T4. Significant differences were also found on the ADQ 'Hope' factor between T1 and T2, between T2 and T3 and again between T1 and T4. No significant differences appeared on the 'Recognition of Personhood' factor scores.

5.3.2 Staff Behaviour

The second hypothesis was tested through the direct observation method described in Chapter Three. Staff were observed on three occasions, giving a total of 54 possible time frames. An average score across the three time periods was then calculated for each observational category. Table 5.3 shows the mean of the averaged scores for each of the observed areas of focus, at each of the four test occasions.

TABLE 5.3: Mean Observational Scores at Each Test Occasion

Behavioural Observations		T1 (± Nov. 96)	T2 (± July 97)	T3 (± March 98)	T4 (± Sept. 98)
Physical Care	Mean	8.00	6.76	6.82	8.46
	sd	2.89	3.07	2.98	2.20
	n	26	23	11	12
Key qualities (per physical care interaction)	Mean	3.62	4.43	4.48	4.86
	sd	1.00	.91	1.26	.91
	n	26	23	11	12
Purposeful activity/stimulation	Mean	.79	.87	.91	3.33
	sd	.85	1.15	.77	1.80
	n	26	23	11	12
Social engagement	Mean	3.51	5.20	5.68	5.00
	sd	1.90	2.31	3.21	2.72
	n	26	23	11	12
Non-resident contact activities	Mean	4.30	3.50	4.45	2.67
	sd	1.89	2.63	2.07	2.09
	n	26	23	11	12
Number Personal Detractions	Mean	2.89	3.02	2.50	1.29
	sd	1.91	2.11	2.26	.92
	n	26	23	11	12

The reduction in participant numbers that can be seen between T2 and T3 reflects one of the organisational changes that took place between these two time points. Initially, staff worked in four-week rotations between the two units for people with dementia and two other units for older people with physical frailties. In order to improve continuity of care and to enable relationships to develop between staff and residents, this was changed so that staff worked either in the dementia care units or in the physical frailties units. Thus all staff were observed at T1 and T2 during their four-week turn on the dementia care units, whereas those observed at T3 and T4 were those who remained permanently working in the dementia care units.

Paired t-tests were performed on each of the observation scores for each pre and post intervention test occasions (i.e. T1-T2; T2-T3; T3-T4). Paired t-tests were also performed between T1 and T4 in order to examine differences from the beginning to the end of the study. Table 5.4 shows the results of these analyses (means and standard deviations for each of these calculations can be found in Appendix Twelve).

TABLE 5.4: Results of T-Tests on Observational Scores over Test Occasions

Behaviour Observations		T1-T2	T2-T3	T3-T4	T1-T4
Physical Care	<i>t</i>	1.15	-.73	-2.84*	-1.58
	<i>df</i>	19	8	5	5
Key qualities (per physical care interaction)	<i>t</i>	-4.26***	.32	-1.81	-4.72**
	<i>df</i>	19	8	5	5
Purposeful activity/stimulation	<i>t</i>	-1.56	.77	-3.62*	-2.21
	<i>df</i>	19	8	5	5
Social engagement	<i>t</i>	-3.57**	-.31	.65	-.83
	<i>df</i>	19	8	5	5
Non-resident contact activities	<i>t</i>	1.91	-1.68	3.15*	1.59
	<i>df</i>	19	8	5	5
Number Personal Detractions	<i>t</i>	-.96	-.33	2.17	2.15
	<i>df</i>	19	8	5	5

* = significant at the 0.05 level; ** = significant at the 0.005 level; *** = significant at the 0.001 level

Between T1 and T2, significant increases were observed in engagement in social interaction with residents and average number of key qualities (e.g. giving information, offering choice, etc.) per physical care interaction. Significant increases were also found between T3 and T4 in amount of physical care and purposeful activity. There was a significant decrease in the amount of non-resident contact activity. There were no significant differences between T2 and T3. There was one significant difference between T1 and T4 indicating an increase in the number of key qualities used per physical care interaction. However, the sample size for analyses on post Time 2 data are very small and this will limit the conclusions that can be drawn from these results.

5.3.3 Resident Well-being

In order to assess whether any changes in staff performance following training and development, impacted on resident quality of life, DCM scores were compared pre and post each intervention. Table 5.5 shows the mean individual DCM scores on each test occasion.

TABLE 5.5: Mean DCM scores on Each Test Occasion

		T1 (± Nov. 96)	T2 (± July 97)	T3 (± March 98)	T4 (± Sept. 98)
DCM	Mean	1.21	1.24	1.43	1.76
	sd	0.47	0.85	0.58	0.47
	n	24	23	21	24

Paired t-tests did not indicate any statistically significant differences in DCM scores between the various test occasions. As there was less than 10% overlap in subjects between T1 and T4 it was decided to test for group changes in DCM scores as well as individual changes. A One-Way ANOVA was performed with post hoc analysis using Tukey's hsd. This did indicate significant differences in DCM scores between times 1 and 2 and time 4 ($F = 4.07$; $df = 3$; $p < 0.01$). Since these were group differences they may have been a function of different residents and their different levels of functional ability. In order to test for this, independent group t-tests were carried out on the ABRS data. No significant differences were found in any of the ABRS subscales, thus indicating that changes observed in group DCM scores were not as a result of changes in the level of impairment among residents.

To further test for changes in residents' quality of life, DCM wib values were also explored. Wib values represent the level of well or ill being of residents on a six-point scale, which are attributed to each five-minute time frame during the observational period. The distributions of wib values were examined for each of the two units and are shown in Tables 5.6 and 5.7.

TABLE 5.6: Percentages of Well & Ill being values for Unit 1

	-5	-3	-1	+1	+3	+5
T1	0.4	2.9	17.9	57.0	19.5	2.3
T2	0.1	6.7	14.2	55.7	20.4	2.9
T3	0	3.0	11.0	56.8	28.3	0.9
T4	0	0.2	4.0	61.0	32.9	2.0

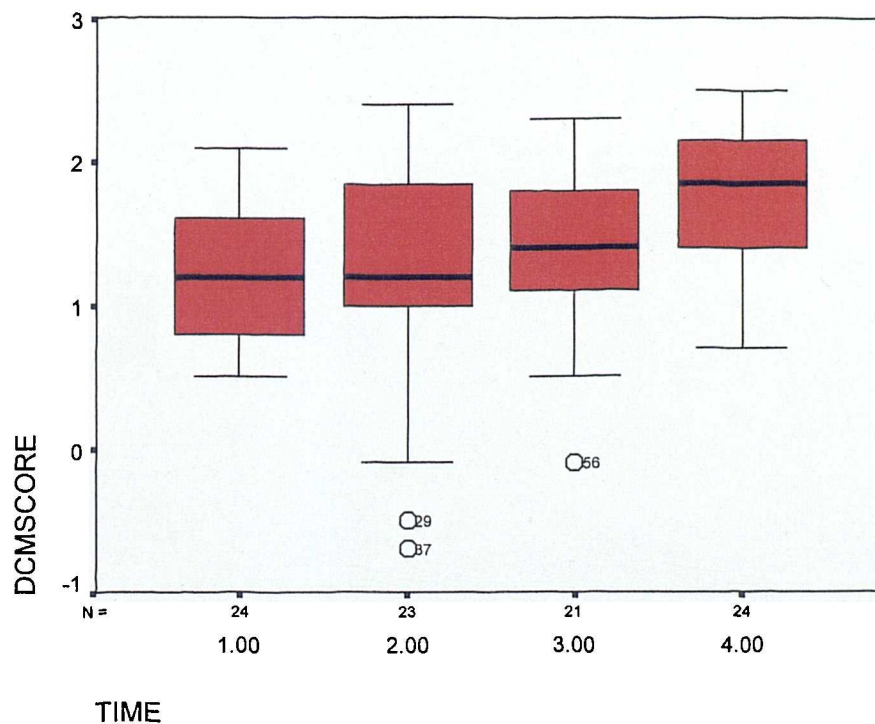
TABLE 5.7: Percentages of Well & Ill being values for Unit 2

	-5	-3	-1	+1	+3	+5
T1	0.1	0.7	10.2	60.4	24.7	4.0
T2	0.4	1.1	5.9	51.5	35.9	5.3
T3	0	0.7	4.4	58.5	34.4	2.0
T4	0	0.3	3.9	50.2	41.6	4.0

To evaluate statistical differences in the distributions, Kolmogorov-Smirnov tests were computed for each pre and post intervention period. Significant differences were found on Unit 1 between T2 and T3 ($K = 1.7$; $p < 0.01$); T3 and T4 ($K = 1.4$; $p <$

0.025); and T1 to T4 showed an even greater level of significance ($K = 3.1$; $p < 0.001$). Significant differences in distribution on Unit 2 were found between T1 and T2 ($K = 2.5$; $p < 0.01$); T2 and T3 ($K = 1.8$; $p < 0.01$); T3 and T4 ($K = 1.9$; $p < 0.001$); and an even greater level of significance was observed when comparing those scores obtained at the start of the project (T1) with those at the end (T4) ($K = 3.9$; $p < 0.001$). Group changes in DCM scores (as indicated in Table 5.5 on page 161) are presented graphically in figure 5.2.

Figure 5.2: Group changes in DCM scores



The increase in mean DCM score can be seen in figure 5.2, indicating improvements in levels of well-being amongst residents across the 2 year period. The increased variability in scores at Time 2 is noticeable and also reflects greater variation in DCM wib values. In reviewing Tables 5.6 and 5.7, it can be seen that at Time 2, although

there were increases in the percentages of +3 and +5 wib values attained, there was also an increase in the percentage of -3 wib values attributed.

5.4 DISCUSSION

This chapter examined the extent to which measurements of staff attitude and behaviour were responsive to change following training and development interventions. Simultaneous changes in resident well-being were also evaluated.

The results detailed in tables 5.1 and 5.2 show that there was a steady increase in the positive attitudes of staff, particularly in the 'Hope' dimension. Paired t-tests indicated that this increase was statistically significant following both the first and the second intervention periods. There was a slight further increase after the third intervention, which was not statistically significant, however an overall improvement in 'hopeful' attitudes was seen from the beginning to the end of the study. Attitudes reflecting 'respect of personhood', on the other hand, showed little change from one test occasion to the next and there may be a number of reasons for this. Firstly, as discussed in Chapters Two and Four, this may be because staff are fairly confident about what answers they are supposed to give to items on this factor and this remains the same across test occasions. It is also possible that because scores on this factor are relatively high to begin with, there is little room for improvement, indicating that there may be a ceiling effect on this factor. Despite the lack of change on the 'respect of personhood' factor, total scores do change over time and this must be largely due to changes on the 'hope' factor.

It would be expected that following training, staff would become more positive about what they could achieve with residents and this was indeed reflected in the increased 'hopeful' attitudes that were found. Thus attitudes changed in an expected direction, confirming that the ADQ was sensitive enough to reflect changes in the attitudes of care staff.

Changes in staff behaviour were also observed. In particular, tables 5.3 and 5.4 show statistically significant improvements in both the level of social engagement and number of key qualities used amongst staff following the first intervention period. Scores in both of these areas then appear to plateau, however further changes are observed in other areas of behaviour following the third intervention. Specifically, significant increases are seen in the amount of time spent engaged in both physical care and purposeful or stimulating activities and accordingly, there was also a significant reduction in the amount of time spent in non-resident contact activities. The one area of behaviour that did not show any statistically significant changes was the number of personal detractions used. Although not significant, a reduction in the number of PDs was shown across test occasions and this approached significance at both the T3-T4 and the T1-T4 comparisons, indicating a trend in the expected direction.

The results reported in Chapter Four regarding the relationship between attitudes and behaviour showed that attitudes of 'hope' correlated strongly with both key qualities and social engagement. This relationship is further supported in these results, since increases in the number of key qualities used and in level of social engagement are both seen following the first intervention, as are increases in 'hopeful' attitudes.

Attitude scores continued to increase on the 'hope' factor following the second intervention and although no further significant changes were seen in key qualities or social engagement, the improvements made at T2 were maintained.

The type of interventions that took place during that time might in part explain the lack of change in behaviour following the second intervention period. The second intervention consisted of feedback from the second DCM evaluation and a number of organisational changes which included stopping the rotation of staff between units in order to maintain consistency and aid better relationships between staff and residents and a number of personnel changes. However, the feedback from the second DCM evaluation was given some months after it had taken place, thus potentially reducing its impact on staff. Further, the organisational changes taking place were quite unpopular amongst the staff group, which may have hampered motivation to develop their practice.

The patterns of change occurring across test occasions in other areas of behaviour show that significant changes only occurred following the third intervention. This intervention also consisted of feedback from a DCM evaluation and organisational changes. However, this time DCM feedback was given less than a week after the observations occurred. Organisational changes in this intervention included changing the shift times so that staff could have a handover period and the introduction of an induction programme. These were viewed more positively by staff as factors that would facilitate their working practice. On this occasion, feedback from DCM emphasised the limited range of activities available to residents and amount of time spent in them. The development plan which emerged from staff as a result of the

feedback focused quite strongly on factors such as increasing the variety of activities available to residents, encouraging residents to participate in household activities and purchasing appropriate equipment to facilitate greater activity. The statistically significant increase seen in staff engagement in activities with residents and the significant decrease seen in non-contact activities following this intervention indicates that this intervention had an impact on staff behaviour and that the observational method used to assess this was sensitive to these changes.

Evaluations of resident well-being over the four test occasions also showed some changes. A steady increase was shown in mean DCM scores (see table 5.5), however, differences in these scores were not found to be significant for the paired scores that were considered at each comparison. Group scores on the other hand did indicate a significant increase in level of well-being between T1 and T4 and T2 and T4. Distributions of DCM wib values also showed statistically significant changes over time, which were highly significant when comparing the distributions across the first and the last test occasion. The DCM data does appear to suggest that changes in well-being for residents came later in the project than did the changes in staff attitude and behaviour, which were evident at Time 2.

Although no conclusive assumptions can be made regarding a causal link between staff attitudes, staff behaviour and resident well-being, the results presented in this chapter do show that simultaneous improvements in scores occurred in each of these three areas. Stronger evidence for such a link might have been demonstrated had greater sample sizes been available across the test occasions, enabling ANOVAs to be carried out on the data.

One of the limitations of this study was the level of staff turnover, making it difficult to assess whether changes over time were due to the development of existing staff or to there being a different staff group. Thus changes could only be assessed from one time point to the next and not across the full two-year period. One of the reasons for the relatively small sample size at T3 and T4 was that staff no longer rotated between working with residents with dementia and those with physical frailties. While there was no significant differences in attitudes and behaviour between the group of staff who left the dementia units and those who remained, staff were given the opportunity to choose where they would prefer to work, thus those who remained would have expressed some preference for working with people with dementia. Consequently, this preference, combined with them now working permanently in dementia care, may have meant that this group of staff were more motivated to develop their skills than those who left, which could have contributed to the improvements seen in quality of care. Further information about participants thoughts and feelings on organisational changes such as this and their rationale for their decision about where to work, could have been obtained through interviews with staff, which would have been elucidating.

Despite the limitations outlined above, this study has shown that both the attitude scale and the observational technique developed were able to demonstrate responsiveness to changes over time which were most likely a result of training and development interventions.

Questions remain regarding what exactly led to the behavioural changes observed. Was training alone sufficient to account for it, or would the DCM interventions have

been equally effective had the training not preceded them? It could be argued that one of the most significant factors in the effectiveness of the training, was that it was provided by one of the leading experts in the field of dementia care, thus indicating that it may be difficult for others to replicate such improvements. However, while there were significant changes in staff attitudes and some staff behaviours following training, behaviour change in other areas only occurred following DCM interventions and subsequent organisational change. Furthermore, significant changes in resident well-being did not occur until Time 4, indicating that the training provided did not have an immediate effect on resident well-being. Thus it is possible that training in and of itself, even when provided by the leading expert in the field, is insufficient to have any significant impact on the well-being of people with dementia. Alternatively, however, it is also possible that the training, which did have an impact on staff attitudes and some behaviour, laid the foundations upon which staff could further develop their skills. One would expect, the process of receiving information during training, thinking about what has been learnt, changing your attitudes towards what has been discussed, relating it to your own practice, and developing your skills in response to this takes some time and this process may only have occurred to a sufficient extent to impact on resident well-being towards the end of the study. However, it is also likely that the DCM interventions and the organisational changes that occurred would also have contributed to this process as well as impacting upon staff who joined the organisation after the training had occurred. The impact of DCM on staff behaviour could certainly be seen in relation to the increase in time spent in activities at Time 4, which had specifically been addressed in the action plan arising from DCM.

In essence, the exact factors that led to behavioural change remain unclear. Both training and DCM appeared to lead to some change in staff behaviour and it may be that the combination of these interventions, rather than one or the other, was the key to the improvements observed. Without directly comparing the effectiveness of staff training and DCM by providing them separately to comparable homes, it is impossible to say which would be more effective. However, even if such a study were to be carried out, caution would be needed in interpreting the findings, since comparisons of different homes using one of these methods (DCM) indicated it to have different levels of effectiveness depending on the home (Innes & Surr, 2001). Furthermore, while one could compare these interventions by providing them separately, training provided in isolation, without follow-up and without being provided in an organisation that is conducive to change, is unlikely to have long-term benefits, particularly given the high levels of staff turnover. Equally, however, DCM provided in isolation, would lack the preparatory training that could enable staff to develop more positive attitudes towards their work, giving them the opportunity to reflect on their current practices in the light of new learning. Moreover, this would occur in an environment that could be perceived as less threatening than a DCM feedback session as it would not be commenting on specific instances of staff members work, but still raised questions for them about their own practice. It is likely that such a process would result in staff feeling supported in their work and potentially more receptive to subsequent DCM interventions. In conclusion, it seems wise to suggest that best practice would require both induction training to ensure staff understand the principles of person-centred care, and the regular quality evaluations, feedback and action plans provided by the DCM method.

CHAPTER SIX

6.0 General Discussion

As previously outlined in section 3.1.1, much of the research into care for people with dementia has only evaluated component parts of the relationship between attitudes, behaviour, resident well-being and staff training. This may be a reflection of the complexity of the relationships between these variables in addition to reflecting the methodological difficulties associated with quantifying such concepts. At the outset of the present research, although there was some evidence to support the positive impact of staff training on self-reported attitudes, the relationship with other variables remained unclear.

This study was designed to address some of these issues through a detailed study of staff and residents within the context of a nursing home specialising in the care of people with dementia. The research took place over a two and a half year period, during which time appropriate measures were developed, evaluations carried out and organisational changes and training interventions were implemented and monitored.

The major finding from this research was that certain aspects of staff attitudes and staff behaviour were correlated. Specifically, staff with more positive 'hope' attitudes were more likely to engage socially with residents, to engage them in purposeful activities and to offer qualitatively better physical care interventions.

'Hope' scores appear to represent an amalgamation of appraisals made by staff about whether they view people with dementia as helpless and whether they believe that

people with dementia will inevitably decline rapidly. This is evidenced by statements such as 'people with dementia are unable to make decisions for themselves', 'people with dementia are very much like children', 'there is no hope for people with dementia' and 'it is important not to become too attached to residents with dementia'. Differing levels of these attitudes were also manifested in staff members' behaviour, in that those who were more positive about residents' abilities and less focused on their decline engaged socially with residents, participated in purposeful activities with them and offered qualitatively better physical care interventions compared to those with more negative 'hope' attitudes. Thus it seems that staff perceiving people with dementia as dependent and unlikely to survive much longer would be less likely to care for residents' psycho-social needs as well as their physical ones.

The research also demonstrated that improvements could be seen in levels of positive attitudes following training. In addition, after the initial period of training, these positive developments in attitudes were reflected in the quality of care being delivered through increased levels of social engagement and increased use of quality indicators, such as giving choice and information during physical care tasks. In reviewing the course of the changes that took place, there appeared to be an initial burst in development of both attitudes and behaviour following the first training intervention. Developments following subsequent interventions were less concurrent, with attitudes improving after the second intervention, but further developments in behaviour not occurring until after the third intervention at which time levels of purposeful activity significantly improved.

Alongside progressions in staff attitude and quality of care, there was some evidence to suggest that resident well-being also improved. Group DCM scores steadily increased over the course of the two years and significant improvements were also seen in distributions of well and ill-being values.

6.1 Implications

The results of this research have a number of implications both in terms of contributing to debates within the literature and in terms of practical implications for those working in the field.

This research supports the view that attitudes and behaviour are related when the measures used to assess them are specifically focussed on the same target, in this case older people with dementia. The only study found to have previously tested the relationship between attitudes and behaviour towards people with dementia was that of Salmon (1993) whose results contrasted with those produced in this study. As discussed in previous chapters, Salmon found a very limited relationship between attitudes and behaviour and this difference may well be explained in terms of the specificity of the measures used as suggested by Ajzen & Fishbein (1977). The two attitude scales used in the Salmon (1993) study were designed for use with physically ill patients and for older people generally, even though observations were being made of staff interactions with people with dementia. The scale developed in this study was more specifically focussed on views towards people with dementia and the type of care they should receive and was therefore compatible with the type of observations that were carried out. From this research, it would seem that attitudes and behaviour

are related when the specificity of measures are sufficiently congruent, thus supporting Ajzen & Fishbein's (1977) hypothesis.

The results found in this study also provide support for arguments that attitudes are comprised of multiple components. The 'hope' scale of the ADQ could be said to be largely affective in nature. As outlined above, the items contained within it encompassed statements reflecting views about a person's helplessness and prognosis. This factor was most closely related to behaviour, and in view of this, it could be argued that staff who are reluctant to engage with residents hold underlying fears about what will happen to the people they care for, so in order to protect themselves from painful emotions they limit the emotional investment they make in developing relationships with them. *These findings are also consistent with Fazio & Zanna's* (1981) suggestion that congruity between behaviour and the affective component of attitudes is likely to be higher for attitudes developed out of personal experience. Staff working in nursing homes spend a great deal of time with people who have dementia and are therefore very familiar with the degenerative aspects of the condition. Thus their personal experience of people with dementia may lead them to unconsciously conclude that forming attachments with residents with dementia results in high emotional consequences.

In exploring the personal resources that are required of nursing carers, Kitwood (1997) draws on psychodynamic theory to describe the way in which staff members may rely on psychological defences to block out the difficult feelings associated with becoming involved with clients. Although the purpose of this research was not specifically to explore these aspects of psychological functioning, the findings do

appear to support this theory. The practical implications of these issues for dementia care environments is that in order to support the psycho-social well-being of residents, care organisations also need to consider and support the psychological well-being of staff so that they are enabled to develop meaningful relationships with residents whereby the benefits of doing so outweigh the consequences.

Previous research highlighting the role of optimism or pessimism in predicting attitudes is also relevant here. Solomon & Vickers (1979) found that people who were generally pessimistic or had a negative outlook on life had the most negative attitudes towards older people. In this study use of the term 'hope' to describe one of the subscales of the ADQ is synonymous with concepts of optimism or pessimism towards residents' abilities and futures. Thus further to Solomon & Vickers work, it could be hypothesised that those with the most pessimistic outlook on life would not only be likely to have the most negative view of older people, but would also be less likely to interact and develop relationships with them. Evidence showing lower self-efficacy to be related to more negative attitudes (Kahana et al., 1996) may similarly reflect a negative view of self that extends beyond the working environment.

Although this study has shown that those with more positive attitudes towards older people with dementia also behave more positively towards them, in view of previous literature, questions remain about how these attitudes are developed and maintained. It is possible that an individual's negative perceptions of people with dementia may represent a more fundamentally negative style of viewing life and the future. Accordingly, training may have the same function on people's attitudes within their work as cognitive therapy (Beck, 1970, 1976) might have on aspects of their personal

lives. Explicitly, training may provide the opportunity for cognitive restructuring of previously negative attitudes in order to bring about more positive ways of working and more fulfilment in the activities carried out.

A number of further practical implications of this research remain. It is important to highlight that although training did appear to be related to changes in staff attitudes and behaviour, in isolation it did not appear to be sufficient to lead to improved outcomes for residents. However, the improved outcomes in resident well-being that subsequently occurred following further organisational changes may have been underpinned by such staff changes. The research suggests that improvements in staff training may have little impact on resident well-being where there are organisational obstacles that prevent implementation of positive change.

The key role played by the organisation in helping to form and maintain attitudes and behaviour of care staff is consistent with systemic theory. The organisation is seen as a unit structured on feedback and over time, such feedback becomes identified as pattern (Maturana, 1978). Within systemic theory, meaning and behaviour have a recursive or circular relationship, whereby people behave as they do because they have certain beliefs about the context they are in and these are challenged or supported by the feedback they get. Thus when staff feel unvalued and unsupported by the organisation, they develop patterns of behaviour in response to this which may include not listening to their managers, not complying with their requests, or leaving the organisation. These behaviours impact on the quality of care they are able to deliver, thus effecting the well-being of residents, which may in turn impact upon managers, for example through the reputation and popularity of the home. Thus

feedback loops develop within the organisation whereby behaviour is observed and responded to by other members in the interconnected system. Within such a system, one would expect higher quality care amongst organisations who invest in their staff with ongoing professional development programmes, who value the individuality of their staff, and who support staff through emotionally difficult periods, for example by providing support groups or supervision. Psychodynamically, such approaches could potentially allow staff to lower their defences about engaging with residents as risks to their own emotional well-being would be reduced. However, barriers to good quality care could include those identified by Beck, Ortigara, Mercer & Shue (1999), who highlight poor pay, minimal long-term benefits and insufficient training, recognition and support for the physically and emotionally labour-intensive role that they carry out.

The research presented here also has potential implications for the type of training offered to care staff. Attitudes reflecting levels of hope or optimism were most closely related to behaviour towards residents. Therefore, training which challenges peoples views of people with dementia as helpless, hopeless and likely to deteriorate rapidly, may have greater potential in improving the delivery of care. If training is able to give staff a different experience of what a person with dementia can be like, if they can learn to value the abilities of people with dementia rather than their deficits and to value the quality of their remaining time rather than its brevity, then the quality of subsequent interactions with residents may be subject to significant improvement.

Consistent with an increasing focus on experiential forms of training and in line with Fazzio & Zanna's (1981) assertion that the affective component of attitudes will be

more closely related to behaviour if based on personal experience, the interventions in this study were largely experiential in nature. Formal training sessions required staff to reflect on their experiences both personally and professionally. In addition, feedback from DCM observations also required staff to think about their experiences of the time observed and about whether there was anything typical or atypical about the interactions that took place on those days. Through discussing these experiences and where necessary offering alternative explanations of what occurred, it appears that staff were enabled to think and feel differently about people with dementia and to develop more positive attitudes and interactions with them. Again this is consistent with systemic theory where the aim of therapy is to create a context where individuals can think differently about behaviour and relationships. In both training and feedback from DCM observations, the facilitator can introduce difference to the way people think, talk and subsequently behave by listening carefully, and posing questions which have the potential to shift beliefs, the meaning of behaviour and context, in much the same way as a systemic therapist.

In addition to formal training and feedback from DCM observations, the organisational changes that took place during this study included the introduction of a development nurse who worked alongside care staff, providing immediate feedback and guidance to staff about their work and acting as a role model. This type of intervention has recently been investigated more fully in an American study by Bourgeois (2000), who found improvements in the quality of staff interactions with residents following training that focussed on the use of effective communication techniques. Staff were trained in using skills such as announcing who they are, using the resident's name, giving positive feedback and using biographical information.

Daily hands on training of skills was given for two to three weeks, following which 93% of participants had reached the required 80% performance criterion. Another recent study that focussed on skills based training was that of McCallion, Toseland, Lacey & Banks (1999). This study, which implemented a communication skills programme, found improved outcomes for residents who showed fewer depressive signs following staff training. Similarly, Proctor et al. (1999), also found improved levels of resident depression as well as reductions in levels of cognitive impairment following staff training on the psychosocial management of resident behavioural problems followed by weekly visits from an experienced RMN who offered ongoing support and advice. These findings demonstrating the effectiveness of training aimed directly at changing staff behaviour appear to be contradictory to the assertions made above suggesting that training should aim to change people's attitudes. These different emphases on aspects of human experience seem reminiscent of the continuing debate amongst cognitive and behavioural theorists and therapists about whether change in cognition is sufficient to change behaviour or whether changes in behaviour will subsequently change cognition. In Padesky's (1994) model, behaviour, cognition, emotion and bodily sensations are inextricably linked, thus changes in one area are likely to impact on one or more of the others. Furthermore, in practice, many clinicians aim to initiate change through more than one avenue, for example by encouraging both behavioural and cognitive adaptations. In the present study, the training employed and the subsequent development work was consistent with the models of attitude described in Chapter One. In particular, it seems that the interventions were able to challenge staff members' pre-existing ideas, assumptions, or beliefs about people with dementia and how they are treated, creating dissonance in the way that staff members view people with dementia and promoting them to

think and subsequently to act differently towards them. In view of this, it seems likely that training which incorporates skills based modelling together with some form of cognitive restructuring or systemic reframing would provide a more thorough approach to staff development. Future research could aim to test the effectiveness of the various methods or combinations of them and to evaluate differences in their long-term efficacy.

As reported above, improved outcomes in resident well-being were only achieved towards the end of the study when a number of training programmes and organisational developments had been put into place. The implications of this are that organisations not only need to implement training and structural developments, but also that some form of regular and ongoing evaluation such as DCM is required in order to monitor progress, provide goals and incentives for staff to improve practice and provide feedback to them on their development.

The final implication of this research worthy of some discussion is the potential use of the measure used in this study in staff development and selection procedures. In this study, the ADQ provided information about the attitudes of staff that did appear to be an indication of the type of care they would deliver. However, it is important to note that this finding was based on group means and the scale may not be able to sufficiently discriminate between individuals, to be used in this way. Furthermore, this study found that attitudes could be changed through appropriate interventions. In reality, care homes are often short staffed and rarely have the luxury of selecting 'ready-made', 'ideal' staff from amongst a host of applicants. The attitudes of potential staff may have been influenced by societal views or previously negative

experiences of employment in nursing homes which could potentially be developed given the right support and education. These factors suggest that the onus is on employers to provide appropriate training for new staff rather than to exclude applicants who score poorly on attitude scales, but who may have the potential to develop more positive attitudes. In thinking about selection, however, it may be worth remembering, Petty & Cacioppo's (1985) finding that the more extremely pro or anti a person's attitudes, the less likely they are to change.

The contribution of this research to the literature can be summarised by revisiting the model presented in Chapter One in light of the findings reported above. Figure 6.1 shows an adapted version of the model with the additional information from this study providing evidence for relationships between variables and adding confirmation to previously inferred relationships.

From figure 6.1 it can be seen that the above research has provided additional information that can be added to the diagram in Chapter One. First and perhaps the most significant finding from this study is a link that can now be seen between attitudes and the nature of staff engagement with clients. Evidence from this study shows that attitudes are associated with the quality of an individual's involvement with clients thus affecting the quality of care they deliver. Second the diagram has been extended to show the impact that quality of care has on resident well-being. Improved quality of care, evidenced by increased levels of engagement with clients, does indeed appear to lead to improved levels of resident well-being and this relationship is now also supported by studies such as those of Bourgeois (2000), McCallion et al. (1999) and Proctor et al. (1999).

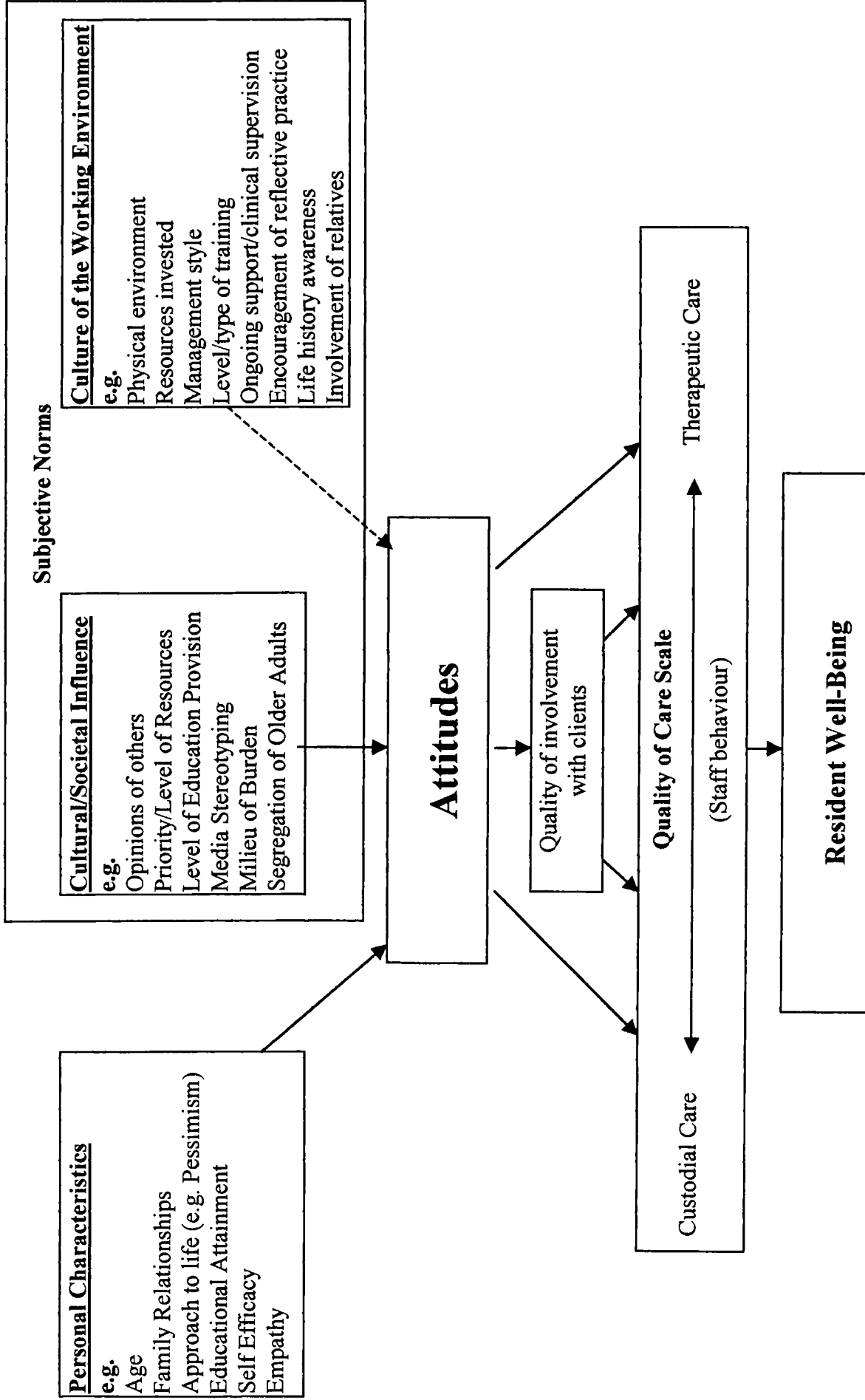


Figure 6.1: Summary of attitude predictors and their potential effects (dotted lines indicated inferred relationships).

Third whilst a correlation between working environment and staff members' attitude was thought to exist, empirical evidence of this relationship was limited. The results of this study add further support to this relationship by showing a link between improvements in staff attitudes following training, by demonstrating the importance of ongoing feedback and by indicating the need for staff support or supervision.

Speculatively, the research presented here could lead to further examination of theories suggesting that the attachment style of members of care staff may influence the way in which they relate to and care for the clients they work with. According to attachment theory (Bowlby, 1969, 1973, 1980) individuals need to form close affectional bonds during infancy in order to achieve a sense of security. Ainsworth, Blehar, Waters & Wall's (1978) well-known 'Strange Situation' studies identified a number of typical attachment styles, based on infants' responses to separations and reunions with their caregiver. This work indicated that individuals could be classified as either securely or insecurely attached and later work (e.g. Collins & Read, 1994) has suggested that internal models of attachment based on early experiences remain relatively stable across the lifespan, thus providing a prototype for later relationships. The implications of this for older adults needing care is that the way in which staff relate to them may be strongly influenced by the staff members' attachment style. In this study, the findings indicate that staff members have different ways of interacting with residents and that these correlate with their attitudes towards people with dementia, particularly their 'hope' attitudes. It is possible that variations seen in the quality of interactions with residents could be attributable to different styles of attachment amongst care staff. However, further research would be required to confirm such a hypothesis and also to gain a greater understanding of how attachment style might influence attitude.

Within each of the three global spheres thought to influence attitude a number of different subheadings are included. This study was not able to investigate every one of these factors, or find evidence for their relative impact. However, it is likely that some of these factors will be more influential than others, for example, within the working environment category it is possible to imagine that an excellent management style and high levels of support may well overcome the limitations of a less than ideal physical environment. Similarly, within the personal characteristics section optimism and a secure attachment style may compensate for a lack of educational attainment.

If the model presented in figure 6.1 is to be viewed as a systemic model of attitude and behaviour within nursing home staff, consideration of the feedback loops occurring between the various levels of the model are also required. Evidence for many of the relationships shown are correlational rather than causal as indicated by the dual direction of the arrows. However, it is also possible that factors such as resident well-being or delivery of care could have a direct impact on some of the other variables such as attitude or indeed on self efficacy or managerial factors. For example, if staff observe high levels of resident well-being they may experience a greater sense of self efficacy and might also hold more positive attitudes towards residents. Thus although the research described above contributes to certain areas of the model shown in figure 6.1, further areas of investigation remain and these will be discussed in the light of the limitations of this study.

6.2 Limitations

Despite finding support for the research aims outlined in Chapter One, there remain a number of limitations to the study, which will be discussed below.

In relation to development of the ADQ, one main limitation can be identified. As shown in table 2.3, there is little variability in responses to many of the 'recognition of personhood' items. This factor also showed limited relationship with any of the behavioural observations and did not show change over time. It is possible that had the study used the technique of generating large numbers of potential items initially and subsequently selecting those demonstrating the highest factor loadings and greatest variability, these difficulties might have been overcome.

Criticisms of the behavioural observation technique could include those inherent in observational work per se. For example, a typical criticism of the observational technique is that the presence of an observer could alter participant behaviour. Theories about the impact of observers on the behaviour of those observed has been the subject of much debate over many years. Some authors suggest that when people are observed, a 'Hawthorne effect' will occur whereby their behaviour changes because of the presence of the observer (e.g. Roethlisberger & Dickson, 1939). Others argue that such atypical behaviour can only be maintained for short periods of time, after which participants' patterns of behaviour return to normal. For example Kitwood & Bredin (1994) argue that staff are typically too busy to do anything out of the ordinary and that when they do try harder to perform well, they can only do so using the skills and insights they already have. In the present study, observers generally spent a few minutes before each observation

orientating themselves to the environment and the location of various people within it and allowing participants time to adjust to their presence. Furthermore, several hours of observations took place with each individual. It could therefore be argued that the potential impact of Hawthorne effects on the results in this study would have been limited. However, it is possible that some of the staff observed may have been able to 'fake' good practice in the presence of the observer and were able to maintain this for the period of time observed. Similarly, some particularly perceptive staff may have been aware of the ADQ responses that would indicate more positive care. The implication of this is the possibility that a few participants, who were able to give the 'right' answers on the ADQ and perform with the 'right' behaviour when being observed could have influenced the results by artificially inflating the correlations between staff attitudes and behaviour.

Observational techniques have also been criticised for often being labour intensive, time consuming and difficult to follow by anyone other than the person responsible for their development. In this particular study, the latter of these criticisms may be unfounded, since great effort was invested in producing detailed guidelines for the technique and inter-rater reliability was achieved. The former criticism, however, may indeed be relevant in this study. The technique is certainly time consuming and labour intensive, particularly if all members of staff within a home are to be included. However, it is possible that specific elements of the technique, such as the number of key qualities used during physical care interactions, could be extracted from the method and used independently for educational or training purposes.

The time consuming, labour intensive nature of the observations, also poses problems for decisions about what can and cannot be included within the observations. One important

area of skill that proved difficult to incorporate within the observational technique was that of responding to 'challenging behaviour', described in this study as 'expressions of need'. Attempts to code responses to expression of need elicited some valuable information about the range of different responses used and about the types of behaviour that could be considered an expression of need. However, observations of response to expression of need proved problematic largely due to constraints of time, in that very few expressions of need might occur within the one and a half hour period, but also due to the limitations of what can be observed at any one time. Development of an observational tool for assessing response to expression of need would require detailed definitions of which resident behaviours were to be included under the heading 'expression of need', as well as a detailed coding framework that accurately represented the various types of response that might be given. This study was not able to incorporate such a task within the already extensive and detailed observations of staff members that were taking place. Additional work in this area could provide further valuable information about the skills of staff in relating to residents. However it is likely that observations of response to expression of need would need to take place separately from the observations already described in this study.

Further potential criticism of the observational technique used in this study, is that trials have only taken place in one care setting and therefore it may not be generalisable to other contexts. The home observed in this study may have been particularly suited to the type of observations that were being carried out. For example, the layout of the building was such that it was possible to do the majority of observations from communal lounge areas. Further, as quality of care improves within homes, one would expect staff to be engaging in more varied activities and to be changing between activities more frequently. This

would clearly have implications for the type of observations that could be carried out and whether the observer would be able to remain unobtrusively in one position. It is likely that adaptations to the technique would be required as quality of care improves and also to suit different care environments.

Finally in relation to the observational technique, the method only achieved relatively low levels of re-test reliability, particularly for the key qualities aspect of the measure. Perhaps if test-retest observations had been carried out at the same time of day for each sampling period and incorporating at least 5 physical care interactions a more consistent finding could have been found. Despite this limitation, when 5 or more physical care interactions had taken place some relationship between different time periods was indicated and future use of the scale would need to incorporate at least this many physical care interactions in order to provide a representative sample of care.

Limitations could also be said to exist in some of the relationships observed between the various measures used. Some correlations carried out produced only moderate or small coefficients, which although statistically significant, may have limited predictive value in practice. Furthermore, some correlations that might have been expected, for example between attitudes and personal detractions, were not found. One would expect those with more positive attitudes would show fewer personal detractions. However this result was not established, raising questions over the validity of either the attitudes scale or of the accuracy of personal detraction recording. This finding remains unexplained and further research would be needed to examine the relationship more closely.

A further complication in the training evaluation aspect of the study is the difficulty in distinguishing exactly which factors were responsible for producing the positive changes that took place in staff attitudes and behaviour and eventually in resident well-being. There were a number of different interventions that took place, any of which could conceivably have been responsible for change either in isolation, or more probably in combination with each other. In addition, there would inevitably have been a number of extraneous changes that occurred during the three-year period. This study did not incorporate investigations within an equivalent home providing a control environment where interventions were not taking place. Hence no information is available on what changes would have occurred spontaneously or naturalistically over the three year period. The observations that took place at the beginning of this study indicated that much could be done to improve the quality of care offered to residents. In the opinion of the researcher, to have maintained such an environment as a control study by withholding much needed training and development interventions would have been extremely unethical. Furthermore, even if it had been possible to use a 'control' home without ethical concerns, the difficulty remains of how to match homes sufficiently to ensure that one acts as a control. In order to balance out the large number of extraneous and confounding variables one would need such a large number of experimental and control homes that the study would be impractical and extremely costly. The advantage of studying one home using an action research style of methodology is the depth with which that home can be studied.

Given the depth with which the home was studied, one could argue that in addition to participants being subject to Hawthorne effects, the organisation could also have been subject to such effects, since they would clearly want their home to be portrayed in a

positive light. The implication of this is that the positive steps taken by the organisation to improve standards of care may not have occurred had the home not been part of a research study. However, the organisation involved did actively invite the research study to take place in their home, as they were keen to develop good practice in dementia care, were keen to receive regular updates on the progress of the research. They also prided themselves on providing high quality care for older people and were involved in organising conferences and awards to promote good quality dementia care. Consequently, they may have been more interested in the research and more motivated to take appropriate action following feedback on the findings than other organisations would have been. Clearly the attitudes and actions of an employing organisation are likely to effect the outcome of interventions such as those carried out during this study and commitment to the development of good quality care is likely to be crucial if standards are to improve and be maintained. Given the particular organisation involved in the study and their proven commitment to improving care for people with dementia, it seems unlikely that improvements were only made as a result of taking part in the research.

The problems highlighted are implicit within this type of research and should not detract from the detailed analysis that could be achieved by using the methodology employed. Ultimately, the original purpose of the study which was to evaluate whether change could occur over time was fulfilled and the results were able to indicate that it could.

The difficulty in distinguishing which factors produce change are indicative of the problems inherent within longitudinal studies generally. Evaluations of both staff and resident factors were subject to attrition rates, leaving a reduced sample of people for whom data was available at all points in the study. In addition, those that remain may

embody a biased sample, as those who stay may be systematically different from those who leave and those who leave may be different from the people who replace them. Another difficulty with longitudinal studies is that of sample conditioning, whereby participants who are observed across a number of occasions come to know what is required of them and therefore may no longer be 'naïve' respondents.

Finally, it is possible that the research may have been biased by having one researcher involved in a number of ways over the period of the research. The same researcher was responsible for designing both the questionnaire and the observational technique, for distributing and collecting questionnaires, for collecting observational data on staff, for carrying out DCM observations and giving feedback on these to care staff, and for co-facilitating training sessions. In addition, the researcher spent some time outside of formal data collection periods, socially interacting with residents in the home in order to help them feel more at ease during observations. Such involvement in the home could potentially have confounded the data that was being collected, for example by biasing the researcher's 'objectivity' during observations or by influencing the behaviour or responses of care staff through them becoming more aware of the researcher's beliefs and expectations. In addition some modelling could have occurred from staff observing the researcher's interactions with residents which may have influenced their own behaviour and this could have obscured the extent of change that was due to the specified interventions. A number of steps were taken in order to minimise the effects of such biases. First, the employment of a second observer to assess and corroborate the inter-rater reliability of both the staff observations and DCM observations enabled greater confidence in the objectivity of the observations. Second, the DCM feedback and the formal training sessions were primarily facilitated by someone else, with the researcher

taking a relatively minor role in order to minimise the influence of their presence during observations. Third, through giving feedback on DCM observations, an open process was facilitated whereby staff could express their views about what had taken place during the DCM observations and could comment on whether they felt the observations typically represented their everyday experience. Lastly, it could also be argued that having one person carrying out all of the observations could have been a potential benefit to the study, since both staff and residents would become more desensitised to their presence and would therefore be more likely to behave normally.

6.3 Recommendations For Future Research

Progressions from the research presented above could be made in a number of areas, including further exploration of the relationships within the model suggested in figure 6.1, further exploration of the types of training likely to lead to provision of the highest in quality of care standards and further exploration of the psychological characteristics required by staff in order to provide such high quality care.

Replication of the findings presented in this study across different services would certainly add support to the validity of the measures used and would also help to substantiate some of the relationships proposed in the systemic model of nursing home care. Thus further work in this area would have particular confirmatory value.

One of the main findings of this study was the correlational link between attitudes and behaviour. Although the hope factor appeared particularly strong, the personhood factor did not appear to be as meaningful. Further research to both confirm the presence of a

'hope' factor and to investigate whether there are other important dimensions of attitude that also relate to behaviour would be of value. Evaluation of the specific profile of the hope dimension would also be interesting in order to tease out exactly what this factor represents. For example, does a low score on this factor represent a negative outlook specifically towards people with dementia or is it more likely to represent a more global negative outlook on life? Could it be indicative of an individual's underlying fears about what will happen to the people in their care, or a more personal fear of weakness, dependency and mortality? Explorations of the psychological profile of care staff and the impact that characteristics such as pessimism and self esteem have on their delivery of care may help to answer some of these questions. In addition, the importance of staff members' attachment style in enabling them to engage with residents and form meaningful relationships with them could provide a further interesting area of exploration. The relationships between attitudes, optimism, self-efficacy and attachment style warrant further investigation as does the dynamic that exists between each of these factors and behaviour. Such investigations could have further implications for the type of training and support that is provided for care staff and could provide valuable information about the personal characteristics that most lend themselves to this type of work.

Another interesting avenue for future research would be further evaluations of the type of training and interventions that prove most effective in developing staff skills that can be maintained in the long term. Recent research evaluating staff training (McCallion et al., 1999; Proctor et al., 1999; Bourgeois, 2000) has focused on changing behaviour, yet from this study it can be seen that attitude is closely related to behaviour and may provide an additional avenue through which effective change could be implemented. Most studies, including those cited above, evaluate the changes made over a relatively short space of

time. It could be argued that behavioural changes are unlikely to be maintained in the long-term, if staff do not have the an understanding and belief in the value of their actions underlying their behaviour. Research that aimed to evaluate the relative effectiveness of either attitude or behaviour training or combinations of both could help to identify which has the potential to produce the most effective long term change.

6.4 Conclusion

Over the last 10-20 years, as a consequence of changes in government policy, large numbers of older people with dementia, previously housed in hospital psychogeriatric wards, are now cared for in specialised units or nursing homes in the community. While this has been an important step in reducing the institutionalisation and impersonal care provided by such establishments, the social stigma often attached to older people and those with mental health problems is not removed merely by moving their location.

Those working in this field are not exempt from negative and prejudicial attitudes and such attitudes can potentially be reinforced by misunderstandings about clients' behaviour and a lack of awareness about the person with dementia and their needs. One particularly problematic feature of dementia care is the inheritance of a culture (Kitwood, 1997) whereby negative attitudes and stereotypes towards older people are highly entrenched in the type of care that is given. While it is important that the physical environment in which older adults with dementia live is as pleasant as possible, their quality of life is unlikely to undergo significant improvement if the psychosocial environment provided through interaction with care staff remains unchanged. Without comparative changes in the attitudes of staff and organisational practices in residential care, all that is achieved by the

development of community homes is the relocation of institutional practices to numbers of smaller, nicely decorated buildings, rather than any actual improvements in the quality of care or the quality of life of residents.

Appropriate and adequate training aimed at challenging negative beliefs and establishing a greater appreciation of what might be achieved in terms of improving residents' quality of life, amongst care staff is essential for the improvement and maintenance of high quality care. In addition the context in which staff work needs to provide an environment where people are supported in their relationships with residents and where their own psychological resources are supported in order to help them carry out what is an extremely demanding role.

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APPENDICES

Approaches to Dementia Questionnaire

Appendix One

Please indicate to what extent you agree or disagree with each of the following statements:

1. It is important to have a very strict routine when working with dementia sufferers.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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2. People with dementia are very much like children.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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3. There is no hope for people with dementia.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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4. People with dementia are unable to make decisions for themselves.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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5. It is important for people with dementia to have stimulating and enjoyable activities to occupy their time.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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6. Dementia sufferers are sick and need to be looked after.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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7. It is important for people with dementia to be given as much choice as possible in their daily lives.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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8. Nothing can be done for people with dementia, except for keeping them clean and comfortable.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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9. People with dementia are more likely to be contented when treated with understanding and reassurance.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
----------------	-------	-------------------------------	----------	-------------------

10. People with dementia should be treated just like any other person.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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Appendix One

11. Once dementia develops in a person, it is inevitable that they will go down hill.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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12. People with dementia need to feel respected, just like anybody else.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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13. Good dementia care involves caring for a person's psychological needs as well as their physical needs.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
----------------	-------	----------------------------	----------	-------------------

14. It is important not to become too attached to residents.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
----------------	-------	----------------------------	----------	-------------------

15. It doesn't matter what you say to people with dementia because they forget it anyway.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
----------------	-------	----------------------------	----------	-------------------

16. People with dementia often have good reasons for behaving as they do.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
----------------	-------	----------------------------	----------	-------------------

17. Spending time with people with dementia can be very enjoyable.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
----------------	-------	----------------------------	----------	-------------------

18. It is important to respond to people with dementia with empathy and understanding.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
----------------	-------	----------------------------	----------	-------------------

19. There are a lot of things that people with dementia can do.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
----------------	-------	----------------------------	----------	-------------------

20. People with dementia are just ordinary people who need special understanding to fulfil their needs.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
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Appendix Two

The Bradbury Centre Research Project into Staff Training in Dementia Care

STAFF INFORMATION - SEPTEMBER 1996

Research Psychologist: Tracey Lintern

Dear

You may already be aware that the RSAS have commissioned a research project into dementia care, to take place at the Bradbury Centre over the next couple of years. I have been employed as the research psychologist for this project since June this year, and many of you will have seen me around the home by now. While I have spoken in detail to some people, others of you may still be wondering what exactly it is that I do. I hope this letter will explain a little more about the research that I will be doing here, although I still hope to talk to you all personally as well.

The main purpose of the research is so that we can gain a better understanding of the way in which dementia care relates to: (a) quality of life and level of functioning of the residents; (b) staff morale and job satisfaction; and (c) staff training in caring for people with dementia.

The research team involved in this project understand that providing care for people with dementia is a difficult and potentially stressful task. It is our hope that this research and the programme of staff training that will accompany it, might go some way towards reducing the stress and frustration that is sometimes related to dementia care, as well as improving the well-being of residents. Your contribution to the research is crucial in achieving this aim and it is important to us that you are as involved and informed as possible.

The main part of the research will involve the following:

Observations

Some of you will already have seen me sitting in Wolfson or Wedgwood wings, observing residents and their interaction with staff. Most of these observations have been to look at what activities and behaviours the residents engage in and their state of well-being. Some also look at their level of interaction with, and response to other people. Over the next few months I will be doing more of these observations and on a few occasions I may have another observer with me, to ensure accuracy. We realise that having someone 'watching' for a large part of the day can be very uncomfortable, particularly when you don't know what it is that is being observed. However, these observations may be beneficial to you, as well as to the residents, since they help to identify areas in which training is needed and support required. It is important for you to know that these observations will not be used to report on what individual members of staff are doing or to single out or criticise individuals. This is not the intention of the research and no 'reports' on staff will be made as a result of the

Appendix Two

observations (see section on confidentiality). Initially, it will not be possible to disclose the findings of observations, however, following a second period of training in May 1997, feedback sessions will be held with staff, where you will be able to find out about what has been observed.

Questionnaires/Interviews

In addition to observations, I will also be asking all members of staff to complete a number of questionnaires (many of which you will have seen before) and also to discuss your work with me in interviews. By 'interviews', I do not mean the sort of formal interview you would have for a job, but more of an informal discussion on what you think and feel about the work here. The purpose of using interviews is that information can sometimes be missed in questionnaires, because the questions do not always cover everything you might want to say. The interview, on the other hand will give you the opportunity to state what you think in your own words, without restriction.

Staff Training

The first period of staff training for nurses and care assistants, has been planned to take place towards the end of this year. Those who do not receive training by the end of December can expect to have it in March 1997. The training will be provided by the Bradford Dementia Group who are very experienced and provide excellent training in dementia care for both professional and family carers. They take a 'person-centred' approach to dementia care, aiming to help carers to develop a better understanding of dementia and how it affects the individual.

Follow-up of the training will involve observation of any changes that occur after training and further questionnaires and interviews.

CONFIDENTIALITY

All the information obtained, whether from observations, interviews or questionnaires, will be treated with the strictest of confidence. Any information fed back to senior staff of the Bradbury Centre or of the RSAS, will be of a general nature and will not refer to specific staff members or incidents. Only in the unlikely event of extreme circumstances (for example if the safety of a resident was at risk), would specific information be disclosed. Confidentiality will be strictly adhered to, in the hope that you will feel able to be as frank and honest as you can.

I hope this letter goes some way towards explaining the project, if you have any concerns or uncertainty about it, or if there is anything else you would like to know, please feel free to come and talk to me. I can usually be found either in the dementia wings, or in the consulting room (off the concourse). If you work night duties, and would like to talk to me, please leave a message for me in the consulting room, stating when and where I can contact you, and I will get back to you as soon as possible.

I look forward to talking to you.

Appendix Two

CONSENT FORM
ROYAL SURGICAL AID SOCIETY

**THE BRADBURY CENTRE RESEARCH PROJECT INTO STAFF TRAINING
IN DEMENTIA CARE**

Investigators: Professor Bob Woods, Professor of Clinical Psychology of the Elderly,
University of Wales, Bangor.
Ms Tracey Lintern, Research Psychologist, University of Wales,
Bangor.

Aim of the study

The purpose of this study is to evaluate the effects of a programme of staff training and supervision on quality of care, staff morale and resident quality of life.

Procedure for participants

You will be asked to participate in a programme of staff training and development in caring for people with dementia. You will be asked to complete a number of questionnaires regarding your general health, job satisfaction and morale. You will be asked to participate in interviews, where you will be asked to give your opinion regarding dementia care within the home and also to answer multiple choice style questions regarding typical situations that you might encounter during your work. The study also involves observations of both staff and residents during their normal daily activities, in the communal living areas of the home.

All information is confidential and will not be distributed.

I agree to participate in this study. I understand the procedures involved which have been explained to me. I understand that I may withdraw from the study at any time, without giving reason for doing so. I have been told that there are no risks or costs involved and that participation in the study will not effect my position as a member of staff at the Bradbury Centre. I understand that confidentiality normally applied to medical records will be maintained.

Signed (Member of staff)

..... (Position)

Signed (Researcher)

Signed (Witness)

Date

Appendix Two

The Bradbury Centre Research Project into Staff Training in Dementia Care.

INFORMATION FOR RELATIVES

Research Psychologist: Tracey Lintern - 01932 226698

Dear

As you may already be aware, the RSAS have commissioned a research project to take place at the Bradbury Centre over the next two years. You may already have been contacted by Sarah Worsley, who was working on the project until March this year. I took over from Sarah in June and will continue to develop the research until the end of 1998, when the project ends.

Specifically, this research is designed to evaluate the effects of a programme of staff training in dementia care, in order to improve training in this area. To do this, researchers will examine the relationships between staff training, staff morale, and quality of care provided for residents at the home. The overall aim of the study is that the quality of life for older people with dementia in the home will be enhanced by a program of staff training and development.

In order to assess the areas mentioned above, researchers need to make detailed observations of both the social environment in which residents live and the type and quality of care being provided. Focus will be on observing the social atmosphere in the home, the level and quality of activity amongst staff and residents, and the quality of interactions experienced.

Residents will not be expected to engage in any specific tasks, they will not be required to complete any questionnaires or to be interviewed. Observations are aimed at recording the normal daily activities and interactions of residents in a way that is as unobtrusive as possible. Priority will be given to respecting the personal privacy of residents and observation will only take place in communal areas, not bedrooms or bathrooms. Any information obtained will be treated in the strictest of confidence.

Appendix Two

I hope this letter goes some way towards explaining the project, if you have any concerns or uncertainty about it, or if there is anything else you would like to know, please do not hesitate to contact me and I will be very happy to discuss the research with you. I can usually be found either in Wolfson or Wedgwood wings, or in the consulting room (off the concourse).

I look forward to talking to you.

Yours sincerely

Tracey Lintern
Research Psychologist

Appendix Two

CONSENT FORM ROYAL SURGICAL AID SOCIETY

THE BRADBURY CENTRE RESEARCH PROJECT INTO STAFF TRAINING IN DEMENTIA CARE

Investigators: Professor Bob Woods, Professor of Clinical Psychology of the Elderly,
University of Wales, Bangor.
Ms Tracey Lintern, Research Psychologist, University of Wales,
Bangor.

Aim of the study

The purpose of this study is to evaluate the effects of a programme of staff training and supervision on quality of care, staff morale and resident quality of life.

Procedure for participants

Participation on the part of residents requires that they are observed during their normal daily activities, so that information may be gained regarding the social atmosphere and level of activity in the home. Observations will take place in communal living areas of the home and will not extend to private areas such as bedrooms and bathrooms. Residents will not be required to engage in any specific tasks or activities, they will not be required to take part in interviews or to complete questionnaires. Questionnaires will be completed on the residents behalf, by a member of staff who knows the person well. These questionnaires refer to the living environment and functional ability of residents.

All information is confidential and will not be distributed.

I agree for (residents name) to participate in this study. I understand the procedures involved which have been explained to me. I understand that I may withdraw the participant from the study at any time, without giving reason for doing so. I realise that the study may not be of direct benefit to myself or the participant. I have been told that there are no risks involved, that participation or non-participation will not effect the treatment or care of the participant and that confidentiality normally applied to medical records will be maintained.

Signed (Next of Kin/Nursing Advisor)

on behalf of (Resident)

Signed (Researcher)

Signed (Witness)

Date

Approaches to Dementia Questionnaire

Appendix Three

Please indicate to what extent you agree or disagree with each of the following statements:

1. It is important to have a very strict routine when working with dementia sufferers.

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

2. People with dementia are very much like children.

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

3. There is no hope for people with dementia.

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

4. People with dementia are unable to make decisions for themselves.

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

5. It is important for people with dementia to have stimulating and enjoyable activities to occupy their time.

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

6. Dementia sufferers are sick and need to be looked after.

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

7. It is important for people with dementia to be given as much choice as possible in their daily lives.

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

8. Nothing can be done for people with dementia, except for keeping them clean and comfortable.

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

9. People with dementia are more likely to be contented when treated with understanding and reassurance.

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

Appendix Three

Approaches to Dementia Questionnaire - Scoring Sheet

1. It is important to have a very strict routine when working with dementia sufferers.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	2	3	4	5

2. People with dementia are very much like children.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	2	3	4	5

3. There is no hope for people with dementia.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	2	3	4	5

4. People with dementia are unable to make decisions for themselves.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	2	3	4	5

5. It is important for people with dementia to have stimulating and enjoyable activities to occupy their time.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
5	4	3	2	1

6. Dementia sufferers are sick and need to be looked after.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	2	3	4	5

7. It is important for people with dementia to be given as much choice as possible in their daily lives.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
5	4	3	2	1

8. Nothing can be done for people with dementia, except for keeping them clean and comfortable.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	2	3	4	5

9. People with dementia are more likely to be contented when treated with understanding and reassurance.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
5	4	3	2	1

10. Once dementia develops in a person, it is inevitable that they will go down hill.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	2	3	4	5

Appendix Three

11.	People with dementia need to feel respected, just like anybody else.				
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	
5	4	3	2	1	
12.	Good dementia care involves caring for a person's psychological needs as well as their physical needs.				
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	
5	4	3	2	1	
13.	It is important not to become too attached to residents.				
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	
1	2	3	4	5	
14.	It doesn't matter what you say to people with dementia because they forget it anyway.				
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	
1	2	3	4	5	
15.	People with dementia often have good reasons for behaving as they do.				
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	
5	4	3	2	1	
16.	Spending time with people with dementia can be very enjoyable.				
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	
5	4	3	2	1	
17.	It is important to respond to people with dementia with empathy and understanding.				
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	
5	4	3	2	1	
18.	There are a lot of things that people with dementia can do.				
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	
5	4	3	2	1	
19.	People with dementia are just ordinary people who need special understanding to fulfil their needs.				
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	
5	4	3	2	1	
TOTAL		_____			
Hope		_____			
Recognition of Personhood		_____			

Appendix Four

CODING FOR TYPE 1 VIDEO VIGNETTES

Does respondent recognise:

- A. Need for Physical Safety e.g.**
 - i) Made sure brakes were on
 - ii) Shouldn't tip the wheelchair back in case it falls
 - iii) Took the finished cup away from the walking resident to prevent injury

- B. Need for Practical Assistance e.g.**
 - i) Feeding with undue care and attention
 - ii) Not proper lift/assist from chair
 - iii) Gentle persuasion and assistance to drink tea

- C. Need for Information e.g.**
 - i) Didn't explain what was happening
 - ii) No warning given to the resident about what was about to happen
 - iii) Stood behind resident so she couldn't see who it was

- D. Need for Reassurance/Comfort e.g.**
 - i) Reassuring, touching, bending forward, caring manner
 - ii) Comforted her
 - iii) Talk to her, be with her

- E. Need for Understanding e.g.**
 - i) Didn't give resident opportunity to respond/explain
 - ii) Resident being understood and helped
 - iii) No attempt to 'connect' with resident, offer help or a listening ear

- F. Need for Occupation/Stimulation e.g.**
 - i) Left sitting in wheelchair with nothing to do
 - ii) Resident bored
 - iii) Engaged him in a conversation when he seemed to want just that

- G. Need for Privacy/Dignity e.g.**
 - i) Not discreet. Embarrassing for resident
 - ii) Discussion about resident in public within residents hearing
 - iii) Taking resident quietly to change her

- H. Need for Self Worth e.g.**
 - i) Encouragement of feeling worth something
 - ii) Helped resident feel better about herself
 - iii) Instilling confidence in resident

Appendix Four

I. Need for Independence e.g.

- i) Didn't let resident carry own cup
- ii) Taking over when the resident was trying to help
- iii) Putting her in front of the table, stopping her from doing anything

J. Need for a Social Environment e.g.

- i) Excluded resident from others
- ii) Resident sitting in appropriate grouping for tea
- iii) Chats with residents

K. Need to be treated as individuals e.g.

- i) Rushing from one to another, no thought for residents
- ii) Takes resident's feelings into account
- iii) Treated resident like a human being

L. Residents' right to choose e.g.

- i) Moved resident against her wishes
- ii) No permission asked for
- iii) Forces resident to eat/drink

M. Impact of carers on residents

- i) Lifted wheelchair back, frightening the resident
- ii) Humiliated/upset her by saying "you're all wet"
- iii) Last carer would have made the resident feel comfortable and sure because she talked to her, bending down and with a lovely voice.

N. Need to provide a neat environment

- i) Should have moved the flowers off the table
- ii) Shouldn't have tea tray in the lounge
- iii) Resident put near something they could destroy

O. Needs of Visitors

- i) Re-assured daughter when residents didn't want to see her
- ii) Tried to explain to the relative what was wrong
- iii) Could have worried the daughter by what she said

Appendix Four

CODING FOR TYPE 2 VIDEO VIGNETTES

Record all strategies present.

Immediate Responses

- X1** Calming the person, reassuring, talking with (emotion focused).
- X2** Divert the person, occupy them with something else, turn 'problem' into something constructive.
- X3** Remove the person from the 'problem' situation. Separate protagonists.
- X4** It's not acceptable. Don't do that. Not allow it.
- X5** Explain why can't do it.
- X6** Practical measures for the immediate effect on the situation.
- X7** Practical measures for the immediate physical care of the resident
- X8** Awareness of needs of other residents shown.
- X9** Awareness of needs of relatives/visitors
- X10** Ignore the behaviour

Problem Solving

- Y1** Ask the resident why.....
- Y2** Check care plan/record in it/modify care plan.
- Y3** Find out why.....(from sources other than the resident)
- Y4** Observe/think about common situations. When is this likely to happen?

Prevention

- Z1** Teaching the resident - repetition of desired action/use of praise.
- Z2** Prevent future incidents by arranging things differently.
- Z3** Arrange medical assessment. Consult other health professionals. Give drugs.
- Z4** Supervise more. Keep an eye on them. Have more staff present.

Appendix Five

T-tests between ADQ and Type 1 Video Vignettes

Need For:	ADQ Total			
	t-value	group	mean	s.d.
A. Physical Safety	-1.85	low	72.69	6.64
		high	75.60	10.45
B. Practical Assistance	-2.99	low	71.22	4.73
		high	76.85	9.64
C. Information	-3.05	low	72.12	6.55
		high	78.33	8.50
D. Reassurance/Comfort	-2.41	low	71.81	6.63
		high	75.60	8.78
E. Understanding	-3.21	low	71.41	4.66
		high	76.46	9.94
F. Occupation/Stimulation	-2.99	low	71.56	6.39
		high	76.15	7.78
G. Privacy/Dignity	-3.01	low	71.61	5.98
		high	78.00	8.77
H. Self Worth	-3.06	low	71.14	6.16
		high	77.50	7.44
I. Independence	-3.03	low	71.44	6.18
		high	79.50	7.31
J. Social Environment	-1.60	low	72.76	6.65
		high	74.67	9.95
K. Individualised treatment	-1.99	low	72.45	6.68
		high	75.11	8.53
L. A right to choose	-2.34	low	71.51	6.28
		high	77.09	7.86
M. Impact of carers on residents	-2.87	low	72.03	5.95
		high	77.12	10.06
N. Provision of a neat environment	-1.70	low	72.92	7.16
		high	78.00	0.00
O. Needs of visitors	2.90	low	73.39	7.07
		high	70.00	7.83

** indicates $p > .005$ (N = 37)

Appendix Five

Need For:	ADQ Factor 1 <i>Hope</i>			
	t-value	group	mean	s.d.
A. Physical Safety	-1.85	low	24.56	3.86
		high	26.20	5.16
B. Practical Assistance	-3.20	low	23.89	3.68
		high	26.69	4.13
C. Information	-2.62	low	24.36	3.76
		high	27.17	4.87
D. Reassurance/Comfort	-2.02	low	24.58	3.80
		high	26.10	4.72
E. Understanding	-4.18**	low	23.86	3.37
		high	26.76	4.65
F. Occupation/Stimulation	-1.58	low	24.51	4.07
		high	25.30	3.92
G. Privacy/Dignity	-3.52**	low	24.06	3.70
		high	27.33	4.18
H. Self Worth	-3.68**	low	23.73	3.85
		high	27.33	3.22
I. Independence	-2.49	low	24.32	3.89
		high	26.62	4.17
J. Social Environment	-1.16	low	24.72	3.93
		high	25.00	4.73
K. Individualised treatment	1.08	low	24.78	3.90
		high	24.66	4.58
L. A right to choose	-3.05	low	23.96	3.76
		high	27.00	3.94
M. Impact of carers on residents	-2.38	low	24.35	3.81
		high	26.50	4.56
N. Provision of a neat environment	1.69	low	24.82	4.02
		high	22.00	0.00
O. Needs of visitors	-1.12	low	24.73	3.92
		high	25.00	5.35

** indicates $p > .005$ (N = 37)

Appendix Five

Need For:	ADQ Factor 2 <i>Personhood</i>			
	t-value	group	mean	s.d.
A. Physical Safety	-1.37	low	46.13	4.63
		high	47.00	7.10
B. Practical Assistance	-2.67	low	45.41	4.32
		high	48.07	5.72
C. Information	-2.23	low	45.86	4.85
		high	48.50	4.88
D. Reassurance/Comfort	-1.98	low	45.37	4.82
		high	47.10	4.58
E. Understanding	-2.23	low	45.62	4.39
		high	47.61	5.79
F. Occupation/Stimulation	-3.11	low	44.96	4.67
		high	49.07	4.23
G. Privacy/Dignity	-2.47	low	45.66	4.73
		high	48.33	5.14
H. Self Worth	-2.81	low	45.40	4.86
		high	48.33	4.47
I. Independence	-3.02	low	45.29	4.67
		high	50.25	3.77
J. Social Environment	-2.05	low	45.91	4.91
		high	48.16	4.62
K. Individualised treatment	-2.47	low	45.66	4.72
		high	48.33	5.17
L. A right to choose	-2.64	low	45.51	4.92
		high	48.27	4.36
M. Impact of carers on residents	-2.31	low	45.76	4.69
		high	48.25	5.49
N. Provision of a neat environment	-2.42	low	46.07	4.82
		high	53.00	0.00
O. Needs of visitors	4.06**	low	46.44	5.08
		high	44.25	1.25

** indicates $p > .005$ (N = 37)

Appendix Five

Spearman's correlations between ADQ and Type 2 Video Vignettes

Response Type:	ADQ Total	ADQ: Factor 1 <i>Hope</i>	ADQ: Factor 2 <i>Personhood</i>
Immediate Responses - total	.41	.46**	.16
X1 Calming the person, reassuring, talking with (emotion focused).	.09	.14	.02
X2 Divert the person, occupy them with something else, something constructive.	.30	.46**	.18
X3 Remove the person from the 'problem' situation. Separate protagonists.	.31	.12	.26
X4 It's not acceptable. Don't do that.	-.03	-.15	.05
X5 Explain why can't do it.	.14	-.00	.05
X6 Practical measures for the immediate effect on the situation.	.22	.14	.09
X7 Practical measures for the immediate physical care of the resident	.29	.30	.09
X8 Awareness of needs of other residents shown.	-.01	.12	-.11
X9 Awareness of needs of relatives/visitors	.09	.11	.01
X10 Ignore the behaviour	-.12	-.05	-.02
Problem Solving - total	.09	.05	.08
Y1 Ask the resident why	-.02	-.17	.05
Y2 Check care plan, record in it/modify care plan.	.25	.23	.25
Y3 Find out why.....	.25	.23	.25
Y4 Observe/think about common situations. When is this likely to happen?	.21	.26	.13
Prevention - total	.06	.08	.13
Z1 Teaching the resident - repetition of desired action/use of praise.	.39	.41	.30
Z2 Prevent future incidents by arranging things differently.	.14	.11	.18
Z3 Arrange medical assessment. Consult other health professionals. Drugs.	.25	.23	.25
Z4 Supervise more. Keep an eye on them. Have more staff present.	.06	-.08	.02

** indicates $p > .005$ (N = 37)

Appendix Six

Varimax-rotated Factor Matrix for the ADQ (with skewed variables transformed)

(See Table 2.3 for full statements)	Hope	Recognition
	Factor 1	Factor 2
4. unable to make decisions for themselves	.72	.16
2. very much like children	.63	.21
8. nothing can be done except keep them clean/tidy	.59	.18
3. there is no hope for people with dementia	.60	.10
14. it's important not to become too attached to them	.60	.15
6. sick and need to be looked after	.59	-.17
11. it's inevitable they will go down hill	.58	.00
1. important to have a very strict routine	.50	.00
18. important to respond with empathy/understanding	-.00	.81
12. need to feel respected, just like anybody else	.00	.75
13. important to care for psychological and physical needs	-.00	.73
17. spending time with them can be very enjoyable	.26	.67
9. more content when given understanding/reassurance	.00	.69
5. important to have stimulating/enjoyable activities	-.00	.60
20. just ordinary people needing special understanding	.00	.69
19. lot of things that people with dementia can do	.40	.58
7. important to give them as much choice as possible	.30	.60
15. it doesn't matter what you say as they forget it anyway	.14	.48
16. they have good reasons for behaving as they do	.14	.46
Eigenvalue	2.65	5.48
Variability Explained	13.9	28.9

(N = 123)

DCPA Observations Form

Participant Number	Date		Place		# Residents		# Staff		# PDs
	Time								
	B								
	CS								
	KQ	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s
	B								
	CS								
	KQ	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s
Participant Number	Time								
	B								
	CS								
	KQ	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s
	B								
	CS								
	KQ	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s	a c d f i p s s

Notes:

- B = Behaviour category
- CS = Care Style (for Admin. and domestic duties)
- KQ = Key Qualities (for Physical Care interventions)
- #PDs = Number of Personal Detractions use

Appendix Eight

Personal Detraction Coding

1. Treachery – using some form of deception in order to distract or manipulate a person, or force them into compliance.
2. Disempowerment – not allowing a person to use the abilities that they do have; failing to help them to complete actions that they have initiated.
3. Infantilization – treating a person very patronizingly (or ‘matronizingly’), as a parent who is insensitive or insecure might treat a very young child.
4. Intimidation – inducing fear in a person, through the use of threats or physical power.
5. Labelling – using a category such as dementia, or ‘organic mental disorder’, as the main basis for interacting with a person and for explaining their behaviour.
6. Stigmatization – treating a person as if they were a diseased object, an alien or an outcast.
7. Outpacing – providing information, presenting choices, etc., at a rate too fast for a person to understand; putting them under pressure to do things more rapidly than they can bear.
8. Invalidation – failing to acknowledge the subjective reality of a person’s experience, and especially what they are feeling.
9. Banishment – sending a person away, or excluding them; physically or psychologically.
10. Objectification – treating a person as if they were a lump of dead matter; to be pushed, lifted, pumped or drained, without proper reference to the fact that they are sentient beings.
11. Ignoring – carrying on (in conversation or action) in the presence of a person as if they were not there.
12. Imposition – forcing a person to do something, over-riding desire or denying the possibility of choice on their part.
13. Withholding – refusing to give asked for attention, or to meet an evident need; for example, for affectionate contact.
14. Accusation – blaming a person for actions or failures of action that arise from their lack of ability, or their misunderstanding of the situation.

Appendix Eight

15. Disruption – disturbing a person’s action or inaction; crudely breaking their ‘frame of reference’.
16. Mockery – Making fun of a person’s ‘strange’ actions or remarks; teasing, humiliating, making jokes at their expense.
17. Disparagement – telling a person that they are incompetent, useless, worthless etc; giving them messages that are damaging to their self-esteem.

Appendix Nine

T-tests comparing am and pm observations

Code	Behaviour	Style	t-value
A	Activities (stimulation)		1.14
B	Bathing, washing, shaving		-.65
C	Conversation	r - with resident c - with colleague v - with visitor	-1.43 -.66 -.21
D	Dressing/Undressing		-1.44
E	Escorting	l - leading p - walking for pleasure	-1.70 .57
F	Feeding		.64
G	Grooming		1.43
H	Housework	i - independently s - socially a - as an activity	-2.50* -.37 none recorded
I	In/out of chair		-.89
K	Kitchen work	i - independently s - socially a - as an activity	-.36 -1.14 none recorded
L	Laundry duties	i - independently s - socially a - as an activity	-2.46* -1.58 -1.00
M	Making beds	i - independently s - socially a - as an activity	1.70 none recorded none recorded
N	Nursing duties		1.30
O	Observing	c - colleague r - resident	none recorded .78
P	Paperwork		-1.13
Q	Quiescent (inactive)		.00
R	Response to challenging behaviours	n - normalising p - person-centred b - behavioural d - distraction m - medical	.93 -.53 1.70 -1.45 none recorded
S	Supervising	c - colleague r - resident	none recorded none recorded
T	Toileting		1.21
U	Unaccountable		.82
V	Verification		-.57
W	Waiting on	i - independently s - socially a - as an activity	.00 .21 none recorded
X	eXits (goes for break)		3.83**
Z	Zero option		1.00

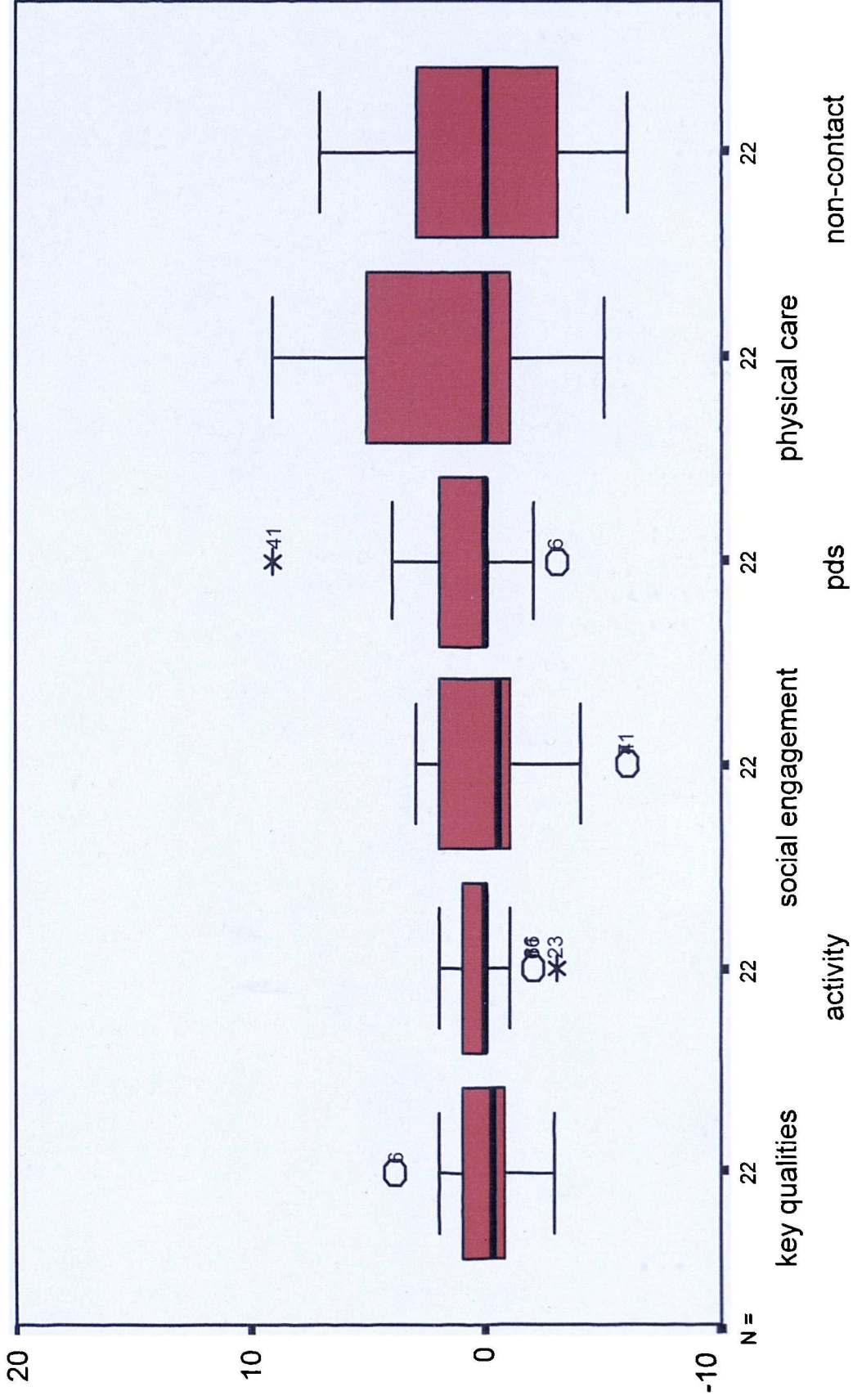
Appendix Nine

	Physical Care Key		
a	attention (individual)		.89
c	choice		-1.11
d	independence encouraged		-2.55*
f	feedback requested		-.70
i	information given		-.65
p	privacy respected		2.50*
s	social interaction		-.81
sp	speed (appropriate pace)		.66

* = significant at the 0.05 level, ** = significant at the 0.01 level (N =23).

Due to the large number of calculations carried out, a stricter criterion for those considered statistically significant is necessary. Therefore only those reaching significance at the 0.001 level would be considered significant.

Boxplots showing outliers on observations



Appendix Eleven

Means and standard deviations used in t-tests of ADQ scores across testing occasions

	Pairs	Mean	Std. dev.
Factor 1 - <i>Hope</i>	T1	24.89	4.18
	T2	26.85	3.36
	T2	26.67	2.71
	T3	28.58	2.50
	T3	28.58	3.82
	T4	28.26	3.81
	T1	24.69	3.79
	T4	27.88	2.78
Factor 2 - <i>Personhood</i>	T1	46.62	.92
	T2	46.12	.78
	T2	45.58	.87
	T3	47.17	1.00
	T3	48.37	.89
	T4	47.79	1.11
	T1	46.63	1.15
	T4	47.44	1.12
Total	T1	73.77	7.44
	T2	75.12	6.13
	T2	74.08	3.29
	T3	77.67	4.46
	T3	78.89	6.32
	T4	78.00	7.22
	T1	73.69	7.33
	T4	77.38	5.46

Appendix Twelve

Means and standard deviations used in t-tests of observation scores across testing occasions

	Pairs	Mean	Std. dev.		Pairs	Mean	Std. dev.
Physical Care	T1	8.12	3.02	Social Engagement	T1	3.48	2.07
	T2	7.30	2.72		T2	5.70	2.02
	T2	5.89	3.12		T2	5.00	1.85
	T3	7.00	2.41		T3	5.17	2.49
	T3	6.58	3.43		T3	6.67	4.01
	T4	8.25	2.44		T4	5.25	1.48
Key Qualities	T1	7.00	1.92	T1	4.44	1.13	Non-contact activity
	T4	8.83	1.44	T4	5.00	1.98	
	T1	3.59	1.01	T1	4.45	1.50	
	T2	4.51	.87	T2	3.50	2.73	
	T2	4.50	.79	T2	3.11	1.65	
	T3	4.37	1.21	T3	4.72	2.12	
Purposeful Activity	T3	4.29	1.23	T3	4.42	1.96	Personal Detractions
	T4	5.14	.26	T4	2.00	2.05	
	T1	3.13	1.06	T1	3.72	1.02	
	T4	4.72	.91	T4	1.92	1.93	
	T1	.53	.67	T1	2.81	1.86	
	T2	.98	1.20	T2	3.28	2.15	
	T2	1.39	1.58	T2	3.06	1.94	
	T3	.89	.82	T3	2.78	2.35	
	T3	.83	.61	T3	3.25	2.88	
	T4	4.25	1.99	T4	1.17	1.13	
	T1	1.06	.95	T1	3.39	1.65	
	T4	3.42	2.16	T4	1.42	.97	