



Student radiographers' attitudes towards the older patient: Six and twelve months post intervention



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ABSTRACT

Purpose: To design and evaluate the effects of an educational intervention on Norwegian student radiographer attitudes towards older people.

Design: A longitudinal study design, using pre-test and post-test data was used to determine student attitudes to older people across their educational tenure. Attitudes were measured using Kogan's attitudes towards older people scale. This paper, the second in the series, reports on the changes in student radiographer attitudes, post an educational intervention and post their first experience of clinical placement.

Results: Although students initially demonstrated significantly improved attitudes towards older people ($p = 0.01$), this significance was not noted at 6 months and 12 months post intervention. In fact average scores reduced to an almost identical level to those found pre-intervention

Conclusion: Whereas an educational intervention can have an initial positive effect on student attitudes towards older people, the experience of clinical placement reduces these initial effects.

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Introduction

It is well documented that the world's population is ageing^{1,2} and in Norway it is estimated that 20% of the population will be aged over 67 by 2060.³ With this decreasing mortality comes an additional burden of increasing morbidity.⁴ However, "[T]he extent to which population ageing is inevitably accompanied by an increased prevalence of chronic disease and disability ... remains controversial".⁵ Andrews cites the work of Fries, who argues that incapacity and invalidity are more often seen in those aged over 85 years and due to this there is a "compression of morbidity" between the later stages of life and death. In 2012 the United Nations reported that "people aged 80 years or over accounts for 14 per cent of the population aged 60 years or over"⁶ (p.1). They proceed to state that the over-80s are the fastest growing segment of the population and as a consequence "... by 2050, 20% of the older population will fall into this age group". Therefore, the growth in this age group and subsequent compression in morbidity has

implications for both health and social care policy.⁷ Whether or not one agrees with the argument that decreasing mortality creates a burden of increased morbidity, it is well documented that some diseases are indeed associated with later life. Vascular and cardiac disorders, cancer, arthritis, osteoporosis and dementia are clear examples thereof.^{8–11}

In Norway, we see that 34% of hospital admissions are patients aged 67 years or older.⁸ This hospitalisation is not without it risks. A number of studies comment on functional decline associated with hospitalisation, a decline that persists even once the original acute complaint has been treated.^{12–14} This decline is, furthermore, associated with nursing home admission and, in some cases, death.^{12,14} Graf¹³ argues that although functional decline is associated with hospitalisation, certain measures can be put in place for its prevention. For example: ambulation programmes, feeding assistance and sensory stimulation.

Central to preventing functional decline in older patients is the body of staff charged with care of these patients.¹³ Prior research, however, has investigated the older person's experiences of hospital care, and found that they were made to feel passive and inferior by staff, which in turn led to feelings of helplessness, isolation and depression.¹⁵ The inquiry at the Mid-Staffordshire trust (UK) in 2009¹⁶ supports this finding, with complaints made

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against staff regarding their unsympathetic moving and handling of clients, their failure to use given names, and also rudeness and hostility. Feeding assistance, as discussed by Graf,¹³ is important for preventing functional decline. Nevertheless, it was reported in the inquiry to be sub-optimal, as were attending to patients' basic needs such as assistance with mobilising to and from the toilet.¹⁶ The passiveness and inferiority felt by older patients as reported in Ekman's study¹⁵ is correspondent with the findings of the mid-Staffordshire inquiry, with patients "characterised by a reluctance to insist on basic care or medication for fear of upsetting the staff".¹⁶ Although there were a number of contributing factors to the poor care patients experienced at Mid-Staffordshire NHS trust, the inquiry is damning with respect to how (a) staff attitudes, (b) poor communication and (c) a general acceptance of poor standards contributed to this.

Mid-Staffordshire was not the first evidence to suggest that practitioners' attitudes towards older patients can be lacking. Research conducted by Lovell¹⁷ in nursing, for example, found a negative attitude towards the older patient. Cozort¹⁸ also reports that there is a general reluctance to work in gerontological care, as it is seen to be boring, labour intensive and related to death and dying. Moreover, elderly patients are seen as frustrating and depressing. In radiography, Fowler¹⁹ demonstrates that radiographers find working with older adults difficult, especially in a busy environment – a view also supported by Kearney.²⁰

It is against this backdrop that the current study was undertaken. We have previously reported on the initial phase of a longitudinal study that was designed to evaluate the impact of an educational intervention on Norwegian student radiographers' attitudes towards older people.²¹ This study, undertaken before students had embarked on the clinical component of their education, revealed that at the start of their training students generally had positive attitudes towards older people. After intervention, however, these positive attitudes increased significantly ($p = 0.01$).

The intervention took place over two days, and consisted of didactic lectures around ageing, pathology and ageing processes, and also role play where the conditions of ageing were simulated using ageing simulation suits (Sakamoto Model M176). The intervention was based on the work of Aday and Campbell²² and Blundell et al.,²³ who found improvements in attitudes towards older patients post intervention. However, we could find few studies that demonstrated the effects of interventions over time and particularly once students have been exposed to clinical placement. This paper reports on student radiographer's attitudes towards older people, six months and twelve months post intervention.

Materials and methods

Participants

At the point of sampling, in 2014, $N = 42$ undergraduate radiography students were registered on the BSc Radiography course at Bergen University College. All agreed to take part in the study, however only $N = 38$ of these completed the training programme. The results from the training programme have been previously reported by Booth and Kada.²¹ As the research progressed a further nine students left the course, therefore $N = 29$ students remained in the study at the terminal point. The mean age of these students was 24.41, (SD 5.67). 72% were female. As students had been given a unique study code, it was possible to remove the nine withdrawals from the initial data. As such, the initial data with these nine individuals removed was analysed using Wilcoxon. Very little difference is noted in the originally reported findings²¹ and those that are reported here.

Measures

Kogan's attitude towards older people scale (KOP)²⁴ has been used consistently throughout the research, i.e. at all four time points allowing direct comparisons to be made. The KOP has been historically employed in gerontological research, and shows high levels of reliability and validity.²¹ The KOP was translated into Norwegian using the translation-back-translation procedure, though as we previously reported,²¹ this is not the first time the KOP has been translated into a Scandinavian language.²⁵ The scale itself is made up of 17 positive statements and 17 negative statements around attitudes towards older people. Students were asked to indicate how strongly they agreed or disagreed with each statement using a seven point Likert scale. Response alternatives include, strongly agree (7), slightly agree (6), agree (5), uncertain (4), disagree (3), slightly disagree (2) and strongly disagree (1). Negative statements are reversed scored when analysed. The total score ranges are from 34 to 238, with a score of 136 indicating a neutral attitude; scores above 136 signify a more positive attitude.²⁴

Procedure

The study followed ethical guidelines for research conducted on students in Norway. Once approval was given from the Dean of the Faculty of Health and Social Sciences, Bergen University College, students were informed of the study. They were informed that although a study code number would be assigned, it would not be used to identify them and anonymity was promised. They were also informed that they could withdraw at any time.

Students completed the KOP at four time points. Six months into the course, prior to embarking on clinical practice and prior to the intervention (pre-test). Students then attended the two-day intervention, and were asked to complete the questionnaire again (post-test). The intervention has been previously described in detail by Booth and Kada.²¹ The first day consisted of didactic lectures, whereas day two involved the use of simulation suits that mimic many of the conditions associated with ageing e.g. muscle fatigue, sight and hearing loss. Both days were designed to dispel many of the myths and stereotypes surrounding older people as discussed by Palmore.²⁹ The interventions were delivered by two experienced radiography lecturers, one of whom has researched extensively in the field of older patients in radiography, the other with a background in research related to patient care in radiography. Six months after this intervention, (therefore 12 months into their training), students completed a questionnaire again, immediately on their return from their first clinical placement. This consisted of 5 weeks nursing experience. Finally they completed a fourth questionnaire 12 months post intervention (therefore 18 months into their training), at this point students had also undertaken their second clinical placement which consisted of 8 weeks in the radiology department.

Data analysis

There were four testing points (pre-test, post-test immediately after intervention, post-test six months and post-test one year after the intervention). Descriptive statistics (frequencies, percentages, means and standard deviations (SD)) were presented for the KOP summary scores for the four testing points. Statistical comparisons were made using the Friedman test to identify if there were any significant differences between the mean scores. The threshold of significance for Friedman test was $p = \leq 0.05$. Differences between two points were carried out by Wilcoxon signed rank test with Bonferroni correction, $p = \leq 0.008$ (0.05/6). Statistical package of

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