NURSES' PERCEPTIONS OF CARING FOR ELDERLY PATIENTS AT UNIVERSITY TEACHING HOSPITAL'S ADULT HOSPITAL AND LEVY MWANAWASA UNIVERSITY TEACHING HOSPITAL: IMPLICATIONS FOR TRAINING

BY

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A Dissertation Submitted to the University of Zambia in Partial Fulfilment for the Requirements of Master of Science Degree in Clinical Nursing.

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Lusaka

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DECLARATION

I **Tracy Sijatwa Muvwimi** declare that *"Nurses' Perceptions of Caring for Elderly Patients: Implications For Training."* is my own piece of work, that it has not been submitted before for any degree or examination in any other university or college, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

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CERTIFICATE OF COMPLETION OF DISSERTATION

I, **Tracy Sijatwa Muvwimi** hereby certify that this dissertation presented for the Degree of Master of Science in Clinical Nursing, is in all entirely the results of my own independent investigations. The various sources to which I am indebted are gratefully acknowledged in the text and in the references.

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CERTIFICATE OF APPROVAL

This dissertation by **Tracy Sijatwa Muvwimi** is approved in partial fulfilment of the requirement for the award of the degree in Master of Science in Clinical Nursing by the University of Zambia.

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ABSTRACT

Nurses are key health professionals involved in the frontline care of patients, including the elderly. The World Health Organization predicted that the proportion of people aged over 60 years will increase from 11% to 22% between 2000 and 2050. Aligned with this increase in the ageing population is a greater demand for nursing care. Nurses' perceptions of working with elderly people is of global interest because of many reported negative perceptions of care and limited number of qualified nurses interested in the field of caring for elderly patients. This study aimed at exploring the nurses' perceptions of caring for elderly patients at Zambia's main referral hospitals, University Teaching Hospital-Adult Hospital and Levy Mwanawasa University Teaching Hospital in Lusaka. The study used a mixed methods approach. Data were obtained from 148 randomly and 18 purposively sampled nursing staffs through a structured interview schedule and Focus Group Discussions respectively. Binary Logistic Regression and content analysis of main themes were used to identify factors associated with perceptions of caring for elderly patients.

Majority of the nurses (81%) had negative perceptions towards care of elderly patients. There was no statistical significance between the social demographic data, knowledge of caring, availability of resources, staffing levels and management support and perceptions of caring for elderly patients despite these reflecting in the obtained data from both the interview schedule results and sentiments from the focus group discussions. This could have been due to a small sample size which was used. The negative perceptions about caring for elderly patients in this study could be associated with the lack of knowledge specific on care of elderly patients, training units and geriatric specific guidelines and infrastructure in Zambia to aid in the adaptation process for nursing staff. Therefore, the nursing curriculum content should be reviewed to include care of elderly patients, infrastructure, staffing and equipment friendly to care of elderly patients should be put in place for these were seen to be essential in improving the nurses' perceptions.

DEDICATION

To my grandmother Mrs Martha Muchindu Siakapoto who has taught me to be human and understand issues of life in so many ways which has seen me where I am today. Thank you “mucembele” life could not have been life without you.

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in all my endeavours throughout this project.

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ACRONYMS

AIHW	Australian Institute of Health and Welfare
AIDS	Acquired Immunodeficiency Syndrome
CDH	Cancer Diseases Hospital
CSO	Central Statistical Office
DHS	Demographic Health Survey
DOH	Department of Health
FGD	Focused Group Discussion
GNC	General Nursing Council of Zambia
HIV	Human Immunodeficiency Virus
HSE	Health Service Executive
MOH	Ministry of Health
NCAOP	National Council on Aging and Older People
OR	Odds Ratio
SHM	Society of Hospital Medicine
SPSS	Statistical Package for Social Sciences
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNZA	University of Zambia
UNZABREC	University of Zambia Biomedical Research Ethics Committee
UTH	University Teaching Hospital
W H O	World Health Organization
ZDHS	Zambia Demographic Health Survey
ZUNO	Zambia Union

CHAPTER ONE: INTRODUCTION

1.1 Background Information

The population of elderly people is increasing in all countries of the World (Horiuchi and Robine, 2005; World Health Organization (WHO), 2006; United Nations (UN), 2007). Elderly population may be defined as those aged 60 years and over (WHO, 2006). On the other hand, Velkoff and Kowal, (2006) argued that this definition of elderly people may not be appropriate for the sub Saharan Africa because life expectancy at birth of 50 years may be akin to life expectancy at birth 65 and over in United States of America.

Globally, there are an estimated 605 million people aged 60 years and above (Anil et al, 2006; Abdulraheem and Abdulrahman, 2008). By 2050, one out of five will be 60 years or older. Velkoff and Kowal, (2006) have however shown that the great majority (two-thirds) of those over 60 years of age live in the developing world; and that the proportion is rising steadily and will reach nearly three-quarters by the 2030s. In the sub-Saharan Africa although the elderly population makes up a small number, the absolute number of elderly people is growing. In 2006 there were 35 million people and it was projected that by 2030 this number will rise to 69 million (Velkoff and Kowal, 2006). However, these figures may be under reported as countries in this region concentrate on issues of more concern in the younger population such as HIV/AIDS at the expense of elderly population.

Zambia may not be classified as an ageing country due to its youthful population, however, population aging process has already been initiated, and the absolute number of people aged 60 years and above is growing tremendously (Mapoma, 2013). According to 2010 census of population and housing, Zambia had estimation of 340,409 elderly people while the Zambia demographic and health survey (2013–14) indicated that more than 3 percent of Zambia's population is aged 60 years and above. With this increasing age, however, it invariably entails some physical deterioration in elderly people increasing the need for basic palliative medical assistance (Crimmins, 2004). This may have an impact on health resources as people in this age group are perceived to require significantly more medical resources and quality nursing care by nurses (Abdulraheem and Abdulrahman, 2008; Hall et al, 2010). Literature found overwhelming cases of negative perceptions and attitudes from the health personnel. Nurses admitted that when elderly people are admitted, they would be heard saying, "There is trouble on bed xxx".

Older people indicated that they have often been turned away and told that they were not sick but were just old. It was also found that sometimes older people are injected with water even when a drug has been purchased for them. The drugs would then be used on a younger patient. Older people also indicated having witnessed hospital staff hitting, slapping, rudely rebuking and pushing patients. Also found, were major problems related to scarcity of resources at the hospitals resulting in older people not being prioritized in treatment and care. For instance, it was found that they would sleep on the floor instead of being provided with beds (Help Age International (HAI), 2001).

In Zambia anecdotal observations revealed neglect, poor quality care and attention given to achieve the desired needs of the elderly. However, it is not clear how the nurses in Zambia perceive caring for the elderly patients. Therefore it has become increasingly important to gain insight and understanding of nurses' perceptions of caring for elderly patients considering that it is from these perceptions that attitudes, ageist behaviors, discrimination and mistreatment of elderly patients may develop. In addition, ageist behaviors, discrimination and mistreatment of elderly patients might compromise the quality of care given to elderly patients. Hence, this study sought to establish what is currently known about nurses' perceptions of caring for elderly patients, how these perceptions may be influenced by nurses' knowledge of caring for elderly patients, knowledge of aging and aging process, availability of resources for care, increased workload against staffing levels and management support.

Elderly people are large consumers of health-care services (Commonwealth Department of Health and Ageing, 2012). This is of particular importance, as older people require more and better integrated health-care services than younger people and often have an extended stay in hospital due to the complexity of their presentation, (Higgins, 2007). Older people often have chronic and complex care needs, resulting in extra burden on an already overcrowded public health system and creating challenges for nurses delivering care.

Elderly patients are perceived as frail, ill, suffering mental deterioration, poor and dependent individuals (Vincent et al, 2001). It is thought that these perceptual sentiments by health workers lead to poor quality of care provided to this group of people and are likely to further reinforce the portrayal of elderly patients as a burden (National Council of Ageing and Older People, 2005a).

Although it is estimated that American nurses spend half of their time at work taking care of elderly patients, little research exists about what influences nurses' feelings about working with this group of people (Wendel et al, 2010). Numerous studies show that nurses' perceptions of working with aged clients are often negative, which results directly in a decreased quality of patient care (Gilhooly 2001; Perry 2005; Arnold-Cathalifaud et al., 2008; Allan and Johnson 2009; McGarry et al., 2009).

Further, Alabaster (2007) highlighted that many nurses find care for elderly patients both difficult and undesirable to provide. A later study by Rees, et al (2009) found that caring for elderly patients confronts nurses with unique ethical issues rarely seen with other patient populations. Ageism as a major source of ethical dilemma has been noted to cause emotional distress that stays with a nurse even after his or her workday is done. This distress which may include feelings of guilt and powerlessness can be severe enough to cause nurses to quit their jobs.

Nurses in particular are in contact with elderly patients at different levels of care but they have negative perceptions about old age which is reflected in their attitudes towards elderly patients (Oyetunde, 2013). Many nurses in acute care settings have had little, if any, specialist education in the care of elderly people and therefore do not understand the extent of their needs. Coupled with the lack of specialist knowledge is the low status of elderly persons cared for in these settings (Oyetunde 2013). Oyetunde's (2013) findings show that, how nurses relate to elderly patients result in negative- care outcomes. An ageing population requires nurses to be fully equipped to care for their specialist needs (Kerridge, 2008; Abendroth and Graven, 2013). This may be enhanced by developing care models focused on population-specific factors as these have a positive impact on nurses' perceptions of their practice environments (Choi et al, 2004; Friese et al, 2008).

Welford (2014) identified key areas for development in gerontological nursing which include methods by which theoretical education is delivered and the quality of clinical placement experiences to increase the knowledge of caring, ageing and the aging process to affect nurses' perception of elderly patients. This is even more pertinent because in some settings elderly patients are not cared for in special wards (geriatric wards) to provide a good learning environment and change of perceptions. Instead, they are mixed with others and nurses may find it difficult to focus their care specifically to this group of patients.

This entails that nurses may not have choice of their working environment as it is with children yet these are all extremes of life span. Nurses may therefore be left feeling coerced into working in an area that is considered either undesirable due to inclusion of a specific age population (Pursey and Luker 1995; McLafferty and Morrison 2004,) or outside their current educational and practical knowledge (McLafferty and Morrison 2004).

McCormack (2001) argues that nurses working with elderly patients require specific competencies. He describes these as listening, negotiating, enabling opportunities and choices, and enabling decision making. This may be part of the education that nurses may need in order to develop positive perceptions toward elderly patients. McCormack and McCance, (2006) further emphasized that nurses' interpersonal skills and commitment to the job can ultimately affect and improve an elderly person's quality of life.

Other researchers also agreed that nurses working with elderly patients should be motivated to take flexible and innovative approaches to care as well as being committed to understanding the person as a whole (Reed et al, 2007; Welford et al, 2010). All are pointing toward nurses developing positive perceptions that would enhance their compassion for elderly patients.

It is against this background that this study is designed to explore nurses' perceptions of caring for elderly patients. This study will also look at nurses' knowledge of aging and aging process to establish whether levels of knowledge influence how they perceive elderly patients.

1.2 Statement of a Problem

Elderly patients are currently perceived to have reduced reservoir of resilience and the ability to rebound after an insult (SHM, 2005; O'Shea, 2014). Their needs are complex and require knowledgeable and competent nurses to provide nursing care (Lumby and Waters 2005; Graf 2006; Boltz et al, 2010; Kim et al 2010). If skilled nursing care is not provided, elderly patients are more likely to be discharged with increased health problems or with a greater likelihood of not returning to their own homes (AIHW 2007). This entails that elderly patient care is a specialty area that needs to be addressed with much greater concern.

However, the above literature from developed countries revealed that nurses have negative perceptions of elderly patients and their knowledge about geriatric care is inadequate. Similarly Oyetunde et al, 2013 asserted that nurses in Africa have negative perceptions of elderly patients which may be attributed to several factors which include lack of gerontological nursing training, lack of clinical placement, negative attitude, diminutive resources, and behavior of the elderly patients themselves. However due to previous small figures of elderly people living in Africa it seems gerontological nursing care has not really been considered (Oyetunde et al, 2013). This may be seen from scarcity of information about elderly patient care and perceptions from the African nurses' perspective.

This situation is similar for Zambia. Currently anecdotal observations showed that the University Teaching Hospital- Adult Hospital and Levy Mwanawasa University Teaching Hospital in Zambia have about 340 nurses working on the general wards where most of the elderly patients may be nursed from but none of these nurses is trained in gerontological nursing and their perceptions regarding this group of people are not clear. According to this table below elderly patients seen in these hospitals are increasing each year.

Table 1.1: Number of elderly patients seen per year

Year	Hospital	Number of elderly patients
2016	UTH-Adult Hospital	523
	Levy Mwanawasa	492
2015	UTH-Adult Hospital	398
	Levy Mwanawasa	379
2014	UTH-Adult Hospital	316
	Levy Mwanawasa	303

*Source: Patient Records: UTH-*Adult Hospital *and Levy Mwanawasa University Teaching Hospital*

With this increasing number, the information about how these nurses perceive caring for elderly patients in Zambia is scarce. There is however, anecdotal reports that nurses in many care facilities in the country have negative attitude towards care of patients in general. Therefore, identifying the nurses' perceptions towards care of elderly patients constitutes the first step in understanding the many facets of interactions between nurses and elderly patients and the quality of care that nurses provide to this group of patients.

Further, the nursing education curricular has very little information on gerontological nursing (General Nursing Council, 2014) to prepare the nursing students who are future nurses to meet the challenges in the care of elderly patients. Yet again anecdotal information from General Nursing Council, Levy Mwanawasa University Teaching Hospital.

Hospital and UTH-Adult Hospital shows that this area of care and nursing is not a specialty area as it is also indicated by lack of hospitals, clinics or wards for clinical placements of nurse students as well as being a working environment for qualified nurses where nurses can begin to develop specific perceptions of elderly patient care. However, this group of patients is seen and cared for in general wards for various medical and surgical problems.

It is for this reason that it has become important to explore the nurses' perceptions of caring for elderly patients and their knowledge of aging and the aging process to understand, predict, and if necessary, to foster the use of critical thinking and professional judgment, necessary in maintaining the quality of care needed by elderly patients. This study will consider the implications for gerontological nursing training.

1.3 Significance of the Study

Recent developments have emphasized the need to focus attention on the way elderly people are perceived so that steps can be taken to reduce negative perceptions and the current mistreatment of elderly people (Welford et al, 2010; Doherty et al, 2011; Murphy and Welford, 2012; Oyetunde, 2013; Liu et al, 2013). The way elderly people are perceived may have implications on how they are treated by nurses. However, the existence and level of nurses' perceptions of ageing and elderly people among nurses in Zambia are unclear. Similar studies were conducted in developed countries where it was observed that negative perceptions were predominant but this information is scarce in Zambia creating a gap that needs to be addressed by conducting this study.

Therefore without an evidence base for the existence and level of perceptions of elderly people and ageing, it may be difficult, if not impossible, to target resources efficiently and effectively to place and promote measures that will help to improve the quality of care that elderly patients need.

The purpose of this study is to provide a foundation for the investigation of this topic in Zambia. The study will contribute to science and body of knowledge in the sense that nurses' perceptions and their knowledge of caring for elderly patients in Zambia will be established. It is also of a notion that preliminary suggestions could be given for how to make geriatric nursing a more positive experience for all involved because the perceptions discussed above may influence the quality of care given to elderly patients.

The results of this study will therefore be used to inform policy to develop strategies that will enhance positive perceptions and reduce negative perceptions among nurses and to increase their knowledge of geriatric care. The strategies may include developing clinics and or wards where elderly patients will be cared for by specialized nurses. Also to urge hospitals to adopt ageing-sensitive principles which imply embedding such principles to ensure that elderly patients receive specialized care throughout their hospital experience, regardless of unit location.

The findings will also help to inform nursing education (the General Nursing Council of Zambia) to reinforce the importance of gerontological content in nursing curriculum, in particular, the way that gerontological education can positively influence nurses' perceptions of elderly patients with a view to influence their perceptions and attitude toward elderly patients.

1.4.0 Research Questions

1. What are nurses' perceptions of caring for elderly patients?
2. What are the nurses' knowledge levels on aging and the aging process in relation to care of elderly patients?
3. Does availability of specialised resources for elderly patients' care at UTH-Adult Hospital and levy Mwanawasa University Teaching Hospital affect nurse's perceptions and knowledge of caring for elderly patients?
4. Is there any management support in care of elderly patients?

1.5.0 Hypotheses

1.5.1 Null Hypothesis

There is no relationship between nurses' knowledge and perceptions towards caring for elderly patients and the quality of care they provide to them.

1.5.2 Alternative Hypothesis

There is a relationship between nurses' knowledge and perceptions towards caring for elderly patients and the quality of care they provide to them.

1.6.0 Research Objectives

1.6.1 Main Objective

To explore nurses' perceptions of caring for elderly patients at UTH-Adult Hospital and levy Mwanawasa University Teaching Hospital

1.6.2 Specific Objectives

1. To determine nurses' perceptions of caring for elderly patients
2. To estimate nurses' knowledge levels on aging and the aging process in relation to care of elderly patients
3. To asses availability of specialised resources for elderly patients' care at UTH-Adult Hospital and levy Mwanawasa University Teaching Hospital that affect nurses perceptions and knowledge of caring for elderly patients
4. To determine the staffing levels of nurses at UTH-Adult Hospital and levy Mwanawasa University Teaching Hospital for adequate care of elderly patients
5. To evaluate management support on care of elderly patients at UTH-Adult Hospital and levy Mwanawasa University Teaching Hospital

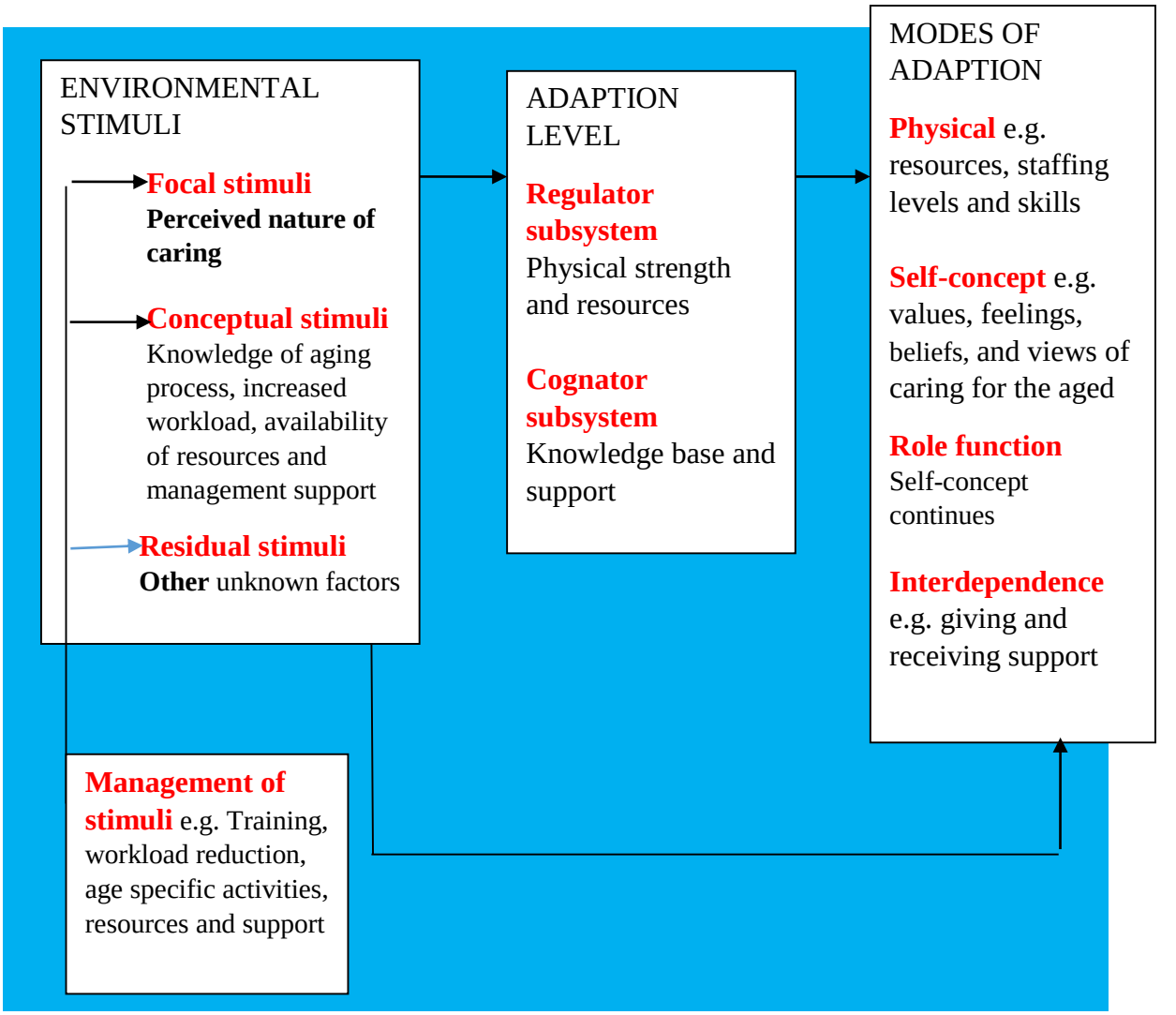
1.7.0 Theoretical Framework

The Roy Adaptation Model provided the theoretical framework for this study. This model was chosen because it facilitated understanding of nurses' perceptions of caring for elderly patients which according to literature are said to be predominantly negative. The Roy adaptation model represents the person as a holistic adaptive system in a constant interaction with the internal and external environment. The main task of the human system is to maintain integrity in the face of environmental stimuli (Phillips, 2010) and the goal of nursing is to foster successful adaptation. Adaptation level is therefore defined as a "changing point that represents the person's ability to respond positively in a situation" (Roy and Andrews, 1991). For the purpose of this study, the subject of the study is the nurse who is described as a holistic adaptive system, and the elderly patient is the recipient of nursing care, who also needs to be helped to adapt well by the nurse. Therefore, the focus of this model will be on the response of the nurse to the constantly changing environment (Fawcett, 2009).

In this environment there are all circumstances and influences surrounding and affecting the development and behavior of nurses towards caring for elderly patients.

These circumstances known as stimuli which include how nurses perceive caring for elderly patients and their knowledge of aging and the aging process, increased workload, availability of resources for care and management support to do things properly may cause constant conflict in the environment.

Figure 1.1: Roy's Adaption Model



Source: Roy's Adaptation Model 2009

The nurses may respond to the environment in effective or ineffective ways. Effective or positive responses are viewed as positive perceptions. The environment has three types of stimulus, for the purpose of this study the focal stimulus is the nurses' perceptions of caring for elderly patients while the contextual stimulus are all factors present in the situation which are believed to affect the way nurses perceive elderly patients.

These include knowledge of aging and the aging process, Knowledge of caring, availability of resources for care, increased workload and management support to facilitate caring for elderly patients. Environmental factors arising from the residual stimuli have unclear effects and nurses may not be aware of how they affect their perceptions. So these three types of stimuli combine to make a nurse's adaptation level.

The adaptation process using this model is categorized as the regulator and cognator subsystems. The regulator subsystem is a basic type of adaptive process and it responds through neural, chemical, endocrine and perception pathways. This information is channeled automatically producing an automatic unconscious response to it. The cognator subsystem responds through four cognitive emotional channels, perceptual and information processing, learning, judgment and emotion. Perceptual and information processing includes activities of selective attention, coding and memory, learning involves imitation, reinforcement and insight. Judgment includes problem solving and decision making.

Defenses are used to seek relief from anxiety and make affective appraisal and attachments through the emotions. The process of perception bridges the two mechanisms.So the regulator-cognator subsystems function to maintain integrated life processes. Despite the nature of the life process, they are all manifested in the behaviors of the individual or group. Behavior is viewed as an output of the human system and takes the form of either positive responses or negative responses (Roy, 2009). These responses serve as feedback to the system with the human system using this information to decide whether to increase or decrease its efforts to cope with the stimuli (Roy, 2009). Therefore, Roy views adaptation both as a process and a product (Lutjens, 1991).

Behavior can be observed in four categories or adaptive modes, physiologic-physical mode, self-concept mode, role function mode and interdependence mode. It is through these modes that responses to and interaction with the environment can be carried out and adaptation can be observed. The underlying need for the physiologic mode is physiologic integrity and for groups (physical mode) is resource adequacy or wholeness achieved by adapting to changes in physical resource needs (Roy 2009). The self-concept mode includes the components of the physical self and moral ethical-spiritual self (the psychic and spiritual integrity) that is the need to know who one is so that one can be or exist with a sense of unity.

It comprises interpersonal relationships, culture and social milieu. The role function mode focuses on the role of the person in society and roles within a group. There is need to know who one is in relation to others so that one will know how to act. The interdependence mode focuses on interactions related to giving and receiving of love, respect and value. There is need for relational integrity for example the significant others and support systems for an individual or member capability for groups should be recognized.

In the adaption level the nurses are expected to employ certain coping mechanisms through the two subsystems, the regulator and the cognator subsystems. In the Regulator subsystem nurses may respond to their Physical status in terms of health such as physical strength to meet the challenges of caring for elderly patients as well as the availability of physical resources to enable care provision and stress management through managerial support and provision of adequate staff to relieve them of huge workloads.

In the Cognator subsystem nurses may attain the adaptation level considering their educational level, knowledge base, source of decision making, power base, degree of openness in the system to input, ability to process the acquired information for the purpose of developing positive perceptions of elderly patients. These processes are happening in all four modes of adaptation.

In the physical mode, nurses are adapting through the adequacy of resources. Resources include the physical structures where elderly patients can be nursed from, staffing levels, materials and equipment necessary for care provision. All these when they are not in place can be stressors which may affect the physiological mode negatively and impair nurses' perceptions and quality of care.

On the other hand the self-concept mode constitutes nurses views of themselves in terms of meeting caring goals and assisting the elderly patients to meet their own goals, the extent to which they see themselves as self-directed as well as the values and the degree of understanding their responsibilities towards the care of this group of people, all these enshrined in scientific, socially and culturally acceptable manner. The nurses begin to understand themselves so that they can understand elderly patients and provide the required nursing care to alleviate their problems. In the functional mode, change of self-concept continues as nurses continue to describe their role in care of elderly patients.

They are also striving to understand the elderly patients and their environment in order to provide the needed care considering how care decisions are arrived at. In the interdependence mode, the nurses will look at the extent to which elderly patients are incorporated into their own care as well as the involvement of support systems and the significant others. There is also the need to be open to information, willingness to work with other disciplines within the care system as well as maintaining good working relationship among themselves.

The goal is promotion of adaptation in each of the four modes. The nurse, by understanding her own beliefs and perceptions about aging and the aging process, can make more objective assessments and can intervene more effectively to provide quality care for elderly patients thereby promoting elderly patients' effective adaptation.

1.8.0 Conceptual Definitions

The following conceptual definitions were used in this study:

1.8.1 An elderly person

An elderly person is defined as a person who is 60 years of age and above

1.8.2 Knowledge

Knowledge is the information, understanding and skill one gains through education and experience

1.8.3 Perception

Perceptions consist of the process whereby people take in information about others, understand it and form impressions of them. Our perceptions of other people influence and reflect our thoughts, feelings and actions. Some commonly used terms representing or relating to perceptions include attitude and beliefs

1.8.4 Gerontological Nursing

Gerontological nursing involves the care of aging people and emphasizes the promotion of a high quality of life and wellness

1.8.5 Quality elderly patient care

Quality elderly patient care has been defined as aging-sensitive, evidence-based, individualized care that promotes informed decision-making and is continuous across settings

1.8.6 Age discrimination

Age discrimination is treating people in some unjustly negative manner because of their chronological age or their appearance of age and for no other reason

1.8.7 Ageism

Ageism is defined as stereotyping and discrimination against people because they are old.

1.8.8 Aging

Aging is an inevitable and steady progressive process that begins at conception and continues through-out the remainder of life

1.9.0 Operational Definitions

1.9.1 An elderly person

An elderly person is one who has advanced chronological age of 60 years and above

1.9.2 Knowledge

Knowledge of caring for elderly patients this is the information and skill that nurses have to enable them care for elderly patients

1.9.3 Perceptions

Perceptions of caring for elderly patients are views, feelings or thoughts held by nurses which may be positive or negative and influence their behavior towards care of elderly patients

1.9.4 Quality elderly patient care

Quality elderly patient care**,** this is the acceptable care by society which promotes independence and wellness of elderly patients

1.9.5 Availability of resources for care

Availability of resources for care of elderly patients describe a status of not having or having materials and equipment, wards, hospitals, clinics among others designed and intended for use in the care of elderly patients.

1.9.6 Management support

These are arranged or planned activities put in place by authority to enhance the care of elderly patients for the purpose of developing or maintaining positive perceptions of elderly patients. These may include strategies that are specific and sensitive to the care of elderly patients in care institutions and acknowledging personal effort in caring for elderly patient.

1.9.7 Staffing Levels

Staffing levels these are numbers of nurses available to care for elderly nurses at the UTH-Adult Hospital and levy Mwanawasa University Teaching Hospital.

1.9.8 Aging process

Aging process is the progression of events in the aging person's life leading to diminishing of his or her functioning ability and death.

1.10.0 Variables and Cut-Off Points

A variable is a property or characteristics of persons, things or situations that change or vary and are manipulated, measured or controlled in research (Burns and Grove, 2005). This research consists of one dependent and four independent variables.

A dependent variable is the response, behavior or outcome that the researcher wants to predict or explain (Burns and Grove, 2005) while an independent variable is a stimulus or activity that is manipulated or varied by the researcher to create an effect on the dependent variable (Burns and Grove, 2005).

1.10.1 Dependent Variables

Nurses' perceptions of caring for elderly patients

1.10.2 Independent Variables

The following are the independent variables

- Knowledge of caring for elderly patients
- Availability of specialized resources for care
- Staff levels
- Management support

Table 1.2: Variables and cut off points

VARIABLES	CUT OFF POINTS	INDICATORS	SCORE	QUESTION NUMBER
DEPENDENT VARIABLE				
Perceptions of caring for elderly patients	Positive	Ability to accept elderly patients and treat them as patients who need their services and offer these services as required according to the presenting problems without attributing them to their age as necessary	29 – 56	6 – 19
	Negative	If respondent has no interest at all in these patients, does not consider giving quality care because of their age and regards them as a problem or difficult.	1 - 28	
INDEPENDENT VARIABLES				
Knowledge of caring, aging and the aging process	Adequate	Shows understanding that aging is a normal physiological process which comes with many medical needs which are different from one individual to another in terms of onset and intensity and that not all medical problems faced by elderly patients are due to old age	26 - 40	20 – 39
	Inadequate	Shows some understanding that aging is normal and these people have several problems which are all absolutely attributed to their age and treating them is somehow waste of resources	1 – 25	
Availability of geriatric	Adequate	Ability to acknowledge that the resources are available which may include; infrastructure, staff, information, support from relevant authority, training and workshops	9 – 16	40 – 43

resources for care	Inadequate	If the resources are not there to meet the requirements of the users, both nurses and the elderly patients	1 – 8	
Staffing levels	Adequate	Having both specialized and non-specialized nurses to meet the demands of elderly patient care	9 – 16	44 – 47
	Inadequate	Not having enough nurses to meet demands of caring for elderly patients	1 -8	
Management support	Adequate	Having strategies that are specific and sensitive to the care of elderly patients in care institutions and acknowledging personal effort of nurses in caring for elderly patients by institution management	9 – 16	48 – 51
	Inadequate	Not having strategies that are specific and sensitive to the care of elderly patients in care institutions and acknowledging personal effort of nurses in caring for elderly patients by institution management	1 – 8	

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Literature review is an organized written presentation of what has been published on a topic by scholars and it includes a representation of research conducted in a selected field of study. It refers to extensive, exhaustive and systematic examination of publications relevant to the research project (Burns and Groove, 2005). The purposes for analyzing or reviewing existing literature are to generate research questions, to identify what is known and not known about a particular research problem or situation. In short literature review conveys to the reader what is currently known regarding the topic of interest (Burns & Grove, 2005).

In this study literature review is intended to help to determine what is known about nurses' perceptions of caring for elderly patients. The reviewed literature was drawn from various publications accessed from internet and other sources. An advanced search was performed using the words 'perception', and 'elderly'. Only clinical research articles that stated within the objective to explore nurses' perceptions of caring for elderly patients were evaluated and selected for inclusion in the study.

2.2 Perceptions of nurses on elderly patients

Care of older adults occurs in a cultural context in which the elderly in society are poorly valued. Although the concept of ageism is not fully understood. Levin and Levin (1980) suggest the term alludes to stereotypes or beliefs toward elderly people that categorize them, or attribute characteristics to them, that are not necessarily based on certain evidence. Elderly people have reported experiences of others making assumptions about their levels of illness and frailty based solely on their age, rather than on knowledge of them as individuals (Jansen and Morse, 2004). Ageist perceptions may lead to discrimination and mistreatment of elderly patients. Perceptions of elderly people are influenced by a variety of factors, including the amount of gerontological knowledge nurses possess (Baumbusch and Goldenberg, 2000), the environment in which nurses work and the workload nurses experience in diverse practice settings (McLafferty and Morrison, 2004). There are also societal views held by nurses that add to the way they perceive their elderly patients which may enhance the positive or negative treatment outcomes. Perceptions of elderly

patients, at both individual and societal level can vary widely (Kite et al. 2005; Narayan 2008). Perceptions that have been reported are multi-dimensional in nature (Kite et al. 2005). In other words, ambivalent findings regarding perceptions of elderly people and ageing are indicative of the fact that most people tend to rate old age positively on some dimensions whilst rating it negatively on others (Williams et al. 2007; Gilbert and Ricketts 2008).

Whether elderly people are perceived positively or negatively is often dependent on the different dimensions they are being perceived on for instance physical appearance, health, and adaptability among others. Further, it is likely that people do not have fixed positive or fixed negative perceptions of old age, but rather they have different views of the many and varied features of ageing and elderly people.

Ageism in health, among nurses in particular may occur because health problems in elderly people are believed to be 'normal aspects of ageing' (NCAOP 2005b). Thus, it is deemed acceptable for elderly people to suffer from many illnesses without adequate care. Furthermore, society believes elderly people practice witchcraft hence there is no need for them to live (Chirwa and Kalinda 2016; Nhongo, 2006). Young ones fear the elderly people because they believe red eyes and talking to themselves is a sign of witchcraft. It is happening in many African countries where witchcraft accusations may lead to death of elderly people especially women or they flee from their homes to seek refuge elsewhere (Chirwa and Kalinda 2016; Nhongo, 2006). Society also neglects elderly people because they believe they are a financial burden (Mapoma 2013) and wishes death upon them to relieve themselves.

Many of the negative perceptions about the elderly patients tend to be reported by younger age groups (Kite et al. 2005; Woolf 2006; Cottle and Glover 2007). They wish these elderly patients should perform at their pace. Also the younger ones because of the witchcraft that is attributed to elderly people coupled with their appearance they tend to dislike or fear them (Cottle and Glover 2007). However the young ones who have been exposed to well elderly people at one point or another tend show positive perceptions of elderly people.

Generally, there has been a tendency among nurses to stereotype elderly people as frail, passive, dependent and incapable of making decisions (NCAOP 2005b).

This has been evidenced in practice where healthcare staffs have been known to speak to families of elderly patients regarding their conditions and care without consulting the elderly patients themselves (NCAOP 2005b). Elderly patients have further experienced prejudicial attitudes in acute care settings such as being referred to as 'bed-blockers' meaning they are taking space for younger patients who usually have shorter admission periods (NCAOP 2005b).

It is believed that, elderly patients have more diagnostic tests, and higher admission rates than younger cohorts (Banerjee, Dehnadi et al., 2011; National Ambulatory Care Reporting System [NACRS], 2012). Higher rates of readmission (McCusker et al., 2003) and functional loss and mortality rates (Sklar et al., 2007) which are in part due to the higher prevalence of chronic diseases and their susceptibility to frequent exacerbations of these conditions (Salvi et al., 2007; Samaras et al, 2010). They have more complex presentation of disease and illness than younger people due to atypical presentations coupled with higher incidence of multiple comorbidities, polypharmacy, functional impairments (Schnitker, et al., 2011), communication problems, and cognitive impairment (Press et al., 2009; Salvi et al., 2007). There are also concerns about pain management (Hwang et al., 2010) and inadequate information sharing (Baillie, 2005; George et al., 2006). These factors lead to negative perceptions of this group of patients as they increase the nurses' workload.

Nurses perceive elderly patients to often have more care needs than younger patients which can make it increasingly difficult to provide quality care (Doherty et al., 2011). This is because of their advanced age that may lead them to suffer from debilitating diseases and cognitive impairment (Doherty et al., 2011). They often manifest with dementia behaviors and frequently have communication problems, making it difficult for nurses to identify their needs (Morgan et al., 2002, Cocco et al., 2003). This explains the reasons for nurses' preference to care for younger patients with acute illnesses that are curable compared to elderly patients (Nay and Garratt, 2004). Vlachos, (2012) also noted that life is generally much slower with elderly patients such that nurses spend more time performing care activities than it is with younger patients.

In addition elderly patients' high dependency which results in performing care activities all the time makes nurses to view this area of care negatively. One would have expected this to have changed with the development of individual patient-centered care and public awareness of the aging process, but this is not the case (Wells et al., 2004; Doherty et al., 2011; Murphy and Welford, 2012; Liu et al., 2013).

For example, elderly people are stereotyped as having poor health with diminishing mental ability, negative personality traits, unhappy, and lonely (Arnold-Cathalifaud et al., 2008; Musaiger and D'Souza 2009). However, it is felt that these views build attitudes in nurses. True as these may be elderly people are individuals and may not be the same or undergo problems in the similar manner or at the same time just like their younger counterparts.

The elderly are also perceived as passive, frustrating, boring, fragile, depressed, lonely and useless (Aud et al., 2006). They are also categorized as senile, rigid in thought and manner, old-fashioned in morality and skills by younger people. Butler (1993) further stated that ageism allows the younger generation to see the elderly people as different from themselves; thus they subtly cease to identify with their elders as human beings. Perceptions of elderly people may also be the result of cultural influence and may contribute to favorable and unfavorable reaction toward them (Katz, 1991).

McGuire et al, (2008) used the Ageism Survey (Palmore, 2001) to measure the frequency and occurrence of ageism. The study examined the types of ageism reported by older adults in the East Tennessee region of the United States. Sixty two percent of participants reported that they were told a joke that ridiculed elderly people. The author further stated that, 51.4% of the participants indicated they were sent a birthday card that poked fun at older people, 40% of participants reported being ignored or not taken seriously patronized or 'talked down to' because of their age. In addition, 22.8% of the participants recorded that they were treated with less dignity and respect because of their age. The literature above showing that the ill health of elderly people makes nurses to perceive them negatively and would not want to take care of them like they would do to other categories of patients. Nevertheless, decisions about treatment and healthcare should be made on the basis of each individual's clinical needs, overall health status, ability to benefit from treatment, and their personal wishes, rather than basing decisions solely on a patient's age.

Furthermore, studies have also found that working with elderly patients among nurses is amongst the lowest preference career choice (Kaempfer et al., 2002; Weiss 2005; Lee et al., 2008). This is because caring for elderly patients is often perceived basic, unchallenging and unrewarding based on the commonly held perception that elderly patients do not get better and therefore work in this area is of limited value (Brown et al., 2008). Similarly, NCAOP, (2005b) revealed that nurses felt that there was little opportunity for career development within the care of elderly patients.

Working with children or in areas perceived as more technical such as acute care settings tend to be preferred as they are considered more worthwhile, more exciting and dynamic as they result in observable and useful outcomes (Happell 2002).

On the contrary, it has also been revealed that elderly people are sometimes perceived in a positive light, as active members of the community, loyal, sociable and warm, sincere, kind, and motherly (Cuddy et al., 2005; Barrett and Cantwell 2007). Similarly, Davidovic et al. (2007) highlighted that most of the nurses had positive perceptions in the sense that many remarked that old age was not unattractive if a person is in good health, or stated that it depended on the person themselves and his or her own attitude. This in itself denotes the complexities inherent in perceptions held of elderly people. Another study found that almost 40% of the nurses surveyed do enjoy working with this population (Wells et al., 2004). Positive perceptions about aging promote longevity and healthy aging (McGuire et al., 2008). According to Higgins et al. (2007), nurses hold negative views about old age which are reflected in their attitudes.

However, ageist perceptions are not the sole factors that may contribute to elder abuse but may give rise to a culture which creates fertile environments in which elder abuse can develop, leading to age discrimination, devaluing and disempowering elderly people who come to seek care in health facilities (HSE, 2009). Perceptions may further impact on the formulation and implementation of health policies affecting the elderly people (Arnold-Cathalifaud et al., 2008; Musaiger & D'Souza 2009). For example, as people age, their need for day-to-day support and need for healthcare are likely to increase (Boltz et al., 2011). However, perceptions held by nurses toward elderly patients can impact on the quality of care and the general treatment of elderly patients under their care. According to Zhou. (2007), good quality care services and healthy relationships with elderly people are necessary, but are unlikely if the nurses' views of elderly people are negative.

Most of the revealed literature has uncovered that nurses have negative perceptions of elderly patients which spills over to the way they deliver their services to them. A few studies however showed positive perceptions which entails light at the end of the tunnel for this special group of people.

2.3 Knowledge of caring for elderly patients

Caring for elderly patients requires specialized nursing knowledge and expertise (Plonczynski et al., 2007). However, many nurses lack the appropriate knowledge, assessment protocols, or time at the bedside to adequately assess elderly patients and their presenting health conditions (Fick and Foreman, 2000; Foreman et al., 2001). Without focused elderly knowledge and expertise, nurses are unable to develop appropriate care plans. This is evident in such things as the limited understanding many nurses possess related to the elderly patients' need for extended recovery times when facing acute illness. In a hectic work environment, nurses inadvertently may view older adults as no longer acutely ill and resort to the use of objectifying labels, such as alternative level of care or bed blockers (McLafferty and Morrison, 2004;). Without focused gerontological knowledge, some nurses demonstrate a reluctance to care for dependent older adults, perceiving them as "cantankerous and complaining" (Gallagher et al., 2006).

The most important factor identified as influencing nurses' perceptions of elderly patient care is the nurse's level of knowledge of ageing and the aging process (Halroyd et al. 2009). Mahanil et al. (2008) established that there is knowledge deficit among nurses regarding aging process and normal changes of aging. They lack knowledge of how elderly patients differ from their younger counterparts in symptom presentation and potential complications. Some nurses do not realize that elderly patients experience particular illnesses differently from their younger counterparts, such as myocardial infarctions, pneumonia, drug interactions, and depression (Robinson and Mercer, 2007). Cognitive impairment may complicate the assessment of pain, resulting in nurses feeling uncertain about their assessments and reluctant to administer pain medication (Barry et al., 2012) and may also impede end of life care (Robbinson et al. 2014).

Further, health related challenges arising from hospitalization are often not recognized and addressed by nurses. For instance, hospitalization often results in a functional decline in elderly patients, and yet many nurses lack knowledge of preventing and treating deconditioning (Cheng et al., 2012; Laoingco and Kamau, 2013) as well as delirium, a frequent and potentially life threatening condition experienced by hospitalized elderly patients, they fail to recognize it (Rice et al., 2011; Christensen, 2014). Furthermore, the negative stereotyping and prejudicial perceptions may result in elderly patients being inadequately assessed and thus being omitted from services most appropriate to their needs (Department of Health (DoH) 2001; NCAOP 2005b).

For example, concerns have been expressed as to whether elderly patients are more likely to be denied cardiopulmonary resuscitation on the grounds of age (DoH 2001). Similarly, several studies have suggested that mental health disorders in elderly patients are often under-diagnosed, misdiagnosed and under-treated (Ólafsdóttir et al., 2004; Jeste et al., 2005; Vink et al., 2008). Inadequate assessment, service rationing and inappropriate or delayed treatment can mean that elderly patients become unnecessarily dependent on outside help (NCAOP 2005b). Literature reveals that the more dependent older adults are on receiving nursing care, the more likely it is for nurses to project a negative attitude (McLafferty and Morrison, 2004).

When health care environments do not offer effective models of care structured to the needs of an aging population, nurses succumb to socializing forces that actually may reinforce ageist perceptions. This would include the belief that elderly care does not require complex knowledge and understanding (Plonczynski et al., 2007). Unfortunately, when nurses do not receive adequate educational support, they face learning about the complex needs of elderly patients in a predominantly chaotic work environment (Dahlke and Phinney, 2008; McLafferty and Morrison, 2004). New graduates find themselves learning about elderly patients from nurses on the job, most of whom have little or no focused gerontological education (Lange et al., 2006).

Such knowledge deficit may be rectified through formal and continuing education which may, increase nurses' understanding of aged people's needs. Otherwise, elderly people in long- term care centers would be in danger of being victims of inaccurate nursing care. This is consistent with (Deasey et al., 2014) who asserted that nurses' knowledge about the ageing processes may affect therapeutic interactions between nurses and their elderly patients. This was attributed to their past experiences and gerontological education. Deasey et al. (2014) further alleged that awareness or knowledge of gerontological nursing would contribute to achieving desired cultural change in nurses.

2.4 Availability of Geriatric resources for care

Chang et al. (2007) found that evidence based nursing practices framed by models of care that addressed functional needs, enhanced elderly patients' satisfaction, and health outcomes. On the other hand, nursing decisions made about the amount and type of care required by elderly patients in health facilities can be constrained by economic rationalist policies. For example, chronic underfunding and low priority given to the development of services for elderly people is considered to profoundly influence how healthcare workers perceive working with elderly patients (Kite et al,. 2005; Narayan, 2008). This is coupled by insufficient staffing and lack of geriatric nursing knowledge and skill which results in a loss of quality care required by debilitated elderly patients and can lead to adverse events and even death (Mion, 2003; Chang et al. 2007; Laoingco & Kamau, 2013).

While the global picture shows availability of geriatric resources for care, Oyetunde, (2013) revealed that these resources are scarce in low income settings. Resources include appropriate staffing, availability of equipment and services specific to the needs of elderly patients and management support in communicating with elderly patients and families (Boltz et al. 2013). Life through the Eyes of the Elderly in Zambia, (2003) found that out of the nine (9) old people homes in Zambia, only two (2), namely, Mitanda and St. Therese's Village had health facilities and medical personnel specifically for the aged and located within their premises. The rest of the homes had to take residents who fell ill to clinics and hospitals in the surrounding communities. In some cases, the aged had to endure long queues and slow service, which was not good for their health status. This finding is consistent with Ndonyo (2011) who indicated that residents in old people's homes in Zambia had no provision for medical support staff such as nurses, attached to them.

This shows the short comings imbedded in the way health care resources are distributed. It is clear that geriatric resources for care may be of less priority which may influence how nurses perceive this group of people.

2.5 Staffing Levels

Acute care protocols that are poorly suited for chronically ill elderly patients persist in the health care environment. These inadequate models of patient care result in extreme workload pressures for nurses who work in a health care environment where overcapacity is commonplace. Compounding this situation even further is the failure within the care organizations to recognize the complex nature of elderly patient care. It may also be true that negative perceptions add to the nurses' workload as fear of hospitalization attributed to such remarks may reduce the functional ability of the elderly patients. On the other hand availability of suitably qualified staff with an interest in working with elderly patients and the quality of health care currently available to elderly patients raises concerns globally (Happell 2002; Brown et al. 2008). Aiken and associates (2001) surveyed nurses in five countries and found that nurses consistently reported perceived hospital nurse staffing levels that were inadequate to provide safe care, leading to increased pressure to accomplish work, need for overtime, and stress-related illnesses.

2.6 Management Support

Leadership permeates all aspects of care, with a lack of leadership resulting in fragmented, task-based approaches to the care of elderly patients quality of care is reduced (Forbes-Thompson & Gessert, 2005; Swagerty et al., 2005). Geriatric experts in a variety of disciplines have developed best practices for the care of elderly patients based on research (American Association of Colleges of Nursing, 2004; Agency for Healthcare Research and Quality, 2006; American Geriatrics Society 2006). However, while nurses strive to provide the best quality geriatric care, there is little evidence that these guidelines are used in daily care of elderly patients (Mezey et al., 2004). Nurses consider institutional practices that support the use of evidence-based policies and guidelines with adequate and appropriate resources, administrative commitment and support of specialized geriatric nursing knowledge and skills as essential to quality geriatric care (Mezey et al., 2004, Murphy 2007a, b, Boltz et al., 2008a, Boltz et al., 2012, Boltz et al., 2013).

Encouragement and praise for achievement are essential to the success of this leadership style, and can help to gain trust and respect from staff, thereby improving motivation and morale. However, research showed that nurses do not receive feedback on their scores and they are not aware that they could and even should use these data to monitor and improve the quality of their work (Kieft, 2014).

This shows that efforts may not be recognized by management or may be recognized but there is no much effort made by management to increase the nurses' effort both in knowledge base and physical work provided to the elderly people. One of the core management roles is to ensure staffing levels and knowledge bases (skill mix) are allocated appropriately to ensure provision of best practice which may not be the case. It is important for managers to understand that nurses with appropriate knowledge and skills in gerontology will maximize benefits to both the patient and the institution.

2.7 Summary

This review identified and brought forth the perceptions held by nurses towards elderly people and the factors which influence such perceptions such as the knowledge of caring for elderly patients, aging and the aging process, issues within management support, increased workload and nursing staff shortages. It highlighted how these factors influences nurses' perceptions of caring for elderly people and how together can have a significant negative impact on the lives of elderly people. Most of the literature demonstrated negative perceptions that are held by nurses and underpinned the associated attitudes to lack of adequate gerontological nursing education.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter discusses the research design, the study setting, population, ethical consideration and sampling methods which were used to answer the research questions. The data collection tools, data collection technique and data analysis methods, validity and reliability, pre-test was also be stated. It was aimed to guide the researcher to do things in a careful, systematic and logical way. This study was exploring the nurses' perceptions of caring for elderly patients at University Teaching Hospital's Adult Hospital and Levy Mwanawasa University Teaching Hospital.

3.2 Research Design

A mixed methods approach was used in this study. A mixed methods research design involves the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the integration of the data at one or more stages in the process of research (Creswell et al., 2003). Thus quantitative and qualitative methods were undertaken concurrently, employing a convergent parallel design. Meaning, the two strands were independent at data collection and analysis but merged at interpretation of findings. In this case, the qualitative results provided the content analysis that explains the quantitative findings (Johnson and Onwuegbuzie, 2004).

The quantitative approach is a method of research used to quantify the problem by way of generating numerical data or data that can be transformed into useable statistics. It is used to quantify attitudes, opinions, behaviours, and other defined variables and generalize results from a larger sample population (Wyse, 2011). On the other hand, the qualitative approach is used to uncover trends in thought and opinions, and dive deeper into the problem (Wyse, 2011).

3.3 Research Setting

The research setting is the physical location and conditions in which data collection takes place (Polit and Beck, 2014). This study was conducted at the University Teaching Hospital (UTH) – Adult Hospital and Levy Mwanawasa Teaching Hospital in the surgical and medical units/wards. These hospitals are located in Lusaka the capital city of Zambia. The university teaching hospital is the nation's referral hospital where all types of patients go for specialist treatment while Levy Mwanawasa Teaching Hospital is a provincial referral hospital.

These hospitals were chosen because elderly patients are seen and may be admitted and be nursed in the wards and units of these hospitals frequently and may be for longer periods.

3.3 Population

A population is the entire aggregation of cases in which a researcher is interested (Polit and Beck, 2003). The study population in this study included all the nurses who worked in the medical and surgical wards of the University Teaching Hospital's Adult Hospital and Levy Mwanawasa University Teaching Hospital when the study was being conducted.

3.3.1 Study Population

The study population was all the nurses working in the medical surgical wards for three months in which they were expected to have nursed elderly patients. Generalizations of the study was made from this group of nurses. The total number of nurses in these wards at the time of the study was three hundred and forty (340).

3.3.2 Accessible Population

The accessible population included all nurses who had worked for three months in the medical and surgical wards of the University Teaching Hospital's Adult Hospital and Levy Mwanawasa University Teaching Hospital at the time of the study. Those who were available at the time of the study and met the designated criteria which also represented the study population as much as possible (Fain, 2009). These nurses were able to provide necessary information on the nurses' perceptions and knowledge of caring for elderly patients.

3.4 Sample Selection

Sample selection is the process of selecting subjects, objects, or elements for a study in such a way that these subjects, objects, or elements represent the larger group from which they were selected (Fain 2009).

The University Teaching Hospital's Adult Hospital and Levy Mwanawasa University Teaching Hospital had a total population of one thousand three hundred and twenty (1320) nurses with three hundred and fourty (340) nurses working in the medical and surgical wards at the time of the study.

The University Teaching Hospital's Adult Hospital and Levy Mwanawasa University Teaching Hospital were selected to be the study sites for this study because according to anecdotal reports from Zambia Union of Nurses Organization (ZUNO) show that UTH has a largest number of nurses among all the hospitals, being a national referral hospital, elderly patients from all provinces with different social cultural background are nursed in this hospital. This enriched the study as nurses had a feel of caring and making comparisons between elderly patients from totally different backgrounds. This is similar for Levy Mwanawasa University Teaching Hospital which is a provincial referral hospital in the capital city where people from all provinces are found and may seek medical care from this hospital.

The following methods were used for sampling participants;

3.4.1 Quantitative Method

Probability sampling using stratified random sampling method was used to identify subgroups in the population that were represented in the sample (Fain, 2009). This was done by grouping the nurses according to their homogenous population based on their level of nursing training that is; enrolled nurses, registered nurses and those with the Bachelor of Science degree in nursing from the accessible population. This ensured to have adequate representation from all groups of nurses in the study who had the opportunity to provide information that helped to identify the nurses' perceptions and knowledge of caring for elderly patients.

Thereafter, the selection of the specific sample was done within the groups randomly for equal opportunity of participating in the study. In each duty shift, nurses were selected using simple random method in order to allow each nurse to take part in the study which enhanced fairness and reduced biasness.

Quantitative data was collected from UTH – Adult Hospital which had a total number of 240 nurses in the medical surgical wards. Therefore, the proportion was according to the total number of nurses as outlined in the sample size below.

3.4.2 Qualitative Sampling

Purposive, also known as judgmental or theoretical sampling was used. It is a type of non-probability sampling in which the researcher "hand-picks" or selects certain cases to be in the study (Fain, 2009).

These participants were selected from the nurses who were found working in the medical surgical wards of Levy Mwanawasa University Teaching Hospital to participate in the focus group discussions. Nurses who were found on duty and met the inclusion criteria were invited to participate in the study. The participants were expected to have nursed a number of elderly patients for a reasonable period of time which facilitated collection of data on nurses' experiences and how they adapted to caring for elderly patients.

Purposive sampling was also used to sample the study sites. These sites had the adequate study population for the study with an advantage of elderly patients being nursed in these hospitals coming from different social cultural background around the country giving nurses adequate experience about their care.

3.4.3 Inclusion Criteria

By confirming specific criteria that defined who would be eligible to participate in the study Polit & Beck (2008) believed individuals who are selected should be good examples of the desired population. The following were included in the study as they met the inclusion criteria set by the researcher.

1. All nurses aged 18 years and above who have been working in medical and surgical wards for a minimum period of three months at the time of the study

2. The nurses who were available at the time of the study and were willing to participate

3.4.4 Exclusion Criteria

Nurses who did not meet the inclusion criteria set by the researcher were excluded from the study. Practically, the following were excluded:

1. All nurses who were not willing to participate and did not give consent.
2. Those nurses who worked in medical surgical wards for less than three (3) months
3. Nurses who did not fall in the category of enrolled nurses, registered nurses or holder of a bachelor of nursing science degree.
4. Nurses from other wards who were doing part-time at the time of the study

3.4.5 Sample Size Determination

Sample size is the number of participants in a sample, (Khadam and Bhalerao, 2010).

3.4.5.1 Quantitative Method Sample Size

The sample size was calculated manually using a formula (Krejcie and Morga, 1970) for determining sample size. The total population for nurses working in the medical and surgical wards was two hundred and forty (240).

Formula:

$S = \frac{x^2 NP(1-P)}{d^2(N-1)}$, *Where:*

- ✓ *S = the required sample size*
- ✓ *N = Population size*
- ✓ *X = Z value (e.g. 1.96 for 95% confident level)*
- ✓ *P = Population proportion (expressed as decimal) (assumed to be 0.5(50%)*
- ✓ *d= Degree of accuracy (5%) expressed as a proportion (0.05); it is the margin of error*

$Therefore, Sample\ size = \frac{x^2 NP(1-P)}{d^2(N-1)} = \frac{1.96^2 * 240 * 0.5(1-0.5)}{0.05^2(240-1)} = 148$

A total of 148 respondents were enrolled proportionally to the number of nurses of each nursing qualification category using the following formula:

$Number\ of\ Respondents\ per\ Category = \frac{K}{N} * S.$

$where\ K = the\ number\ of\ nurses\ per\ qualification\ category,$

$N = total\ population, and$

$S = overall\ sample\ size$

Table 3.1: Number of Study Participants per professional Qualification

	Nurse Population	Formula	Sample Size
Enrolled Nurses	95	95/240*148	59
Registered Nurses	135	135/240*148	83
BSc. Nurses	10	10/240*148	6
Total	**240**		**148**

Therefore, a total of 59 enrolled nurses, 83 registered nurses and 6 Bachelor of Science in nursing degree holders were enrolled for quantitative data. This promoted adequate representation from all groups.

3.4.5.2 Qualitative Method Sample Size

The sample size for qualitative data was based on reaching data saturation. Polit & Beck (2008) noted that there are no rules for sample size in qualitative research. Sample size should be based on information needed. Hence, a guiding principle in sampling is data saturation, identified when each new interviewee adds no new information and redundancy is reached.

In this regard three FGDs of six (6) participants each were enough to get the information required. They were grouped according to the level of nursing qualification to ensure those with similar characteristics were together. Therefore, a total of 18 nurses were enrolled for qualitative data collection. Group one consisted of enrolled nurses, group two were registered nurses and group three were nurses who hold a degree in nursing sciences.

3.5 **Data Collection Tools**

A data collection tool is an instrument or device used in gathering information needed to address a research problem. It may take the form of a questionnaire or an interview schedule among others (Polit and Beck, 2014). Two data collection tools were used for this study to collect the quantitative data and qualitative data.

3.5.1 Quantitative Tool - Structured interview schedule

In this study, a structured interview schedule was used to collect the required quantitative data. A structured interview guide is an instrument used in structured report studies that specify the wording of all questions to be asked of respondents (Polit and Beck, 2008). It is read to the respondents while they give answers.

This tool was selected because it permitted anonymity which resulted in more honest answers and it was easy to administer. It also afforded the interviewer to clarify the questions whenever respondents were not clear.

The interview schedule was adapted from two instruments namely: Kogan attitudes toward old people scale (Kogan, 1961), and Facts on Ageing Quiz-2 (Palmore, 1988) The interview schedule comprised five sections: Section A consisted of demographic data, Section B contained items that elicited information on perception of respondents towards ageing and care of older people. It contained 12 items using a 4-point Likert scale ranging from strongly agree, agree, disagree to strongly disagree corresponding to 1 to 4 respectively, summed to give a total score ranging from 12 to 48 with 12 being the minimum score and 48 the maximum score. Perception was rated as negative (1-24) and positive (25–48).

Section C comprised items that elicited information on knowledge of ageing and caring for elderly patients. It had 20 items in “no” or “yes” format. For the responses, score of 1 and 2 was given for correct and incorrect knowledge items. The minimum score was 20 and the maximum score was 40. The total score was ranked as 1–25, inadequate knowledge of caring for elderly patients and 26 – 40 as adequate knowledge of caring for elderly patients.

Furthermore, section D had four items that were soliciting responses on availability of resources for care of elderly patients. It used a 4-point Likert scale with responses ranging from strongly agree, agree, disagree to strongly disagree corresponding to 1 to 4 respectively. The section is summed up with a minimum score of 4 and the maximum score of 16. The total score was ranked as 1 –8 inadequate resources and 9 – 16 as adequate resources.

Similarly, section E comprised four items solicited responses on staffing levels and workload. Also a 4-point Likert scale with responses ranging from strongly agree, agree, disagree to strongly disagree corresponding to 1 to 4 respectively.

The section is summed up with a minimum score of 4 and the maximum score of 16. The total score was ranked as 1 – 8, inadequate staff and 9 – 16 as adequate staff.

The final section consisted of four items assessing management support on care of elderly patients. A 4 point likert scale with responses ranging from strongly agree, agree, disagree to strongly disagree corresponding to 1 to 4 respectively. The section is summed up with a minimum score of 4 and the maximum score of 16. The total score was ranked as 1 – 8, inadequate management support and 9 – 16 as adequate management support.

3.5.2 Qualitative Tool - Focus Group Discussion Guide

To collect qualitative data, a focus group discussion guide was used. The focus group discussion had nine (9) questions eliciting information on nurses' perceptions of caring for elderly patients as well as factors that may affect these perceptions.

3.6 Data Collection Plan/Technique

According to Polit and Hungler, (2008) data collection technique is the actual method of data collection. It explains the whole process of how data was obtained from the participants.

3.6.1 Data collection technique for quantitative data

The researcher introduced herself and the topic understudy. Oral and written instructions were given to ensure adequate understanding and making of an informed consent by the participants. The interview was conducted through face to face interaction with participants.

During the interview process, questions on the interview schedule were read and the interviewee was answering while the interviewer was recording the responses in the provided answer spaces.

Where necessary, questions and answers were repeated for clarity. At the end of the interview, participants were thanked for their time and participation. Each interview lasted for an average of 15-18 minutes and a minimum of five clients were interviewed per day.

3.6.2 Data collection technique for qualitative data

Focus Group Discussions were conducted in a private room that was provided for by the researcher within hospital. The focus group discussions are interviews with groups of about 6 to 12 participants whose opinions and experiences are solicited simultaneously (Burns and Grove, 2008).

Before each discussion began, the researcher introduced herself to the respondents. A recorder was used to audio record during the entire discussions and the research assistant was taking notes of the discussion and other behaviours observed.

The participants were informed about recording of the discussions. The purpose, risks, and benefits of the study were also explained to the participants, and confidentiality was assured. This helped participants to feel at ease. The participants were then assigned numbers to ease discussions because their names were withheld to maintain confidentiality. Permission was sought from the respondents to begin the discussions, and they were all encouraged to participate.

The discussions were conducted in English language. Using the focus group discussion guide, the discussions were initiated by the researcher and the participants were asked to discuss freely while the researcher was moderating the discussion. Talkative participants were thanked for their contributions but were asked to give chance to the quiet ones to also express their views so that the discussions were not dominated by the same participants.

The discussions lasted for about 30 to 45 minutes each. At the end of the discussion, participants were given chances to ask questions which were answered accordingly. Each participant was individually thanked at the end of the discussion.

3.6.3 Pilot Study/ Pre – Testing

Pilot testing identifies and corrects any problems before the actual study is implemented in its final form. Advantages of a pilot test include a prospect to evaluate the psychometric properties of instruments, practice in collecting data, and revealing questions and/or instructions that might be ambiguous, consider reliability of subjects, and estimates time associated with data collection (Fain, 2009).

The pilot study was conducted among nurses who had similar characteristics with the study sample at Cancer Diseases Hospital. They included 10% of the actual study respondents totalling 15 respondents. Stratified random sampling was used to select five from each group of nurses. They helped the researcher to identify parts that needed modification.

The pilot study was also conducted for the focus group in order to test the focus group discussion guide and to assess the duration of each focus group discussion session. The focus group with a total of 6 participants was conducted. Thereafter, adjustments were made to the interview schedule and the FGD guide as needed.

3.7 Quality Measures

3.7.1 Quantitative data

Validity

Validity refers to whether a measurement instrument accurately measures what it is supposed to measure (Wood and Haber, 2006). When an instrument is valid, it truly reflects the concept, it is supposed to measure. Validity comprises internal and external validity. Internal validity refers to interpretation of the findings within the study or data collected. It is concerned with the extent to which conclusions can be drawn about the effects of one variable on another, for example, the independent variables on the dependent variable.

Therefore, to ensure validity of data the same questions were asked to all research participants and the questions were made simple, concise and brief in order to give participants chance to give clear and precise answers which brought forth perceptions of caring for elderly patients.

Content validity was measured by checking items in the data collection tool against the objectives of the study and the concepts in the conceptual framework, to establish whether all elements investigated were measured.

To ensure external validity, selection of an appropriate study design, careful designing and pre-testing of the interview schedule was done. In order to pre-test the questionnaire a pilot study was conducted in which simple random selection of study participants was observed to avoid biases. This was done in order to ensure that the instrument measured what it was intended to measure. After pre testing the data collection tool, corrections were made to the tool to make it simple to both the interviewer and the participants.

Reliability

Reliability is the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure (Polit and Beck, 2010). Reliability focuses on aspects such as stability, and homogeneity among others. Stability is an assessment of the consistence of repeated measures (Burns and Grove, 2005).

This was achieved by testing the tool that was used by conducting a pilot study to check whether the instrument was able to bring out consistent information about nurses' perceptions of caring for elderly patients. Adjustments to the data collection tool were then made as necessary.

3.7.2 Qualitative data

Trustworthiness

Trustworthiness was established using the criteria proposed by Guba and Lincoln (1989) cited in Graneheim and Lundman (2004). These included credibility, dependability, conformability, and transferability.

Credibility

Credibility refers to confidence in how well data and processes of analysis address the intended focus (O'Leary, 2010). Credibility was achieved through selection of participants who have had nursed elderly patients which shaded more light on the research question from a variety of aspects. The data was also confirmed by the participants at the end of each interview session. This will helped in confirming the information and corrections of any errors in the data collected during interview.

Dependability

Dependability has been defined as an inquiry that provides its audience with evidence that if the study was to be replicated with the same respondents, in a similar context, similar findings will be revealed (McFarland, 2009). This was achieved by transcribing the interview data verbatim to ensure representation of participant information. Conformability which refers to objectivity of the researcher (McFarland, 2009), explain how the findings were supported by the collected data. This involved repeated reading of data to identify relationships between the responses, categories and the whole text.

Transferability

Transferability has been defined as the extent to which the findings can be transferred to other settings or groups (Polit & Beck, 2012). According to Granheim and Lundman, (2003) transferability can be achieved through giving a clear and distinct description of culture and context, selection and characteristics of participants, data collection and process of analyses.

The work was evaluated as it developed through the use of a reflective journal, these are journals kept by the researcher in order to reflect on, tentatively interpret and plan data collection (Wallendorf and Belk, 1989). It helped in detecting influences of the researcher's personal frame of mind, biases, and tentative interpretations on the data being gathered.

3.8.3 Data Storage

All materials that were used for data collection and processing were kept by the researcher in a lockable cabinet in the researcher's office. This included the interview schedules, audio tape recorder, processing sheets, reflective journals and digital backup systems such as the flash disks. This helped to prevent unauthorized access to information.

3.9 Data Analysis Methods

3.9.1 Quantitative Data Analysis

Sorting out of data was done on the day of the interview to look for and remove any errors, incompleteness or inconsistency in the data as these had the potential to distort the result of the enquiry (Kombo & Tromp, 2009). After editing, all responses were finally quantified in numerical form. Data was then analysed using Statistical Package for Social Sciences (SPSS) version 23 and manually with the aid of the scientific calculator. Frequency tables, pie charts and graphs were formulated to describe the characteristics of the variables. The association of the categorical variable and the dependent variable was done using Chi square test. Logistic regression was used to predict the existing relationship between the dependent variable and the independent variables, how these are important in relation to influencing nurses' perceptions of caring for elderly patients. Logistic regression was used to assess how well sets of predictor variables predict or explains the dependent variable.

Chi square and Binary Logistic Regression was used since the dependent variable is categorical. The confidence interval for the study was set at 95% and level of significance was achieved if p value was < 0.05.

3.9.2 Qualitative Data Analysis

Content Analysis was used to identify important themes and concepts from the commencement of data collection. Responses were then analysed according to Colaizzi's (1978) phenomenological method to 'identify essential themes' (Polit & Beck, 2008).

Firstly, preparation of data transcription was done which included putting all interview questions into transcripts. Each transcript was read several times to gain an understanding of the interview. The second step involved reading each successive transcript to identify significant phrases or sentences that were relevant to participants' lived experiences with elderly patients.

Units were formulated from significant statements and phrases. Units were words, phrases, sentences, or passages (Polit & Beck, 2008) that described the phenomenon. Codes were assigned to each meaning unit. Similar codes were grouped into categories. This immersion resulted in the exposure of common ideas and threads (categories) that were noted. Each of these coded categories was then matched to themes previously identified from the literature (Brown, 2012). Finally main themes were developed from categories that described the manifest meaning. According to Creswell, (2007), an in-depth description of emerging themes is presented as the final product of the phenomenon.

3.10 Ethical Considerations

Ethical approval was sought from the University of Zambia Biomedical Research Ethics Committee (UNZABREC). A written permission was also obtained from the Medical Superintendents for University Teaching Hospital's Adult Hospital, Levy Mwanawasa University Teaching Hospital and Cancer Diseases Hospital. Furthermore permission was sought from the in charges of the medical and surgical wards at the two hospitals.

The purpose of the study was explained and a written and signed consent was obtained from each participant before the study. Respondents were also reminded that they were free to withdraw from the study at any time without suffering any consequences. Interviews and discussions were conducted in privacy that were organised by the participants. The participants were further assured of anonymity by using serial numbers on the questionnaires instead of writing their names. It was feared that those who participated in the focus group discussions hold the information as they feared that there could be breach of confidentiality by fellow participants. They were reassured of confidentiality that all discussed issues remained among themselves and everyone was encouraged to give their own views. All responses remained anonymous and no names are mentioned in the report.

After data collection, the interview schedules, Focus Group Discussion notes and audio tapes were kept under lock and key for security and confidentiality. No one, apart from the principal investigator was allowed access to the collected data. Participants were not subjected to any physical harm as the study did not involve invasive procedures.

CHAPTER FOUR: RESEARCH RESULTS

4.1 Introduction

This chapter deals with analysis and interpretation of data obtained during the study, the purpose is to address the findings unveiled in the study. The results describe information on nurses' perceptions of caring for elderly patients, knowledge levels on aging and care of elderly patients, socio-demographic factors associated with perceptions of geriatric nursing care, availability of resources for care, staffing levels and management support. In this case both quantitative and qualitative findings are presented.

4.2 Quantitative Results

4.2.1 Response Rate

Out of the grand total of 148 questionnaires that were administered, all were satisfactorily responded to, generating a response rate of 100%. From the grand total of participants, 40% (59) were enrolled nurses, 56% (83) registered nurses and 4% (6) were holders of Bachelor of Science in nursing degree nurses. This promoted adequate representation from all groups.

4.2.2 Socio-Demographic Information

This section shows the frequencies of all the socio-demographic characteristics that were discussed in the study (i.e. age, qualification, gender, duration of service and exposure to elderly person). These social demographic characteristics were used to measure how they influenced the respondents' perceptions of caring for elderly patients.

Table 4.1 Socio –Demographic Characteristics of Respondents in quantitative data

Socio-Demographic Characteristics	Frequency (n)	Percentage (%)	Total Participants (n)
Age (In years)			
24 or under	33	22.3	148
25-34	81	54.7	
35-44	34	23.0	
Level of Education (Nursing Qualification)			
Certificate	59	39.9	148
Diploma	83	56.1	
Bachelor's Degree	6	4.0	
Gender			
Female	114	77.0	148
Male	34	23.0	
Number of Year(s) in Service			
under 1year	62	41.9	148
1 to 5 years	53	35.8	
6 to 10years	18	12.2	
11 to 15 years	15	10.1	
Exposure to living with elderly person (s)			
Yes	123	83.1	148
No	25	16.9	

Table 4.1 above shows that the study consisted of 148 participants who were all nurses in the medical and surgical wards at UTH Adult Hospital. Majority (54.7%) of the respondents in Table 4.1 above were aged between 25 and 34 years. Respondents under 24 years of age were 33 (23.2%). On the other hand, majority of the respondents (56%) were diploma holders while only (4%) were Bachelor of Science in nursing degree holders. Additionally, (40%) of the respondents had a certificate in nursing.

Table 4.1 above also shows that the majority of the respondents that participated in the study were females and accounted for 77 percent and only 34% were males. On the other hand, the majority (62%) of the nurses in the medical and surgical wards at UTH Adult Hospital had less than a year of work experience in the nursing profession. A considerable percentage accounting to 36 percent had work experience of between 1 and 5 years. Very few had served for over six years. It is also clear from Table 4 above that 83 percent of the respondents answered in affirmative to having had experience of living with elderly relatives and only 17 percent answered otherwise.

4.2.3 Perceptions of caring for Elderly Patients

This section examines the nurses' perceptions of caring for elderly patients. They were answering questions which ranged from strongly agree, agree, disagree to strongly disagree. The responses are presented in a table while the level of perception is presented in a pie chart.

Table 4.2 Perception of Caring for Elderly Patients = (n=148)

Perceptions	Frequency (n)	Percentage (%)	Total Number of Participants (n)
Elderly people have unpredictable behavior			
Strongly Agree	91	61.5	148
Agree	49	33.1	
Disagree	7	4.7	
Strongly Disagree	1	0.7	
Elderly patients cannot express themselves on their conditions			
Strongly agree	71	48	148
Agree	57	38.5	
Disagree	19	12.8	
Strongly disagree	1	0.7	
Elderly patients are so slow delaying other ward activities			
Strongly agree	120	81.1	148
Agree	25	16.9	
Disagree	2	1.4	
Strongly disagree	1	0.7	
It is foolish to claim that wisdom comes with age			
Strongly agree	59	39.9	148
Agree	45	30.4	
Disagree	27	18.2	
Strongly disagree	17	11.5	
Elderly patients sometimes feck cognitive impairment			
Strongly agree	40	27	148
Agree	58	39.2	
Disagree	35	23.6	
Strongly disagree	15	10.1	
Waste of resources administering expensive treatment to elders			
Strongly agree	56	37.8	
Agree	36	24.3	
Disagree	35	23.6	
Strongly disagree	21	14.2	

I find it difficult to nurse elderly patients			
Strongly agree	24	16.2	148
Agree	106	71.6	
Disagree	15	10.1	
Strongly disagree	3	2	
If a ward is set to nurse elderly patients would ask for exemption			
Strongly agree	15	10.1	
Agree	81	54.7	
Disagree	30	20.3	
Strongly disagree	22	14.9	
Its time consuming to care for the elderly			
Strongly agree	95	62.2	148
Agree	43	29.1	
Disagree	10	6.8	
Strongly disagree	3	2	
Elderly take longer to recover			
Strongly agree	66	44.6	148
Agree	74	50	
Disagree	8	5.4	
Elderly cannot learn new things			
Strongly agree	51	34.5	148
Agree	76	51.4	
Disagree	18	12.2	
Strongly disagree	3	2	
Some elderly people practice witchcraft			
Strongly agree	5	3.4	148
Agree	55	37.2	
Disagree	80	54.1	
Strongly disagree	8	5.4	
Elderly get set in own ways and cannot change			
Strongly agree	21	14.2	148
Agree	118	79.7	
Disagree	9	6.1	
The elderly are dependent making their care so tiresome			
Strongly agree	77	52.4	148
Agree	62	41.9	
Disagree	9	6.1	

Table 4.2 above shows that the majority (61.5%) of the respondents strongly agreed that elderly patients have unpredictable behaviour and 33 percent agreed that elderly patients have unpredictable behaviour while only 4.7 percent of the respondents disagreed that elderly patients have unpredictable behaviour. Fourty eight percent of the respondents strongly agreed that elderly patients cannot express themselves regarding their conditions and 38.5 percent agreed while only a few (12.8) disagreed. A magnitude (81.1%) of the respondents strongly agreed that elderly patients are so slow such that other ward activities are delayed and only 17 percent disagreed to this matter. Table 4.2 above here also shows that a good number (40%) of respondents strongly agreed that it is foolishness to claim that wisdom comes with age, 30 percent agreed and only eighteen percent disagreed that it is foolishness to claim that wisdom comes with age. On the other hand, about (39.2%) of the respondents strongly agreed that elderly patients sometimes feck cognitive impairment making their care difficult while only 23.6 percent of the respondents disagreed that elderly patients sometimes feck cognitive impairment making their care difficult. About (37.8%) of the respondents strongly agreed that it is waste of resources to administer expensive procedures and treatment to elderly patients while almost the equal number 24.3 percent and 23.6 percent respectively agreed and disagreed that it is a waste of resources to administer expensive procedures and treatment to elderly patients. It is evident in table 4.2 above that majority (71.6%) of the respondents agreed that they find it difficult to nurse elderly patients while only 10 percent disagreed to the core. More than half (54.7%) of the respondents agreed that if a ward was set to admit and nurse elderly patients they would ask for exemption and 20 percent said they would not ask for exemption.

Furthermore, it is also evident that the majority (62.2%) of the respondents strongly agreed that it is time consuming to care for elderly patients, 29 percent agreed while only a few 4.7 percent disagreed that it is time consuming to care for elderly patients. On the other hand, half (50%) of the respondents agreed that elderly patients take longer to recover from physical and psychological stress which makes them loose hope, 45.3percent strongly agreed and only (4.7%) disagreed that elderly patients take longer to recover from physical and psychological stress.

It is also indicated in table 4.2 that most (51.4%) of the respondents agreed that elderly patients cannot learn new things, 34.5 percent strongly agreed while only 12.2 percent disagreed that elderly patients cannot learn new things.

Fifty-four percent of the respondents disagreed that most of the elderly patients practice witchcraft with 37.2 percent agreeing. It is also clear in table 4.2 that a large number (79.7%) of the respondents agreed that elderly people get set in their own ways and cannot change while about 6.1 percent disagreed that elderly people get set in their own ways and cannot change. slightly above half (52%) of the respondents strongly agreed that elderly patients are dependent making their care so tiresome, 41.9 percent agreed while only (6.1%) disagreed that elderly patients are dependent making their care so tiresome.

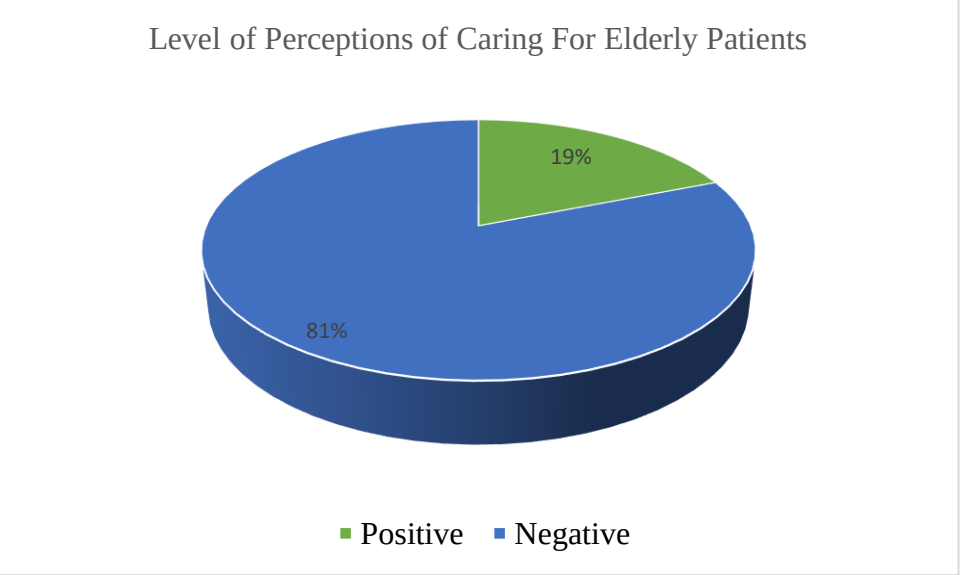


Figure 4.1: Level of perception (n: 148)

It is clearly shown in Figure 4.1 above that the majority (81%) of the respondents had negative perceptions of caring for elderly patients and 19 percent of the respondents had positive perceptions.

Table 4.3: Socio-demographic Characteristics and Level of Perceptions (n: 148)

Socio-Demographic Characteristics		Perceptions of caring for the elderly		P value
		Positive [n (%)]	Negative [n (%)]	
Overall Perceptions		**28 (18.9)**	**120 (81.1)**	
Age (In years)	< 24	4(2.7)	29(19.6)	0.4954
	25-34	17(11.5)	64(43.2)	0.140
	34-44	7(4.7)	27(18.2)	
Level of Nursing Education	Certificate	11(7.4)	48(32.4)	0.251
	Diploma	13(8.8)	70(47.3)	
	Degree	4(2.7)	2(1.4)	
Gender	Female	21(14.2)	93(62.8)	0.90
	Male	7(4.7)	27(18.2)	
Number of Year(s) in Service	<1year	11(7.4)	51(34.5)	
	1-5yrs	8(5.4)	45(30.4)	0.159
	6-10yrs	4(2.7)	14(9.7)	0.624
	11-15yrs	5(3.4)	10(6.8)	
Lived with elderly person (s)	Yes	23(15.5)	100(67.6)	0.835
	No	5(4.0)	20(13.5)	

According Table 4.3 above, the overall level of negative perception was 81.1 percent with a high proportion of nurses who have never lived with elderly people (67.6 percent) having displayed more negative perceptions of caring for elderly patients compared to only 15.5 percent of nurses who have the experience of living with elderly people. In terms of age, negative perceptions were highest among nurses aged between 24 and 35 (43.2 percent). Negative perceptions were higher among those with diploma in nursing (47.3 percent) and females (62.8 percent) compared to their male counterparts (18.2 percent). It is interesting to note that the percentage of nurses with negative perceptions of caring for elderly patients steadily reduced with increasing number of years in service, from 34.5 percent of nurses who had less than a year in the nursing service to 6.8 percent of nurses with more than 16 years in service.

4.2.4 Knowledge on Aging and care of elderly patients

This section describes the various factors that suggest whether the respondents who participated in the study had knowledge about aging and care of elderly patients. Respondents were asked questions on their training on care of elderly patients, ageing and the ageing process, diseases associated with ageing and care of elderly patients. They were yes and no responses which were divided into two knowledge categories. Those who answered 60 percent or more of the questions correct were classified as having adequate knowledge while anything less was classified as having inadequate knowledge. The results are presented in a frequency table for knowledge characteristics and a pie chart for the level of knowledge of caring for elderly patients.

Table 4.4 Knowledge on caring for elderly patients (n=148)

Knowledge questions	Frequency(n)	Percentage (%)	Total participants
Any lectures on care of elderly			
No	141	95.3	148
Yes	7	4.7	
Were the lectures adequate			
No	148	100	148
Any short course or workshop			
No	148	100	148
Elderly care serious problem			
No	73	49.3	148
Yes	75	50.7	
Elderly do not receive quality care			
No	136	91.9	148
Yes	12	8.1	
Elderly suffer debilitating illnesses			
No	58	39.2	148
Yes	90	60.6	
Aging process varies in individuals			
No	137	92.6	148
Yes	11	7.4	
Arthritis disturbs activity in elderly			
No	140	94.6	148
Yes	8	5.4	

Dementia is common in elderly			
No	104	70.3	148
Yes	44	29.7	
Pain is not normal in elderly			
No	121	81.8	148
Yes	27	18.2	
Some senses decline in elderly			
No	126	85.1	148
Yes	22	14.9	
Elderly suffer depression			
No	118	79.9	148
Yes	30	20.3	
Not all illnesses due to old age			
No	133	89.9	148
Yes	15	10.1	
Elderly have cognitive impairment			
No	144	97.3	148
Yes	4	2.7	
Most elderly easy to understand			
No	129	87.2	148
Yes	19	12.8	
Elderly demand for care is necessary			
No	96	64.9	148
Yes	52	35.1	
Elderly do not like hospitalization			
No	118	79.9	148
Yes	30	20.3	
complications difficult to recognize			
No	58	39.2	148
Yes	90	60.8	
Adequate rapport required			
No	74	50	148
Yes	74	50	
Need patience to deal with elderly			
No	66	44.6	148
yes	82	55.4	
Total	148	100	148

Table 4.4 above shows that the majority (95.3%) of the respondents did not receive lectures or tuition during their nursing training on care of elderly patients while only 4.7 percent acknowledged that they received lectures or tuition during their nursing training on care of elderly patients. On adequacy of lectures received to deal with elderly patients the all (100%) said that the lectures they received during their nursing training were not adequate to enable them deal with elderly patients. This includes the 4.7 percent of respondents who acknowledged receiving lectures during their training. Additionally, all (100%) respondents did not attend any short course or workshop on care of elderly patients during their work experience.

On the other hand majority (50.7%) of the respondents acknowledged that elderly patient care is a serious problem in their care institutions while 49.3 percent said it is not a problem at all. Asking the respondents on whether elderly patients receive quality care that they deserve in table 4.4 above, majority (91.9%) of the respondents argued that elderly patients do not receive quality care that they deserve while 8.1 percent of the respondents said that they do receive quality care.

Table 4.4 above also shows that majority (60.8%) of the respondents agreed that all elderly patients suffer from debilitating illnesses and only a few 39.2 percent answered otherwise. A magnitude (92.6%) of respondents said that aging is the same in all aging people while only a few 7.4 percent said it varies in different individuals. Also 95 percent of the respondents disagreed that arthritis disturbs elderly people's activeness while hardly any agreed (5%) that arthritis disturbs elderly people's activeness. Seventy percent of the respondents said that dementia is not common in elderly people and only 30 percent said it is common among elderly people. It is also clear from this table that most (81.8%) of the respondents confirmed that pain is normal in elderly patients and only 18.2 percent argued that this is not part of normal aging process. Additionally a large number (85.1%) of the respondents confirmed that in elderly all five senses declined while only 14.9 percent said this is not true. A large number (79.7%) of the respondents refuted that some elderly patients suffer depression while 20.3 percent affirmed to this matter.

Furthermore, the majority (89.9%) of the respondents affirmed that all medical problems suffered by elderly people are due to old age while the minority 10.1 percent answered otherwise. Ninty seven percent of the respondents said that elderly patients have cognitive impairment and only 2.7 percent did not agree that elderly people have cognitive impairment.

Majority (87.2%) of the respondents in table 4.3 above dismissed allegations that most elderly people are easy to understand just like young people while the minority (12.8%) said they are easy to understand just like young people. More than half (64.9%) of the respondents said that the demands for care made by elderly patients are not necessary and 35.1 percent acknowledged that the demands are necessary. Also a large number (79.9%) of respondents said that the elderly have no problems with hospitalization while only a few (20.3%) said that hospitalization may impair function ability in the elderly. Most (60.8%) of the respondents said they find it difficult to recognize complications in elderly patients and a small number (39.2%) said recognizing complications in the elderly is not difficult. The same number (50%) of respondent agree and disagreed that there is need to create adequate rapport in order to deal with the elderly patients. More than half (55.4%) of the respondents said that there is need to exercise patience when dealing with elderly patients and 44.6 percent said there is no need.

4.2.4.1 Knowledge on care of elderly patients

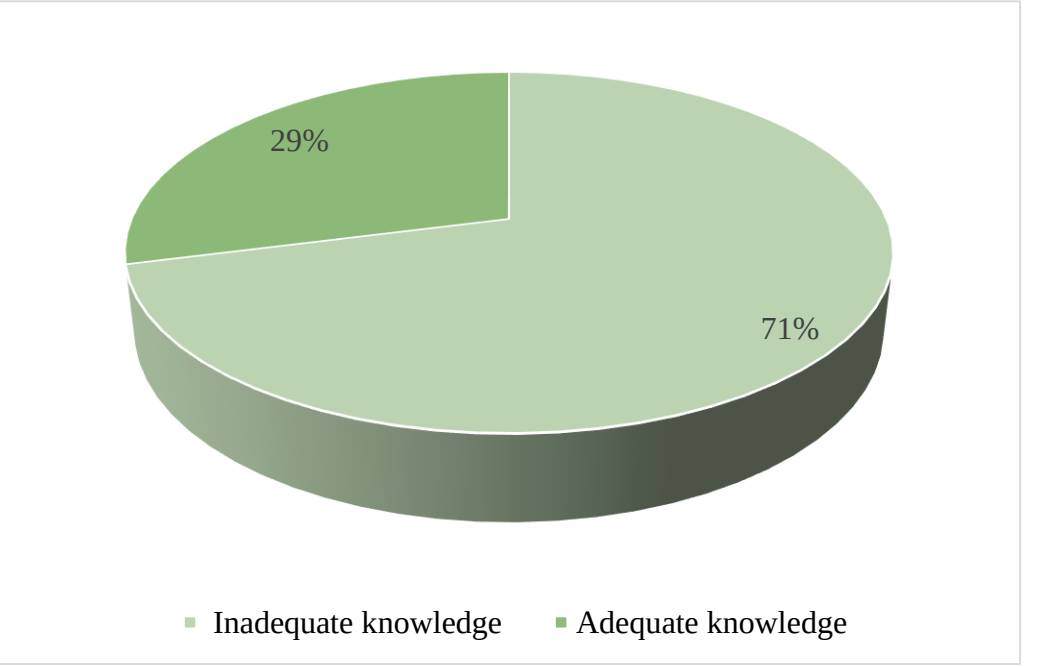


Figure 4.2: knowledge levels on care of elderly patients (n: 148)

Figure 4.2 above shows that more than half (71%) of the respondents had inadequate knowledge of caring for elderly patients and 29 percent of the respondents had high knowledge of caring for elderly patients.

Table 4.5: knowledge of caring for elderly patients and Level of Perceptions (n: 148)

Knowledge of caring	Perceptions of caring for the elderly		Total [n (%)]	Chi-square value	p-value	OR	CI 95%
	Positive [n (%)]	Negative [n (%)]					
Inadequate	16(10.8)	89(60.1)	105(100)	3.192	0.074	0.44	0.2,1
Adequate	12(8.1)	31(20.9)	43(100)				

The table 4.5 above shows that majority of the respondents (60.1) who had negative perceptions had inadequate knowledge of caring for elderly patients while out of twenty nine percent of the respondents who had adequate knowledge the majority 20.9 percent had negative perceptions of caring for elderly patients.

4.2.5 Availability of Resources for Care of elderly patients

The information in this section reveals responses of respondents on availability of resources for elderly care (Table). The questions included, availability of specific resources such as wards and equipment, whether or not these were adequate or inadequate for care of elderly patients. These variables were used to measure their influence on nurses' perception of caring for elderly patients. The levels of institutional factors were divided into two, inadequate and adequate resources. The responses are presented in the table below while a bar chart was used to illustrate the level of availability of resources for care of elderly patients.

Table 4.6 Availability of Resources for Care of Elderly Patients = (n=148)

Availability of Resources questions	Frequency (n)	Percentage (%)	Total Number of Participants (n)
No specific resources directed towards the care of elderly patients			
Strongly Agree	117	79.1	148
Agree	27	18.2	
Disagree	3	2	
Strongly Disagree	1	0.755	
Available resources for care of elderly patients are not adequate			
Strongly agree	92	62.2	148
Agree	49	33.1	
Disagree	6	4.1	
Strongly disagree	1	0.7	
Elderly not entitled to the same attention as their younger counterparts			
Strongly agree	41	27.7	148
Agree	45	30.4	
Disagree	62	41.9	
Strongly disagree	0	0	
There are no health facilities built and designed for the care of elderly patients			
Strongly agree	100	67.6	148
Agree	48	32.4	
Disagree	0	0	
Strongly disagree	0	0	

Table 4.6 above shows that seventy nine percent of the respondents strongly agreed that there are no specific resources directed toward the care of elderly patients at their work place, 18.2 percent also agreed while hardly any (2%) disagreed that there are no specific resources directed toward the care of elderly patients at their work place. The same table 4.6 above indicates that most (62.2%) of the respondents stated that the available resources are not adequate to care for elderly patients and 33.1 percent agreed while only 4.7 percent disagreed that available resources are not adequate to care for elderly patients.

On the other hand, 41.9 percent of the respondents disagreed that elderly patients are not entitled to same attention as their younger counterparts and 30.4 percent agreed that elderly patients are not entitled to same attention as their younger counterparts while 27.7 strongly agreed to this matter.

On availability of health facilities designed for elderly patients, most (67.6%) of the respondents strongly agreed that there are no health facilities built and designed for elderly patient care and 48 percent agreed that there are no health facilities built and designed for elderly patient care.

4.2.4.2 Level of availability of resources for care of elderly patients

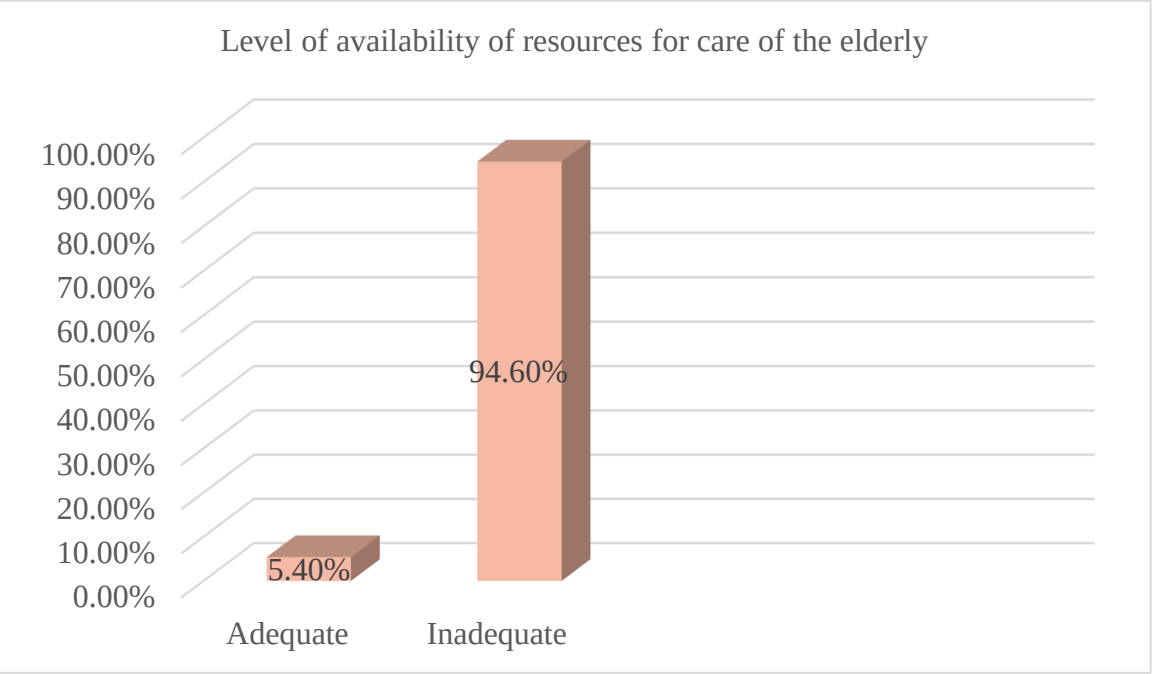


Figure 4.3: Level of availability of resources for care of elderly patients (n: 148)

It is clearly evident in figure 4.3 above that a magnitude (94.6%) of respondents confirmed that available resources to meet the demand of elderly patient care are not adequate while only 5.4 percent said that available resources are adequate to meet the demand of elderly patient care.

Table 4.7: availability of resources for care and Level of Perceptions (n: 148)

Availability of resources for care	Perceptions of caring for the elderly		Total [n (%)]	Chi-square value	p-value	OR	CI 95%
	Positive [n (%)]	Negative [n (%)]					
Adequate	1(0.7)	7(4.7)	8(100)	0.227	0.634	0.42	0.05,3.72
Inadequate	27(18.2)	113(76.4)	140(94.6)				

The table 4.7 above shows that majority of the respondents 140(94.6%) who indicated inadequacy of resources for care of elderly patients majority 113(76.4) had negative perceptions of caring for elderly patients while almost all 7(4.7) of the respondents who indicated adequacy of resources for care of elderly patients had negative perceptions. Chi-square 0.227 and a p value of 0.634.

4.2.6 Staffing and increased workload

This section is giving responses related to nurses available to care for elderly patients in view of the demand of care that is called for by this group of patients. They were answering questions which ranged from strongly agree, agree, disagree to strongly disagree. However none of the respondents disagreed or strongly agreed to any statement in this section. Staffing levels were either adequate or inadequate. The responses are presented in the table below while a pie chart was used to illustrate the staffing levels.

Table 4.8 staffing levels= (n=148)

Statements on staffing	Strongly agree [n(%)]	Agree [n(%)]	Total participants [n(%)]
There is shortage of staff to meet the demand of care	124(83.8)	24(16.2)	148(100)
No specialized nurses in care of elderly patients	123(83.1)	25(16.9)	148(100)
The same nurses caring for the elderly patients care for others	132(89.2)	16(10.8)	148(100)
Nurse patient ratio in my ward is more than 1: 25	131(88.5)	17(11.5)	148(100)

Table 4.8 above shows that most of the respondents (83.8%) strongly agreed that there is shortage of staff to meet the demand of caring for elderly patients while 16.2 percent agreed. On the other hand eighty three percent of the respondents strongly agreed that there are no specialised nurses to care for elderly patients and 17 percent of the respondents also agreed that there are no specialised nurses to care for elderly patients. Additionally, eighty nine percent of the respondents strongly agreed that the same nurses caring for the elderly patients care for rest of the patients on the ward and 10.8 percent of the respondents agreed that the same nurses caring for the elderly patients care for rest of the patients on the ward. The same table 4.5 above indicates that majority of of the respondents strongly agreed that the nurse patient ratio in their wards was more than 1: 25 while 11.5 percent are also in agreement.

4.2.6.1 Staffing level

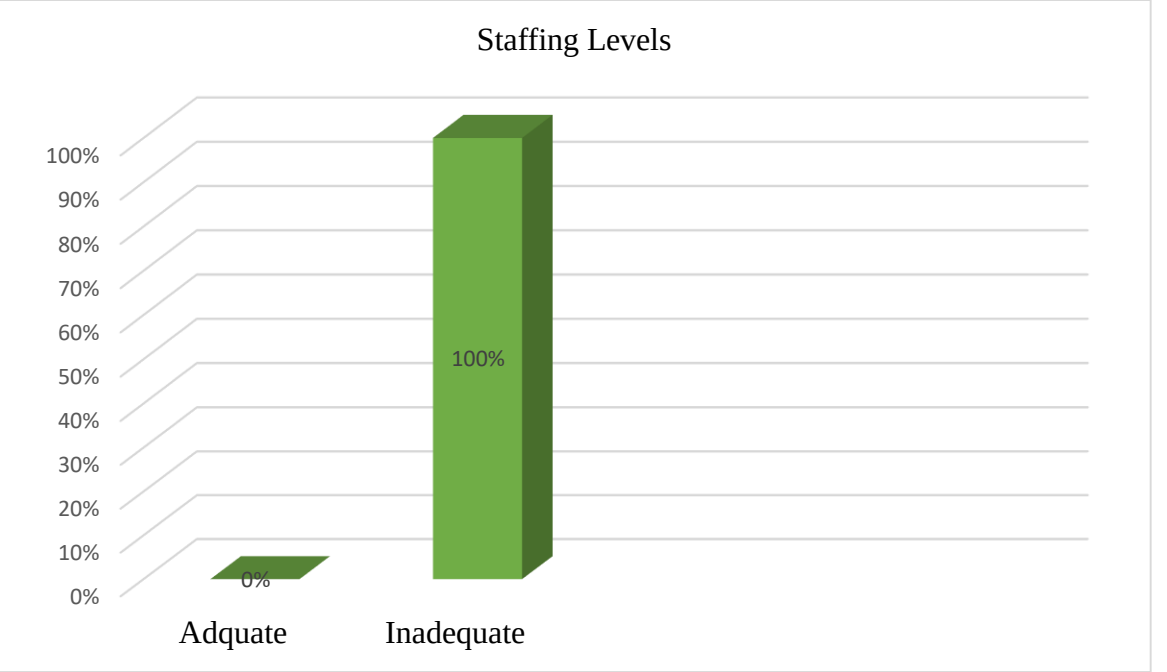


Figure 4.4 staffing level (n: 148)

The staffing level in figure 4.4 above shows clearly that all (100%) of the respondents indicated that the staffing levels are not adequate to meet the demand of caring for elderly patients.

4.2.7 Management support

This section shows responses relate to management support on care of elderly patients.

Table 4.9 Management Support (n=148)

Statements on management support	Strongly agree [n(%)]	Agree [n(%)]	Disagree [n(%)]	Strongly disagree [n(%)]	Total participants [n(%)]
Institutional support to meet the demand of caring for elderly patients is not adequate	80(54.1)	52(35.1)	14(9.5)	2(1.4)	148(100)
There are no age specific and sensitive guidelines on care of elderly patients in my ward	69(46.6)	54(36.5)	19(12.8)	6(4.1)	148(100)
Personal effort to care for elderly patients is not acknowledged by management	69(46.6)	56(37.8)	19(12.8)	4(2.7)	148(100)
Relatives are not allowed by management to supplement care in my ward	61(41.2)	46(31.1)	34(23)	7(4.7)	148(100)

Forty seven percent of the respondents in table 4.9 above strongly agreed that there are no age specific and sensitive guidelines on care of elderly patients at their work place and only a few (12.8%) disagreed that there are no age specific and sensitive guidelines on care of elderly patients at their work place. It is also evident that more than half (54.1%) of respondents strongly agreed that institutional support to meet the demand of caring for elderly patients is not adequate and only a few (9.5%) of the respondents disagreed that institutional support to meet the demand of caring for elderly patients is not adequate. A good number (46.6%) of the respondents strongly agreed that personal effort to care for elderly patients is not acknowledged by management, 37.8 percent also agreed and only a small number (12.8%) disagreed that personal effort to care for elderly patients is not acknowledged by management. On the other hand, fourty one percent of the respondents strongly agreed that relatives to patients are not allowed by management to supplement care in their wards, 31 percent also agreed and 23 percent of the respondents disagreed that relatives to patients are not allowed by management to supplement care in their wards.

4.2.7.1 **Level of Management Support**

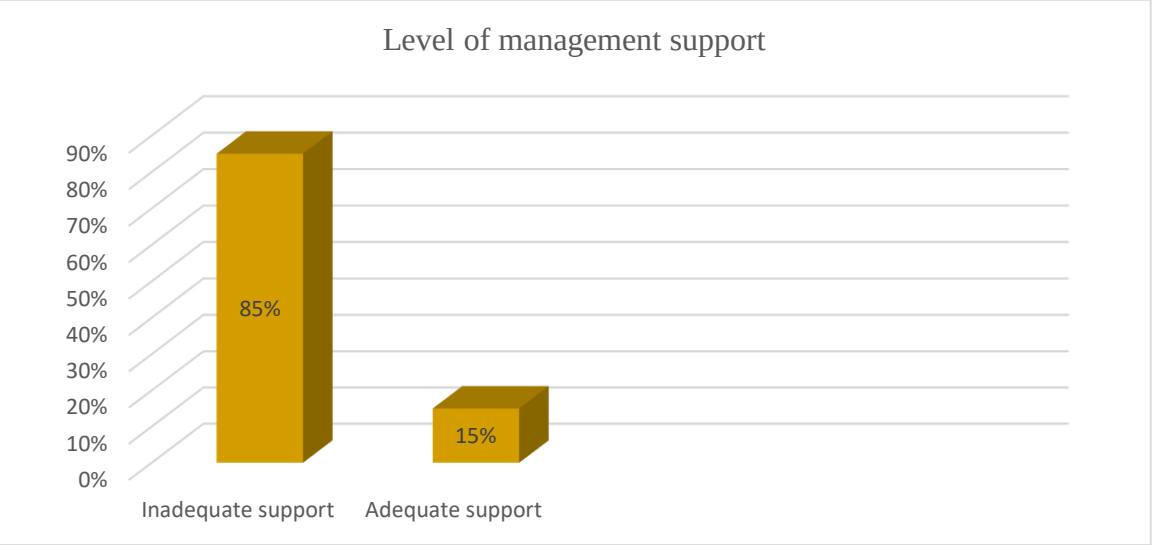


Figure 4.5 above evidently shows that majority (85%) of the respondents said that management support for care of elderly patients is not adequate and only a few (15%) indicated that management support for care of elderly patients is adequate

Table 4.10: Management Support and Level of Perceptions (n: 148)

Management support	Perceptions of caring for the elderly		Chi-square	p-value	OR	CI-95%
	Positive [n (%)]	Negative [n (%)]				
Overall Perceptions	**28 (18.9)**	**120 (81.1)**				
Inadequate	22(14.9)	104(70.3)	1.176	0.278	0.51	0.2,1.5
Adequate	6(4.1)	16(10.8)				

The table 4.10 above shows that majority of the respondents (70.3) who had negative perceptions of caring for elderly patients indicated that management support for care of elderly patients was not adequate, out of 14.9 percent of the respondents who indicated adequate management support 10.8 percent had negative perceptions of caring for elderly patients.

4.3 Qualitative Results

The total of 18 participants took part in the focus group discussions of which 6 participants took part in each group. Participants were grouped according to their level of nursing education e.g. enrolled nurses, registered nurses and BSc nurses giving a total of 100% response. The results of this section supplements the quantitative findings. The results from the qualitative data are discussed in relation to thematic findings. Five central themes emerged that represent a lack of respect for elderly people, knowledge deficit, time and staff to do things right, a safe and enabling environment.

Theme one: Lack of respect for elderly people

Data revealed that some nurses had some negative perceptions toward older adults. Negative descriptions of older adults focused primarily on attributes of personalities which depict a lack of respect for elderly people. Older adults were perceived as having unpleasant personalities such as being grumpy and crabby. The following statements in table 4.12 below confirmed those perceptions, "*elderly are grumpy*." "*There is always a mean one.*" making reference to a neighbour.

Another example of negative statement was, "*elderly people are needy, confused, and wanting interaction*". Some nurses assumed that aged persons are witches. Like one respondent narrated, *"…they are just a burden, and it's difficult to tell whether they are sick or it's just one of those things for old people …..It's hard to handle, a frail, passive patient and….might even be a wizard, they need too much care! It's hard to manage, all the time demanding this and that!"*

Table 4.11: Statements of Negative Perceptions of elderly people

Statements/Respondents	**Descriptors Categories**	**Formulated Meanings**
Elderly people can be mean it's just an expression of who they are. *Nurse* 2, 3, 4 and 5	Personality	Nurses had stereotypical perceptions of older adults
Bad tempered (crabby) sometimes, too forgetful. *Nurse* 2, 3, 4, 5, 7, 9, 10, 11, 12, 14,15 and 18	Personality	Nurse's preconception about older adults
Needy, and confused. It's like the majority of them are needy and confused. *Nurse* 4, 5, 8, 9, 10, 11, 12, 13 and 14	Personality	Nurse had ageist attitude about elderly people
Elderly patients have self-care deficit, dependent, Very slow in action and thinking. *Nurse* 3, 4, 5, 8, 9, 10, 11, 12, 13, 14,15 and 18 These people can't reason anymore or express themselves…., better to engage a relative into a productive conversation about them *Nurse* 2, 3, 4, 5, 7, 9, 10, 11, 12, 14,15 and 18	Personality	Nurse's preconception about the elderly
They are just a burden, and it's difficult to tell whether they are sick or it's just one of those things for old people …..It's hard to handle, a frail, passive patient and….might even be a wizard, they need too much care! It's hard to manage. *Nurse* 2, 3, 4, 5, 7, 9, 10, 11, 12, 14,15 and 18	Personality	Nurse had ageist attitude about elderly people

However, a few respondents expressed positive perceptions of elderly people which reflected a valuing and respect for the elderly in table 4.12 below. These were those who indicated to have had some experience living with elderly relatives and described their relationship with elderly patients as similar to the relationship they shared with grandparents. "*They become like your grandparents."* Nurses' perceptions reflected a love for elderly people and an appreciation of who they were. Nurses perceived elderly people as persons who lived exemplary lives and were good role models. They were described as having admirable community, and family values. One nurse reported, *"They agree to whatever care you want to offer them, so satisfying because you feel I have given care to a patient who really needs it."* Another nurse spoke fondly of her grandparents' attitudes of thankfulness and of their openness in talking about good morals. Nurses expressed appreciation for their truthfulness. For example, "*They don't pretend…..they appreciate your work from deep down their hearts."* Statements like, *"You get attached and it's hard to say that I won't be there for them".* Confirmed the nurses' feelings in table 4.12 below. Several other statements confirmed that nurses liked spending time with elderly people. For example, "*I like elderly people… I think they are just like younger adults." "I actually found out they have a sense of humour."* Some nurses acknowledged that they enjoyed having social interactions with the aged. They identified deriving pleasure from spending time with elderly people. Statements such as *"Well I became much more comfortable with them," or I wanted to try to connect with them"* say it all**.**

Table 4.12: Positive Statements Describing Positive Perceptions of elderly patient care

Statement	**Categories of Descriptors**	**Formulated Meanings**
It is wonderful to sit and talk with them, listening to their stories *Nurse*: 1, 8 and 17	Comfort with elderly	Nurse enjoyed being with elderly patients
So satisfying because you feel that I have given care to a patient who really needs it *Nurse*: 1, 6, 8, 13, 16, and 17.	Comfort with elderly care	Nurses experienced job satisfaction in elderly patient care
They appreciate your work from deep down their hearts *Nurse*: 1, 6, 8, 13, 16, and 17.	Positive role model Positive values	The elderly modelled positive values
They don't pretend….they are real *Nurse*: 8, 13, 16 and 17.	Positive values	Elderly people valued truthfulness

Agree to whatever care you want to offer them *Nurse*: 8, 16, and 17.	Easy to care	The elderly live exemplary lives
How they keep track of history, so amazing *Nurse*: 6, 16, 17.	Role models	The elderly live exemplary lives
I give them respect. *Nurse*: 1, 6, 8, 13	Valuing	Nurses valued the elderly
Some of the nicest patients I have come across *Nurse*: 1, 6, 13, 16, and 17	Positive personality	Nurses looked forward to caring for elderly patients
Felt attached, was difficult to leave them, likened them to my grandparents, I see my own time coming. *Nurse* 1, 6, 8, 13, 16 and 17. I like elderly people… I think they are just like younger adults." "I actually found out they have a sense of humour Well I became much more comfortable with them or I wanted to try to connect with them *Nurse*: 1, 6, 8, 13	Easy to care Valuing	valued and respected elderly people

Theme Two: Knowledge Deficit

Respondents realized that they don't have the capacity in terms of knowledge to take care of the elderly patients as depicted in table 4.13. Most of them said, '*It is so difficult to nurse these patients because we don't have that education about their care, we use the general patient care knowledge which we learnt from schools… would be better if we had even a few specialized nurses like our friends in other countries*'. Others said, "*it is hell…, these people will choose to be mute whenever they feel like, that's why it's better to talk to their relatives who may also not be available. Sometimes it's so upsetting we yell at them*''. Nurses think elderly just enjoy being in hospital and expect them to understand as was remarked by these sentiments, "*They will come with one problem… another one starts, they feel good to be in hospital, ……. old age does not require prolonged hospitalization because getting sick is part of old age what do you expect*?.

Table 4.13: Statements depicting knowledge deficit on caring of elderly patients

Statements/Respondents	Descriptors Categories	Formulated Meanings
It is so difficult to nurse these patients because we don't have that education about their care, we use the general patient care knowledge which we learnt from school. Would be better if we had even a few specialized nurses like our friends in other countries". Nurse 1, 2, 3, 4, 5, 6 7, 8, 9, 10, 11, 12, 14,15 and 18	Knowledge deficit	Need for training
These people will choose to be mute whenever they feel like, that's why it's better to talk to relatives, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12. Sometimes we yell at them	Knowledge deficit	Lack of understanding aging and some conditions that may be related to aging
They will come with one problem another one starts, they feel good to be in hospital,……. old age does not require prolonged hospitalization because getting sick is part of old age. 2, 3, 5, 7, 9, 10, 12, 17	Personality	Nurse had ageist attitude about elderly people related to lack of understanding aging and some conditions that may be related to aging

Theme Three: Time and staff to do things right

Most of the nurses in table 4.14 below indicated that with their overloads an addition of an aged person in a ward is asking too much from them. Some nurses said, "*Elderly are very difficult, very demanding, not easy at all, you spend all your time caring. There is just a lot to do, everything you do for them… it is so tiresome, lots of wired things about them. So difficult to cope. You really need to be strong and patient. Imagine, alone the whole ward, this one and that one want attention……. If only staffing levels can improve*." Others confirmed ignoring elderly patients in order to attend to serious cases. *If I have four or three elderly patients my day is good, it is just to give them their medicine and forget about them, I can't manage with emergencies on people who still have days to live."*

Table 4.14: Statements depicting lack of time and staff to do things right

Statements/Respondents	Descriptors Categories	Formulated Meanings
Elderly are very difficult, very slow, very demanding, not easy at all you spend all your time caring. *Nurse* 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14, 15 and 18	Increased work load	Shortage of staff
There is just a lot to do, everything you do for them… it is so tiresome, lots of wired things about them. So difficult to cope. *Nurse* 2, 3, 4, 5, 7, 9, 10, 11, 12, 14,15 and 18	Increased work load	Shortage of staff
Imagine, alone the whole ward, this one and that one want attention……. If only staffing levels can improve. *Nurse* 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14,15, 16,17 and 18	Increased work load	Shortage of staff
It takes a strong and patient person to work with elderly, If I have four or three elderly patients my day is good, it is just to give them their medicine and forget about them, I can't manage with emergencies on people who still have days to live*". Nurse* 2, 3, 4, 5, 7, 9, 10, 11, 12, 14,15 and 18	Increased work load	Shortage of staff

Theme four: A safe and enabling environment

A safe and enabling environment demonstrates a salient awareness of the influence of the physical environment among nurses for adequate provision of required elderly care with easiness to care providers. The respondents felt that staffing levels, and other managerial issues surrounding care of elderly patients should be sorted out. For example some respondents said, "*management should improve staffing levels…., put up structures intended for care of the elderly for example handrails in bathrooms and toilets, non-slippery floors, provide adequate equipment and supplies such as low beds wheel chairs as well as organizing deliberate workshops on care of elderly patients*" others said, "*wards put up for the elderly would make sense because it is not easy at all with them in the general wards"*

Table 4.15: Statements representing a safe and enabling environment

Statements/Respondents	Descriptors Categories	Formulated Meanings
Improve staffing levels. *Nurse* 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18. Relatives to stay with them during hospitalization *Nurse* 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14,15, 16,17 and 18	Work load reduction	Safe and enabling environment
Put up structures intended for the elderly care *Nurse* 1, 2, 3, 10, 12, 13, 16,17 and 18	Adequate resources	Safe and enabling environment
Put and monitor geriatric specific and sensitive guidelines *Nurse* 1, 5, 6, 7, 8, 13, 14, 17 and 18	Support	Safe and enabling environment
Adequate equipment and supplies Nurse 5, 6, 10, 11, 12, 13, 14,15, 16,17 and 18	Adequate resources	Safe and enabling environment
Organize deliberate workshops on care of elderly and recognize personal effort for quality care *Nurse* 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14,15, 16,17 and 18	Management support	Safe and enabling environment

4.3 Summary

This chapter has explained how data was prepared for analysis and processing that data from interview schedule was checked for completeness coded and analysed by SPSS and data from the focus group discussions was transcribed, coded into categories and meaning units such that themes that emerged were presented as the findings from the data.

The presentation was done systematically using various tables and figures to aid the leader into major study variables showing results and their significance in the study.

Therefore, the results of this study showed that the age of the respondents was mostly the younger age group dominated by females. Most of the respondents had no opportunity to live with an elderly person at one point in their lives. A higher percentage of respondents were females who had a diploma in their nursing education level. Generally the results demonstrated negative perceptions of nurses towards the care of elderly patients although there was no statistical significance on the variables.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This chapter discusses the findings of the study that was aimed at establishing nurses' perceptions of caring for elderly patients. The study used 166 participants, 148 for the quantitative data and eighteen for the qualitative data. The nurses included in the study were those who worked in medical and surgical wards at UTH- Adult Hospital and Levy Mwanawasa University Teaching Hospital during the time of study and for at least three months prior. The interview schedule and focus group discussion guide were used to obtain data from the respondents. Therefore this chapter discusses the findings in light of related literature following the order of the research variables.

5.2 Discussion Of Variables

Provision of quality health care to elderly patients requires nurses to have positive perceptions about their caring role. However, in this study it was revealed that nurses had both positive and negative perceptions about the elderly patients though negative perceptions were predominant. From both the interview schedule and three FGDs responses, it was very clear that majority of the respondents had negative perceptions of elderly patients. The overall negative perception level from interview schedule responses was 81% and 66.7% for FGDs.

This entails that quantitative findings akin those of qualitative findings. In this study, describing nurses' views surrounding elderly patient care, provides insight into the organization of the existing geriatric education and care system. Most of the contributions that were made underpinned the need for service delivery to develop an attitude of respect for the status. Respect for elderly patients and their relatives, describes the social climate in hospital, consistent with that defined by Parke and Chappell (2010). Respect is apparent an observable communication between staff, elderly patients, and family members. The attitudes that staff display during their interaction with patients, such as promoting privacy and expressions of empathy, are important factors in supporting a sense of well-being in elderly patients. However, nurses displayed negative views towards these patients which stemmed from the reality that the majority of elderly people live inactive and unproductive lives which renders them to be too much dependent on others. Also their personality left less to be admired by nurses.

In addition, elderly patients refuse nursing interventions, are believed to be witches and sometimes yelled at participants when they had been trying to provide care for them. There is poor communication and lack of compassion among nurses. "*We yell at them and think they are deaf*" One nurse described, "*I believe that many elderly are just ignored because they can't communicate or are confused*." Nurses have a problem with receptive abilities. These findings are consistent with those of Slater (2008) who reported that In Western societies, negative perceptions regarding the elderly people have been at the heart of ageism, with elderly people portrayed as dull, intolerant or unproductive, while in reality elderly people are productive members of society. Decision making was described by a nurse as "respect for participation by elderly patients in there care and their wishes about their treatment." Nurse 4 in group one reported, "*I find it comfortable to speak directly to the family about elderly patient's condition and not the elderly patient him/herself* and I believe *most of us including doctors do so."* Another nurse, nurse 2 from the same group opined, *".....yes…. these people can't reason anymore or express themselves…., better to engage a relative into a productive conversation about them. . . .*"

Such perceptions and the attitudes have a direct negative effect on elderly patient care and outcome. The findings suggest lack of knowledge and understanding on issues surrounding the care of elderly patients among nurses, therefore, there is need for continued education through workshops to reorient the nurses to the best practice through evidence based care. The subtle and maybe unintentional stereotypical perceptions of nurses toward older adults that were revealed in this study were cause for concern. The description of elderly people as "needy", "Crubby" mirrors the findings of previous research by Cuddy et al, (2005). In that study, older people were viewed as incompetent and needy and mean.

In as much as it might be a matter of truth that elderly are frail, suffer mental deterioration among others these may not always be true and same in all elderly patients to the extent of denying them the care that they deserve. These findings are consistent with the findings of Blomberg et al., 2013 and Doherty et al., 2011 who asserted that nurses experienced the needs of elderly patients as being demanding even when they expressed an understanding that these could be age related. Age related illnesses coupled with the demanding nature of elderly patients increased the nurses' workload living them exhausted such that they did not look forward to caring of elderly patient the following day.

It is therefore suggested that nurses should exercise a little patience and comply with the needs of these elderly people and provide to the individualised care. When all is done then the nurses have reached the adaptation level and elderly patient care outcomes are supposed to improve. It will also be interesting to find out from elderly patients the meaning of their illnesses and how they wish to be treated.

On the other hand this study indicates that not all nurses have a negative attitude towards elderly patients. Religious and cultural systems, social structures and individual nurses' values were found to affect how elderly patients were valued or viewed in these hospitals. One nurse said "….*at church, home and even way back in schools we were taught to respect elders……., they have done a lot for us and they deserve our attention ,respect and care.*" These good perceptions displayed by respondents may be associated with the fact that the study setting is a similitude of true African society which holds the elderly in high esteem. Musaiger and D'Souza (2009) believed that the elderly are repositories of experience, memories, authority, and wisdom. Therefore, they should be treasured and protected. These findings further support the reports of Ajala (2006) which revealed that Yorubas in Nigeria traditionally, are people who view elderly people as a source of wisdom and guidance based on their varied life experiences. The perceptions are however, contrasted by the work of (Celik et al., 2010) who observed a negative attitude towards geriatric nursing among nursing staff.

Exposure to elderly people within a nurse's personal life was also associated with assisting in creating positive perceptions among nurses. Hweidi and Al-Hassan (2006) reported that nurses who were living with an elderly relative had a more positive attitude towards their elderly patients than nurses who had little or no exposure to elderly relatives. This suggests a difference between stereotypically held views about elderly people and views and behaviors based on actual experiences with individual elderly people. Nurse 6 from group 2 said, "*They become like your grandparents, it's difficult to ...like say... am not going to be there for you. You see, I see my own time coming"* Perceptions here reflected a love for elderly people and an appreciation of who they were. Nurses perceived elderly people as persons who lived exemplary lives and were good role models. A similar study performed by Tuohy (2003), reflected these findings that the nurses exhibited positive attitudes towards elderly people and in general valued them.

The respondents were aged between 22 and 44 which was relatively young sample. The results showed that there was no relationship between age and perception of caring for elderly patients. However despite lack of statistical significance, the results showed that those aged between 24 and 35 (43.2 percent) recorded higher negative perceptions than those with older age group. This entails that the younger the age the more negative perceptions they displayed towards the care of elderly patients. The results were similar to those of Woolf 2006; Cottle and Glover 2007 which negatively correlated age to perception of caring for elderly patients. They found that the older age group had positive perceptions because these have started experiencing some physiological changes that make them understand what the elderly patients go through. This is coupled with the experience as they have taken responsibility of taking care of these elderly patients in their own homes and probably have more years of experience caring for elderly patients.

On the other hand, perceptions of caring for elderly patients were not statistically associated with gender even though females reported a higher (62.8 percent) percentage of negative perceptions compared to their male counterparts (18.2 percent). However, Kaur, et al 2014 disputes these results adding that females have more positive perceptions of caring for elderly patients compared to their male counterparts. This is because culturally females spend their time caring and as such they gain more and more knowledge through experience. The differences between the current study and other studies were probably this study had a small sample of males (23%) with most (77%) of the participants being female. Therefore, there was no much variation from male responses on which conclusive inferences could be made, therefore there is need to have a gender sensitive sample.

Furthermore, it is interesting to note that the percentage of nurses with negative perceptions of caring for elderly patients steadily reduced with increasing number of years in service, from 34.5 percent of nurses who had less than a year in the nursing service to 6.8 percent of nurses with more than 16 years in service.

The results showed that there is no statistical significance between knowledge of caring for elderly patients and perception of caring for elderly patients. However, inadequate knowledge of caring for elderly patients was reflected in the data gathered from respondents. The most important factor identified as influencing elderly patient care is the nurse's level of knowledge of caring for elderly patients. The overall level of adequate knowledge of caring for elderly patients among nurses was at 29 percent.

This is a source of concern especially that the study areas are Zambia's main referral hospitals. The implication is that elderly patients are not given the specialised care and attention they require. The lack of knowledge is due to the fact that the majority (95.3%) of the respondents did not receive lectures on care of the elderly patients during their nursing training. All (100 %) of respondents said that their nursing training was not adequate to enable them deal with elderly patients. Furthermore, in terms of continued professional development all (100%) said nothing was offered with regards to caring for the elderly patients.

Additionally, these results akin those from qualitative data where overall nurses expressed lack of knowledge about aging and general care of elderly patients. Nurses bemoaned lack of specialized knowledge about care of elderly patients which makes it so difficult for them to understand the patients as well as to institute the required care. This shows a direct link between knowledge and nurses perceptions from the nurses' sentiments. Nurse # 2 from group 2 said, "*It is so difficult to nurse these patients because we don't have that education about their care, we use the general patient care knowledge which we learnt from school. Would be better if we had even a few specialized nurses like our friends in other countries*". This emerged from the findings that majority of the nurses who had knowledge deficit also had negative perceptions of elderly patients. As knowledge increases the attitude become more positive. As nurse #1 from group 3 recited "….*for example we yell at elderly patients thinking that they are deaf which is not good because this increases their confusion and fear… as such they become apprehensive and choose to be mute*." A nurse with such understanding of elderly people has more positive perceptions and her approach to the elderly patients will be different from one who has no such knowledge. These findings agree with findings of Eltantawy, 2013; Montejo et al., 2011), whose study demonstrated that nurses lack good knowledge of caring for elderly patients. However, these results contradict findings by Oyetunde et al. (2013) who affirmed that nurses have a negative attitude towards the care of the elderly even though they displayed a fairly good knowledge of geriatric care. Perceptions can influence an individual's behavior and that people with a positive attitude towards anyone will have more positive thoughts about them (Fishbein and Ajzen, 1975). Cultivation of positive perceptions towards elderly people and specialized knowledge about care of elderly patients are of utmost priority. Zwakhalen et al. (2007) further asserted that important knowledge that is available may not reach the nurses in the field and their study, confirm the findings that the information is not sufficiently being disseminated to practicing staff.

Therefore, there is need for continuing education on quality care to improve nursing practice in the care of elderly patients. The knowledge deficit among nurses may contribute to elderly peoples' feelings of loss of independence and control and prolonged hospital stay and readmissions.

However, these findings are contrary to the findings of Faronbi et al. (2017) who found that generally, nurses had good knowledge about care of elderly people. The respondents recognized causes and prevention of complications when providing care to the older adults. Deasey et al. (2014) in their study further stated that good knowledge about the care of the older adults was attributed to nurses' past experiences and education on care of elderly patients which if achieved would contribute to achieving desired cultural change in nurses' perception of caring for elderly patients. It is therefore important to evaluate and revise the contents of the courses to ensure that the knowledge and skills required to work with elderly people are accorded appropriate value and attention.

The study also shows that there was no statistical significance between availability of resources for care of elderly patients and perceptions of caring for elderly patients among nurses. Despite this, majority of the respondents 140(94.6%) who indicated inadequacy of resources for care of elderly patients majority 113(76.4%) had negative perceptions of caring for elderly patients while almost all 7(4.7) of the respondents who indicated adequacy of resources for care of elderly patients had negative perceptions. This entails that nurses generally have negative perceptions of caring for elderly patients. The difference might have arrived due to a small sample size (148). Therefore, there is need to use a larger sample size in future investigations. However, the qualitative data indicated that there is a relationship between perceptions of caring for elderly patients and availability of resources for caring of elderly patients. Like, "*management should improve staffing levels…., put up structures intended for care of the elderly for example handrails in bathrooms and toilets, non-slippery floors, provide adequate equipment and supplies such as low beds wheel chairs as well as organizing deliberate workshops on care of elderly patients*" others said, "*wards and units put up within hospital for the elderly would make sense because it is not easy at all with them in the general wards"*

It was seen that an environment that supports the plight of elderly people would help to change the way nurses perceive elderly patients thereby improving their illness outcomes. Similarly**,** Bolzt et al, (2013) and WHO, (2015) asserted that it was possible to change the perceptions of nurses with provision of the enabling environment which is user friendly. However, Fakuda et al, (2015) in a study that was conducted in India, found that even there the hospitals have no separate units/wards for the older people. The elderly people are admitted and being provided care along with other adult patients in the wards but nurses demonstrated good level of knowledge and attitude towards care of elderly people.

These results mirrored the findings of Boltz et al, (2008) who showed that inadequate resources for elderly patient care gave a sense of burden to take care of elderly patients to nurses thereby compromising the quality of care that they provide to this group of patients. The study by Kihlgren et al. (2005) and Smith. (2006) also directly linked nurses' perceptions of caring for elderly patients to availability of resources for elderly care. Their study concluded similar concerns expressed by nurses in this study that there should be provision of elderly care resources for nurses to cope with the burden of caring as well as to aid in improving their perceptions.

These results agree with Oyetunde, (2013) who revealed that these resources are scarce in low income settings though available in developed countries. Boltz et al. (2013) went further to categorically state the resources that they include appropriate staffing, availability of equipment and services specific to the needs of elderly patients and management support if needs of the elderly people are to be addressed. Also these findings concur with the report by Life through the Eyes of the Elderly in Zambia, (2003) that health facilities and medical personnel specifically for the aged and located within their premises are not available.

These findings suggest the need not only for institution initiative but also a national political will to allocate resources and construct elderly care specialised hospitals, clinics, and wards that will support the needs of elderly people as this will woo the interest of nurses to work with them. Desirable design features included access to toileting facilities, handrails throughout the unit, shock-absorbent flooring and adequate seating. Important equipment cited included pressure relieving mattresses and incontinence products to prevent skin breakdown, wider stretchers or access to beds to promote repositioning.

The availability of hearing amplifiers were also described as practical supports and comfort aids (WHO, 2015) that will support development of positive perceptions of caring for elderly patients for health staff dealing with their care. However, there are no empirically tested standards for these units; their feasibility as well as clinical and cost-effectiveness is an important area for future investigation.

The biggest challenges were huge workload related to understaffing and lack of specialized staff and infrastructure for elderly patients. The theme, *time and staff to do things right*, suggests the need to consider not only just the number of staff but also the adequacy of preparation, role scope, and deployment of human resources as a critical component in care of elderly patients (Parke and Chappell 2010;). Nurses showed negative perceptions toward care of elderly patients emanating from difficulties related to team work and overload associated with high degree of dependence of elderly patients. Most of the nurses were of the view that with their overloads an addition of the elderly person in a ward is asking too much from them. They felt that the burden of care could be lightened if staffing levels, and other managerial issues surrounding care of these patients could be sorted out. However, the study shows that there was no statistical significance between staffing levels and perceptions of caring for elderly patients among nurses despite the majority 148(100%) of the respondents indicating that staffing levels were inadequate. The results are similar with those for qualitative where most of the nurses indicated that they are overwhelmed with workloads due to shortage of staff. Nurse #8 from group 2 recalled, "*Elderly are very difficult, very demanding, not easy at all, you spend all your time caring. There is just a lot to do, everything you do for them… it is so tiresome, lots of weird things about them. So difficult to cope. You really need to be strong and patient. Imagine, alone the whole ward, this one and that one want attention……. If only staffing levels can improve*." Others confirmed ignoring elderly patients in order to attend to what they termed serious cases and these are to do with the much younger age groups. *If i have four or three elderly patients my day is good, it is just to give them their medicine and forget about them, I can't manage with emergencies on people who still have days to live."* "*There is just a lot to do, everything you do for them… it is so tiresome, lots of wired things about them…. so difficult to cope……I think it takes a strong and patient person to care for elderly patients*".

These findings are in agreement with Bolz et al, (2013) whose findings stated that the elderly, in most cases, are dependent on nurses to attain activities of daily living including self-care, thus requiring greater availability of nursing staff. Nurses felt pressure because of a lack of time and an

inability to respect the patients' wishes, as also reported in previous studies (Borbasi et al., 2006; Nolan, 2007; Taniguchi, 2006; Jakobsen and Sorlie, 2010; Yamamoto et al., 2010). It is such short comings that amount to negative perceptions among nurses in care of elderly patients. It is therefore necessary that adequate staff are placed in care units as this may improve the nurses' perceptions as well as their attitude towards elderly patients.

Nurses also mentioned the importance of a family members accompanying the elderly patient during their stay in hospital to relieve their burden of caring. However, nurses bemoaned the attitude of elderly patients' relatives that they are not cooperative. "*They just come to dump them may be to relieve themselves of this burden as well. Those who are luck relatives will once in a while come to check on them but with little understanding of the workload and shortage of staff which makes them shout at us because they want their patient to receive all the attention from the nurse and yet the nurse has all these other patients on the ward who may need emergency care……it's tough"*. These finding agree with those of Fakuda et al. (2015) who alleged that nurses need assistance from families but such assistance is distant or is impossible to obtain and leaves nurses frustrated. Borbasi et al. (2006) also recognized that the family is important in the acute care settings, they are beneficial assets to patients and staff. In contrast the Ministry of Health, Labour and Welfare (2010) in Japan said care facilities aim to relieve family carers of physical and mental load. Therefore, nurses should understand that they cannot gain assistance from families. Nurses need to believe that by caring for some of the elderly patients especially those with dementia they are also caring for the patients' families. This is suggesting even a more workload to nurses which increases the level of negative perceptions.

Additionally, there are no deliberate institutional or government policies for management of elderly patients. Majority of the respondents (70.3) who had negative perceptions of caring for elderly patients indicated that management support for care of elderly patients was not adequate, out of 14.9 percent of the respondents who indicated adequate management support 10.8 percent had negative perceptions of caring for elderly patients. This did not give the statistical significance between the two variables as the Chi-square was 1.176 and a p value of 0.278. These results support those of Dahlke & Phinney, (2008) who found that overall, nurses believed they were in a care context that did not acknowledge or adequately support the unique health care needs of older adults with lack of geriatric specific and sensitive guidelines.

Nurses said, "*let them improve staffing levels…. put and monitor geriatric specific and sensitive guidelines, put up structures intended for the elderly, provide, adequate equipment and supplies as well as organizing deliberate workshops on care of elderly patients*".

5.3 Implications For Training

The implications are related to the problem under study, which explored the nurses' perceptions and knowledge of caring for elderly patients with implications for gerontological nursing training. The implications have their significance on different aspects of gerontological nursing which include, education, research, practice and administration.

5.3.1 Education

More emphasis on gerontological curricula and training in various aspects of gerontological programs are strongly needed. Nurse educators should consider restructuring nursing curricula in Zambia so that integration of aspects related to nursing elderly people takes place early in the program courses. The gerontological content which seems to be scant now need to increase so that nurses are equipped with knowledge and skill to meet the challenges of caring for elderly patients. Higher institutions of learning should provide such education to both in-service and direct nurses who will give guidance in nursing practice.

5.3.2 Practice

The care of the elderly patients is no longer the sole domain of specialist geriatric nurses and is an increasing part of the clinical workload of nurses in the medical surgical wards. Care providers require knowledge, skill and good judgment to carry out the task of caring for these patients. Therefore, there is need for capacity building in practicing nurses to improve their caring skill and knowledge which will assist in reversing the way they perceive elderly patients.

Additionally by providing the knowledge and skills to nurses, it will help to sensitize the community also to dismiss the myths and beliefs about the elderly people such as pain being a normal part of aging and the aging process. Nurses come from these communities with these perceptions of elderly patients which impair the way they provide care to them.

5.3.3 Research

It should be noted that this study is limited to a particular care setting, focusing on the perception of nursing professionals, which shows the importance of further research in other realities that also unveil the perspective of other health professionals and elderly users of health facilities.

Furthermore, it will be interesting to conduct a qualitative study to explore how the elderly people feel about the care they receive or how they perceive the nurses' attitude towards them.

5.3.4 Administration

The practice of holistic care, which is the very essence of nursing, can be undermined due to cost pressures relating to nurse/patient ratios. One of the core management roles is to ensure staffing levels and knowledge bases (skill mix) are allocated appropriately to ensure provision of best practice. Nurses report that workloads are the main factor associated with negative perceptions of elderly patients. It is important for managers to understand that nurses with appropriate knowledge and skills in gerontology which are associated with positive perceptions of elderly patients will maximize benefits to both the patient and the institution. Therefore management should support gerontological nursing so that they recruit and deploy nurses who have the appropriate knowledge and skill for the core.

5.4 Conclusion

This study explored the nurses' perceptions and knowledge of caring for elderly patients. The nurses' descriptions of the pressing issues surrounding care of elderly patients provide useful information for quality improvement activity including organizational initiatives aimed at creating an enabling environment for both users.

A low awareness of ageing and ageing process was reflected in the data gathered from respondents. Educational attainment, exposure to living with aged people and working experiences helped nurses recognize the relationships between aging, common illnesses, and the required care. Results showed that more than half of the nurses (81%) had negative perceptions of caring for elderly. This means they could not offer good health care to the aged.

The study revealed that there was no statistical significance between nurses' level of education, exposure to elderly persons, experience and the age to perceptions of caring for elderly patients. Therefore, the more a nurse is qualified, exposed, experienced and aged, the more likely he/she understood health care need for the aged and the better their perceptions about them. In terms of availability of resources for care of elderly patients most of the patients who indicated the inadequacy of resources had negative perceptions towards the care of elderly patients.

The biggest challenges were increased workload related to understaffing and lack of specialized staff and infrastructure designed for the elderly people. These findings are consistent with other studies.

The elderly population in Zambia is growing. A major goal of nursing education should be to impact nurses' understanding and attitudes toward care of the older adult patients, as well as to influence their career choices toward meeting the health care needs of this growing ageing population. An educational intervention consisting of a robust gerontological nursing content, intentional interaction with the elderly and on-going discussions and reflections of these activities can impact perceptions toward elderly patients in a more positive direction. Also positive feedback from management acknowledging nurses' self-education and reflections about their practice could also contribute to a positive experience for older people.

5.5 Recommendations

Nurses' perceptions toward older adults are important for several reasons which include, elderly population is increasing rapidly, elderly patients often have three or more chronic illnesses that require frequent uses of various health care institutions and perceptions toward working with elderly patients can influence career choices and the quality of care provided to elderly people.

5.5.1 General Nursing Council (GNC)

Nurses who care for this population should demonstrate an interest and willingness to work in that field. The low level of nurses' knowledge and bad perceptions about caring for the aged in this study are associated with the lack of specific gerontological nursing training units in Zambia. There is a need to expose nurses to a nursing curriculum that supports the development of positive perceptions and attitudes toward elderly patients. The findings of this study suggested that clinical practicum with elderly patients in pre service, and educational interventions with a rich gerontological content can positively influence the perceptions of nurses towards care of elderly patients.

Therefore, The GNC should also consider to introduce a nursing specialization in gerontological nursing as this will help to aid in consultation and direction of care needs of elderly people. As such, in-service training through MoH should be intensified for all nurses that are interested in care of elderly patients so that elderly care can be client centered. Change of nurses' perceptions to acceptable levels begin with provision of knowledge and skill that make a difference from perspectives that are held by the general public that may devalue and stereotypes the elderly people.

Further, without education in elderly patient care, the deploying body will deploy nurses without appropriate knowledge and skill, which will counteract staff shortages without looking into the plight of the elderly people being attended to in health facilities.

5.5.2 Government through UTH and LMGH

The government through MoH should establish geriatric friendly care institutions where nurses can do their practicum which in turn will begin to change the way nurses perceive caring for elderly patients. It will also give them a choice of their work environment which will reduce their stress.

5.6 Dissemination of findings

Dissemination of research findings is the diffusion or communication of research findings by presentation and publication to a variety of audiences, such as nurses, other health professionals, policy developers and consumers (Burns & Grove, 2005).

It involves the measures that would be undertaken to make known to the relevant authorities and the study participants what the study has measured. For this study the findings will be printed and bound into reports. The results of the study will be disseminated by submitting a copy of the research report each to the University of Zambia – School Of Nursing and Medical Library for educators and students to use as reference. An executive summary will be sent to the University Teaching Hospital-Adult Hospital and Levy Mwanawasa University Teaching Hospital which were the selected study sites, for management and staff nurses to refer to. The general nursing council which is responsible for nursing education and curriculum development will also receive a copy and one copy will remain with the researcher.

A meeting will be arranged where presentation of research findings and recommendations will be discussed with management of the University Teaching Hospital-adult hospital and Levy Mwanawasa University Teaching Hospital. Findings will also be published in one of the nursing journals and an online presentations will be done in one of the scholarly conferences or seminars.

5.7 Limitations and Strengths of the Study

The study was conducted in government hospitals only due to limited resources which might not have given an adequate representation of how nurses perceive caring for elderly patients in private hospitals. Furthermore the interviews were conducted in the nurses' work places which (though in privacy) are thought that nurses might have censored their responses.

Nevertheless, a conducive environment was created by creating good rapport and assuring them of confidentiality. Also the inconsistencies in wording and definitions of elderly made it difficult to come up with data that represented the meaning of the study topic, however, only the articles that defined the elderly according to their chronological age as those aged between 60 and above regardless of differences in wording for example older adults, geriatrics, elders among others were included in the study.

Three focus groups were conducted due to limited number of nurses with BSc in nursing, one each with diploma nurses, certificate holders and BSc holders. Although we gained a broader insight into the perspectives of nurses, every sector has its specific dynamics and context. Therefore, one focus group per sector might have been insufficient. However, we reached data saturation as new information did not appear and similar themes emerged within the focus groups.

Finally, this study was limited to nurses, but to fully understand the nuances of this relation, it might have been interesting to analyse patients' views.

However, the strength of this study lies in the extensive search of literature. The inclusion of papers utilizing different methodological approaches, including mixed-methods papers provided in-depth insight into factors that influence nurses' perceptions and knowledge of caring for elderly patients despite lacking multiplicity of similar studies carried out in Africa and Zambia for comparison and discussion.

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APPENDICES

Appendix I: **Interview Schedule** SN:

THE UNIVERSITY OF ZAMBIA

SCHOOL OF NURSING SCIENCES

INTERVIEW SCHEDULE

TOPIC: NURSES' PERCEPTIONS AND KNOWLEDGE OF CARING FOR ELDERLY PATIENTS: IMPLICATIONS FOR TRAINING

DATE OF INTERVIEW: …….

PLACE OF INTERVIEW: ……..

NAME OF INTERVIEWER: …….

INSTRUCTIONS TO INTERVIEWER

1. Introduce yourself to the respondent
2. Explain the purpose of the interview
3. Get written consent from the respondent and do not force them to be interviewed
4. Indicate response by ticking in the appropriate space for closed ended questions and indicate responses by filling in the spaces provided for open ended questions

5. Give the respondent an opportunity to ask questions at the end of the interview
6. Do not write name of the respondent on the interview schedule

SECTION A: DEMOGRAPHICS

1. What was your age on your last birthday?
   a. 24 or under
   b. 25--34
   c. 35--44
   d. 45--54
   e. 55--64
   f. 65 or above
2. What is your gender?
   a. Female
   b. Male
3. How many total years have you been practicing nursing? .....
4. What is your highest level of education in nursing?
   a. Certificate
   b. Diploma
   c. Bachelor's Degree
   d. Other (please specify) ……
5. Have you at one point in your life lived with an elderly person?
   a. Yes
   b. No

SECTION B: PERCEPTION AND BELIEFS OF CARING FOR ELDERLY PATIENTS

6. Elderly patients are so slow delaying other ward activities

Strongly disagree	Disagree	Agree	Strongly agree

5	3	2	1

7. It is foolish to claim that wisdom comes with age

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

8. Elderly patients sometimes feck cognitive impairment

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

9. Elderly patients are dependent making their care so tiresome

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

10. Elderly patients cannot express themselves regarding their conditions

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

11. Elderly take longer to recover from physical and psychological stress which makes me loose hope

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

12. I find it difficult to nurse elderly patients

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

13. Its time consuming to care for elderly patients

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

14. Elderly people have unpredictable behaviour

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

15. Elderly people cannot learn new things

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

16. Most of the elderly people practice witchcraft

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

17. Most elderly people get set in their ways and are unable to change

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

18. It is a waste of resources to administer expensive procedures and treatment on elderly patients

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

19. If a ward is set up to admit and nurse elderly patients I would ask for an exemption to work from there

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

SECTION: C KNOWLEDGE DOMAIN

No	**Question**	**No**	**Yes**
20.	In your training as a nurse did you receive any lectures or tuition in care of elderly patients?	1	2

21.	If the answer is yes, do you consider the lectures or tuition you received adequate to enable you deal with elderly patients	1	2
22.	Have you at any time during your working as a nurse attended a short course or workshop on care of elderly patients?	1	2
23.	Elderly care is a serious problem in Zambia	1	2
24.	Elderly patients do not receive quality care that they deserve	1	2
25.	Elderly suffer debilitating illnesses	1	2
26.	Pain is not normal in elderly patients	1	2
27.	Dementia is common in elderly patients	1	2
28.	Some elderly patients suffer from depression	1	2
29.	Aging and aging process varies in different individuals	1	2
30.	Arthritis disturbs their activeness	1	2
31.	Not all medical problems faced by elderly people are due to old age	1	2
32.	Have cognitive impairment	1	2
33.	Some senses Decline in the elderly	1	2
34.	Most elderly people are easy to understand just like young people	1	2
35.	Most elderly people make necessary demands for care	1	2
36.	Hospitalization may impair function ability in the elderly	1	2
37.	Difficult to recognize complications in elderly patients	1	2
38.	Need to build adequate rapport to deal with the elderly	1	2
39.	Need patience to deal with the elderly	1	2

SECTION D: AVAILABILITY OF RESOURCES FOR CARE

40. There are no specific resources directed towards the care of elderly patients

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

41. Available resources for care of elderly patients are not adequate

Strongly disagree	Disagree	Agree	Strongly agree

4	3	2	1

42. Elderly patients are not entitled to the same attention in health facilities as their younger counterparts

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

43. There are no health facilities built and designed for the care of elderly patients

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

SECTION E: STAFFING LEVELS

44. There is shortage of staff to meet the demand of caring for elderly patients

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

45. There are no nurses specialized in care of elderly patients in my ward

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

46. The same nurses caring for the elderly patients are the one to care for rest of the patients

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

47. The nurse patient ratio in my ward is more than 1: 25

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

SECTION F: MANAGEMENT SUPPORT

48. Institutional support to meet the demand of caring for elderly patients is not adequate

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

49. There are no age specific and sensitive guidelines on care of elderly patients in my ward

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

50. Personal effort to care for elderly patients is not acknowledged by management

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

51. Relatives are not allowed by management to supplement care in my ward

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

END OF INTERVIEW

THANK YOU

Appendix II

FOCUS GROUP DISCUSSION GUIDE

UNIVERSITY OF ZAMBIA: SCHOOL OF NURSING

TITLE: **NURSES' PERCEPTIONS AND KNOWLEDGE OF CARING FOR ELDERLY PATIENTS: IMPLICATIONS FOR TRAINING**

Composition of Participants: ……..

Number of Participants: …….

Facilitator: ……..

Recorder (s): ……..

Language used during discussion: ……

GUIDE

1. What is your experience with caring for elderly patients?
2. What thoughts and emotions were generated during your experience with caring for elderly patients?
3. Why do you think you experienced these thoughts and emotions?
4. Explain what you disliked about this experience
5. Explain what you liked about this experience
6. In your own opinion, what do you think is the meaning of aging?
7. Describe what you would want to see happen in the nursing profession to improve your perceptions and knowledge of caring for elderly patients
8. Describe what you would want to see happen in health facilities to improve how you perceive elderly patients
9. Is there anything important you would want us to share pertaining to this topic which we have left out?

THANK YOU

Appendix III

PARTICIPANT INFORMATION SHEET- Quantitative Data

Title of this Research Study

Nurses' Perceptions of Caring for Elderly Patients: Implications for Training

Invitation

My name is Tracy Sijatwa Muvwimi; a student pursuing a Master of Science Degree in Clinical Nursing at the University of Zambia. I am kindly requesting for your participation in the research study mentioned above. The information in this form is meant to help you decide whether or not to participate.

Why are you being asked to be in this research study?

You are being asked to be in this study because you are a nurse working in the medical surgical wards who has worked for a period of more than three months and have nursed elderly patients during this period.

What is the reason for doing this research study?

This research is designed to (1) explore the nurses' perceptions and knowledge of caring for elderly patients (2) determine the nurses' knowledge of aging and the aging process and (3) to find out whether the availability of geriatric resources for care influence how nurses perceive this group of people.

What will be done during this research study?

Your involvement in this study will consist of an interview to answer several questions relating to your perceptions of caring for elderly patients, knowledge of caring for older patients, your knowledge of aging and the aging process and how the availability of geriatric resources for care

affect how you perceive caring for elderly patients, social cultural, institutional and patient related factors that may affect your perceptions and knowledge of caring for elderly patients.

During the interview permission to use information from your interview to complement research data will be sort. The interview should last approximately 25-30 minutes and responses will be recorded on the provided spaces on the interview schedule.

What are the possible risks of being in this research study?

There are no known risks to you from being in this research study.

What are the possible benefits to you?

There will be no direct benefits to you. You may get some satisfaction from knowing that you helped to generate information that will be included in the study.

What are the possible benefits to other people?

The information you provide may add to the body of nursing knowledge and help improve the quality of gerontological education and care of the elderly patients.

What are the alternatives to being in this research study?

Instead of being in this research study you can choose not to participate.

What will being in this research study cost you?

There will be no costs to you as a result of taking part in this study.

Will you be paid for being in this research study?

You will not be paid or compensated for being in this research study.

What should you do if you have concerns during this research study?

If you have a problem as a direct result of being in this study, you should immediately contact one of the people listed at the end of this consent form.

How will information about you be protected?

Reasonable steps will be taken to protect your privacy and the confidentiality of your study data.

Confidentiality will be maintained by changing your names to numbers on all written records. Only the researcher will have access to written records with written names. Records of actual names of participants will be kept in a locked cabinet in the researcher's office.

What will happen if you decide not to be in this research study or decide to stop participating once you start?

You can decide not to be in this research study, or you can stop being in this research study at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator, or with the University of Zambia. You will not lose any benefits to which you are entitled.

If the research team gets any new information during this research study that may affect whether you would want to continue being in the study, you will be informed promptly.

Authorized Study Personnel

Principal Investigator: _____Tracy Sijatwa Muvwimi_____ Phone: _____ 0977849548 email tracysijatwa@yahoo.com

Faculty supervisor: _____Dr. Lonia Mwape _____Phone:____ 0979093045

Chairperson UNZABREC +260 1 256067 email unzarec@unza.zm
The University of Zambia, Biomedical Research Ethics Committee, Ridgeway Campus, P.O. Box 50110, Lusaka, Zambia

Respondent's Initials_____

Appendix IV

INFORMED CONSENT FORM – Quantitative Data

Participants Form

The purpose of this study has been explained to me and I understand the purpose, the benefits, risks and discomforts and confidentiality of the study, I further understand that taking part in the study is purely voluntary, if I accept to take part in this, I can withdraw at any time without having to give an explanation.

I, _____(Names)

Agree to take part in this study.

Signed _____Date: _____ (Participant)

Participants' signature

Signed: _____Date: _____ (Witness)

Signed: _____Date: _____(Researcher)

For further information

We will be glad to answer your questions about this study at any time. You may contact us by phone or email

Principal Investigator: Tracy Sijatwa Muvwimi, Cell. 0975899570

P.o Box 34566, Lusaka, Zambia

Faculty supervisor: Dr. Lonia Mwape Cell. 0979093045
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The University of Zambia, Biomedical Research Ethics Committee, Ridgeway Campus, P.O. Box 50110, Lusaka, Zambia

Appendix V

PARTICIPANTS INFORMATION SHEET – Qualitative data

Title of this Research Study

Nurses' Perceptions and knowledge of Caring for Elderly Patients: Implications for Training

Invitation

My name is Tracy Sijatwa Muvwimi; a student pursuing a Master of Science Degree in Clinical Nursing at the University of Zambia. I am kindly requesting for your participation in the research study mentioned above. The information in this form is meant to help you decide whether or not to participate.

Procedure

The study will involve signing of the consent form. There will be a face to face focus group discussion with other participants with the researcher as the moderator. The discussion will be recorded using a recorder. Guiding questions will be asked which will be recorded in the audio recorder. The interview will take about 45 to 60 minutes; it may be repeated until the required information is captured.

Confidentiality/anonymity

The data we collect do not contain any personal information about you. The discussion and information collected in this study will be kept strictly confidential.

No one will link the data you provided to the identifying information you supplied (e.g., address, email).

Risks and discomforts

There is no risk involved in this research though part of your time will be spent discussing the mentioned topic.

Benefits

There will be no direct benefit to you by participating in this study, but the information which will be obtained will help the policy makers and the training institution to devise programs to improve the learning experience in care of elderly patients. The information obtained will also be used to improve perception of elderly patients among nurses which facilitate provision of quality care to this group of patients.

Voluntary Participation

Participation in this research study is entirely voluntary, that is you may or may not want to participate. Refusal to participate or withdrawal from the study will not result in penalty. Therefore if are not willing to participate in this discussion you will not be required to sign the consent form.

Right to withdrawal

If you choose to participate you may stop at any time. You may also choose not to answer particular questions that are asked in the study. You will also have the right to have your questions about the procedures answered (unless answering these questions would interfere with the study's outcome). However, if you feel like withdrawing at any time, you are free to do so and this will not affect your nursing carrier.

Cost, reimbursement and compensation

Your participation in this study is voluntary. You will receive no money for your participation; however you will have some refreshment after the focus group discussion.

For further information or clarification

We will be glad to answer your questions about this study at any time. You may contact us by phone or email

Principal Investigator: _____Tracy Sijatwa Muvwimi_____ Phone: _____ 0977849548 email tracysijatwa@yahoo.com

Faculty supervisor: _____Dr. Lonia Mwape _____Phone:____ 0979093045

Chairperson UNZABREC +260 1 256067 email unzarec@unza.zm

The University of Zambia, Biomedical Research Ethics Committee, Ridgeway Campus, P.O. Box 50110, Lusaka, Zambia

Appendix VI

Informed consent form – Qualitative data

Participants Form

You have been asked to participate in a focus group discussion being conducted by Tracy Sijatwa Muvwimi. The purpose of the focus group discussion is to explore nurses' perceptions and knowledge of caring for elderly patients.

1. We hope you can be honest even when your responses may not be in agreement with the rest of the group.
2. There are no right or wrong answers to the focus group questions. We want to hear many different viewpoints and would like to hear from everyone.
3. In respect for each other, we ask that only one individual speak at a time in the group and that responses made by all participants be kept confidential.
4. You can choose whether or not to participate in the focus group and stop at any time.
5. Although the focus group will be tape recorded, your responses will remain anonymous and no names will be mentioned in the report.

I, _____ _____ (Names)

Agree to take part in this study.

Signed _____Date: _____ (Participant)

Signed: _____Date: _____ (Witness)

Signed_____ Date: _____(Researcher)

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