Ageism in care home staff: Do staff attitudes towards ageing affect the quality of life of care home residents?

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Abstract

Ageism is prevalent in health and social care, both in terms of the structure of services, as well as the attitudes and behaviours of professionals (CPA, 2009). This thesis explores the ways in which ageism (i.e. ageist attitudes), manifests in health and social care and the consequences of these for residents in health and social care settings. Specifically, the research explores the factors which are associated with attitudes held by care home staff, and the extent to which these attitudes affect the quality of life of the residents they support.

Two empirical studies were carried out on a sample of 18 care homes, from which attitudinal data was collected from 131 staff, and social care related quality of life (SCRQoL) data from 174 residents. Study 1 looked at the attitudes towards ageing held by staff, in terms of prejudice (feelings towards the elderly outgroup), stereotyping (agreement with ageist statements), and anxiety about own ageing. Drawing on intergroup contact theory, the study found that more negative contact with care home residents was associated with stereotyping, whereas positive contact was related to lower ageing anxiety. Subjective wellbeing and job satisfaction were also predictors of ageing anxiety. Negative outgroup attitudes were related to lower job satisfaction and education level. In line with previous research ageing anxiety was additionally found to mediate the relationship between negative contact and outgroup attitudes.

Study 2 investigated the relationship between the staff attitudes established in study 1, and resident SCRQoL. Multilevel analysis showed that a higher average level of ageing anxiety in staff was related to poorer resident SCRQoL. Dementia diagnoses, resident health, and care home quality were also all significant predictors in the final model.

Implications for care homes are discussed, including the need to negate the effect of negative contact reported by staff, as well as the ageing anxiety felt by staff. Training is identified and explored as a potential intervention.

Chapter 1: Ageism in health and social care

Background

There is a growing demand for elderly health and social care in the UK, due to a population that is living longer (Office for National Statistics, 2015), but that is likely to experience poorer health and difficulty with activities of daily living after the age of 65 (NatCen Social Research, 2016). Despite an increase in government policies, which aim to keep older people independent and out of residential care (Humphries, Thorlby, Holder, Hall, & Charles, 2016), much of the health and social care provision for older adults in the UK is provided by nursing and residential homes. A recent report by Laing and Buisson (2017) stated that there are 421,100 people aged 65 and over in the UK living in care homes, a number which has remained stable over the years (ONS, 2015). As it appears that this model of care is here to stay, it is important that high standards of care are maintained and that there is a sufficient supply of care staff and nurses who are knowledgeable and committed to working with older adults in care homes.

Research has shown that ageism is a significant issue, reducing the level of care and support that is being provided to elderly individuals in these settings. Alongside stories of elderly abuse in the media (e.g. “Rosecroft Residential Home abuse case”,(23 December 2016), there is evidence of older people being subject to more subtle, yet frequent, discrimination because of their age. Older people are less likely to be referred by their GP for mental health problems (Age Concern, 2000) or be diagnosed with depression (Linden & Kurtz, 2009), and are more likely to be excluded from decisions being made about the care they receive (Dobbs et al., 2008).

These examples are all indicative of ageism in health and social care professionals. Ageism is defined as prejudicial attitudes towards the elderly, as well as the aging process more generally (R. Butler, 1975). Although ageism can be experienced by all age groups

(Abrams, Eilola, & Swift, 2009), older people requiring care are likely to be vulnerable to the negative effects of prejudicial attitudes, especially so when these attitudes are held by the individuals providing this care. This is evidenced by a UK Care Quality Commission report (Care Quality Commission, 2011) which identified staff attitudes as a major factor in explaining unacceptably low care standards for older people in a fifth of hospitals in the UK. This suggests that there is a link between attitudes held by care providers and the quality of life outcomes of the care recipients, but there is not currently any clear empirical evidence demonstrating the impact of this relationship.

Thesis aims and overview

The aim of this thesis is to understand more about the attitudes towards ageing held by health and social care staff, what these attitudes are and what factors are associated with them. It will then explore how these staff attitudes affect the quality of life of the residents they support. This will be done via three main activities. Firstly, a review of the literature, as well as the current policy surrounding ageism in health and social care, will be undertaken. The aim of this is to explore and evaluate previous research, as well as gain a theoretical understanding of the psychological mechanisms behind ageism; how it arises and how it applies to health and social care settings.

Secondly, two empirical studies are reported. The first study draws upon intergroup contact theory to investigate the role of positive and negative contact with care home residents in the presence and absence of attitudes towards older people and ageing, held by staff members. Ageing anxiety is considered both in its role as an ‘attitude towards ageing’ outcome variable, as well as a mediator between the relationships of contact, prejudice and stereotyping. The second study reports on the relationship between resident quality of life and the attitudes towards ageing held by the staff that support them. Study two uses a

multilevel approach to control for variation between care homes, whilst exploring the individual- and contextual-level factors that explain resident's quality of life.

Lastly, the research findings are discussed in relation to psychological theory, and their implications for health and social care practice are explored. Limitations of the studies are discussed and suggestions are made for further research.

What is ageism?

Ageism is a term introduced by Robert N. Butler (1969), defined as the negative attitudes towards older people, old age and the ageing process. It has also been described as the stereotyping, prejudice and/or discrimination of older people because of their age (Iversen, Larsen, & Solem, 2009). This latter definition reflects the popular tripartite view of the mechanisms behind attitudes (Eagly & Chaiken, 1998) in that attitudes are represented by affective (prejudice), behavioural (discrimination) and a cognitive (stereotyping) components. These three aspects of ageism can be studied individually or collectively as mechanisms that result in ageism (Cuddy & Fiske, 2002).

Ageism can be present both in individuals in the form of attitudes, as well as in terms of the cultural and institutional discrimination against older people. This refers to the way in which older people are discriminated against within societal institutions, such as enforced retirement (Palmore, 1999). Institutional ageism is evident in the structure of the health and care support provided to the different age groups. Whereas care homes for older people which can house upwards of 30 people is commonplace, the same would not be considered acceptable for younger adults (CSCI, 2008).

Evidence of ageism in health and social care

Although one might assume that those choosing to work in the field of elderly care would hold positive attitudes towards the elderly, there is evidence to suggest that ageism is fairly prevalent within the sector. The Centre for Policy on Ageing (CPA) conducted literature-

based reviews across different health and social care services in the UK, which uncovered an extensive body of research that indicated ageism in social care professionals (CPA, 2009). They found that case managers would make not take into account an older person's social needs as they would with younger adults when assessing them for care (Roberts, Robinson, & Seymour, 2002). Also found were reports of staff making the ageist stereotype assumption that older people are not interested in sex when doing assessments, purposefully omitting questions based around sexuality (Billings, 2006). Separate research by Wang and Chonody (2013) found that trainee carers considered older people requiring care as crotchety, difficult, and less rewarding than work with younger adults, therefore preferring to work with the younger cohort. These are examples of how prejudice (i.e. dislike for older people and subsequently their care), stereotyping (i.e. older people as 'crotchety' and asexual), and discrimination (i.e. not attempting to meet older people's social needs), the three facets of the tripartite theory of ageism (Eagly & Chaiken, 1998), all exist within health and social care.

The ageist views held by individuals in the caring profession is not particularly surprising when one takes into account the prevalence of institutional ageism in the UK, in terms of the structure and provision of services for older people. For example, the Commission for Social Care Inspection report into the state of social care in England (CSCI, 2008) posited how it is deemed perfectly acceptable to have 30 or 40 older people living in a residential home, whereas having 40 younger people with a learning disability living together in a hostel is regarded as 'outrageous'.

Further to this, institutional ageism is also evident in the services available for older people, where adults under 65 have a range of specialised services they are referred to depending on need, such as mental health, learning disability, physical disability, whereas those aged 65 or over get referred to the more generic 'older people's services' (CPA,

2009). It also manifests in the attitudes of those who commission those services, as health and social managers will pay significantly more for younger adult services (Roberts et al., 2002), and commissioners have low expectations of the services that are provided for older people (Gazder, 1999).

The difference in the provision of care in younger and older people settings was considered by Kane et al. (2007) to be because older people are considered to be frail and vulnerable, therefore requiring more protection than younger adults with a disability. Dobbs et al. (2008) suggested that this resulted in a difference in the care facilities provided, for example older people are placed in nursing or residential care, where staff carried out the majority of daily tasks such as cleaning, cooking, and making the bed. However, in younger care facilities there is more of an emphasis on promoting independence, with an aim to maintain or improve functional abilities and health (Dobbs et al., 2008). Higgins et al. (2007) found evidence to support this in a study involving nurses in an acute care setting. One nurse described how they were more likely to spend more time and work harder to get a sixty-year-old patient regaining independence, as opposed to an older person who would be going back to a nursing home. This suggests that attitudes and expectations care professional have of younger vs older patients impact on clinical decisions and health care provided to them.

Consequences of ageism for care recipients

The pervasiveness of ageism within the health and social care structure and workforce clearly will have consequences for those on the receiving end of this discrimination. Although no empirical work has been carried out to look at the direct impact that ageist attitudes held by staff have on care recipients, there is evidence that the experience of ageism can affect a person's quality of life. Groger (1995) found that institutionalised older adults were likely to accept other's definition of them as being incompetent when they

were labelled and stigmatized as such. Further to this, when made aware of ageist stereotypes, older people were more likely to report feeling lonelier and displaying more dependent behaviour (Coudin & Alexopoulos, 2010). Marques et al. (2014) also found that older people primed with elderly stereotypes exhibited a reduction in 'will to live', as measured by a hypothetical scenario concerning the acceptance of treatment for a terminal illness. There is also evidence of a relationship between ageist views held by care workers and psychological abuse of older people living in a care home (Bonnie & Wallace, 2003). These consequences of ageism for care recipients highlight the need to reduce ageist attitudes in health and social care professionals. In order to do so, it needs to be understood how ageism arises and how it applies to the care setting.

Theories of ageism and their manifestation in health and social care

In order to investigate which factors are responsible for influencing ageism, it is important to first understand the theories that underlie the basis of ageism, as well as the ways they manifest themselves in health and social care. There are multiple theories that have been put forward to explain the processes behind ageism, although the theories reported here will focus on: Social Identity Theory; age categorisation and the formation of stereotypes; and Terror Management Theory and the role of ageing anxiety.

Social Identity Theory. Social Identity Theory (SIT; (Tajfel, 1981) is defined as "that part of the individual's self-concept which derives from their knowledge of their membership of a social group (or groups) together with the value and emotional significance attached to that membership" Tajfel (1981, p.255). The theory explains how individuals derive their self-concept from the membership in social groups, such as age or nationality, considering themselves to have similar characteristics to others in that group. This process of assigning individuals, and one's self, to social groups, is known as social categorisation.

Indeed, a key facet of SIT is that members of the same social group (the ingroup) are considered similar and more favourably, to other social groups (outgroups). This provides ingroup members with a sense of 'us', which is distinct from the outgroup 'them'. The theory goes on to suggest that ingroup members will seek to further themselves from the outgroup and enhance their own self-image by holding prejudiced views towards outgroup members.

In terms of ageism directed towards older people, SIT would posit that young adults are the ingroup, who would hold prejudiced views about the elderly outgroup in order to differentiate themselves and enhance their self-image. Research has evidenced these prejudicial attitudes towards older people. A large-scale study of ageism across Europe found that people aged 70 and above were perceived as having the lowest social status (Abrams, Russell, Vauclair, & Swift, 2011).

Within a care home setting, SIT would suggest that the social categories might entail carers as one group and elderly care recipients as the other. If carers identify as part of this ingroup, then the theory holds that they may hold prejudiced attitudes towards the elderly care recipient outgroup. Evidence for this comes from Wang and Chonody (2013) who found that trainee carers considered older people needing care as difficult and crotchety, preferring not to work with that group. These negative feelings towards the outgroup within health and social care settings are problematic as they not only contribute to a shortage of care staff, but also have the potential to underpin negative discriminatory behaviours towards older people. To further investigate the prevalence of prejudice in these setting, study 1 will explore prejudice feelings of staff members towards older people.

Age categorisation and stereotypes. Stereotypes are defined by Cuddy and Fiske (2002, p.4) as 'cognitive structures that store our beliefs and expectations about the characteristics of members of social groups'. Categorising others into groups with the belief that each member has similar characteristics can be advantageous in the way that it allows people to simplify complex information about outgroups, and easily access information based on previous experience or knowledge of that group. However, the outcome can often be detrimental, where oversimplifications and generalisations ignore individual differences and lead to assumptions that are incorrect. Allport (1954) posited that prejudice is formed from the categorisation and overgeneralisation of groups. This prejudice then leads to individuals making prejudgement about others based on their 'group', and rationalises behaviours stemming from this.

Common stereotypes of older people include that they are helpless, dependent, irritable, inflexible and have diminished cognition (Robinson & Cubit, 2005). These stereotypes reflect early theory that stereotypes are uniformly negative and unidimensional (Cuddy & Fiske, 2002). Fiske et al. (2002) put forward a different model of stereotypes known as the Stereotype Content Model (SCM), positing that stereotypes are framed by two dimensions: warmth and competence. Elderly people have been consistently found to fall under the categories of 'warm' and 'incompetent' (Fiske, Xu, Cuddy, & Glick, 1999; Fiske et al., 2002), which elicit feelings of pity and sympathy. This is based on the view that older people are seen as low status, and not competitive.

Further work by Cuddy, Fiske and Glick (2007) suggested that stereotypes and affect towards a group shape the way that individuals behave towards that group. They created a model to explain the different discriminatory behaviours towards different groups based on the SCM, known as the Behaviours from Intergroup Affects and Stereotypes (BIAS) Map.

When testing this framework, they found that pitied groups (which include older people), were most likely to experience active helping or passive harm, based on which of the stereotypes of 'warmth' or 'incompetence' (respectively) was most salient. Within a care setting such as a residential or nursing home where an older person is residing due to their dependency, it is likely that the incompetence stereotype of older people (Fiske et. al, 2002) will be confirmed. According to the BIAS Map, this could put them at risk of being disregarded and ignored by the outgroup (i.e. staff), however this has not yet been tested on this population.

Although there is limited empirical research regarding the SCM in health and social care settings, the warm and incompetent stereotypes fit comfortably into the findings from research in this area. Nurses in Helmuth et al.'s (1998) study perceived their interactions with older people in their care as pleasant, although also believed that they were incapable of carrying out vital tasks, or making their own decisions. If care staff hold similar beliefs and subsequently do everything for the residents, rather than enabling them to do it for themselves, this effectively stops them from being independent. Independence is something highly valued by older people (Steele, Lo, Secombe, & Wong, 2009), and having control over aspects of one's own life, including decisions about care, contributes positively to a person's quality of life (Netten et al., 2012).

Another way in which the incompetent stereotype manifests in social care is in the prevalence of elder speak. This is the way in which people 'over-accommodate' their language to communicate with older people, by speaking louder and slower, being overly polite and talking in simple sentences (Giles, Fox, Harwood, & Williams, 1994). This patronising behaviour by staff has been identified as damaging to older patients' dignity

(Gallagher, Li, Wainwright, Jones, & Lee, 2008), another concept that is key to a person's quality of life (Netten et. al, 2012).

The nature of age-related stereotyping is that older people are seen as a homogenous group rather than individuals. An initiative that aims to reduce this and thereby improve care provision is person-centred care, part of the personalisation agenda set out by the UK government (UK Parliament, 2014). If staff believe in age stereotypes, and consider all old people to be similar, they may be less likely to work towards a personalisation work ethos. Even if these stereotypes are not necessarily negative, for example 'old people like bingo', it is more likely that their personal preferences will not be taken into account when planning their care. Many care homes nowadays collect information about the resident when they move into the facility, including information on their likes and dislikes, personal routines, hobbies and interests (Bupa, n.d.), and use this to put together a personalised care plan. However, research has found that care homes do not include residents in decisions about their care, instead consulting family members, and also base activities on a stereotypical assumptions of what older residents would enjoy (Dobbs et al., 2008). For instance, a study by Smith et al. (2017), found very low levels of activity-based occupation in residents, which was explained by care home staff as being due to older people preferring to sleep a lot. This generalisation is problematic as it allows homes to not engage residents in activity, when other research has shown that engagement in meaningful activity is related to higher levels of happiness, better mobility and higher survival rates (Mozley, 2001; Schreiner, Yamamoto, & Shiotani, 2005).

Study 1 will add to this literature by exploring the ageist stereotypes endorsed by staff in care home settings, and which factors are associated with their level of endorsement.

Terror management theory and ageing anxiety. Martens et al. (2004) suggested that negative attitudes toward the elderly arise from three things that people fear older people represent: the future and its inevitability of death; the possibility of losing control of our bodies through dementia; and the anxiety of the deterioration of cognitive and social functioning. Terror Management Theory (TMT) was proposed by Greenberg, Psyzczyski and Solomon (1986). They described it as the psychological conflict between being aware of the inevitability of death and the desire to live. They posited that this produces a 'terror', which individuals attempt to manage by seeking meaning and value in life from symbolic systems and cultural values. Key to this theory is self-esteem, which is described by Becker (1971) as the mechanism by which an individual perceives themselves as having value, as well as a sense of permanence. He stated that self-esteem is the buffer against the anxiety about death, or 'terror'.

Greenberg et al. (1986) suggest in their theory that older people are a reminder of one's mortality, which leads to the association of negative feelings towards them. The theory goes on to suggest that by stereotyping older people, younger adults are able to distance themselves from that group psychologically, and therefore fool selves into believing they will not die. Later work by Greenberg et al. (Greenberg, Schimel, & Martens, 2002) suggested that this can cause a negative cycle, where the more negatively younger people treat older adults, the more negatively they perceive them. This greater negative perception then increases anxiety about death, causing more ageist behaviour. Within a care home setting where it is likely that staff will experience residents passing away, this may compound the fear and subsequently then behave in a more ageist manner in an attempt to psychologically distance themselves.

Experiencing the passing of residents is also likely to induce mortality salience within individuals, which has been found to lead to negative reactions towards those who

challenge the individuals' worldview of a stable, meaningful and permanent reality (Becker, 1971; Greenberg, Solomon, & Pyszczynski, 1997). Martens et al. (2004) manipulated mortality salience in a laboratory study of 105 psychology students. Participants who were primed with thoughts about their own death were more likely to view elderly people less positively. This study demonstrates that mortality salience can be primed successfully and impact on attitudes within a lab setting, by asking participants to think about death. In a care home where it is highly likely that staff will experience the passing of residents, this experience of death could make thoughts of mortality highly salient. In this case, it is the elderly residents who would be the target of the subsequent negativity.

Closely linked to TMT is the anxiety that people feel about their own ageing. Lasher and Faulkender (1993) defined anxiety about ageing as a ‘‘combined concern and anticipation of losses centred around the aging process’’ (p. 247). As suggested by Martens et al. (2004), negative attitudes towards older people may stem from thoughts of the future and the end of life. However, Vickio (1985) noted that there are mixed findings around the relationship between anxiety towards death and ageist attitudes. Whereas some researchers have found them to be positively related, the opposite was found by Salter and Salter (Salter & Salter, 1976). Vickio and Cavanaugh (Vickio & Cavanaugh, 1985) also found that nursing home staff who were comfortable talking about dying and death were less likely to have anxiety about their own ageing.

Lynch (2000) stated that death anxiety is distinct from anxiety about ageing, as ageing anxiety is more specifically concerned with worries about one's decline in physical and cognitive ability, health, appearance, financial well-being and social losses. For care staff, these concerns may be exacerbated, particularly when they see examples of residents who

have had to sell their homes to be able to afford their care, or those who have moved into the home because of their decline on physical or cognitive ability.

Ageing anxiety has not been specifically tested on health and social care professionals, although there are many studies that have investigated ageing anxiety in undergraduates (Allan & Johnson, 2008; S. Harris & Dollinger, 2001), including those studying for a career in health and social care (Boswell, 2012). These studies however do provide evidence that ageing anxiety is related to negative attitudes towards older people. Both Allan and Johnson, and Harris and Dollinger used the Fabroni Scale on Ageism (FSA; (Fraboni, Saltstone, & Hughes, 1990), which measures both the cognitive (stereotyping) and affective (prejudice) components of ageism. Both studies found that ageing anxiety related to more ageist attitudes. Study 1 will add to this literature by exploring the ageing anxiety of staff in care home settings, and how it is associated with other staff factors.

Summary

There are examples of ageism throughout health and social care services in the UK, both in terms of the attitudes of care providers, and the way in which the services for older people are structured (CPA, 2009). There is evidence of prejudice, stereotyping and discriminatory behaviours towards older people by care practitioners (Roberts et. al, 2002; Billings, 2003), as well as ageing anxiety in carer trainees (Boswell, 2012). There is also evidence of older people's experience of ageism being detrimental to their quality of life (e.g. Coudin and Aleopoulos, 2010), however no studies to date have investigated this relationship directly. This gap in the research is therefore addressed in the current research. Drawing on intergroup contact theory and research exploring the training and education in health care settings, the first study explores which factors are associated with the attitudes towards ageing held by care home staff, and second, investigating the direct effect of these attitudes on the care home residents.

Chapter 2: An empirical exploration of care home staff attitudes towards age and their influence on resident quality of life

Abstract

This chapter first describes the first study of this thesis, which aimed to investigate the relationships between the intergenerational contact between care staff and residents, job satisfaction, education and training, and the attitudes towards ageing held by staff. The attitudes under investigation were feelings about the elderly outgroup, anxiety about own ageing, and agreement with ageist statements. To investigate this, questionnaire data was collected from 131 staff from 18 care homes. Regression analysis found that higher level of education was related to reduced negative feelings towards the elderly outgroup, and that positive contact predicted ageing anxiety, whereas negative contact predicted stereotyping. Mediation analyses found evidence that both positive and negative contact affect outgroup attitudes, through the mediating path of ageing anxiety.

This chapter then goes on to describe study two, which investigates the relationship between the attitudes towards ageing held by staff, and the social care related quality of life (SCRQoL) of the residents they provide care for. This was achieved using the staff questionnaire data, and observational data from the residents in the corresponding homes (174 residents across the 18 homes). Multilevel analysis was then performed to account for the nested nature of the data. The final model included ageing anxiety as a predictor of SCRQoL, as well as CQC rating, plus the individual level variables of resident health needs, and presence of dementia.

Study one: Care home staff attitudes towards age and ageing

As noted in Chapter 1, ageist attitudes are prevalent in health and social care, in terms of prejudiced feelings towards older people, stereotyping and anxiety about ageing. There is the potential for ageism to be exacerbated by working within health and social care,

particularly as stereotypes held about older people being unwell are likely to be confirmed, as well as terror management mechanisms being threatened by the passing of older patients. This next section looks at the psychological and situational circumstances that could influence ageist attitudes in this particular context.

Intergroup contact. Allport's (1954) 'contact hypothesis' proposes that positive contact between groups, under certain conditions, prejudice, stereotyping, and discrimination can be reduced, leading to better interactions. Research has found that this theory holds in a variety of social groups, including groups by age (Pettigrew & Tropp, 2006). The conditions proposed as being required for positive contact to be successful include equal status, having a common goal, support from an institutional or social authority, and co-operation between groups (Allport, 1954). Within the context of a care home, some of these criteria are more difficult to achieve than others when considering younger care staff and older people as the residents. Equal status is particularly difficult as the younger cohort provide care for the older, where many of the latter are dependent on the staff for help in personal aspects of life, such as washing and dressing. However, the help that staff provide to residents could be seen as an example of both working co-operatively, and toward a common goal. The goal in this instance is for residents to be able to live a normal, healthy life, using the support that staff provide to them. This, however, requires the resident to be accepting of help, and the staff to be genuinely motivated to help the resident live well (i.e. not holding an ageist view that older people are of poor health and unable to live well).

Support from an authority in the context of care homes could be interpreted as the support from the care home manager to encourage positive interactions between staff and residents. This may be achieved through training for staff, or creating a care home culture or ethos, to ensure as much of the contact between staff and residents as possible is positive.

If the above conditions are met and positive relationships are formed between staff and residents, according to Pettigrew (1998) this should lead better understanding of the respective outgroups. Providing that the outgroup member characteristics are somewhat salient, which is likely as both residents and staff are at the care home because of the older group requiring care. Brown and Hewstone (2005) posit that this should lead to a positive attitude and less stereotyping towards older adults in general.

Although group salience in collaboration with positive contact is necessary to improve outgroup attitudes, there is a risk that in a care setting staff experience negative contact with the elderly residents. While caring can be a highly rewarding job, the role involves potentially unpleasant tasks and the supporting of people who may not always want to be helped. A high proportion of care home resident have dementia (Quince, 2013), which can cause confusion and in some cases physical and verbal aggression (Rosen et al., 2008), which has the potential to upset staff. Support for this comes from Adelman et al. (1991), who suggested that health care staff may be more likely to hold ageist attitudes because of their continued exposure to unwell and infirm older patients. Lookinland and Anson (1995) give further evidence for this, with both nurses and nurses in training viewing older people as cantankerous, set in their ways and complaining. They posited that this resulted in nursing staff emotionally rejecting and stereotyping the patients.

Even if unpleasant encounters are not very regular, Paolini et al. (2010) found that negative contact increased group membership salience and had more enduring effects than that of positive contact. Drury et al. (2017), conducted a study looking at the positive and negative contact experiences that care workers had with care home residents, and how this relates to the attitudes held by staff towards both the residents and older people in general. They surveyed 56 care staff across 22 homes in South East England, which collected information on the valence of contact experienced with residents, and the presences of both blatant and

subtle ageist attitudes. They found that both negative and positive contact with residents was experienced, but that care staff reported significantly higher positive contact. Positive contact was found to be marginally associated with less blatant ageism towards residents, as measured by the rating of feelings towards residents on a 7-point scale such as cold-warm (adapted from the General Evaluation Scale; (S. C. Wright, Aron, McLaughlin-Volpe, & Ropp, 1997). Subtle ageism however, which was measured by the attribution of uniquely human and human nature traits to residents, was significantly related to higher frequency of negative contact, and this was also generalised towards other older adults. These findings suggest that negative contact is a predictor or the denial of humanness towards care home residents as well as older adults in general, which is concerning considering that care staff do report incidences of negative contact with residents.

Drury's (2017) study highlights that positive and negative contact have different effects on ageist attitudes, however, they noted that the small sample size may have limited the effects found of positive contact. A larger sample may have provided stronger evidence for the study's hypothesis that positive contact reduces prejudice.

Ageing anxiety. Although ageing anxiety comes under the definition of ageism as prejudicial attitudes towards old age and the aging process (Butler, 1975), it is distinct in that it is a concern relating to one's self, rather than towards an external group. However, it has been found to be related to negative attitudes toward older people (Harris and Dollinger, 2001). Allan and Johnson (2008) carried out an experimental study looking at the ageing anxiety and attitudes towards the elderly in 113 university students. Using the Ageing Anxiety Scale (Lasher & Faulkender, 1993) to assess participants' feelings towards their own ageing, they found that anxiety was positively related to ageism. They also found that anxiety mediated the relationship between both contact with elderly people and knowledge of ageing, on ageist attitudes. Knowledge was also found by Boswell (2012) to

relate to ageing anxiety. She found that ageing anxiety was reduced following an educational course in gerontology, as well as a reduction in ageism, suggesting that education specifically relating to older people can improve attitudes towards ageing.

The findings on ageing anxiety are mixed however. Prior and Sargent-Cox (2014) found anxiety to mediate between imagined contact and expectations about ageing only for women, whereas Bousfield and Hutchinson (2010) did not find any mediation effect when investigating the relationship between contact quality and attitudes towards older people. They suggested that this may be due to the strong association between ageing anxiety and personality traits, in particular neuroticism, which has been found to remain fairly stable throughout the life-course (L. Harris & Dollinger, 2003).

All of the above studies regarding ageing anxiety as a mediator however, used students as respondents, therefore their experiences of contact are likely to be very different to that of care staff. A study by Boswell (2012) used undergraduates from a course on allied health and mental health to investigate ageing anxiety and contact, however, no studies were identified using active health or social care staff. One of the key components of ageing anxiety is the decline in physical and cognitive ability (Lasher & Faulkender, 1993), something which is likely to be present in the older people that care staff are exposed to more regularly than care trainees. Additionally, the effect of ageing anxiety has the potential to be more consequential if held by care staff. Any behaviours arising from staff anxiety could be relayed onto the vulnerable population that they care for. Therefore, it is important for research to focus on the factors which are associated with ageing anxiety in care staff, and how they relate to other ageist attitudes within a care setting.

Education and training. According to Wells et al. (2004), negative ageist stereotypes are reflective of a lack of knowledge about the normal ageing process. This is

evidenced in several studies which demonstrate a link between education and ageist attitudes. Hope (1994) looked at the education of nurses in acute hospital settings and found that those with higher levels of professional education held more positive attitudes towards the elderly. It has also been found that number of years of schooling (Natan, Ataneli, Admenko, & Noy, 2013) and both elderly-specific and general education (Reyna, Goodwin, & Ferrari, 2007), are related to fewer ageist stereotypes. Education has also been found to be a possible moderator of depersonalisation, as Zimmerman et al. (2005) found that staff with a higher level of education were more likely to hold person-centred attitudes towards older people receiving care. Studies related specifically to nursing found that registered nurses hold less ageist views than nursing aides (Courtney, Tong, & Walsh, 2000), and less experienced nurses are more likely to stereotype older people and feel more negative towards the elderly (Lookinland and Anson, 1995). Wright (1988) posited that the educational training of staff was the most important factor in determining their attitudes towards older people.

Although education around ageing and also general education have been shown to reduce ageist attitudes, other studies have found that training based on the health problems of older people can actually exacerbate ageist attitudes (Lookinland & Anson, 1995; Treharne, 1990). This is potentially due to the focus on the negative aspects of ageing, as the nature of much medical or social care training is likely to be centred on how to treat dementia or age-related conditions such as incontinence, confusion and aggression. However, although training may cover the negative aspects, it may also prepare staff who have chosen to go into a role in caring. Zimmerman et al. (2005) found that those with dementia specific training were more satisfied when working with residents living with dementia.

Dunworth and Kirwan (2012) found a distinction between care qualified and non-care qualified staff working at a care home, finding that non-care qualified staff such as maintenance, domestic and kitchen staff, were more likely to hold ageist views. This raises the question of not only training, but also job roles within the care home setting. Although carers are the staff most likely to have regular contact with residents, other staff members can reasonably be expected to have some form of interaction with residents, and therefore have the potential to impact on their wellbeing. Indeed, Dobbs (2008) put forward that even administrative staff, who do not usually have direct contact with residents, make decisions about resident admission and discharge, suggesting that these transitions could be associated with stigma towards older people.

Education therefore, in terms of schooling, professional qualifications and gerontology specific training, has the potential to affect attitudes towards ageing. Although education has been found to improve attitudes towards older people (Hope, 1994) and reduce stereotyping (Reyna et. al, 2007), there is also evidence that training which focuses on elderly health problems can increase ageism (Lookinland & Anson, 1995). However, there is also evidence that dementia focused training can help care staff feel more prepared and subsequently feel more positively towards work with this group (Zimmerman et. al, 2005). These mixed findings indicate a need for further research into the effects of both professional qualifications and job-based training.

Job satisfaction. Caring for elderly people within a care home is often considered to be a rewarding yet difficult job, which is not particularly well paid, involves long hours, and has a higher staff turnover than in other care settings (The National Care Forum, 2016). The Care Quality Commission (CQC) requires care homes to "provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times" (UK Parliament, 2014). This can be difficult

for providers to uphold at a time of national austerity, where the social care budget has been cut dramatically (ADASS, 2015), and the introduction of the living wage, putting financial pressure on providers to keep their staffing levels to the required standard. This, coupled with an often negative perception of care homes in the media (Davies & Nolan, 2003), has the potential to make recruitment of care home staff difficult.

Job satisfaction is therefore an important aspect to consider for care homes, as it is known to be associated with turnover intention (Parsons, Simmons, Penn, & Furlough, 2003), unreliable work ethic, and absenteeism (Castle, Degenholtz, & Rosen, 2006). Where residents rely on staff for many of their needs, poor work ethic may lead to their needs not being met, and a high turnover of staff makes it harder for residents to build a relationship with them. More directly affecting the residents, job satisfaction is also associated with quality of care (Chou, Boldy, & Lee, 2002), resident satisfaction (Chou, Boldy, & Lee, 2003), and Parsons et al. (2003) even found that staff who were dissatisfied in their job may show aggression towards residents.

As there is a clear impact on resident care and staff job satisfaction, it is therefore important to consider the potential determinants of satisfaction. Zimmerman et al. (2005) found that older staff experienced less stress and more satisfaction in their work. Brodaty et al. (2003) suggested that staff who thought about residents in a negative light would be less involved in their work, therefore becoming less satisfied in their jobs.

Working with residents with high levels of cognitive impairments has been related to stress in nursing home staff (Everitt, Fields, Soumerai, & Avorn, 1991), as has work with residents who show aggression or threatening behaviour (Rodney, 2000). In line with this, Novak and Chappell (1996) found that job satisfaction was greater when working with residents who had fewer cognitive impairments. These findings suggest that staff from

nursing or dementia specialist settings may be more likely to experience higher levels of stress and less job satisfaction, than staff in residential care settings.

Hypotheses

The findings from previous studies suggest that there is evidence of ageist attitudes in health and social care staff, specifically in terms of the stereotyping of older adults, holding negative views about this older outgroup, and also having anxiety about one's own ageing. There is also evidence that these attitudes can be influenced by the level of training and education an individual has, as well as the type of contact that they have with older people. Therefore, the hypotheses for Study 1 are as follows:

1) Staff with more education and training in health and social care will have hold more positive attitudes towards ageing, incorporating: more positive feelings about the elderly outgroup (outgroup attitudes), less anxiety about their own ageing (ageing anxiety), and agreement with fewer ageist statements (ageist assumptions)
2) Staff reporting more frequent positive contact with residents will hold more positive attitudes towards ageing
3) Staff reporting more frequent negative contact with residents will hold more negative attitudes towards ageing
4) Ageing anxiety in staff will act as a mediator between contact with residents, and outgroup attitudes and ageist assumptions

Method

The research presented in this thesis was conducted alongside another project, Measuring Outcomes of Care Homes (MOOCH), which involved the author and colleagues at the Personal Social Services Research Unit, at the University of Kent. MOOCH is exploring the social care-related quality of life of older people living in care homes. Ethical approval was granted for this project by both the University Ethics Committee, and the national

Social Care Research Ethics Committee. The resident data collected as part of the larger study will be treated as secondary data for the purpose of this thesis, and will be reported in Study 2.

Participants and design

Recruitment of care homes. Thirty care homes across Kent and Medway were recruited to take part in the MOOCH project. This was a purposive sample, achieved by inviting equal numbers of homes registered as residential and nursing to take part. Both nursing and residential homes provide care and support to residents, however nursing homes additionally provide medical care by a registered nurse throughout the day and night (CQC definition). Nursing home residents are therefore more likely to have more complex health needs, and therefore staff are likely to have different contact experiences with them.

Home managers were sent an information sheet about the study, and an invitation letter, which was then followed up with a phone call to gauge interest. Homes were invited in batches of 50 with a view that there would be a low response rate of below 50%, as care homes are known to be difficult to recruit (Netten, Beadle-Brown, & Welch, 2011). The recruitment of homes was then a continuous process, inviting homes to take part in the same manner until the target of 30 homes was reached.

Staff. In each home, initially staff named as keyworkers for the participating residents were asked to complete a questionnaire concerning their training, job satisfaction, attitudes towards older people (i.e. agreement with ageist statements and a rating of older people on various attributes), quantity of positive and negative intergroup contact, and feelings about their own ageing. The aim then, was for this data to be matched to the individual resident outcomes. However, this method was adapted after the first few homes as it became evident that not all homes worked under a ‘keyworker’ system. Instead, care

staff were expected to get to know all of the residents and share responsibility for their care. Because of this, and also because residents are likely to have regular contact with multiple staff members because of shift patterns and different staff roles (e.g. activity co-ordinators, domestic staff), all staff who had been interviewed about the participating residents (part of the resident data collection, described in Study 2) were invited to complete the questionnaire. Staff participating in interviews needed to know each resident well enough to answer questions around their preferences, routines and support required. This method allowed for the assumption that participating staff had regular contact with participating residents.

The only eligibility criteria for staff was that they needed to have worked at the care home for three months or more, which was deemed as sufficient time for any attitudes they held to have an impact on the residents they cared for. They also needed to have some form of regular contact with the residents. This differed by home, as some homes encouraged staff in certain roles, such as domestic or catering, to build relationships with residents, whereas in other homes their role would keep them completely separate.

All staff were given an information sheet and consent form, distributed by the care home manager. The information sheet and consent form advised the staff member what taking part in the research would involve, as well as making it clear that participation is voluntary. These documents covered both participation in the MOOCH project and the present study.

Because staff would likely complete the questionnaire outside of work hours, each staff participant who completed and returned the questionnaire were given a £10 high street voucher to thank them for their time.

Measures

The staff questionnaire was formed following a review of the constructs to be measured, identified during the literature review. Each construct, i.e. job satisfaction, had a range of possible measures that were available. The measures selected for the questionnaire were chosen based on their appropriateness for a care staff population, with a preference for measures that were reliable yet brief. It was important to maintain a fairly short questionnaire as previous evidence has shown that care staff, and more generally survey respondents as a whole, are less likely to complete a lengthy questionnaire (Sheehan, 2001). The questionnaire items are described below.

Demographics. Gender and age group were requested, based on the ONS Primary Principles for collecting demographic information (ONS, 2015). Age groups were based on their 'harmonised principle 4', using 5-year intervals. Ethnicity group options were taken from the ONS guidelines on collecting ethnicity data (ONS, online).

Training and qualifications. Training items were taken from a study by Netten et al. (Netten et al., 2011), which looked at ways to measure the productivity of workforce development in care homes. The options are specifically created for care home staff, and include types of training that are most relevant to this group. The first item acts as a filter, which asks 'Have you had the opportunity to undertake any formal education or training as part of your employment?'.

Qualification options were taken and adapted from the National Minimum Dataset for Social Care (NMDS-SC; (Urquhart & Dunn, 2013). The options were shortened, in line with Towers et al., (Towers, Smith, Palmer, Welch, & Netten, 2016).

Job role. Job roles were taken and adapted from the NMDS-SC (as above).

Job satisfaction. Many of the existing job satisfaction measures that have been used within social care work are very long (e.g. 43 item Measure of Job Satisfaction (MJS), (Traynor & Wade, 1993), or the 21-item Nursing Home Nurse Aide Job Satisfaction Questionnaire (NHNA-JSQ, Castle et al., 2007). Because of the requirement to keep the questionnaire as short as possible, the 6-item measure of job satisfaction by Abrams et al. (Abrams, Ando, & Hinkle, 1998) was used. The reliability of the measure was reported to be $\alpha = .90$. The items were presented on a five-point Likert scale from 'very dissatisfied' to 'very satisfied'.

Subjective wellbeing. Subjective wellbeing was measured by two items, rated on a five-point scale, where 1 = 'very dissatisfied/ unhappy', and 5 = 'very satisfied/happy': "Overall, how satisfied are you with your life?", and "Overall, how happy do you feel?". The items were taken from the ESRC report to the ONS on measuring subjective wellbeing (ESRC, 2011). The happiness item was changed from 'Overall, how happy did you feel yesterday', in order to try and reflect an overall happiness rather than based on the previous day, to match the life satisfaction item.

Ageing anxiety. A longer measure was deemed acceptable for measuring anxiety about ageing as it was a key concept in the study, forming part of the model of 'attitudes towards ageing'. The measure used was the Aging Anxiety Scale (AAS, Lasher and Faulkender, 1993), where respondents are asked to rate on a five-point Likert scale how much they agreed with statements concerning their anxiety towards their own ageing. A higher score on the summed items meant less anxiety about ageing. The original measure had 20 items, with a Cronbach alpha of .82. However, due to an administrative error, one item was missed from the scale when creating the questionnaire in the present study. The current scale using 19 items was still found to be reliable, with a slightly higher Cronbach alpha of .84.

The measure is made up of 4 subscales: Fear of old people; Fear of loss; Physical appearance; and Psychological concerns. 'Fear of old people' is intended to measure the discomfort felt when being around those who represent the ageing process. 'Fear of loss' measures the anxiety associated with age-related loss, e.g. loss of friends. The 'Physical appearance' subscale looks at how respondents feel towards changes in their appearance during the course of ageing, and 'Psychological concerns' measures attitudes towards subjective wellbeing in later life.

Ageist assumptions. Thompson's (2006) measure of ageism was used for the second element of the 'attitudes towards ageing' model: the stereotyping component of ageism. The measure is made up of eight statements which Thomson defined as ageist, and for each item, agreement indicates a more ageist view. Two items were added to the measure that were reverse coded (higher agreement = less ageist), in order to check for acquiescence: 'Old people are wise and experienced' and 'It is important to respect older people'. These items also allow insight into potential positive ageism, in that they think positively about older people but that they still agree with older people stereotypes. The inclusion of these additional items however, reduced the reliability of the measure from $\alpha = .73$ down to $\alpha = .69$. Therefore, they were excluded from the final analysis.

All items were rated on a five-point scale, ranging from strongly disagree to strongly agree.

Negative outgroup attitudes. An adapted version of Wright's General Evaluation Scale (Wright et al., 1997) was used to measure prejudice in staff towards the elderly 'outgroup'. Wright et al.'s original method used six bipolar scales to measure how respondents felt towards an ethnic outgroup. The present study used the same bipolar scales (e.g. cold-warm, friendly-hostile), rated on a nine-point scale, but as in Drury et al. (2017) changed the framing of the question to 'Please describe how you feel about elderly people in

general (excluding family members)'. Drury et al. (2017) found that the averaged items (once positively coded items were reversed so that a higher score equalled more negative attitudes) resulted in a reliable index with a Cronbach alpha of .91. The current study had a similar result, with a Cronbach alpha of .89.

Contact. Contact with elderly service users was measured using two items, adapted from Dhont et al. (2010). This measure was adapted to be about the elderly and reduced to two items concerned with the frequency of positive and negative contact: 'How often during work do you have positive experiences (friendly, pleasant or constructive contact) with elderly service users?' and 'How often during work do you have negative experiences (conflicts, unpleasant or hostile contact) with elderly service users?'. Items were scored on a nine-point scale, ranging from 'Never' to 'Very often'.

Analysis

Staff data were analysed initially by running descriptives on all variables, and then correlations for all interval-level and ordinal data. Spearman's rho was computed when looking at any relationships with Outgroup Attitudes as this data was non-normally distributed. For comparisons across the two types of care home registration, nursing and residential, chi-squared ($\chi 2$) tests were used for investigating categorical variable relationships. For continuous variables, t-tests and ANOVA were used, using post-hoc tests to ascertain the nature of the relationships.

Mediation models were run to test the mediating effect of ageing anxiety on the relationship between contact and the other ageing attitude variables (negative outgroup attitudes and ageist assumptions). All analysis was completed using SPSS version 24.

Results

Staff sample

Staff data was collected from 18 care homes, resulting in a total sample of 131 staff. The number of staff who returned a completed questionnaire varied by home, the response frequency ranging from one to 16, a mean of approximately seven staff per home. Because of the change in method mentioned previously, where initially 20 questionnaires were distributed per home, followed by a reduction of distribution to match the number of participating residents (see methods section), it is difficult to judge the actual response rate. It is therefore important to note that the descriptives below can only describe the sample, and are not necessarily representative of all staff in the participating homes.

The age, gender and ethnicity of the staff sample were in line with the adult social care workforce population in the UK as a whole (Skills for Care, 2015). The majority of staff in the sample were female (approximately 91%), and the age of the sample also had a similar normal distribution to that of the social care workforce, ranging from under 20 years to over 65, with a slightly larger proportion of staff aged 55 and over (28% in the present sample, compared to 21% in the skills for care sample). Eighty-three per cent of the sample were from a White British background. The two other groups that were of notable size came under ‘Asian or Asian British’ (9%) and ‘any other white background’ (7%).

The length of time that staff respondents had been in post at their current workplace ranged from three months to 32 years, with a mean of approximately 5 and a half years (*SD* = 5.67). The majority of the sample worked full-time (75%), however, the hours worked per week reported by full-time staff varied from 22 hours to 60 hours per week (*M* = 40.8, *SD* = 7.03).

The professional qualifications of staff, held specifically in a health and/or social care related area, varied across the sample. Twenty-one percent of staff held no professional

qualifications relating to health and social care. Within those with no qualifications, the majority were care workers (58%), with smaller numbers identifying themselves as senior care worker (4%), housekeeping (4%), catering staff (12%), activity staff (8%), and 'other' (15%). In the remaining sample, a large proportion had undertaken some form of further education (post-GCSEs) (62%), with a further 18% undertaking a higher education (university) qualification in health and social care.

Nursing qualifications were grouped under higher education; however, they were also measured separately. Fourteen percent of the sample held a nursing qualification, all of whom worked in a nursing home rather than a residential setting, however, only half of these currently worked as a registered nurse. The remainder of staff with nursing qualifications held job roles mainly around management, either as regional (6%), registered home (11%), unit (22%), or deputy (6%) manager. Surprisingly, one qualified nurse identified their job role as housekeeping staff.

Positive and negative contact

Staff reported incidences of both positive (M = 6.25, SD = 0.90) and negative (M = 3.35, SD = 1.65) contact with elderly service users. However, positive contact was experienced significantly more frequently than negative ($t(113) = 15.20$, $p < .001$). Education level was found to be a factor in the reporting of negative, but not positive contact with service users ($F(2,126) = 4.87$, $p=.009$). Post hoc testing revealed that those who had undertaken higher education (undergraduate or above) (M = 2.71, SD = 1.40) reported significantly less negative contact than those whose highest level of education was up to post-GSCEs (e.g. A-level or equivalent) (M = 3.72, SD = 1.68).

Further to this, when taking nursing qualifications into account separately (rather than being grouped under 'higher education', those with a nursing qualification reported less negative contact ($t(127) = 2.33$, $p=.021$). These findings may suggest that an education in

social care, might prepare staff for experiences they are likely to have when caring for residents, therefore they perceive their interactions more positively.

Contact was also related to whether the staff member had had the opportunity to undertake any formal training as part of their employment. Independent t-tests indicated that staff reported significantly higher levels of positive contact when they had undertaken some form of training ($t(124) = -3.11$, $p = .002$). When broken down into type of training, negative contact was only related to a lack of statutory training ($t(124) = 2.15$, $p = .03$). Positive contact however was related to staff receiving training in statutory training ($t(124) = -1.98$, $p = .05$), administering medication ($t(98.42) = -3.29$, $p = .01$), palliative care ($t(124) = -3.4$, $p = .01$), end of life care ($t(124) = -2.46$, $p = .02$), care planning ($t(124) = -2.08$), $p = .04$), dementia care planning ($t(34.57) = -2.71$, $p = .01$) and person centred dementia care ($t(109.59) = -2.50$, $p = .01$). Again, this might suggest that specific training prepares staff for these forms of contact. For instance, palliative and end of life care may be upsetting to provide, but receiving training in these areas might allow the staff to perceive it more positively.

Subjective wellbeing, measured by satisfaction with life and happiness, was also related to contact. Both items were negatively skewed, therefore are treated as non-parametric. Satisfaction with life was related to more positive contact ($r_s(125) = .38$, $p < .001$), and less negative contact ($r_s(125) = -.25$, $p = .02$). Happiness had similar relationships with both positive ($r_s(124) = .32$, $p < .001$) and negative ($r_s(124) = -.23$, $p = .01$) contact. Life satisfaction was unsurprisingly significantly related to greater job satisfaction ($r_s(122) = .34$, $p = .005$), as was happiness ($r_s(121) = .38$, $p < .001$).

Differences between residential and nursing home staff

In order to check for covariates of care home registration (nursing or residential) that may have an effect on staff attitudes, differences between the staff characteristics of the two

types of care home registration were investigated. These comparisons were made as levels of need are higher in nursing care compared to residential settings, and therefore residents in nursing homes are more reliant on, and more influenced by staff (Chou et al. 2003). Therefore, resident outcomes in nursing settings may have a stronger relationship with staff factors.

Chi-squared tests (see table 1) revealed that there was a significant difference between gender ($\chi 2$ (1) = 5.21, p = .02) and that age group was approaching significance (X^2 (10) = 18.19, p = .05) in nursing and residential care homes, although not between ethnicity or job role. Residential homes had higher proportions of staff in the older age groups.

There was a significant difference observed in the education level of staff between nursing and residential homes (χ^2 (2) = 21.61, $p < .001$). An examination of the standardised residuals indicates for those with a further education (post-GCSE), more staff worked in a residential home than expected. Also, for those with a higher education (university or above), more staff worked at a nursing home and fewer at a residential home than expected.

A total of 127 staff (97%) respondents said that they had undertaken some formal training as part of their employment, however, this did not significantly differ across residential and nursing homes. Neither did many of the listed examples of training differ across home type, except for administering medication (χ^2 (1) = 7.25, p = .007) and dementia care training (χ^2 (1) = 4.61, p = .03), both of which were more likely to have been undertaken by nursing home staff.

Table 1. *Comparison of staff factors across setting*

	Nursing home N = 76		Residential home N = 55		
	n	%	n	%	
Gender					$\chi^2 = 5.21$
Male	10	7.7	1	0.8	$p = .02$
Female	66	50.8	53	40.8	
Age group					$\chi^2 = 18.91$
Under 20	2	1.5	0	0.0	$p = .052$
20-24	12	9.2	4	3.1	
25-29	12	9.2	3	2.3	
30-34	3	2.3	3	2.3	
35-39	6	4.6	4	3.1	
40-44	5	3.8	11	8.4	
45-49	10	7.6	5	3.8	
50-54	9	6.9	3	2.3	
55-59	8	6.1	12	9.2	
60-64	6	4.6	7	5.3	
65 and above	1	0.8	3	2.3	
Prefer not to say	2	1.5	0	0.0	
Ethnicity					$\chi^2 = 11.97$
White British	56	42.7	53	40.5	$p = .063$
Any other white background	8	6.1	1	0.8	
Indian	1	0.8	0	0.0	
Bangladeshi	1	0.8	0	0.0	
Any other Asian	7	5.3	1	0.8	
African	1	0.8	0	0.0	
Arab	2	1.5	0	0.0	
Job role					$\chi^2 = 15.06$
Managerial	8	6.1	3	2.3	$p = .089$
Care worker	32	24.6	23	17.7	
Senior care worker	13	10.0	15	11.5	
Registered Nurse	9	6.9	0	0.0	
Other (includes housekeeping, activity and catering)	13	10.0	14	10.8	
Working hours					$\chi2 = 14.54$
Full time	62	48.4	34	26.6	$p = .002$
Part time	8	6.3	20	15.6	
Flexi time	2	1.6	0	0.0	
Bank/agency staff	2	1.6	0	0.0	
Education level					$\chi2 = 21.01$
No qualification	18	13.7	9	6.9	$p < .001$
Further education	35	26.7	45	34.4	
Higher education	23	17.6	1	0.8	

Note. Education level is based on qualifications related to health or social care. Further education relates to post GCSE qualifications, and Higher education relates to university qualification or above.

Attitudes towards ageing

'Attitudes towards ageing' is operationalized for the purpose of this study using through three concepts: agreement with ageist statements, hereby referred to as 'ageist assumptions' (higher score indicates more ageist), negative feelings towards an elderly outgroup ('outgroup attitudes', higher score indicates more negative feelings), and anxiety about one's own ageing ('ageing anxiety', higher score indicates more anxiety). Both ageing anxiety and ageist assumptions were normally distributed, however outgroup attitudes had a non-normal distribution, with a skewness of 0.62 (*SE* = 0.22) and a kurtosis of -0.87 (*SE* = 0.44). This indicated a strong floor effect to the data, where a large proportion of the respondents gave the most positive possible score for every outgroup attribute. Subsequently, a non-parametric Spearman's rho was used to compare this variable with the other ageing variables.

Theoretically, the three ageing concepts are related (Eagly & Chaiken, 1998; Harris & Dollinger, 2001), however analysis of the current data found only significant positive relationships between outgroup attitudes and ageing anxiety ($r_s(112) = .37$, $p < .001$) and a significant positive relationship between outgroup attitudes and ageist assumptions ($r_s(112) = .24$, $p = .009$). Ageist assumptions and ageing anxiety were not significantly correlated ($r(112) = .13$, $p = .171$).

Looking at the three concepts individually, we can see similar relationships with other staff variables (see table 2). Higher anxiety towards one's own ageing was related to more negative contact experiences with the elderly residents ($r(112) = .29$, $p = .002$), less frequent positive contact experiences ($r(112) = -.32$, $p < .001$), and better job satisfaction ($r(112) = -.29$, $p = .002$). Overall level of education was marginally significant ($F(2,110) = 2.79$, $p = .066$), but when broken down into the individual levels, there was evidence that those with a further education had more anxiety about ageing than those with no further

education (t(111) = -2.00, p = .048. Additionally, those with a nursing qualification had less anxiety about ageing than those without (t(111) = 2.25, p = .026).. Similarly, higher agreement with ageist assumptions were related to more negative contact ($r(112) = .25$, $p = .008$), but not significantly related to positive contact, education or job satisfaction. Positive attitudes toward the elderly outgroup were also related to both contact and job satisfaction. Additionally, a Kruskall-Wallis test showed significant differences between education level and negative attitudes towards the outgroup (H = 9.38, p = .009). Pairwise comparisons found that both those with a further or a higher education, reported more positive outgroup attitudes, compared to those with no qualification in health and social care.

Subjective wellbeing was found to be related to all ageing attitude measures. The two subjective wellbeing items, life satisfaction and happiness, were averaged to create a subjective wellbeing score. Better wellbeing was associated with less ageing anxiety ($r(112) = -.41$, $p < .001$), less negative outgroup attitudes (r(112) = -.23, $p = .014$, and lower agreement with ageist assumptions ($r(112) = -.19$, $p = .044$).

Table 2. Means, standard deviations and correlations between variables.

Measures	1	2	3	4	5	6	7	8	9	10
1. Age group	-	-.17	.35***	.04	.14	.17	-.17	-.18	-.09	-.08
2. Hours worked per week		-	-.04	.13	.07	.04	.09	-.11	-.05	-.04
3. Length of employment (months)			-	.19*	.12	.06	-.05	.05	-.03	-.13
4. Job satisfaction				-	.37***	.14	-.20*	-.29**	-.40***	-.08
5. Subjective wellbeing					-	.35***	-.23*	-.41***	-.23*	-.19*
6. Frequency of positive contact						-	-.16	-.32**	-.32***	-.18
7. Frequency of negative contact							-	.29**	.27**	.25**
8. Ageing anxiety								-	.37***	.13
9. Outgroup attitudes									-	.24**
10. Ageist assumptions										-
M	6.23	36.11	60.73	21.44	4.35	6.21	3.30	2.52	2.92	2.80
SD	2.77	10.69	60.16	3.87	0.82	1.01	1.62	0.47	1.93	0.58

*Note. N = 114. * p < .05, ** p < .01, *** p < .001.* Job satisfaction, subjective wellbeing, ageing anxiety and ageist assumptions measured on 5-point scale; Outgroup attitudes measured on a 9-point scale; positive and negative contact measured on a 7-point scale. Ageing anxiety, outgroup attitudes and ageist assumptions are coded so that a higher score equals more anxiety/negative/ageist.

Because of the differences found between nursing and residential homes in terms of education, as well as some training items, the ageing attitude variables were also checked across setting. Although only ageing anxiety and outgroup attitudes were related to education, previous research has indicated that training and education are related to attitudes towards ageing and older people (e.g. Boswell, 2012). However, independent t-tests found none of the three ageing attitude variables to be significantly related to setting.

Multiple regression models

In order to investigate the unique effects of the variables on attitudes towards ageing, a multiple regression analysis was conducted for each aging attitude dependent variable: ageing anxiety, outgroup attitudes, and ageist assumptions. To check that the data met the assumptions for a multiple regression, a number of checks were made. A missing values analysis was carried out on the variables of interest in the regression. An examination of the output revealed no patterns of missing data within the selected variables, and this was confirmed through Little's MCAR test. This test was not significant (p = .901), therefore the missing data is ‘missing completely at random’.

The remaining assumptions for a regression were checked for each ageing attitude measure, as part of the multiple regression procedure in SPSS.

The variables were also checked for collinearity and independence in residuals. An examination of the coefficients showed that none of the variables correlated above 0.9, therefore the assumption of no perfect multicollinearity was met. The Durbin Watson statistic was above 1 (1.78), and therefore the residuals can be assumed to be independent.

An investigation into the presence of outliers using the Mahalanobis distance test however, indicated that there were outliers in the data. The critical value of the Chi-square distribution based on the 95% confidence level interval with five degrees of freedom was

used as a cut off point for identifying outliers, based on the number of IVs. Data with a Mahalanobis distance above 11.07 were excluded from the analysis.

For each outcome variable (anxiety about ageing, outgroup attitudes and ageist assumptions), the same predictors were initially put into the model that had either been found to be related to the dependent measure, or were theoretically related in the literature. The predictors were subjective wellbeing, amount of positive and negative contact with service users, job satisfaction, and level of education in health and social care. The training item (Have you had the opportunity to undertake any formal education or training as part of your employment?) was not included in the analysis as all remaining cases in the analysis had a 'yes' response. This gave a total of five predictors. The total number of cases used in the model is 131, which is sufficient in line with Green's (1991) rule of thumb that the minimum number of cases to test the overall regression model is 50+8*k*, where *k* is the number of predictors. To test individual predictors, the minimum sample size is 104+*k*. Even when accounting for the missing data within the variables in question, the lowest total N is 110, which is sufficient for both tests.

Table 3. *Factors associated with variance in anxiety about ageing*

Predictor	Beta	*t*	*p*
Subjective wellbeing	-.25	-2.78	.006
Frequency of positive contact	-.21	-2.31	.023
Frequency of negative contact	.11	1.32	.188
Job satisfaction score	-.20	-2.22	.029
Level of education in H&SC	-.08	-1.01	.317

Note: DV = Anxiety about ageing; N = 122; R^2 = .32, R^2_{Adjusted} = .29, $p < .001$

Using simultaneous entry of independent variables for multiple regression, it was found that subjective wellbeing, contact, job satisfaction and education significantly predict 29% of the variance in staff anxiety about ageing ($F(5,108) = 10.18$, $p < .001$). However, when looking at the variables individually, only subjective wellbeing, positive contact and job satisfaction significantly predicted ageing anxiety.

Table 4. *Factors associated with variance in attitudes towards the elderly outgroup*

Predictor	Beta	t	p
Subjective wellbeing	.08	.82	.416
Frequency of positive contact	-.15	-1.61	.110
Frequency of negative contact	.12	1.36	.177
Job satisfaction score	-.32	-3.45	.001
Level of education in H&SC	-.28	-3.33	.001

Note: DV = Outgroup attitudes, N = 110, $R^2 = .31$, $R^2_{Adjusted} = .27$, $p < .001$

Similarly to the ageing anxiety model, the overall regression model for outgroup attitudes was highly significant ($R^2_{Adjusted} = .27$, $F(5,104) = 9.17$, $p = .001$), however, only job satisfaction and education were significant predictors of attitudes towards the elderly outgroup.

Table 5. *Factors associated with variance in agreement with ageist assumptions*

Predictor	Beta	t	p
Subjective wellbeing	-.10	-1.01	.317
Frequency of positive contact	-.05	-.52	.606
Frequency of negative contact	.20	2.08	.040
Job satisfaction score	-.11	-1.06	.290
Level of education in H&SC	-.12	-1.29	.198

Note: DV = Ageist assumptions, N = 114, $R^2 = .12$, $R^2_{Adjusted} = .08$, $p = .014$

The multiple regression carried out on the predictors of agreement with ageist assumptions, found that the prediction model was significant, although not as highly as the previous models (R^2_{Adjusted} = .08, $F(5,108)$ = 3.01, p = .014). The only significant predictor, when the other variables were controlled for, was frequency of negative contact.

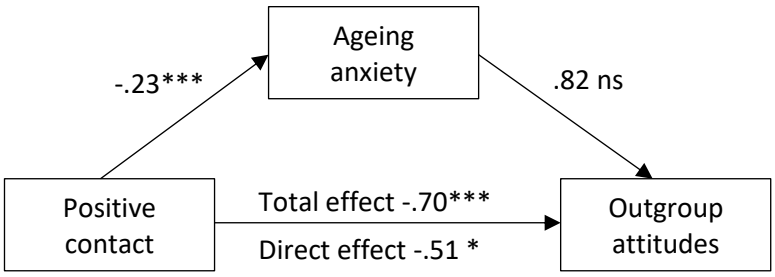
The findings from these multiple regressions suggest that the first hypothesis, staff with more education and training in health and social care will hold more positive attitudes towards ageing, was only partially supported. Education level had a positive effect on the attitudes held towards the elderly outgroup, although not on ageing anxiety or agreement with ageist assumptions. As all respondents in the sample had undergone training, the training variable had to be excluded from the analysis, therefore the current study cannot conclude whether training has an effect on attitudes towards ageing.

The second and third hypotheses, concerning the role of contact in relation to ageing attitudes, was again only partially supported. The second hypothesis that staff reporting more frequent positive contact with residents will hold more positive attitudes towards ageing, was supported only for the regression model relating to ageing anxiety. The third hypothesis: staff reporting more frequent negative contact with residents will hold more negative attitudes towards ageing, was only supported for the outcome variable ageist assumptions.

Ageing anxiety as a mediator

The fourth hypothesis that: ageing anxiety in staff will act as a mediator between contact with residents, and attitudes towards the elderly outgroup and agreement with ageist statements. To test this, four separate mediation models were entered into SPSS using Hayes' (2016) PROCESS model 4, and the indirect path was bootstrap tested with 5000 resamples, bias corrected. The independent variables in the models were frequency of

positive, and frequency of negative contact with residents, and the dependent variables were outgroup attitudes and ageist assumptions.

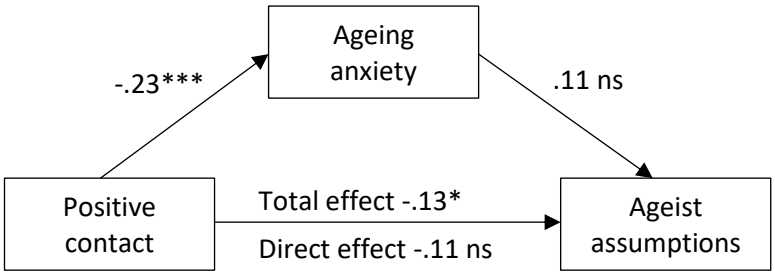


Note. *p < .05, ** *p* < .01, *** *p* < .001.

Figure 1. Indirect effects of positive contact on attitudes towards older adults via ageing anxiety.

There was a significant, negative total effect of positive contact on outgroup attitudes = -.70, SE = 0.20, 95% *CI* [-1.09, -0.30]. This suggests that the experience of positive contact with elderly residents made staff feel more positively towards elderly people. This was reduced but still significant when ageing anxiety was included = -.51, SE = 0.22, 95% *CI* [-0.94, -0.07]. Although there was no significant effect of ageing anxiety on outgroup attitudes, once positive contact was controlled for = .82, SE = 0.39, 95% *CI* [-0.48, 2.05], the mediating indirect path was significant = -.19, SE = 0.09, 95% *CI* [-0.40, -0.04],]. Therefore, there is evidence that ageing anxiety does mediate the relationship between positive contact and outgroup attitudes.

The mediation analysis was run again, this time with ageist assumptions as the dependent variable. The results were similar, the total effect = -0.13, SE = 0.07, 95% *CI* [-0.25, -0.12] was significant, and became non-significant when including ageing anxiety = -.11, SE = 0.07, 95% *CI* [-0.24, 0.03]. However, the effect of ageing anxiety on ageist assumptions was not significant, after controlling for positive contact.



Note. *p < .05, ** *p* < .01, *** *p* < .001.

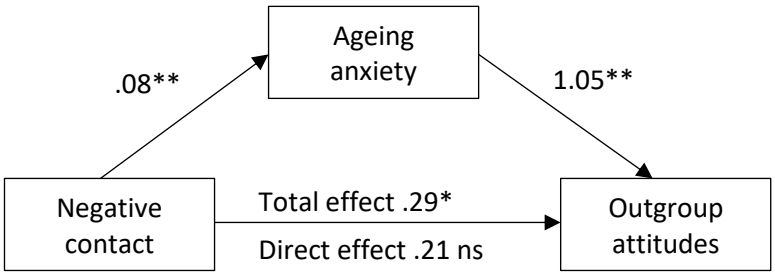
Figure 2. Indirect effects of positive contact on ageist assumptions towards older adults via ageing anxiety.

Next, the mediation models were changed to investigate negative contact as the predictor variable, which the literature suggests can have a stronger, more enduring effect on attitudes towards outgroups than positive contact (Paolini et. al, 2010). In the first model (see Figure 3), with the dependent variable being outgroup attitudes, there was a positive significant total effect = -.29, SE = 0.11, 95% *CI* [0.07, 0.52], suggesting that negative contact with residents had a detrimental effect on the feelings held towards older people. When ageing anxiety is added to the model, the effect of negative contact on outgroup attitudes became non-significant = -.21, SE = 0.11, 95% *CI* [-0.02, 0.44]. The indirect path was significant, = .08, SE = 0.04, 95% *CI* [0.02, 0.19]. Therefore, the relationship between negative contact and outgroup attitudes is fully explained by an indirect effect of ageing anxiety. This suggests that the negative feelings towards the elderly outgroup felt by staff following negative contact with residents, is due to the ageing anxiety induced by that negative contact.

When the dependent variable was ageist assumptions however (see Figure 4), the model showed a similar pattern to the positive contact mediation model. While the total effect was significant = .09, SE = 0.03, 95% *CI* [0.02, 0.15] and reduced, although still significant when controlling for ageing anxiety = .08, SE = 0.03, 95% *CI* [0.01, 0.15], the

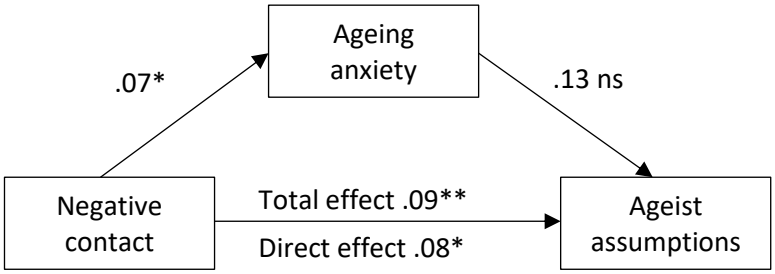
effect of ageing anxiety on ageist assumptions was not significant after controlling for negative contact = .01, SE = 0.01, 95% *CI* [-0.01, 0.04]. Therefore, there was no mediation effect.

In conclusion, the mediation models show that ageing anxiety does not mediate the relationship between either positive or negative contact and ageist assumptions. However, the positive effect of negative contact on the more negative feelings towards the elderly outgroup, can be fully explained by higher levels of anxiety about ageing. Evidence was also found to suggest that the reverse is true for positive contact; positive contact relates to fewer negative outgroup attitudes, due to a reduction in ageing anxiety.



Note. *p < .05, ** *p* < .01, *** *p* < .001.

Figure 3. Indirect effects of negative contact on outgroup attitudes towards older adults via ageing anxiety.



Note. *p < .05, ** *p* < .01, *** *p* < .001.

Figure 4. Indirect effects of negative contact on ageist assumptions towards older adults via ageing anxiety.

Discussion

The aim of study 1 was to investigate what factors are associated with staff attitudes towards ageing, and to test whether ageing anxiety in staff acted as a mediator on the relationship between contact experiences with residents and either outgroup attitudes or ageist assumptions.

The first element of the research, determining which factors contribute to the attitudes towards ageing held by care staff, highlighted a number of key findings. The results found partial support for the hypothesis that staff education levels would be negatively associated with attitudes to ageing. As predicted in line with the literature, education was a significant predictor of 'outgroup attitudes', in that staff with a higher level of education in health and social care were more likely to feel less prejudiced towards the elderly outgroup. Previous research has also found that education can also reduce stereotyping of elderly people (Reyna et al., 2007), however, this relationship was found to be non-significant in the current study. In Reyna et al.'s study however, education was measured using two items that asked respondents about reading materials, training or experience they'd had prior to working with older people, rather than a level of professional qualification. It is possible that the education measure used by Reyna et al. was more similar to the training item used in the present study "Have you had the opportunity to undertake any formal education or training as part of your employment?". It was not possible to include this item in the final multiple regression analysis as all participants had been in receipt of training, however, when looking at the different types of training undertaken, relationships emerged with the ageing attitude variables. Specific training in dementia care and person-centred care was related to less stereotyping (in line with Reyna et al., 2007), whereas training in end of life care was related to a reduction in both prejudice and anxiety about one's own ageing. These findings are of interest as other studies have found that training which focuses on the

negative elements of ageing, such as age-related health problems, can actually increase ageist attitudes (Lookinland & Anson, 1995; Treharne, 1990). Although end of life care could also be associated with other age groups, dementia is most prevalent amongst older adults (Stephan & Brayne, 2008). In the case of person-centred care training, it seems intuitive that this could lead to a reduction in stereotyping, as the nature of person-centred care is to treat the residents as individuals rather than as a homogenous group.

Training items were also found to be related to the reporting of more frequent positive contact in the current study. Positive contact was related to practical training, such as administering medication, as well as different care methods, such as end of life, palliative, dementia and person-centred care. A possible explanation for these relationships is that undertaking training in these areas makes staff feel more prepared for what could potentially be seen as unpleasant experiences, for example caring for a resident living with dementia who is confused and aggressive. A staff member who has an understanding of, and is prepared for these types of interactions, is perhaps less likely to see them negatively. Dementia training may also enable the staff to interact better with those with a dementia diagnoses, therefore these interactions are subsequently more likely to be perceived as positive.

Positive intergenerational contact was highlighted in the literature as a key predictor of attitudes towards older people and ageing, and the current study found some evidence to support this. Staff who reported having more frequent positive contact with elderly residents were less likely to feel anxious about their own ageing. Several studies have considered the role not just of frequency of contact, but of quality of (Schwartz & Simmons, 2001), or even imagined (Prior & Sargent-Cox, 2014) contact. However, few studies have compared the effects of positive and negative contact on ageism (Drury et. al, 2017), and currently no studies have investigated contact valence's effect on ageing

anxiety. The present study therefore provides a novel finding that positive contact with older people can alleviate concern about one's own ageing. This is an interesting finding within a care home stetting as the nature of many interactions in this relationship are likely to be framed by care tasks, for example support with washing, dressing, toileting or medical help. It would be interesting for further research to consider what constitutes positive and negative contact in the eyes of care staff. As noted above, care staff might feel prepared to carry out these tasks, either from training or just by the nature of taking up a job in elderly care, therefore allowing them to perceive these tasks more positively.

Even if care staff perceive care-based tasks as being positive forms of contact, interactions of these kind may not necessarily promote 'equal status', a key requirement in Allport's (1954) contact hypothesis to reduce prejudice and stereotyping. This may be why positive contact did not significantly improve either attitudes towards an elderly outgroup, or the agreement with ageist statements. Additionally, although positive contact was reported frequently, other research has shown that quality of contact is better at reducing prejudice than quantity (Schwartz & Simmons, 2001). A review of intergenerational contact interventions by Christian et al. (2014) found that recreational intergenerational activities could improve attitudes towards older people. This could be applied to a care home setting, where more staff time allotted to doing activities with the residents may result in both good quality and positive contact. This could potentially strengthen the effect that positive contact has on staff attitudes.

Negative contact predicted ageist attitudes, where those who reported more frequent incidences of negative contact were more likely to agree with ageist statements. This finding is in line with that of Drury et al. (2017), who found that negative contact predicted subtle ageism towards care home residents, whereas positive contact did not. This further demonstrates the different roles played by positive and negative contact, and also how a

high frequency of one is not equal to a low frequency of the other. Essentially, it cannot be expected that the effect of positive contact will have an equal but opposite effect to negative contact.

Similar to Drury et al. (2017), negative contact was reported less than positive by care staff. However, any negative contact is problematic as its effects can be long-lasting and increase group membership salience (Paolini et al., 2010). Further to this, negative contact can lead to the denial of humanness of care home residents (Drury et. al, 2017), which could leave them vulnerable to dehumanising treatment by staff (Cayton, 2006).

It would be difficult, if not impossible, for care staff to avoid encountering potentially unpleasant situations with residents. Caring for residents who are very unwell and at the end of life, or those who are confused and aggressive is merely the nature of the job. However, a solution may lie in changing the way that staff perceive these tasks. As reported in the results, staff who had undergone certain types of training reported more frequent positive contact, perhaps due to training preparing them for the relevant encounters. The reporting of more negative contact was related to a lack of statutory training, which lends support to this theory. Without the basic training to support staff in their role as carers, they are likely to feel underprepared to deal with care tasks and therefore perceive them more negatively. A potential solution to improve contact perception and subsequently reduce ageism would therefore be to ensure that all staff undertake at the very least statutory training.

One factor that was key in the prediction of both ageing anxiety and prejudice was job satisfaction, which was also linked to contact. Unsurprisingly, lower satisfaction with work was related to more frequent negative contact with residents, but no relationship with positive contact was found. This provides further evidence that negative contact

experiences have differing and more enduring effects than do positive contact. In this instance, unpleasant experiences with residents were enough to effect happiness with one's job, yet the positive contact was not enough to counter this effect. Again, this points to the importance of the role contact plays on the attitudes held by care staff, even if indirectly through factors such as job satisfaction and training. Further research needs to be undertaken to fully understand these relationships, specifically looking at whether job satisfaction and training mediate the effect of contact on attitudes.

Contact valence was evidently a factor in the prediction of attitudes towards ageing, although potentially via different indirect effects. One other factor highlighted by previous research as a mediator between contact and ageism is ageing anxiety, however, findings are mixed. Allan and Johnson (2008) found ageing anxiety to fully mediate the relationship between contact and ageism, whereas Bousfield and Hutchinson (2010) found no mediation between these variables in a student sample, exploring different context of contact. Further to this, Prior and Sargent-Cox (2014) found the mediation effect was significant for men but not women. The current study found ageing anxiety only mediated specifically between positive and negative contact, and prejudice towards the elderly outgroup. This suggests that either type of contact only affects prejudice indirectly through its effect on ageing anxiety. Anxiety did not mediate the relationship between either type of contact and stereotyping. These mixed findings are unsurprising considering the previous work concerning the mediating effects of ageing anxiety, but they do still highlight the impact of contact and ageing anxiety on prejudice. It is worth noting that the previous studies have all used students when investigating this relationship, whereas the current study involved staff in residential and nursing homes. This is of note for two reasons. Firstly, the type and frequency of staff contact is likely to be quite different from that of students. Secondly, the effect on prejudice could potentially have a greater, more

direct impact on older people, specifically the residents who are dependent on staff for many aspects of their lives. Because of this, it is important to carry out more research with this population, whose attitudes could have real influence on the older people within their care. In particular, further research should investigate how to negate the effects of negative contact through the reduction of ageing anxiety. Knowledge about ageing has been found to reduce ageing anxiety (Allan & Johnson, 2008), and the current study found links between the role of training and perception of contact. This suggest that age-specific education could be key to understanding and improving this relationship in care home staff.

Limitations

A potential issue with the collection of attitude data via self-completion methods, is that they are susceptible to social desirability bias. In a population such as care staff, whose role as protector and supporter of the elderly is likely to be highly salient when completing a questionnaire about their care experience and training, respondents may feel as though they should not report negative feelings towards older people. This may be why the measure of outgroup attitudes had such a strong floor effect due to the number of respondents rating the elderly outgroup as highly positive. Another explanation for this however is that respondents rated older people so highly *because* of their job role, in that they chose to work with older people because they feel positively towards this group. A better way to measure attitudes whilst removing any potential bias would be to use an implicit test, such as the Implicit Association Test (IAT; (Greenwald, McGhee, & Schwartz, 1998). A test such as this was not within the scope of the current study due to the computing resources required, and also the requirement for the survey to be able to be completed in as little time as possible, in order to fit in with the busy schedule of staff.

Future research could consider the use of a computer tablet for staff to complete the questionnaire electronically, incorporating the IAT.

A second limitation to the current study was that it did not include a measurement to check that staff saw themselves as in a different social group to the residents. A possible check could have been to ask at what age staff believed that old age started, as in Abrams et al. (2009). This would have indicated whether the older staff in the sample saw themselves as 'elderly', which would help ascertain whether intergenerational contact was actually responsible for difference in attitudes.

Summary

Study 1 investigated three types of attitudes towards ageing held by care home staff: prejudice, as measured by negative attitudes towards an elderly outgroup (outgroup attitudes); stereotyping, as measured by the agreement with ageist statements (ageist assumptions); and anxiety about one's own ageing (ageing anxiety). Positive and negative contact was predicted to influence all of the attitudes towards ageing but in opposite direction. The results however found that positive contact was only related to less ageing anxiety, and negative contact to higher agreement with ageist assumptions. The attitude measures were calibrated to measure negative attitudes; therefore, it is possible that social desirability bias was responsible for care staff responding in a more positive way.

Ageing anxiety was found to mediate the relationship between negative contact and negative outgroup attitudes, but had no such effect on the outcome variable ageist assumptions, nor for any models with positive contact as the predictor. This adds to the mixed findings on ageing anxiety as a mediator, but does suggest that ageing anxiety should be taken into account to improve attitudes towards the elderly following the inevitable negative contact that can take place in care settings.

Study 2: Do staff attitudes towards ageing affect the quality of life of care home residents?

For older adults that live in a care home, the causes and effects of ageist attitudes by social care professionals is of particular importance to investigate. Care home residents are a vulnerable population, relying on care staff for many aspects of their lives, and therefore have the potential to be greatly affected by staff attitudes. Residents often have high levels of dependency, and a range of physical and cognitive needs (Darton et al., 2012). Undeniably, the reason for many people living in a care home is because they are unable to fully care for themselves or because their needs are too high for family to take on and professional care is required. For a population so reliant on staff, they are at risk of their quality of life being affected by ageist attitudes held by the people who care for them.

As highlighted in Chapter 1, ageism is prevalent in health and social care, both in terms of the attitudes of individual members of the workforce as well as the institutional ageism of the structure and provision of support available (CPA, 2009). There was also evidence that exposure to ageism can have adverse effects on older people in care, such as increase in loneliness (Coudin & Aleopoulos, 2010) and a loss of will to live (Marques et al., 2015).

Many studies have highlighted consequences of ageist attitudes that are likely to impact on a care recipient's quality of life, such as nurses admitting they'll work harder to get younger patients to regain independence (Higgins et al., 2007) or care home managers leaving residents out of decisions regarding their care (Dobbs, 2008). These examples demonstrate how ageism in carers has the potential to impact negatively on the people they care for, but as of yet, only two studies have been identified that address the direct relationship between staff attitudes and quality of life. Zimmerman et al. (2005) looked at the link between dementia care and quality of life, in a study of 421 residents across 35 care homes in America, also collecting attitude data from the staff in each home. They

found there was a significant positive relationship between resident quality of life and staff who rated themselves as having more dementia sensitive attitudes. Lintern (Lintern, 2001) also found that staff with more 'hopeful' attitudes towards dementia would engage more with residents, and in turn residents had better quality of life. The attitudes measured in these two studies, however, are dementia specific, rather than relating to ageist attitudes.

In order to understand how ageist attitudes could influence a resident's quality of life, one needs to consider what is meant by quality of life, as well as which areas of life should be taken into account when investigating its quality.

Quality of life

A definition of Quality of Life (QoL) comes from the World Health organisation: 'individuals' perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns' (Whoqol Group, 1995). QoL is a heavily researched phenomenon, with a plethora of existing measurement tools. Even 14 years ago, Thorgrimsen et al. (2003) stated that there were over 1000 scales that measured QoL.

Despite the large number of measures, there is a consensus that QoL is multidimensional. A popular theory by Lawton (1994) is that a good life is represented by objective (i.e. environmental components) and subjective measures (i.e. wellbeing). There is less consensus, however, on the correct methodology for measuring these components, and variations include face to face interview (e.g. QOLI; (Lehman, 1996), postal survey (e.g. EQLS; (Anderson, Mikuliç, Vermeylen, Lyly-Yrjanainen, & Zigante, 2009) and using a proxy (e.g. DEMQOL-proxy; (Smith et al., 2007).

The latter method is often used for measuring the QoL of people accessing health and social care, particularly in populations with cognitive or communication difficulties, who

are unable to complete a questionnaire or interview. However, proxy measures have been found to have limited reliability when tested against resident self-reports of QoL (Sloane et al., 2005). As more than 80% of UK care home residents live with dementia or experience severe memory problems (Alzheimer's society, 2013), it is crucial that there is a reliable method of assessing the quality of life of these residents, otherwise there is a risk that the experiences of individuals will be ignored.

Observational methods are one solution to ensure the inclusion of all care home residents, regardless of capacity. Dementia Care Mapping (DCM; (Bradford Dementia Group, 1997) is a tool that involves the coding of participant activities based on their behaviour and well- or ill-being. DCM measures QoL via the components of engagement, occupation, wellbeing and affect. The measure has been praised in its use as a research tool (Sloane et al., 2007), however, the subjective nature of the observational coding has been found to produce low levels of inter-rater reliability (Thornton, Hatton, & Tatham, 2004).

Another observational tool, which supplements observations with interviews with residents, family and staff (where possible) is the Adult Social Care Outcomes Toolkit (ASCOT; Netten et al., 2012). This mixed method approach has been found to have good inter-rater reliability (Towers et al., 2016), and is suitable for collecting QoL information on all residents rather than being specialised for individuals living with dementia. ASCOT measures the domains of life that can reasonably be expected to be affected by being in receipt of social care, known as social care related quality of life (SCRQoL). The eight domains are personal cleanliness and comfort, accommodation cleanliness and comfort, food and drink, safety, occupation, social participation, control over daily life, and dignity. The measurement of these domains falls under the objective and subjective principles of QoL as noted by Lawton (1994), as it measures the objective elements of a person's life

(i.e. their accommodation) by rating how well it meets their needs (i.e. is the accommodation to their preference).

Factors associated with quality of life

A review of the literature found that whereas many studies have investigated individual resident factors, home characteristics, and to a lesser extent some staff factors in relation to resident QoL, no studies were identified as investigating the effects of staff attitudes towards ageing. Resident factors that have been found to significantly affect their QoL include depression and anxiety (Hoe et al., 2006), behavioural disturbances (Beer et al., 2010), dependency (Barca, Engedal, Laks, & Selbaek, 2011) and impaired cognition (Wetzels, Zuidema, de Jonghe, Verhey, & Koopmans, 2010).

Factors associated with the care environment or the residential setting have had a more mixed response in terms of their effect on QoL. Zimmerman et al. (2005) accounted for a number of facility level characteristics in their study, including the size, age and affiliation (i.e. independent or part of a chain), however, found none of these to be significant predictors of QoL. Netten et al. (2012) looked at the relationship between care home quality rating rated by CQC and SCRQoL, as measured by the ASCOT, and found there to be a positive relationship for residential homes, but not nursing homes. The authors, however, noted that the way in which CQC rated homes was at a point of transition, and suggested that their future methodology should be more clearly linked to resident outcomes. The new CQC ratings system began being used in homes in 2014, and completed inspections of all services under the new regime by February 2017 (CQC, 2017).

Staff factors were much less researched in relation to QoL. A report by the Institute of Medicine (1986) noted that the motivation and attitudes of staff and management in nursing homes were critical factors affecting resident quality of life, although offered no

empirical evidence. Zimmerman et al. (2005) and Lintern (2001) however both found evidence for a relationship between better resident QoL and staff who held positive attitudes towards dementia.

These studies are novel in that they are able to make direct links between staff and residents, which has not been identified in other studies. They are also subsequently two of the very few studies which take into account any staff attitudes when looking at resident quality of life. These studies, however, are specifically focused on the quality of life of residents with dementia, and the staff attitudes measured in the study are also dementia specific, rather than to do with ageing. At the time of writing, no studies have investigated the direct impact of staff ageist attitudes on the quality of life of care home residents. Therefore, this study seeks to address this gap in the research literature by collecting both staff attitude and resident quality of life data from the same care homes, so that direct associations can be made between the two. This data was collected across multiple care homes, therefore a multilevel approach needed to be used to account for differences between the homes.

Although there is no empirical evidence of staff attitudes towards ageing having an effect of care home resident QoL, there are plenty of studies that highlight the prevalence of ageism in health and social care, as well as the negative implications for older people receiving care. The aim of Study 2 therefore was to investigate the role of the attitudes towards ageing held by care home staff identified in Study 1, on the SCRQoL of the residents they support.

Hypotheses

The hypotheses are as follows:

1) Staff with less anxiety about ageing will lead to better social care related quality of life (SCRQoL) for residents
2) More positive attitudes held by staff towards an elderly 'outgroup' will lead to better social care related quality of life (SCRQoL) for residents
3) Less agreement with ageist statements by staff will lead to better social care related quality of life (SCRQoL) for residents

Method

Participants and design

Recruitment of care homes. The recruitment of homes was as described in Study 1. Thirty care homes were recruited to the study, however only the 18 that returned staff questionnaires were included in the analysis, in order for the staff and resident data to be matched.

Residents. All residents living in the home were eligible to participate, regardless of capacity. Residents were deemed to not have capacity if they were unable to understand the study and the implications of taking part, as well as remember the information long enough to be able to make an informed decision. In line with the Mental Capacity Act (2005), residents without capacity were invited to take part in the research via a personal consultee. This was usually a family member, identified and sent the information by the participating care home manager. Consultees were provided with information about the study and what taking part would involve for their relative. They were then asked to complete a form advising whether they thought their relative would want to take part if they had the capacity to decide themselves. Residents without capacity were included in the study as the MOOCH project is looking at social care related quality of life of older

people living in care homes. Therefore, it is essential that the research does not exclude people with dementia or those who lack capacity, who will inevitably make up a larger proportion of the care home population.

Residents with capacity to give informed consent were approached directly by the care home manager or a dedicated member of staff, and invited to take part. Copies of the information sheets and consent forms given to residents and consultees are included in Appendices B and C.

Care home managers were asked to recruit between 5-10 residents. In order to attempt to get a representative sample of the home, they were asked to randomly select the residents to be invited. A suggested method for this was to select every nth resident on an alphabetised list, with n depending on the total number of residents in the home (i.e. to recruit ten residents in a 30-bed home, every third resident on the list would be invited).

Residents who took part in the study were given a £10 high street voucher to thank them for participating.

Measures

Individual-level variables (Level-1)

Residents. The care home version of ASCOT (CH3) was used to collect SCRQoL resident data. The toolkit uses a mixture of observations and interviews with residents, staff and family members to make a rating of each resident's SCRQoL on eight different domains. The domains cover the basic (personal, cleanliness and comfort, accommodation cleanliness and comfort, food and drink, and feeling safe) and higher order (social participation, occupation and control over daily life) aspects of SCRQoL, and there is also a domain to measure how the way the care and support is delivered impacts on service user's self-esteem (dignity).

Observations are carried out over a minimum two-hour period, which includes a meal time. Interviews are carried out after observations in case anything arises that can then be followed up. A maximum of six residents can be observed during one session. Between two and four days were spent in each home, depending on the number of participating residents.

The mixed methods approach is specifically designed for use with care home residents, as often this population are unable to answer structured interview questions on how they feel about their life, particularly in more abstract domains such as control. Therefore, the observations and interviews with staff and family help to create a comprehensive picture of the individuals' quality of life.

The eight domains are rated by the researcher after collating the evidence from interviews and observations. A four-level scale (Netten et al, 2012) is used to describe the extent to which the resident's needs are met. The levels are as follows:

1. Ideal state: The individual's wishes and preferences in this aspect of their life are (or would be) fully met.
2. No (unmet) needs: The individual has (or would have) no or the type of temporary trivial needs that would be expected in this area of life of someone with no impairments.
3. Some (unmet) needs: Some needs are distinguished from no needs by being sufficiently important or frequent to affect an individual's quality of life.
4. High (unmet) needs: High needs are distinguished from some needs by having mental or physical health implications if they are not met over a period of time. This may be because of severity or frequency.

Residents get an individual score for each domain, as well as an overall SCRQoL score which is calculated using preference weights (Netten et al, 2012), reflecting the importance of each domain in affecting someone's quality of life. The SCRQoL scores can then be aggregated to give a 'home level' score, indicating how well a care home as a whole meets the needs of its residents.

Care home managers were also requested to provide information on the participating residents' demographics, dependency, communication abilities and other relevant characteristics. Specifically, information on age, gender and health needs, as measured by level of help required with activities of daily living (ADL; (Mahoney & Barthel, 1965). This was collected via a short self-completion questionnaire, which managers completed and returned following the completion of fieldwork in each home.

Home-level variables (Level 2)

Staff attitudes. Staff data was collected as described in Study 1. The variables of interest for Study 2 were ageing anxiety, outgroup attitudes (prejudice) and ageist assumptions (stereotyping). For the purposes of comparing staff attitudes with resident outcomes, staff attitude variables were aggregated by home, in line with Tzeng, Ketefian and Redman (2002). They used this method rather than matching staff to specific residents as more than one nurse of carer is usually involved in providing care for a resident. Therefore, each attitude variable reflected the average level of staff attitudes within the home (i.e. average staff anxiety about ageing).

Quality of the care home. Contextual information about each care home was also collected, including the CQC inspection rating (rated on a scale of one to four, where 1 = inadequate, 4 = outstanding). Other information collected included whether the home was

registered as supporting people with dementia, number of beds, and sector (not for profit, for profit, or run by the local authority)

Analysis

Resident data was entered into an SPSS database, separate from the individual staff data. The aggregated staff variables were imported into the resident database, matching by home ID. Descriptives were ran on the resident demographic, health and SCRQoL data. Selected resident (individual level) and home (contextual level) data were then added to multilevel models, with an aim to test which ageing attitude variables significantly predicted SCRQoL when controlling for the differences in homes. Because the data was nested (individuals nested within care homes), a multilevel model approach was appropriate for the analysis, to control for the variation in Social Care Related Quality of Life (SCRQoL) caused by home level (Level-2, contextual) factors.

Initially, an empty model with no predictors was run to see whether there was enough variation in SCRQoL across homes to require a multilevel analysis. The model was then gradually built by adding predictors and checking for improvement in model fit. Model 1a and 1b included the individual level (Level-1) factors, to see whether controlling for differences in certain resident characteristics accounted for differences within homes. Models 2 to 5 added the Level-2 variables separately, to preserve the degrees of freedom. The final model incorporated the significant Level-1 and -2 predictors.

Results

The resident sample with complete SCRQoL data consisted of 174 residents. However, demographic and dependency information was collected separately using a short questionnaire provided to each care home manager. Unfortunately, a lot of this requested data was left incomplete, therefore there were large amounts of missing data for resident

characteristics. These cases with missing data were retained for the analysis, however, as not all of the planned models required this individual level data.

Across the 18 care homes, number of participating residents per home ranged between five and 20. The residents had an age range from 58 to 103 years old *(M* = 84.31, *SD* = 8.65) and the majority of the sample were female (64.9% female, 25.3% male, 9.8% missing). Half of the sample were windowed (50.6%). The marital status of the remaining residents was either married (22.4%), single never married (8.0%), divorced (6.9%) or living as married (1.1%). The health of the residents, as measured by their capability of carrying out different 'activities of daily living' (ADLs), indicated a full range of ability though the sample. Possible ADL scores ranged from one, indicating independence in all ADLs, to four indicating the inability to do any of the ADLs. The mean ADL score was 2.70 (*SD* = 0.85), with a negative skew of -0.29, indicating that the sample had higher levels of needs. This is unsurprising, as the reason many people move into a care home is due to them needing help in the areas of life measured by the ADLs. The prevalence of residents with a diagnosis of dementia was 49 per cent.

SCRQoL, where a higher score (within a range of 0-1) indicates a better quality of life, ranged from 0.31-1.0, with a mean of .78 (*SD* = 0.16). The scores were negatively skewed (skewness = -0.64, *SE* = 0.18, kurtosis = -0.14, *SE* = 0.37), suggesting that a large proportion of residents had a good quality of life. This is a positive finding considering the high level of need in the sample.

Multilevel analysis

SPSS version 24 was used to carry out the multilevel analysis, using the mixed model function. Full maximum likelihood estimation was the method used for the analysis as it allows for the comparison of how well each nested model fits the data. This is done by assessing pairs of nested models using a likelihood ratio test, where the difference in the

deviance statistics (-2 Restricted Log Likelihood) is tested against the chi-square distribution of the associated degrees of freedom.

The first step of the multilevel analysis was to establish how much variation in SCRQoL is due to the residents being from different care homes. This was done by running an empty model (i.e. a model with no predictors, and only 'Home ID' as the Level-2 grouping variable) to calculate the intra-class correlation coefficient (ICC) of SCRQoL between homes. The ICC of SCRQoL was 0.16, meaning that 16% of its variance is due to differences between homes. Therefore, there is adequate variation between homes to use multilevel analysis.

The next step was to add a number of individual level (Level-1) variables to the model (Model 1a), including resident age, gender (1 = male, 2 = female), dementia diagnosis (1 = yes, 2 = no) and health needs (ADL), to account for the difference in resident SCRQoL within homes. This model accounted for 17.32% of the difference in SCRQoL within homes, however, only ADL (B = -.04, SE = 0.02, p = .005) and dementia diagnosis (B = -.09, SE = 0.03, p = .001) were significant predictors of SCRQoL. The model fit, as judged by the -2 Restricted Log Likelihood, for the model incorporating all the Level-1 factors was poor, but improved when removing the non-significant predictors (model 1b). This was confirmed by doing a chi-square test for nested models, which showed a significant improvement in fit when including only ADL and dementia diagnosis, as opposed to all individual level predictors [$\Delta \chi^2(2) = 26.57$, $p < .05$]. Therefore, only ADL and dementia diagnosis were included in further models. Once age and gender were removed from the model, the variance explained between homes increased from a negative number, suggesting that there were variables in the model that were not aiding prediction, to 15.56%. This suggests that a lot of the variation in SCRQoL is due to the differences in dependency across homes. This seems reasonable as it is likely that homes will differ in the

level and type of support they are able to offer residents, for example nursing homes are likely to have higher level health needs, and dementia specialist homes will have the highest frequency of residents living with dementia.

Models 2 to 6 explored the impact of home level (Level-2) factors, which could be responsible for the difference in SCRQoL between homes. CQC inspection ratings were the first Level-2 data added into the model alongside ADL and dementia (model 2), as there is evidence that better quality care homes lead to better quality of life (Netten et al., 2012). Homes are rated by CQC on a one to four scale, with four being outstanding and one being inadequate. For the purpose of this analysis, CQC scores are treated as a continuous variable

Model 2 revealed that ADL, dementia accounted for 14.42% of the variance within homes and CQC accounted for 54.86% of the variance in SCRQoL between homes. All were significant predictors of SCRQoL. Higher health needs (ADL) (B = -.03, SE = 0.01, p = .015) and diagnosis of dementia (B = -.08, SE = 0.03, p = .001) predicted lower SCRQoL, and better quality of care (CQC) (B = .07, SE = 0.03, p = .030) predicted higher SCRQoL. This suggests that including care home quality as a predictor accounts for a large proportion of the differences in SCRQoL between homes, even when health and dementia were controlled for.

The attitudes towards ageing variables (ageing anxiety, outgroup attitudes and ageist assumptions) were added separately into models 3, 4 and 5. CQC was excluded from these analyses to preserve degrees of freedom. Individual level variables ADL and dementia were included in all models. Model 3, which included ageing anxiety as a Level-2 predictor, was the only ageing attitude variable found to be approaching significance as a predictor of SCRQoL, where higher anxiety about ageing in staff was related to poorer

resident SCRQoL (*B* = -.17, *SE* = 0.09, *p* = .088). This model also explained 26.46% of the variance in SCRQoL between homes. Therefore, only ageing anxiety was used in the final model.

Model 6 consisted of ADL, dementia diagnosis, CQC and ageing anxiety, all of which had been significant (or approaching significance) predictors in previous models. When incorporating both individual- and home- level predictors, the model explained 68.73% of the variance in SCRQoL between homes, and 14.85% within homes. The fit of the model was not a significant improvement from the same model without ageing anxiety (model 2), [$\Delta \chi^2(1) = 0.68$, *p* = ns], however the variance explained between homes had increased therefore the model was retained. This final model provides some evidence to support hypothesis 1: Staff with less anxiety about ageing will lead to better social care related quality of life (SCRQoL) for residents. When individual health needs, a diagnosis of dementia, and the role of care home quality is controlled for, residents have better quality of life in homes where staff hold less anxiety about their own ageing. However, outgroup attitudes and ageist assumptions were not significant predictors of SCRQoL, (neither uniquely nor when controlling for ADL, dementia or CQC), therefore the null was accepted for hypotheses 2 and 3.

Table 6. *Multilevel regression models predicting SCRQoL*

	Models						
Parameters	1a	1b	2	3	4	5	6
Intercept	1.00***	.89***	6.78***	1.32***	.85***	.73***	1.18***
Level-1 predictors							
Age	-.001						
Gender	-.024						
ADL	-.044**	-.037*	-.034*	-.039**	-.036*	-.039**	-.036**
Dementia	-.09**	-.083**	-.086**	-.076**	-.083**	-.085**	-.078**
Level-2 predictors							
CQC			.074*				.073*
Ageing anxiety				-.171†			-.152†
Outgroup attitudes					-.021		
Ageist assumptions						.053	
Variance explained							
Within homes	17.32%	15.46%	14.42%	15.87%	15.58%	15.28%	14.85%
Between homes	-4.88%	13.17%	54.86%	26.46%	15.58%	18.03%	68.73%
Degrees of freedom							
Within homes	139	153	154	154	154	154	153
Between homes	17	17	16	17	17	17	16

*Note: † p < .10, *p < .05,** p <.01,***p < .001.* CQC is rated so that a higher score equals better quality. Ageing anxiety, outgroup attitudes and ageist assumptions are coded so that a higher score equals more anxiety/negative/ageist.

Discussion

The aim of study two was to look at how the attitudes towards ageing of care home staff affected the quality of life of the residents they support. As the data collected was nested in nature (residents and staff nested within care homes), these relationships were tested using a multilevel approach. Whilst there has been a lot of research carried out on ageism in health and social care staff and the potential implications for care, the current study is the first to investigate the actual impact of these ageist attitudes on care recipients. Quality of life of care home residents has been researched in terms of its relationship with resident health and dependency (Hoe, Hancock, Livingston, & Orrell, 2006), as well as some contextual home-level factors such as quality rating (Netten et al., 2012), number of beds or resident-staff ratios (Kane et al., 2004). Zimmerman et al. (2005) conducted a study which incorporated staff attitudes as a predictor of resident quality of life, however, these

were specifically related to dementia. Indeed, much of the research surrounding care home resident quality of life is dementia specific (e.g. (Banerjee et al., 2009; Winzelberg, Williams, Preisser, Zimmerman, & Sloane, 2005), therefore the current study is also novel regarding its inclusion of care home residents with different primary needs.

The effect of contextual home-level factors

ASCOT was used as a quality of life measure, specifically the mixed method version that is suitable to collect data on residents with or without capacity (ASCOT CH3, Netten et al., 2012). The tool looks at quality of life in terms of the areas in a person's life that could be expected to be affected by being in receipt of social care, known as SCRQoL. SCRQoL of residents in the study was found to be at the higher end, indicating that on average, residents had a fairly good quality of life. This did however vary across homes, as demonstrated by the multilevel analysis. CQC ratings were identified as a contextual, home-level factor that may be responsible for the differences between homes, and were indeed found to predict resident quality of life. This is unsurprising, particularly since the CQC inspections moved from a more process driven focus (i.e. the mechanisms behind care provision) to a more outcome focused approach, concerning how well service user needs are met (CQC, 2013). Although user outcomes only make up part of the final rating, one would expect there to be some correlation between these outcomes (also measured in terms of 'extent to which needs are met in the ASCOT) and the CQC rating that each home is awarded. Previous research carried out before the revisions to CQC inspections found that ratings were related to SCRQoL, as measured by the ASCOT, but only for residential and not nursing homes (Netten et al., 2012). No differentiation was made between the registration of home in the current study, although CQC rating still held as a significant predictor when accounting for the influence of ADL and dementia. Although these were individual level predictors, they accounted for a sizable proportion of variance between

homes. It is likely that this is due to homes accepting people with different levels of need, for example nursing, non-nursing, and dementia care. These findings therefore indicate that the new CQC ratings predict SCRQoL across both nursing and residential homes.

Attitudes towards ageing and SCRQoL

Of all the variables concerning staff attitudes towards ageing (anxiety about own ageing, attitudes towards the elderly outgroup and agreement with ageist statements), only ageing anxiety emerged as a marginally significant predictor of SCRQoL. The relationship between anxiety and SCRQoL was as expected: residents had poorer SCRQoL in care homes where staff felt more anxious about their age. Although there are no other empirical studies that have measured this relationship before, this finding is in line with terror management theory (TMT; Greenberg, Psyzczyski & Solomon, 1986) in that individuals treat older people poorly in an attempt to psychologically distance themselves from that group (Greenberg et al., 2004). This demonstrates that attitudes held by staff about their own ageing can indeed impact the quality of life of the residents they care for. This is a novel and pertinent finding, as ageing anxiety is concerned with decline in physical and cognitive decline (Lynch, 2000), which is likely to be realised in staff working in a care home with older people who need support because of their decline in these areas. Support from this comes from the findings of Study 1, where the negative contact staff had with residents led to increase in ageing anxiety, which resulted in negative feelings towards the elderly outgroup.

The implication of this finding is that resident SCRQoL could be improved by targeting ageing anxiety in care home staff. Several studies have highlighted that knowledge about ageing can reduce anxiety (Boswell, 2012; Cummings, Kropf, & Weaver, 2000), therefore one potential method for improving anxiety could be for care home mangers to ensure that all staff undergo gerontology training.

The finding that neither outgroup attitudes nor agreement with ageist assumptions significantly predicted SCRQoL was surprising, given the theoretical implications of ageism on care. Although these relationships have not been empirically tested previously, studies have found that stereotyping and prejudiced attitudes can result in lack of personalised care (Dobbs, 2008), and can be a contributing factor to elder abuse (Quinn & Tomita, 1997). The relationship between these variables found in the current study were in the expected direction (negative and ageist attitudes related to worse SCRQoL), however, were not significant. It is possible that the addition of more care homes to the study, therefore increasing the study's power as well as the degrees of freedom when calculating variance between homes, would have yielded more significant results.

The role of dementia

Although the current study was not specifically looking at residents with dementia, approximately half of the sample had a diagnosis of such, which also was a key factor in the prediction of SCRQoL. Residents with dementia were more likely to have a lower SCRQoL, suggesting that homes struggle to meet the needs of residents with dementia as well as they do for more cognitively able residents. A possible explanation for this finding is through terror management theory and its links with ageing anxiety. O'Connor and McFadden (2012) found that older people with dementia invoked feelings of fear and reminders of death. As both resident dementia diagnoses and staff ageing anxiety were found to be predictors of SCRQoL, it would be of interest to investigate the interaction effect between these variables in further research.

Few other empirical studies were identified that have investigated the presence of dementia as a determinant of quality of life, instead they tend to focus on quality of life specifically within populations with dementia (e.g. Hoe et al., 2006). Studies that have included measures of cognitive impairment when looking at quality of life in dementia patients are

mixed, finding that either cognition is a predictor (Sloane et al., 2005) or that it is not (Banerjee et al., 2006). The current study provides support for the former, however, care needs to be taken when making comparisons due to the differing nature of measuring cognition. Using a measure such as the Minimum Data Set Cognition Scale (MDS-COGS; (Hartmaier, Sloane, Guess, & Koch, 1994), which is a more sensitive measure than simply a diagnosis of dementia, could allow for more accurate analysis of the relationship between cognition and quality of life.

One study that did compare quality of life of nursing home residents in both traditional and specialised dementia care units, found that residents in the latter setting had better quality of life despite higher levels of cognitive impairment (Abrahamson, Clark, Perkins, & Arling, 2012). The authors posited that this is likely due to the specialist nature of the facilities which cater for the specific needs of people living with dementia. The current study included a number of homes that were registered as 'dementia homes', although this was not investigated as a contextual factor in the analysis due to the small number of care homes in the sample. One would expect that staff working in a home that specialises in dementia care would have more knowledge and training in this area. As highlighted in Study 1 and supported by other research (e.g. Allan & Johnson, 2008), these are factors which could reduce ageing anxiety, and therefore lead to better SCRQoL. For these reasons, it is recommended that the influence of dementia, both in terms of individual cognition and the effect of dementia specialist settings, should be taken into account when further exploring the link between staff attitudes and resident quality of life.

Limitations

One major caveat that needs to be taken into account when interpreting these results is that the aggregated staff attitude variables were calculated from homes where staff participation varied from between one and 16 respondents. In homes where attitudes data were only

collected from one or two staff, the connection between staff attitudes and resident SCRQoL is more tenuous, and may be the reason for the lack of significant relationship found between them. The attitudes held by one or two members of staff are not necessarily representative of those held by the rest of the workforce within the home. Additionally, although the selection method for recruitment of staff meant that all respondents would have had fairly regular contact with at least one of the participating residents, it cannot be assumed that they would interact with them all. The collection of data from more staff in each home could help solve these issues, and strengthen the link between staff attitudes and resident quality of life. A document published by the NHS suggests that in order to improve responses to staff surveys, on suggestion is to publicise the survey in advance of its distribution, with clear support from senior management (NHS, n.d.). These techniques may improve staff uptake in future research.

Summary

Study 2 is the first to address the direct link between staff attitudes towards ageing and the impact they have on care home residents' quality of life. The study provided evidence that ageing anxiety predicts poorer SCRQoL, however the effect of neither outgroup attitudes nor ageist assumptions were significant predictors. This is potentially due to the low number of participating care homes, which reduced the power of the study to find significant effects. SCRQoL was related to individual level factors, including health needs and diagnosis of dementia. These factors were also responsible for some of the variation between homes. Better care home quality was a significant home-level factor that predicted better SCRQoL. The study is limited by its low number of participating homes, as well as the low response rate of staff in some homes. Further research would need to address the low recruitment rates.

Chapter 3: General discussion and conclusion

This thesis provides a review of ageism within health and social care settings: the mechanisms behind it; the factors associated with it; and how it manifests. It then proceeds to investigate the factors associated with negative attitudes towards ageing within a care home setting, an environment where contact is likely to be with a subgroup of older people that are dependent and of either physical or cognitive ill-health. To test whether the negative attitudes held by staff had a detrimental effect on the residents, a further study was carried out to test the impact of attitudes on resident SCRQoL.

Key findings

Study 1 hypothesised that positive and negative contact would both affect attitudes towards ageing but in opposite directions. However, the results showed only a relationship between positive contact and less anxiety about ageing, and between negative contact and higher agreement with ageist assumptions. However, both types of contact affected outgroup attitudes, via the indirect effect of ageing anxiety. These findings suggest that negative and positive contact have different effects on ageing attitudes, and do not merely act as equal but opposite. This supports previous findings by Drury et al. (2017).

Also in line with Drury et al. (2017) is the finding that positive contact was reported more frequently than negative contact. Despite the nature of care making it more likely that staff will experience potentially unpleasant or negative encounters with residents, the low frequency of negative reporting suggests that it is perception of care tasks which is key. Training was suggested as a possible method of improving contact perception, due to the relationship between certain training items and higher reporting of positive contact. Training may allow staff to feel more prepared to carry out unpleasant tasks, therefore perceiving them more positively. More research needs to be performed to test this theory.

Ageing anxiety in staff was found to be responsible for the effect of contact on negative attitudes towards the outgroup. Anxiety worsens due to negative contact with residents, which then leads to more negative feelings towards the elderly outgroup. The opposite is true for positive contact, which reduced anxiety and subsequently fewer negative feelings towards the outgroup. Ageing anxiety was also the only ageing attitude variable found to effect resident SCRQoL. These findings highlight the role that ageing anxiety in staff plays within a care home setting, and how it can affect both the staff and residents.

Implications for theory

Intergroup contact theory (Allport, 1954) suggests that contact between two groups can reduce prejudice as long as certain criteria are met: equal status, having a common goal, support from an institutional or social authority, and co-operation between groups. It is possible that the equal status criteria within care settings is difficult to achieve, due to the nature of the carer-care recipient relationship. The present study found that there was no relationship between positive contact and either outgroup attitudes (prejudice) or ageist assumptions (stereotyping), therefore providing further support for the integral role of equal status.

A limitation to the Study 1 was that several of that staff themselves were aged 60 or above, but the questionnaire did not include a measure to account for when respondents believed ‘old age’ to start. Therefore, the way in which older staff applied social categories to themselves and residents may differ to the expected younger ingroup (staff) and older outgroup (residents). The SIT (Tajfel, 1981) proposes that the ingroup differentiate themselves from, and hold prejudice towards the outgroup in order to enhance self-image. Therefore, older staff may not feel prejudice towards older people if they identify as older themselves. However, other social categorisation may have taken place, in that staff (including older staff) identify with the ingroup of carers, and the older people in the home

as residents. A test for group identification should be included in further studies with these populations.

The current research also lends support to the theory of the pervasiveness of negative contact (Paolini et al., 2010). Although positive contact experiences were reported more frequently, their effects were not strong enough to counter to effect of negative contact on agreement with statements of ageism. Negative contact was also related to ageing anxiety, a factor found to be detrimental to SCRQoL, as well as negative feelings towards the elderly outgroup via anxiety.

Implications for practice

Both of the studies presented in this thesis provide important implications for the role that ageism has in care home settings. Although attitudes towards ageing were generally positive, particularly in terms of attitudes towards the elderly outgroup, the negative responses in terms of ageing anxiety were sufficient to have an effect on resident quality of life. This is the first time that the damaging effect of ageing anxiety have been demonstrated in a care setting. Ageing anxiety was also attributed to explaining the relationship between both positive and negative contact and outgroup attitudes. These findings suggest that ageing anxiety is a key factor when investigating staff in the context of resident outcomes.

Negative contact is likely to occur within a care context, due to the nature of the role involving potentially unpleasant or upsetting tasks such as toileting or working with aggressive residents. Negative contact has also been found to generalise negative attitudes from residents to all older people (Drury et al., 2017). For these reasons, it is crucial to find ways to negate the effects of negative contact. Although it is not possible to change what the job role entails, it may be possible to change how these tasks are perceived through training and education. Further research to confirm this theory should include a

longitudinal approach to test the intervention of training on contact and thus attitudes. This would also address some limitations of the cross-sectional nature of the current data, which makes interpretation of the effects of contact difficult. For example, where it was found that those with more training reported more incidences of positive contact, it is also possible that those with more positive contact are motivated to take on more training opportunities. Further longitudinal data collection would allow for more causal interpretation.

A review by Christian et al. (2014) found that recreational intergenerational contact can lead to improved relations between older and younger groups, and the reduction of prejudice. This could be integrated into staff roles in homes, where care staff take a more active role in engaging with the residents during activities, rather than one staff member being solely responsible for resident occupation (Smith et al., 2017). This type of contact with elderly residents may meet Allport's (1954) criteria that contact needs to promote equal status in order to reduce prejudice, a component that is perhaps lacking for other staff-resident care based contact.

Further research

The current study did not have the scope to investigate the effect of staff attitudes on individual quality of life domains, only the overall SCRQoL score. The ASCOT measures SCRQoL across eight domains: personal cleanliness and comfort, accommodation cleanliness and comfort, food and drink, safety, occupation, social participation, control over daily life, and dignity. Ageist attitudes have the potential to affect any of these domains, for example Dobbs (2008) found that control was taken away from care home residents in terms of their decisions about care. Further to this, Smith et al. (2017) found that older people were not engaged in activities because 'old people like to sleep a lot'. Dignity is arguably one of the most important aspects of a person's quality of life, and is

measured in ASCOT by asking “How does the way you are helped and treated make you feel about yourself?”. This allows for the closer examination of how potential staff discriminatory behaviours are experienced by the resident, and the impact that they have. Further research should therefore investigate how individual domains are impacted.

Although the findings of the current study are in line with other research that has not used care staff populations, care must be taken when generalising the findings to outside of the care home setting. However, it is likely that the effect of negative contact on attitudes is likely to be applicable to carers who support older people with complex care needs in other settings. Informal carers who look after a family member at home may be also susceptible to the effects of negative contact through caring, potentially more so, due to their closer relationship with the older person. Allan and Johnson (2008) found that people who lived with an elderly relative were more likely to have ageing anxiety than those who interacted with older people at work, suggesting that relationships play a part in the formation of attitudes. Further to this, formal carers who have less frequent and perhaps less intense contact with older people, for example home care carers, may experience the effects of negative contact differently. Home care carers often spend short, discrete periods of time supporting individuals in their home, before moving on to their next client. The relationship built with the care recipient in these circumstances is likely to differ from those built in a care home, where staff are able to spend extended periods of time with multiple residents. It would be interesting for further research to investigate how the attitudes towards ageing varies across carers in different settings, and also whether care recipients are impacted in the same way by these attitudes.

Summary

This thesis provides an insight into the factors associated with care home staff attitudes towards ageing, as well as evidence for the direct impact that these attitudes have on the residents. This was achieved by carrying out two empirical studies.

The first hypothesis of Study 1 tested was staff with more education and training in health and social care will have hold more positive attitudes towards ageing, incorporating: more positive feelings about the elderly outgroup (outgroup attitudes), less anxiety about their own ageing (ageing anxiety), and agreement with fewer ageist statements (ageist assumptions). The achievement of professional qualifications in health and social care (i.e. in further or higher education) was related to more positive feelings towards the elderly outgroup, however, no such relationship was found with either ageing anxiety or ageist assumptions. Training as measured by whether respondents had undertaken any formal education or training as part of their employment. However, this item was not included in the analysis as all respondents had undergone training. Therefore, hypothesis one was only partially supported.

Hypotheses two and three stated that positive contact would predict more positive ageing attitudes (as measured by all three aging attitude items), and that negative contact would predict more negative attitudes towards ageing. Again, these hypotheses were only partially supported. Positive contact predicted less ageing anxiety, and negative contact predicted higher agreement with ageist statements. These findings are in line with those of Drury et al. (2017) who also found that positive and negative contact work independently of each other, and that negative contact predicted ageism. Positive contact has not explicitly been tested in relation to ageing anxiety as most research tends to focus instead on contact frequency or quality, therefore this finding is novel.

Ageing anxiety was predicted by hypothesis four to mediate the relationship between contact and outgroup attitudes and ageist assumptions. Again, this was partially supported, as anxiety mediated between both positive and negative contact and outgroup attitudes, but no other relationships. These findings add to the already mixed evidence on ageing anxiety's effect as a mediator (Allan & Johnson, 2008; Bousfield & Hutchinson, 2010). These findings were also novel in terms of being tested on an active care staff population, who have the potential to experience both contact and anxiety differently from non-carers.

Study 2 looked at resident social care related quality of life (SCRQoL) and how it was affected by the attitudes identified in Study 1. Multilevel analysis was used due to the nested nature of the data. The first hypothesis of this study was that staff with less anxiety about ageing will lead to better SCRQoL for residents. There was support for this prediction as ageing anxiety had a marginally significant effect in the prediction of SCRQoL. There was no such support for the remaining two hypotheses that outgroup attitudes and ageist assumptions would predict worse SCRQoL, as they were both non-significant.

The findings from the studies reported here offer support for previous research involving intergroup contact and the existence of ageist attitudes in health and social care staff. It also provided further evidence for the differing roles that positive and negative contact play in a care home setting, and how negative contact experiences can be more consequential. Additionally, ageing anxiety was highlighted as a key factor in both studies, first in its role in the formulation of negative attitudes towards an elderly outgroup, as well as in the detrimental effect staff with ageing anxiety can have on resident SCRQoL. The present research also adds to the literature in terms of the application of ageing attitude constructs to active care staff (as opposed to undergraduates), and by being the first

empirical study to simultaneously test staff attitudes towards ageing and resident quality of life.

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Appendix A

Staff information sheet and consent form

PSSRU
Personal Social Services Research Unit

University of Kent

Study Information for Staff

Measuring Quality of Life in Care Homes

What is this study about?

The **Personal Social Services Research Unit (PSSRU)** at the University of Kent is conducting a study about the quality of life of care home residents.

We are working in partnership with Kent County Council to use the **Adult Social Care Outcomes Toolkit (ASCOT**) to measure care home residents' quality of life. ASCOT has been used in care homes before and was designed specifically to measure the aspects of quality of life most affected by social care. The research team will be using a version of ASCOT that involves carrying out observations as well as interviews to capture the 'lived experience' of care home residents. We will also be testing the use of a visual aid called Talking Mats, which should enable more residents living with dementia and residents with limited verbal communication to give their views.

As well as observing and talking to the residents themselves, we'll be asking residents' key workers and family representatives (where available) to tell us about residents' lives, through short interviews and questionnaires. This should give us a full picture of residents' quality of life from different perspectives. As a member of staff, you may be asked to help us with this, by completing a questionnaire, taking part in a short interview or helping us contact a family member. This is completely voluntary. You don't have to take part in the research if you don't want to and even if you do, you can withdraw at any time.

In the past ASCOT has been used to see whether services are meeting people's needs, whether there are unmet needs, and if so, to what extent. As part of this research, we are going to also try and capture examples of care homes going that extra mile to enable residents to go beyond just having their needs met. In ASCOT, we call this the 'ideal state'. Evidence of this might come from personalised practice, for example. We want to see whether it is possible to reliably measure this 'ideal state' through observations and interviews.

What does the research involve?

The research team has a lot of experience conducting research in care homes. There are four researchers working on the project: Sinead Rider and Grace Collins will collect most of the research data but Nick Smith and Ann-Marie Towers will also visit some homes. Information will be collected from residents, staff and family members using a variety of methods. These will include:

- A short questionnaire completed by care home managers to get an understanding of the resources of the home.
- Questionnaires completed by staff about the needs and characteristics of the residents they work with, such as questions about their daily activities, e.g. washing and dressing. This information will remain completely confidential.
- Staff will also be asked to complete a short questionnaire about their motivation, job satisfaction and their attitudes towards aging.
- Two-hour periods of observations of the residents in the home. These will be conducted in communal areas of the home, as unobtrusively as possible, causing minimal disruption to the normal routine of those who live and work in the home.
- Interviews with the residents where possible.
- Interviews with the family members, where possible.
- Interviews with the staff about the residents they work with.

We have had positive feedback from care staff and managers who have taken part in previous similar observational research. These are just a few quotes from managers who were asked about how they, the care staff and the residents had found the research process:

> *"From the very onset, once [the residents and relatives] had their letters explaining to them what was going to happen, they were quite enthralled by it and they were looking forward to actually having an outside person come and look at what it is that*

we do here at [the nursing home]. So they were on our side from start to end." (Dementia Nursing Home Manager)

"The staff were actually fine because the staff… are used to people coming in and out…. everybody seemed to be very discreet. I mean, you know, so if they were aware they forgot that you were there." (Independent Care Home Manager)

"There was no disruption to the home at all. [the fieldworkers] just went off, found their residents that they needed to observe, and just basically just took hold of it all and got on with it. It didn't cause any disruption to us whatsoever. "(National Chain Nursing Home Manager)

How you are involved in this study

If you are working at the care home during the periods of research, you will probably see a researcher/researchers walking around carrying out observational work. This should not interrupt daily routines as the researcher will work around you as discreetly as possible. However, to help us collect information about the quality of life of residents, you may be asked to:

- Fill in a short questionnaire about residents' needs and characteristics.
- Be observed during the working day. Most observations will take place Monday-Friday 9am-6pm but occasionally we may observe during evening and weekends so that we can look at any differences between 'office hours' and outside those hours. Although your personal performance at work is not the focus the study, in looking at the quality of life of residents we will observe how they are supported by staff in the care home. We just want you to behave as you normally would at work, ignoring the researcher(s) as much as possible.
- Take part in interviews about certain residents. We may audio record this if it is OK with you, to help us remember what you said. The recording will be kept securely, and your answers will be treated as confidential: only the research team at PSSRU will listen to the recording or see your answers. We check that you are happy with this on the day and if you are not, but are still happy to be interviewed, the researcher will take written notes.
- Complete a questionnaire about your qualifications, training and job satisfaction as well as your thoughts towards aging. As a thank you for your time, every member of staff who completes a questionnaire will receive a £10 High Street voucher. This part of the research is looking at the beliefs and attitudes towards ageing held by members of care home staff. In particular, the research will be

looking at how these attitudes vary between staff, and whether there is a relationship between beliefs held and the quality of life of the care home residents that staff work with.

- You are eligible to take part in this research if you are a member of staff at one of the care homes participating in the 'Measuring Outcomes of Care Homes' study (MOOCH). You must be 18 years of age or above, and have worked at the care home for at least three months.

If you feel very strongly that you do not wish to be involved in this research please talk to your manager. This will in no way affect your conditions of employment. If you are happy to consent, please fill out the consent form enclosed and give it to your manager.

What will happen with the information?

The information that we collect will be used in the following ways:

- Summaries of the results will be written for people interested in the research, including the people who have funded the research, service users and carers, and people in social services departments.
- It will be written up in academic journals.
- It will be used in conference presentations

Some of the information collected will also be used to as part of Masters' project that is being undertaken by one of the researchers.

The researchers will not use individuals' names or the name of their care home in any reports of this work. Names and contact details will not be recorded on information collected through observations, interviews and questionnaires, and or on anything we write about the study afterwards. All identifiable information (e.g. contact name and details) will be kept securely in a locked filing cabinet and discarded after 3 years. The research data (excluding names and contact details) will be retained in an electronic format by the PSSRU at the University of Kent and could be used by other researchers in the PSSRU at the University of Kent for other research in the future.

Questions about the study

If you have any questions about the study and you would like to speak to a member of the research team at PSSRU you can contact **Sinead Rider:** telephone: 01227 823863, or **Grace Collins:** telephone: 01227 823812, or email: moochproject@kent.ac.uk.

Postal address: Personal Social Services Research Unit (PSSRU), Cornwallis Building, University of Kent, Canterbury, Kent, CT2 7NF.

If you have any concerns or complaints about the research, please email the principal investigator for the project, **Ann-Marie Towers** on A.Towers@kent.ac.uk. If you would like to speak to someone independent from the research team, please contact **Dr Simon Kerridge, Director of Research Services**, who is the person at the University of Kent with overall responsibility for all research activities: telephone: 01227 823229, email S.R.Kerridge@kent.ac.uk.

Care Home Staff Consent Form

Measuring Quality of Life in Care Homes

Consent form for _____(Your name)

	Yes	No
I understand that it is up to me whether I take part in the study. I will talk to my line manager if I have an objection to taking part. I understand that this will in no way affect my conditions of employment.	☐	☐
I understand that interviews may be recorded on digital audio and I am happy about this.	☐	☐
I understand that it is up to me whether I take part in the study. I can change my mind and withdraw at any time without giving a reason.	☐	☐
	☐	☐

I understand that all the information collected will be kept confidential and that my name will never be used in anything that is written about the study.

I can ask to see or have read to me what has been written down about me before it is used. ☐ ☐

I agree that the information that is collected about me will be used for research purposes and potentially shared with other researchers but that my name will not be shared ☐ ☐

I agree to take part in the study. ☐ ☐

Signed (Participant) _____ Date _____

Signed (Witness) _____ Date _____

If you have any questions about the study and you would like to speak to a member of the research team at PSSRU you can contact **Sinead Rider:** telephone: 01227 823863, or **Grace Collins**: telephone: 01227 823812, or email: moochproject@kent.ac.uk.

Appendix B

Resident information sheet and consent form

PSSRU
Personal Social Services Research Unit

University of Kent

Study Information for Participants

Measuring Quality of Life in Care Homes

What is this study about?

The **Personal Social Services Research Unit (PSSRU)** at the University of Kent is conducting a study about the quality of life of care home residents.

Researchers at the PSSRU have developed a way to measure the quality of life of care home residents. We call this the **Adult Social Care Outcomes Toolkit (ASCOT)**. The way we measure quality of life in a care home is to carry out observations of what daily life is like for residents, as well as speaking to the residents, their families and the care staff.

We are interested in how quality of life is linked to things such as the training and attitudes of staff, the time of day we do the research and the quality ratings given by inspectors.

Why have I been invited to take part in the study?

The care home you live in has kindly agreed to take part in this research and we would like to know if you are happy to be included in the research as well.

What will happen if I agree to take part?

If you agree to take part the following things will happen:

- The researchers will talk to you about your daily life at the home and how you feel about it. This will last no longer than 45 minutes.
- We will ask staff to fill out some forms about your health and the support they give you, including daily activities, such as washing and dressing. This information will remain completely confidential.
- We will also ask staff and, where available, family members for their views about your quality of life.
- The researchers will spend two hours observing what life is like for you and other residents in the home and will take notes on the things that happen. This will take place around lunch time and we will ask your permission again for this on the day.
- Most observations will take place Monday-Friday 9am-6pm but occasionally we may observe during evening and weekends so we can look at any differences between 'office hours' and outside those hours.
- As well as collecting information about you and the other people who live here, we will be collecting information about the care home as a whole and the staff team.
- The focus of the study is on your quality of life but to help us understand this we will also be observing how staff in the care home support you in your daily life.

The researchers will:

- Carry out most of the research in the communal areas of the home. They will not observe any personal care and will only come into your bedroom to talk to you if you allow them to.

- Talk to you about the notes they have taken, if you want them to.
- Leave if you ask them to at any time.
- Write to the care home after the visit to thank residents and staff for taking part.
- Send you some information about the project when it is completed.

When we talk to you about your quality of life, we may audio record this if it is OK with you, to help us remember what you said. The recording will be kept securely, and your answers will be treated as confidential: only the research team at PSSRU will listen to the recording or see your answers. We check that you are happy with this on the day and if you are not, but are still happy to be interviewed, the researcher will take written notes.

We hope that you will agree to take part in the study. However, if you decide not to take part you do not have to give any reasons and this will not affect any services or support you are getting in any way. Even if you agree now you can change your mind at any time and we will destroy any information we have collected from you. You can ask to see or have read to you the information collected about you before it is used.

If you would like to take part, please fill out the form we have given you and give it to a member of staff or the manager of the home. If you would like help filling in the form or you would like someone to fill it in for you then please ask someone you trust.

As a thank you for your time, you will receive a £10 High Street voucher for taking part in the research.

What will happen to the information?

The information that we collect will be used to compare the quality of life of residents in different care homes. The results will be shared with others in:

- Summaries for the people taking part in the research, including residents, family members and staff.
- Academic journals.
- Conference presentations.

Some of the information collected will also be used to as part of Masters' project that is being undertaken by one of the researchers.

The researchers will not use your name or the name of your care home in any reports of this work. The only time we would tell anyone what you have said or what we have observed is if you are being hurt by someone or you are in danger. We would usually discuss this with you beforehand.

All personal information such as your name and contact details will be kept securely in a locked filing cabinet and discarded after 3 years. The information collected during our visits (except for your contact details) will be saved on computers at the PSSRU at the University of Kent and could be used by other researchers in the PSSRU at the University of Kent for other research in the future.

Questions about the study

If you have any questions about the study and you would like to speak to a member of the research team at PSSRU you can contact **Sinead Rider:** telephone: 01227 823863, or **Grace Collins**: telephone: 01227 823812, or email: moochproject@kent.ac.uk.

Postal address: Personal Social Services Research Unit (PSSRU), Cornwallis Building, University of Kent, Canterbury, Kent, CT2 7NF.

If you have any concerns or complaints about the research, please email the principal investigator for the project, **Ann-Marie Towers** on A.Towers@kent.ac.uk. If you would like to speak to someone independent from the research team, please contact **Dr Simon Kerridge, Director of Research Services**, who is the person at the University of Kent with overall responsibility for all research activities: telephone: 01227 823229, email S.R.Kerridge@kent.ac.uk.

PSSRU
Personal Social Services Research Unit

University of Kent

Research Project Consent Form

Measuring Quality of Life in Care Homes

Consent form for _____(Your name)

	Yes	No
I understand that the research team will be coming into my home to observe and take notes about my daily activities.	☐	☐
I understand that they may ask me questions about how I feel about the home and my quality of life	☐	☐
I understand that these questions may be recorded on digital audio and I am happy about this.	☐	☐

I understand that it is up to me whether I take part in the study. I can change my mind and withdraw at any time without giving a reason. ☐ ☐

I understand that all the information collected will be kept confidential (unless the researchers feel I am in danger or at risk) and that my name will never be used in anything that is written about the study. ☐ ☐

I can ask to see or have read to me what has been written down about me before it is used. ☐ ☐

I agree that the information that is collected about me will be used and potentially shared with other researchers but that my name will not be shared. ☐ ☐

I agree to take part in the study. ☐ ☐

Signed (Participant) _____ Date _____

_____

Signed (Witness) _____ Date _____

_____

If you have any questions about the study and you would like to speak to a member of the research team at PSSRU you can contact **Sinead Rider:** telephone: 01227 823863, or **Grace Collins**: telephone: 01227 823812, or email: moochproject@kent.ac.uk.

Appendix C

Consultee information sheet and declaration of advice form

PSSRU
Personal Social Services Research Unit

University of Kent

Study Information for Consultees

Measuring Quality of Life in Care Homes

What is the study about?

The **Personal Social Services Research Unit (PSSRU)** at the University of Kent is conducting a study about the quality of life of care home residents.

We are working in partnership with Kent County Council to use the **Adult Social Care Outcomes Toolkit (ASCOT)** to measure care home residents' quality of life. ASCOT has been used in care homes before and was designed specifically to measure the aspects of quality of life most affected by social care. The research team will be using a version of ASCOT that involves carrying out observations as well as interviews to capture the 'lived experience' of care home residents. We will also be testing the use of a visual aid called Talking Mats, which should enable more residents living with dementia and residents with limited verbal communication to give their views.

As well as observing and talking to the residents themselves, we'll be asking residents' key workers and family representatives (where available) to tell us about residents' lives, through short interviews and questionnaires. This should give us a full picture of residents' quality of life from different perspectives.

In the past ASCOT has been used to see whether services are meeting people's needs, whether there are unmet needs, and if so, to what extent. As part of this research, we are going to also try and capture examples of care homes going that extra mile to enable residents to go beyond just having their needs met. In ASCOT, we call this the 'ideal state'. Evidence of

this might come from observations of personalised practice or from interviews with residents and/or their family members, for example. We want to see whether it is possible to reliably measure this 'ideal state' in this way.

To do this well, we are hoping to include as many care home residents as possible, including those who have dementia and those who might be unable to speak for themselves. If we do not include people with Dementia, or people who are very frail in the study, we will not be able to judge how well the care home is meeting their needs.

Why have I been given this information?

You have been given this information because your family member, or the person you represent, lives in a care home that is taking part in the research and we have judged that this person lacks the capacity to give informed consent. We would really like to include your family member (or the person you represent) in this research project, as care homes are increasingly caring for people who lack capacity and/or cannot necessarily speak for themselves. Including the most frail and vulnerable in research like this, enables us to independently evaluate how well care homes are meeting their needs.

The Mental Capacity Act requires us by law to seek the advice of an appropriate personal consultee on occasions such as this. The care home suggested that you would be the best person to fulfil this role. We are asking you for advice. In your opinion, would the person you are representing want to take part in the research, if they could decide for themselves? Please be guided by what you know about the person. Try to think about the risks and benefits of taking part. For example, some people like having new people visit them in their home, other do not. As well as asking for your advice, when we visit the home, we will always check that people are happy to talk to us and are comfortable in our presence and will always stop if we think consent has been withdrawn.

What will happen during the study?

If the person you represent takes part in the research the following things will happen:

- We will ask staff to fill out some forms about the person's health and support, including their ability to perform daily activities, such as washing and dressing. This information will remain completely confidential.
- Where possible, residents will also be asked about how they feel about life at the home and how they feel their needs are being met. These interviews will last no more than 45 minutes.
- We will also interview staff and in some cases, family members about residents' quality of life, if they are available and want to take part. If you are able and willing to be interviewed, please let us know.
- The researchers will spend around two hours observing residents in the home, usually around lunch time, and will take notes of the things that happen. We will always stop observations if residents appear at all distressed by our presence. We never observe personal care conducted in bathrooms or bedrooms and much of what we observe takes place in communal areas (unless the resident is unable to leave their bed).
- Most observations will take place Monday-Friday 9am-6pm but occasionally we may observe during evening and weekends so we can look at any differences between 'office hours' and outside those hours.
- As well as collecting information about individual residents, we will be collecting information about the care home as a whole and the staff team.

We have had positive feedback from care staff and managers who have taken part in previous similar observational research.

"From the very onset, once [the residents and relatives] had their letters explaining to them what was going to happen, they were quite enthralled by it and they were looking forward to actually having an outside person come and look at what it is that we do here at [the nursing home]. So they were on our side from start to end." (Dementia Nursing Home Manager)

The researchers will:

- Talk to the resident about the notes they have taken, if they want them to.
- Leave if the resident asks them to at any time.
- Send the care homes and participants information about the project when it is completed.
- Write to the care home after the visit to thank people for taking part.
- Give the person you are representing a high street gift voucher of £10 as a thank you for taking part in the research.

When we talk to the person you are representing about their quality of life, we will audio record this provided they are happy for us to do so. This will help us remember what they said. The recording will be kept securely, and their answers will be treated as confidential. Only the research team at PSSRU will listen to the recording or see their answers. We will also check that the residents we speak to are happy with this on the day.

What should I do now?

Think about and discuss with the staff and other key people the benefits and risks of participation for the person concerned. Please bear in mind that we will not observe any personal care, like bathing or dressing, in bedrooms or bathrooms. During the observations, if there was any reason to believe your relative was becoming distressed or uncomfortable with our presence, we would stop the observation and leave that area of the home.

If you feel that your family member/ the person you represent would choose to take part in the study, please fill out the declaration form enclosed with this information. You can either send it back to us directly in the pre-paid envelope enclosed, or you can give it to a member of staff or the manager of the home. If you would like to learn more about the study, please feel free to contact the research team (details below).

Will this affect the placement or the quality of care provided?

Not in any negative sense. We do not include people's names or contact details on the data we collect. It will not be used to affect the placement of specific people. The only reason anonymity would be waived is if someone is

at risk from abuse or harm, and therefore the relevant people would need to be contacted. This would usually be the local authority safe guarding team and possibly the Health and Social Care regulator, the Care Quality Commission (CQC).

In a general sense we hope that the research will positively affect the quality of support provided in this service.

What will happen with the information?

The information that we collect will be used to compare the quality of life of residents in different care homes.
The results will be shared with others in:

- Summaries for the people taking part in the research, including residents, family members and staff.
- Academic journals.
- Conference presentations.

Some of the information collected will also be used to as part of Masters' project that is being undertaken by one of the researchers.

The researchers will not use individuals' names or the name of their care home in any reports of this work. Names and contact details will not be recorded on information collected through observations, interviews and questionnaires, and or on anything we write about the study afterwards. All identifiable information (e.g. contact name and details) will be kept securely in a locked filing cabinet and discarded after 3 years. The research data (excluding names and contact details) will be retained in an electronic format by the PSSRU at the University of Kent and could be used by other researchers in the PSSRU at the University of Kent for other research in the future.

Questions about the study

If you have any questions about the study and you would like to speak to a member of the research team at PSSRU you can contact **Sinead Rider:** telephone: 01227 823863, or **Grace Collins**: telephone: 01227 823812, or email: moochproject@kent.ac.uk.

Postal address: Personal Social Services Research Unit (PSSRU), Cornwallis Building, University of Kent, Canterbury, Kent, CT2 7NF.

If you have any concerns or complaints about the research, please email the principal investigator for the project, **Ann-Marie Towers** on A.Towers@kent.ac.uk. If you would like to speak to someone independent from the research team, please contact **Dr Simon Kerridge, Director of Research Services**, who is the person at the University of Kent with overall responsibility for all research activities: telephone: 01227 823229, email S.R.Kerridge@kent.ac.uk.

Personal Consultee Declaration Form

Measuring Quality of Life in Care Homes

Name of the person you are representing_____

Your name _____

Address/phone number/email address *(we may contact you in relation to this research project. If you would prefer not to be contacted again, please leave blank):* _____

_____

_____

_____

What is your relationship to the person you are representing (e.g. son/daughter/spouse) _____

If you have talked this through before deciding, please list the other people you have consulted (and their relationship to the person you represent)____

_____

_____

Please indicate whether or not you think it is OK for this person you represent to be involved in the research

☐ **Yes,** to the best of my knowledge, the person named above would choose to take part in the research if they could. They would be happy

for the researcher to observe them and to ask their keyworker for information about their needs and characteristics. I understand that even though I give this agreement, he/she can choose to withdraw at any time if he/she is not happy with being observed or included in the research.

☐ **No,** I do not think the person would choose to take part if they were willing to do so.

In signing this form you are confirming that you have read and understood the accompanying information about the study.

Signed _____ Date _____

If you have any questions about the study and you would like to speak to a member of the research team at PSSRU you can contact **Sinead Rider:** telephone: 01227 823863, or **Grace Collins**: telephone: 01227 823812, or email: moochproject@kent.ac.uk.

Appendix D

Staff Questionnaire

Please note, the personal information that you complete on this front page is for identifying who to send a thank you voucher to, and for the analysis of resident data. This page will be detached once it reaches the office so that the information you complete on the questionnaire is completely anonymous and cannot be connected to you.

Please send the completed questionnaire, along with this front sheet, directly back to the research team using the freepost envelope provided.

Full name:

If you work closely with, are a main carer or keyworker for any of the residents participating in the study, please write their names below (if unsure, please speak to the manager for a list of participants):

Staff questionnaire Unique Identification Number

1. Age

Into which age group do you fall?

- ☐ Under 20 years
- ☐ 20-24 years
- ☐ 25-29 years
- ☐ 30-34 years
- ☐ 35-39 years
- ☐ 40-44 years
- ☐ 45-49 years
- ☐ 50-54 years
- ☐ 55-59 years
- ☐ 60-65 years
- ☐ Over 65 years
- ☐ Prefer not to say

2. Gender

Are you?

☐ Male ☐ Female

3. Ethnicity

Please tick the box that best describes your ethnic background.

A. White	**B. Mixed**	**C. Asian or Asian British**
☐ English/Welsh/Scottish/ Northern Irish/British	☐ White and Black Caribbean	☐ Indian
☐ Irish	☐ White and Black African	☐ Pakistani
☐ Gypsy or Irish traveller	☐ White and Asian	☐ Bangladeshi
☐ Any other White background	☐ Any other mixed/multiple heritage background	☐ Chinese
		☐ Any other Asian background
Please provide details	*Please provide details*	*Please provide details*
D. Black or Black British	**E. Other ethnic group**	
☐ Caribbean	☐ Arab	
☐ African	☐ Any other ethnic group	
☐ Any other Black/African/Caribbean background	*Please provide details*	
Please provide details		

4. Qualifications

a) Which of the following professional qualifications in health/social care do you hold? *(Please tick all that apply)*

- ☐ NVQ level 2
- ☐ NVQ level 3 or above
- ☐ Working towards NVQ level 2 or above
- ☐ Undergraduate degree
- ☐ Postgraduate degree
- ☐ Diploma
- ☐ HND
- ☐ BTEC
- ☐ Nursing qualification (e.g. RN, RGN)
- ☐ No qualification in health/social care
- ☐ Other *(Please specify)*

b) Do you hold any other qualifications not related to health/social care?

- ☐ Yes (Please go to question 4c)
- ☐ No (please go to question 5)

c) If yes, which qualifications do you hold? *(Please tick all that apply)*

- ☐ NVQ level 2
- ☐ NVQ level 3 or above
- ☐ Working towards NVQ level 2
- ☐ Undergraduate degree
- ☐ Postgraduate degree
- ☐ Diploma
- ☐ HND
- ☐ BTEC
- ☐ Other *(Please specify)*

Please provide any additional information about non-health/social care qualifications held (i.e. subject area)

5. Current employment

a) What is your job role?

- ☐ Regional Manager
- ☐ Registered Manager
- ☐ Unit Manager
- ☐ Senior Care Worker
- ☐ Care Worker
- ☐ Registered Nurse
- ☐ Housekeeping staff
- ☐ Catering staff
- ☐ Activity staff
- ☐ Other *(Please specify)*

b) How many years have you been employed in this post?

☐☐

c) Which of the following best describes your contracted working hours?

- ☐ Full time
- ☐ Part time
- ☐ Flexi time
- ☐ Bank/agency staff

d) How many hours on average do you work in this post?

Number per week ☐☐

6. Workload

a) Are you keyworker for any residents?

- ☐ Yes (Please go to question 6b)
- ☐ No (please go to question 7)

b) How many residents are you currently the key worker for (please include people who have been added to your workload because of staff shortages)?

☐☐

7. Professional development

a) Have you had the opportunity to undertake any formal education or training as part of your employment?

- ☐ Yes
- ☐ No

*b) If **yes** please tick all that apply*

- ☐ Statutory training
- ☐ Adult protection
- ☐ Healthy eating/healthy lifestyle
- ☐ Administering medication
- ☐ Palliative care
- ☐ End of life care
- ☐ Care planning
- ☐ Team building/person-centred team working
- ☐ Dementia (care) training
- ☐ Person centred dementia care
- ☐ Falls training
- ☐ Other *(Please specify)*

8. Job satisfaction

a) How satisfied are you with these aspects of your work?

	Very dissatisfied	**Dissatisfied**	**Neither satisfied nor dissatisfied**	**Satisfied**	**Very Satisfied**
All in all, I am satisfied with my current job	☐	☐	☐	☐	☐
My job measures up to the sort of job I wanted when I took it	☐	☐	☐	☐	☐
Knowing what I know now, if I had to decide all over again whether to take my job, I would	☐	☐	☐	☐	☐
I am proud of my job	☐	☐	☐	☐	☐
I enjoy the work that I do	☐	☐	☐	☐	☐
I am satisfied with the supervision I receive	☐	☐	☐	☐	☐

9. Own wellbeing

a) Overall, how satisfied are you with your life?

Very dissatisfied	1	2	3	4	5	**Very satisfied**

b) Overall, how happy do you feel?

Very unhappy	1	2	3	4	5	**Very happy**

10. Attitudes towards ageing

a) How much do you agree with the following statements?

	Strongly disagree	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
I enjoy being around old people	☐	☐	☐	☐	☐
I like to go visit my older relatives	☐	☐	☐	☐	☐
I enjoy talking with old people	☐	☐	☐	☐	☐
I enjoy doing things for old people	☐	☐	☐	☐	☐
I fear it will be very hard for me to find contentment in old age	☐	☐	☐	☐	☐
I will have plenty to occupy my time when I am old	☐	☐	☐	☐	☐
I expect to feel good about life when I am old	☐	☐	☐	☐	☐
I believe that I will still be able to do most things for myself when I am old.	☐	☐	☐	☐	☐
I expect to feel good about myself when I am old	☐	☐	☐	☐	☐
I have never lied about my age in order to appear younger	☐	☐	☐	☐	☐
It doesn't bother me at all to imagine myself as being old	☐	☐	☐	☐	☐

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I have never dreaded the day I would look in the mirror and see grey hair	☐	☐	☐	☐	☐
I have never dreaded looking old	☐	☐	☐	☐	☐
When I look in the mirror, it bothers me to see how my looks have changed with age	☐	☐	☐	☐	☐
I fear that when I am old all my friends will be gone.	☐	☐	☐	☐	☐
The older I become, the more I worry about my health	☐	☐	☐	☐	☐
I get nervous when I think about someone else making decisions for me	☐	☐	☐	☐	☐
I worry that people will ignore me when I am old	☐	☐	☐	☐	☐
I am afraid that there will be no meaning in life when I am old	☐	☐	☐	☐	☐

b) Please describe how you feel about elderly people in general (excluding family members):

Cold	1	2	3	4	5	6	7	8	9	**Warm**
Positive	1	2	3	4	5	6	7	8	9	**Negative**
Friendly	1	2	3	4	5	6	7	8	9	**Hostile**
Suspicious	1	2	3	4	5	6	7	8	9	**Trusting**
Respectful	1	2	3	4	5	6	7	8	9	**Contempt**
Admiration	1	2	3	4	5	6	7	8	9	**Disgust**

c) How much do you agree with the following statements?

	Strongly disagree	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
Health services are scarce and young people should be given priority over old people	☐	☐	☐	☐	☐
Old people often need others to take/make decisions for them	☐	☐	☐	☐	☐
Most old people are ill to some extent	☐	☐	☐	☐	☐
Old people cannot expect to be always well	☐	☐	☐	☐	☐
Old people are often lonely	☐	☐	☐	☐	☐
Old people are wise and experienced	☐	☐	☐	☐	☐
Old people are not interested in sex	☐	☐	☐	☐	☐
It is important to respect older people	☐	☐	☐	☐	☐
People get less mentally sharp as they get older	☐	☐	☐	☐	☐
Most older people are poor	☐	☐	☐	☐	☐

11. Contact with residents

a) How often during work do you have positive experiences (friendly, pleasant or constructive contact) with elderly service users?

Never 1 2 3 4 5 6 7 **Very much**

b) How often during work do you have negative experiences (conflicts, unpleasant or hostile contact) with elderly service users?

Never 1 2 3 4 5 6 7 **Very much**