

Gerontological Content in Canadian Nursing and Social Work Programs



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ABSTRACT

Method

A survey of gerontological content in nursing and social work programs across Canada (English speaking) was conducted. The survey tool was the competencies list developed for interprofessional gerontological education by the National Initiative for the Care of the Elderly (NICE). Deans or designates of English-speaking nursing and social work programs across Canada were contacted by e-mail. Data was collected by Zoomerang.com.

Results

Findings indicate that clear progress is being made in ensuring that students have the knowledge and skills needed to provide the care required by older adults in a variety of settings.

Key words: gerontology, curriculum, interprofessional

INTRODUCTION

About three decades ago, the challenges to be placed upon the future health-care and human service sector by the burgeoning of the older adult population was acknowledged in the nursing and social work literature. It was recognized that few students chose to work with older adults,^(1,2) and few programs included significant gerontological curricula content.⁽³⁾ This resulted in warnings about the need to attract students to gerontological practice, as well as the importance of ensuring gerontological content was in the curricula of many professional educational programs. It was recognized that whether or not future nurses and social workers specifically choose to work with seniors, the increasing number of older adults dictates that most professionals will work with this population at some point in their careers. What has been the result of the warnings? Where are nursing and social work educators “at” in addressing the need for nurses and social workers to respond to the health and social needs of older adults? Have Canadian nursing and social work programs

revised their curricula to educate students in gerontological practice? Have educational strategies changed students’ negative attitudes towards working with older adults and created interest in this population group?

OBJECTIVES

Today, thirty years later, have educators responded to this need? To answer this question, a survey of gerontological content in nursing and social work programs across Canada (English speaking) was conducted. To interpret the results of this recent survey, it is important to situate the findings within a broader literature review.

Literature Review

A literature search in two databases was conducted: Cumulative Index of Nursing and Allied Health Professionals (CINAHL) and Social Work Abstracts. The purpose of the literature search was to examine students’ attitudes towards working with older adults, as well as to determine gerontological content in nursing and social work undergraduate programs. The search of the literature from 2000–2010 included the terms: attitudes, nursing students, social work students, in addition to terms to identify the literature examining curriculum content, such as: curriculum, gerontological content, and nursing and/or social work students. The search yielded 41 articles.

Themes in the Nursing and Social Work Literature

Throughout the literature, there is strong recognition of the need for undergraduate nursing and social work programs to respond to the demographic changes in developed countries; in other words, curriculum that includes gerontological content to prepare practitioners for the future. While there is much less emphasis on the need to increase gerontological content in graduate education, the call for augmenting graduate education is stronger within social work^(4,5,6) than nursing.

Although some studies reveal that students from both professional groups still hold negative attitudes towards older

adults or to working with them,^(7,8) recent research reveals that attitudes of students are not homogenous and attitudes are subject to change based upon learning environments. Flood and Clark compared attitudes towards and knowledge of older adults among nursing and non-nursing students.⁽⁹⁾ Nursing students were found to have significantly better attitudes towards older adults than their non-nursing counterparts. Similarly, Kane⁽¹⁰⁾ compared perceptions of social work students towards older adults to those of criminal justice students. Although he admitted that both groups of students held some ageist views, the criminal justice students held more negative views and social work students expressed greater interest in working in the gerontological field.

Researchers also suggest that the types of contacts with older adults, as well as the timing of exposure to gerontological practice, may influence attitudes positively or negatively. Students who have greater contact with older adults may experience more positive attitudes.⁽¹¹⁾ When students are exposed to older adults in supportive and innovative environments, their attitudes towards older adults improve.^(12,13) Conversely, when students work with older adults in learning environments that have low standards of care, attitudes decline.⁽¹⁴⁾

Much of the recent literature/research links a lack of knowledge about older adults and gerontological practice with negative attitudes towards older adults, leading to disinterest in working within this field.⁽¹⁵⁾ Hence, knowledge, attitudes, and interest are all interconnected. With these linkages made, it is not surprising that much of the gerontological literature examining attitudes and knowledge focuses on “innovative” learning techniques, such as the use of an Internet website that addresses working with older adults,⁽¹⁶⁾ brief gerontological learning modules,⁽⁴⁾ nursing students’ bedside rounds with older adults,⁽¹⁷⁾ modified wellness vacations with students and older adults,⁽¹²⁾ and reminiscence educational programs.⁽¹⁸⁾ Most studies noted that students responded well to learning innovations with enhanced knowledge, improved attitudes, and sometimes increased interest in working in gerontological practice. There are two notable exceptions, however. After introducing mandatory didactic and clinical gerontological experiences in an undergraduate nursing program, Aud *et al.*⁽¹⁹⁾ found that an increase in gerontological knowledge did not lead to an improvement in student attitudes; in fact, the attitudes of the students became more negative. Lee and Waites⁽²⁰⁾ discovered that an infusion of gerontological content into a baccalaureate social work program led to enhanced student attitudes towards older adults, as well as improved knowledge, but did not lead to a significant increase in students’ interest to work with older adults.

Even though the literature and research continues to reveal a lack of gerontological content within nursing and social work programs,^(21,19,15,8,22,23) there is evidence that programs are attempting to address this gap. However, how to introduce greater gerontological content into nursing and social work programs is still not clear within the literature.

There are some differences in opinion on whether an integrated curriculum (where gerontological content is included in the overall curriculum) or stand-alone gerontological courses are more effective. It may be harder to monitor the amount of gerontological content in an integrated curriculum and stand-alone courses, if not mandatory, may not attract students.⁽²⁴⁾ Some researchers call for a mixed approach: stand-alone gerontological courses in addition to an integrated curriculum that addresses gerontological content throughout.⁽²⁵⁾ Regardless how gerontological curriculum is configured within programs, there is a call for curriculum to be linked to gerontological competencies. Gerontological competencies (e.g., within the United States—developed by the American Association of Colleges and John A. Hartford Foundation Institute for Geriatric Nursing, 2010) can be used for programs to map their current curricula, as well as to develop new gerontological curriculum.^(25,26)

Within the Canadian context, there are currently no interprofessional competencies accepted as national guidelines. The National Initiative for the Care of the Elderly (NICE) addressed this gap by developing the Core Interprofessional Competencies for Gerontology.

METHODS

A web-based questionnaire was sent in late December 2008 to Deans and department heads representing 63 nursing and social work schools across Canada (English language programs). Seventy-five per cent (75%) of completed questionnaires were collected from representatives of nursing faculties and departments. Zoomerang.com was used as the data collection tool. Zoomerang.com is an online survey tool that allows users to create, send, and analyze online survey results on demand.

RESULTS

Findings

In addition to offering baccalaureate level programs, 33% of the responding nursing schools offered Masters, Doctoral, and Nurse Practitioner programs. Eighty-three per cent (83%) of social work schools offered a Masters level curriculum. In the three years (2006–2008), respondents reported an annual mean of 157 baccalaureate graduates.

Faculty

Of the total number of faculty (full-time and part-time instructors), those possessing a specialty in gerontology comprised only a small portion (see Figure 1).

On average, 3% of baccalaureate program faculty had adjunct or joint appointments with a clinical agency having a gerontological focus (SD 0.05). Furthermore, 42% of respondent schools reported having a committee or faculty member assigned to develop gerontological courses/programs.

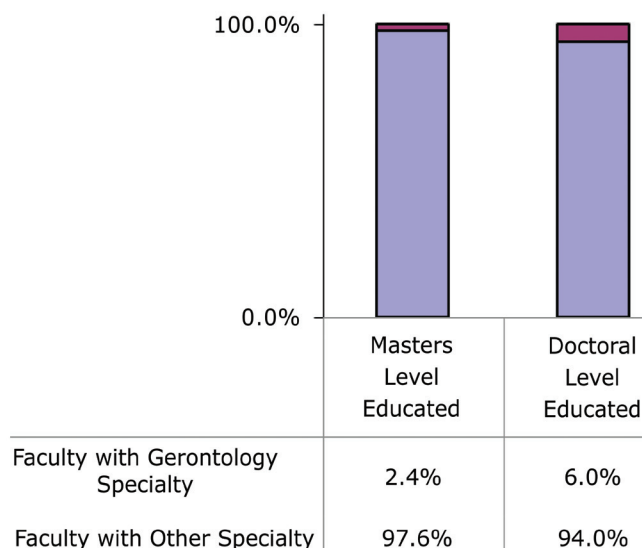


FIGURE 1. Faculty preparation in Gerontology

Program

Seventy-nine per cent (79%) of faculties/departments reported that the gerontological content was primarily integrated within their generic baccalaureate programs.

Presentation of Content

While 42% of schools detailed that they had incorporated significant changes within their generic baccalaureate program with respect to gerontological content or clinical experience as of January 1, 2004 (see Figure 2). Moreover, 37% reported that there were planned modifications to the gerontological content/clinical experience within their programs in the upcoming two years. Since January 1, 2007, 35% of schools had completed curriculum projects with a gerontological outlook which originated from their generic baccalaureate program.

Respondents identified that students within their generic baccalaureate programs were required to spend a mean of 243 hours in clinical study/practicums which had a gerontological focus (SD 318). Details of these field placements are noted below.

Aggregate Student Placement Hours in Selected Field Placements

All schools stated that there was a clinical consolidation/practicum incorporated in the final year of their programs, but only 6% of students graduating in 2008 had selected a gerontological setting.

Core Competencies

Sixty-two core competencies, as identified by the NICE Curriculum Development Subcommittee, were examined within

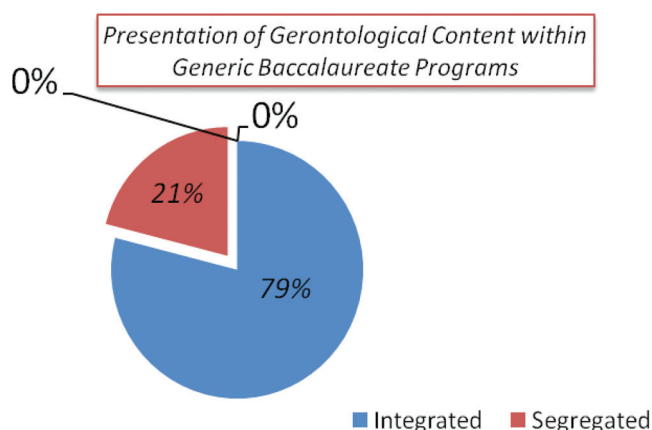


FIGURE 2. Gerontological content in baccalaureate programs

working on interdisciplinary teams are incorporated. Macro-level abilities include advocacy skills, as well as capacity to understand the implications of policies upon older adults and to identify gaps and barriers in the health-care system. There is also a self-assessment component which involves health-care professionals examining their personal values, as well as any ageist biases.

All surveyed programs responded that they included gerontological content pertinent to assessment and intervention of older adults and family members, as well as content related to working within teams and knowledge of the impact of policies upon older adults. The only core competency identified as missing from these programs was evaluating and learning from international models of care.

What is not clear from this survey, however, is how programs define assessment and intervention in the various domains of working with older adults, their family members, and the larger system. For instance, a nursing assessment of the physical status of an older adult may differ significantly from that of social workers. Further, how nurses and social workers might define and provide family counselling and mediation work is probably somewhat different. At a macro level, the opportunities to not only identify gaps in the health system, but also to work to “adapt and revise” programs may be dictated by the constraints of professionals’ roles; that is, nurses working directly in patient care may have less opportunity to be involved in programmatic revisions than their social work counterparts.

DISCUSSION

So how far have we come over the past 30 years? There is increasing recognition in the literature of the need to incorporate gerontological content in undergraduate nursing and social work programs. And, from this recent survey, it appears that nursing and social work programs are attempting to bolster gerontological content. For instance, in this recent survey, 42% of faculties of nursing and social

work reported making changes in their gerontological content since 2004.

However, considering the aging of the Canadian population and the higher utilization of health care towards the end of life, we posit that nursing and social work programs are not doing enough to respond to the curriculum content required by students. For example, from their Canada-wide survey of gerontological content in baccalaureate programs in nursing conducted between 1999 and 2000, Baumbusch and Andrusyszyn⁽²¹⁾ noted that only 5.7% of faculty had educational background in gerontology, and only 5.5% of students chose a gerontological focus for their final practicum. The recent survey, conducted in late 2008, reveals that only 2.4% of faculty with master's degrees and 6.0% of faculty with doctoral degrees have a gerontological focus. Further, only 6% of baccalaureate students specifically chose a gerontological setting for their final clinical placement. The comparison between the two studies, conducted almost 10 years apart, shows little improvement in faculty expertise in gerontological practice or in student interest. What are some possible explanations for the muted progress, and some possible responses?

First, a high proportion (79%) of nursing and social work programs report delivering gerontological content within an integrated curriculum. This proportion is much higher than that reported of Baumbusch and Andrusyszyn⁽²¹⁾—they noted that 52.4% of nursing programs had stand-alone gerontological courses. Although the current survey included social work programs rather than nursing programs only, there seems to be a shift towards integrated curriculums whereby age-specific content is sprinkled throughout the curriculum, rather than in stand-alone courses. Should the mode of delivery be questioned? Are small offerings of gerontological content too paltry to spark interest in and commitment toward gerontological practice? Further, from a pedagogical standpoint, how do programs accurately track gerontological content with little or no stand-alone courses? If there are few faculty members committed to teaching gerontological content within an integrated curriculum, will this important specialty be dropped out of convenience or lack of expertise among faculty? We suggest that there needs to be greater attention placed on recruiting faculty with gerontological expertise and to providing some stand-alone courses that allow for concentrated blocks of time to shift attitudes and knowledge.

Second, with the current situation of many integrated curriculums within Canada, there needs to be a way to track and monitor gerontological content in nursing and social work programs. We suggest that the NICE competencies provide a framework not only to track gerontological content in programs, but also upon which to develop and implement theory and clinical experiences designed with in an interdisciplinary Canadian context.

Third, the complex relationship between attitudes towards old adults, knowledge of gerontological practice,

and interest in gerontological practice needs further unravelling; this is not a simple, linear equation. Even though knowledge often leads to enhanced attitudes towards older adults, this is not always the case. Increased knowledge of and enhanced attitudes towards older adults does not necessarily translate into desire to enter gerontological practice. Indeed, the surveyed programs within this study noted that all of the NICE core competencies are covered, except one; yet the interest in gerontological practice remains very limited. Further studies need to be conducted that examine the process whereby students' attitudes are changed and how this translates into knowledge and commitment to gerontological practice.

Fourth, there is little research completed that addresses interdisciplinary learning and related competencies for working in geriatric teams specific to the needs of nursing and social work students. There is little that provides insight for educators as to how to help these students learn the skills of working in a geriatric team. The implication is that learning is serendipitous, not structured. Educators and researchers working together could give insight into providing the knowledge needed to structure effective practicum learning situations for students and the appropriate times to learn them. Early in their programs, students struggle with learning to understand their own professional roles. They are just beginning to be socialized into their discipline. When should they be introduced to other professionals and in what type of activities? What are effective learning strategies—including the appropriate timing for offering such activities—that will promote effective interdisciplinary geriatric teams? How best can educators augment students' learning on how to work in interdisciplinary teams, so that learning does not occur just "by trial and error" within clinical practice.

Fifth, the results of this survey reveal that Canadian nursing and social work programs are not including learning from international models of care. This is an important omission; the Netherlands and Scandinavian countries are recognized as being advanced in their models of aged care. If core competencies in gerontological care include an ability to identify gaps in the health-care system and work to make revisions in programs for older adults, then learning from other parts of the world could be beneficial.

Sixth, while this survey provides important information about gerontological content in nursing and social work programs across Canada, the information received is skeletal. More in-depth information needs to be acquired in terms of how programs define assessment and intervention of older adults, family counselling and mediation, advocacy and program revisions, etc. In all probability, nursing programs and social work programs define and process these concepts differently. More research about how these concepts are taught in class and in practice may serve as templates for other programs that are seeking not only to bolster gerontological content, but also increase the effectiveness of how that content is taught.

Limitations

Limitations of this study detract from some of the strength of the findings. The response rate was 64% of the e-mail surveys distributed. The non-response bias limits the external validity as it prevents generalization to all nursing and social work students in Canada. In addition, the e-mail survey was sent to identified faculty members with an interest in gerontology; at a site where a name was not available, it was sent to a member of the administrative team obtained from the program's website and a request made to forward to the Chair of the Undergraduate Curriculum Committee. Two follow-up requests were sent, but this did not ensure a response.

CONCLUSION

While faculties of nursing and social work across Canada are making a commitment to preparing students to care for older adults, it is clear that much work needs to be done. In addition to ramping up gerontological content in programs, attention should be given to how gerontological education is delivered, how content is tracked through programs, and how to attract qualified and enthusiastic faculty to teach gerontological content.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

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APPENDIX A

NICE Competencies

Clinician

Definition: The clinician practices safely, ethically and effectively along a continuum of care in situations of health and illness in a variety of health-care environments.

Key competencies:

1. Performs and refines assessment of the older adult in the domains of:
 - a. Physical health and illness conditions
 - b. Functional ability
 - c. Cognitive ability and mental health
 - d. Psychosocial function including social support system and life course changes.
 - e. Spirituality
 - f. Socio-environmental situation
 - g. Safety and Security
2. Selects/administers valid, reliable and age appropriate assessment/ diagnostic/screening tools.
3. Applies evidence-based standards/best practice guidelines to promote healthy activities in older adults.
4. Involves older adults and their families in developing expected outcomes.
5. Performs interventions to: promote health and optimal care; enhance quality of life; prevent disease, injury, and excess disability; maximize function; maintain desired level of autonomy and independence; promote rehabilitation; and provide palliative care to older adults.
6. Uses technology to support the care of older adults and to enhance their function, independence and safety.
7. Recognizes and manages the interaction of normal aging and one or more persistent health conditions in an older person.
8. Recognizes and manages geriatric syndromes common to older adults, and the complex interaction of acute and chronic co-morbid conditions common to older adults (e.g. cancer, depression, hip fracture, influenza, and stroke).
9. Identifies older adults' use of prescription medication, over-the-counter medication, herbal remedies and complementary and alternative therapy.
10. Assesses family knowledge and skills, needs, and level of stress in providing care to older adults.
11. Assists family caregivers to reduce their stress levels and maintain their own mental and physical health.
12. Facilitates group interventions with older adults and their families (e.g. bereavement groups, reminiscence groups).

Communicator

Definition: The communicator communicates effectively and respectfully with older adults and their families, and with other disciplines and members of the health-care team.

Key competencies:

1. Recognizes the changes (e.g. sensory, cognitive) that affect communication with older adults and optimizes the ability of the older adult to communicate.
2. Recognizes that all behaviour has meaning and views challenging behaviour of older adults as an attempt at communication based on need.
3. Identifies that older adults may be at risk in relation to their right to information and privacy of information.
4. Provides information that takes in to account cohort differences in the use of words and expression.
5. Assists and provides counseling to older adults and their families in making complex decisions that arise with aging.
6. Mediates situations of conflict between older adults and their family members.

Collaborator

Definition: The collaborator effectively works with other disciplines and the health-care team to promote optimal care and quality of life, and maximize function for older adults.

Key competencies:

1. Promotes team problem-solving, decision-making and interprofessional collaboration by jointly assessing outcomes of care, planning interventions, implementing new strategies, evaluating the impact on older adults, families, and team members, and developing new and innovative working relationships.
2. Forms partnerships with older adults, their families and communities, to achieve mutually agreed upon health outcomes

Supervisor/Leader

Definition: Based on collaborative process, the manager makes decisions to delegate, guide and direct the care of older adults through other health-care personnel as well as providing expertise in decision-making within the organization to promote optimal care and quality of life, and maximize function for older adults.

Key competencies:

1. Coordinates with health team members to ensure continuity of health services for older adults, families and communities.
2. Facilitates interprofessional case management to link older adults and their families to resources and services.

Advocate

Definition: The advocate initiates and takes opportunities to advocate on behalf of older adults and their families to advance the development and establishment of needed services and programs that contribute to the optimal care and quality of life, and maximize function of older adults.

Key competencies:

1. Supports older adults and their families to draw on their own abilities and resources for self-care and health promotion.

2. Informs and supports older adults and their families while they are making decisions about their health care.
3. Respects and promotes older adults' rights to dignity and self-determination within the context of the law and safety concerns.
4. Applies ethical principles to decisions on behalf of all older adults with special attention to those with limited decisional capacity.
5. Represents the older adult as requested and when the older adult is not able to advocate for self in discussions of care, preferences for care, and decisions related to care within the health-care team and the organization.
6. Advocates on behalf of older adults and their families with agencies and other professionals to help them obtain services.
7. Supports older adults and their families who are dealing with: end of life issues related to dying, death, and grief; limitation of treatment; competency; guardianship; right to refuse treatment; advance directives; wills; and durable power of attorney for medical affairs.
8. Evaluates the accessibility, availability, and affordability of health care for older adults to promote their goals, maximize function, desired level of autonomy and independence, and their living in the least restrictive environment.
9. Advocates for services and programs that will enhance care for older adults within the organization and society.
10. Participates in "social action" that will contribute to the health and well-being of older adults.

Scholar

Definition: The scholar demonstrates a life-long commitment to skill and knowledge enhancement as a means to attain personal and professional growth and to promote optimal care and quality of life, and maximize function for the older adult.

Key competencies:

1. Reviews and synthesizes evidence from research studies pertinent to the care of older adults.
2. Seeks to implement best practices of care for older adults on an organizational basis.
3. Evaluates and learns from differing international models of geriatric care.

Professional

Definition: The professional is committed to promote optimal care and quality of life, and maximize function for older adults through knowledgeable and respectful practice, professional regulation and adherence to standards of practice.

Key competencies:

1. Identifies and assesses one's own values and biases regarding aging.
2. Recognizes that one's own values and assumptions affect interactions between older adults and their families and the interprofessional health-care team.

3. Provides care that demonstrates sensitivity to older adults' cultural and spiritual diversity.
4. Adheres to laws and public policies related to older adults (e.g., elder abuse reporting, legal guardianship, powers of attorney, wills, advance directives, and Do-Not-Resuscitate orders).

Educator

Definition: The educator educates the older adult and family, providing information on prevention, health promotion, and management of conditions that will optimize health and quality of life, and maximize function.

Key competencies:

1. Addresses the health-related learning needs of older adults, their families and communities through assessing learning needs and developing, implementing and evaluating learning plans.
2. Educates the older adult and their families in self care practices.

Health System (Staff) Member

Definition: The context of care is the health-care system and the care to older adults and their families is provided within the availability, accessibility and affordability of programs and services. The member provides maximum opportunities and choices for older adults and their families within the larger health-care system to promote optimal health and quality of life, and maximum function of older adults with an effective and efficient use of the system.

Key competencies:

1. Understands the diversity of older adults' attitudes toward the acceptance of services.
2. Identifies the availability, accessibility and affordability of health care for older adults and their families.
3. Identifies how policies, programs and services affect the health care of older adults and their families.
4. Works with older adults and their families to ensure appropriate use of the health-care system and transition through the system.
5. Evaluates the effectiveness of the health-care system in achieving intended outcomes for older adults and their families.
6. Applies evaluation and research findings to improve the health-care system in achieving intended outcomes for older adults and their families.
7. Identifies gaps, barriers and fragmentation in the health-care system and partners with older adults and their families, and other disciplines to adapt and revise programs and services.
8. Works with other disciplines, community organizations, policy makers, and the public to meet the needs and issues of a growing aging population.