

TIME FOR DEMENTIA

A NEW MODEL OF UNDERGRADUATE HEALTHCARE DEMENTIA EDUCATION?

*Dr Stephanie Daley,
Yvonne Feeney, Molly Hebditch, Dr Wendy Grosvenor,
Professor Juliet Wright, Professor Sube Banerjee*

Overview of symposium

- ▶ Time for Dementia education programme
- ▶ Time for Dementia research study
- ▶ Preliminary student outcomes

- ▶ Time for Dementia and Adult Nursing students – Dr Wendy Grosvenor
- ▶ Implementation of Time for Dementia – Yvonne Feeney
- ▶ Preferences for working with people with dementia – Molly Hebditch

Key learning

- ▶ Innovation in dementia education
- ▶ Real-life **'messy' pragmatic research**
- ▶ Focus on the healthcare professionals and dementia care of the future
- ▶ **'Hearts and minds' and 'relationships'**
- ▶ Using research to support the iterative development of the programme
- ▶ Supporting the development of doctoral research through nested studies
- ▶ Many un-answered research questions still
- ▶ **Impact.....**

What is Time for Dementia



- Novel educational programme for future health professionals to learn about dementia
- Introduced in 2015 at Brighton and Sussex Medical School and University of Surrey
- Longitudinal contact between students, a person living with dementia and their carer
- Visit family in their own home
- Pairs of students visit 3 times per year for 2 years
- Supported by workshop, reflection sessions & stakeholder symposium
- Aim to improve knowledge, attitudes and empathy towards people with dementia

- ▶ Based on Longitudinal Clerkship model
- ▶ Mandatory component of curricula
- ▶ Person with dementia and carer **as 'expert'** teachers
- ▶ Novel approach within non-medical training
- ▶ 5 student cohorts at University of Surrey and Brighton and Sussex Medical School
- ▶ 2600 students to date
- ▶ Partnerships with key organisations & family network (n=550)



One student's experience

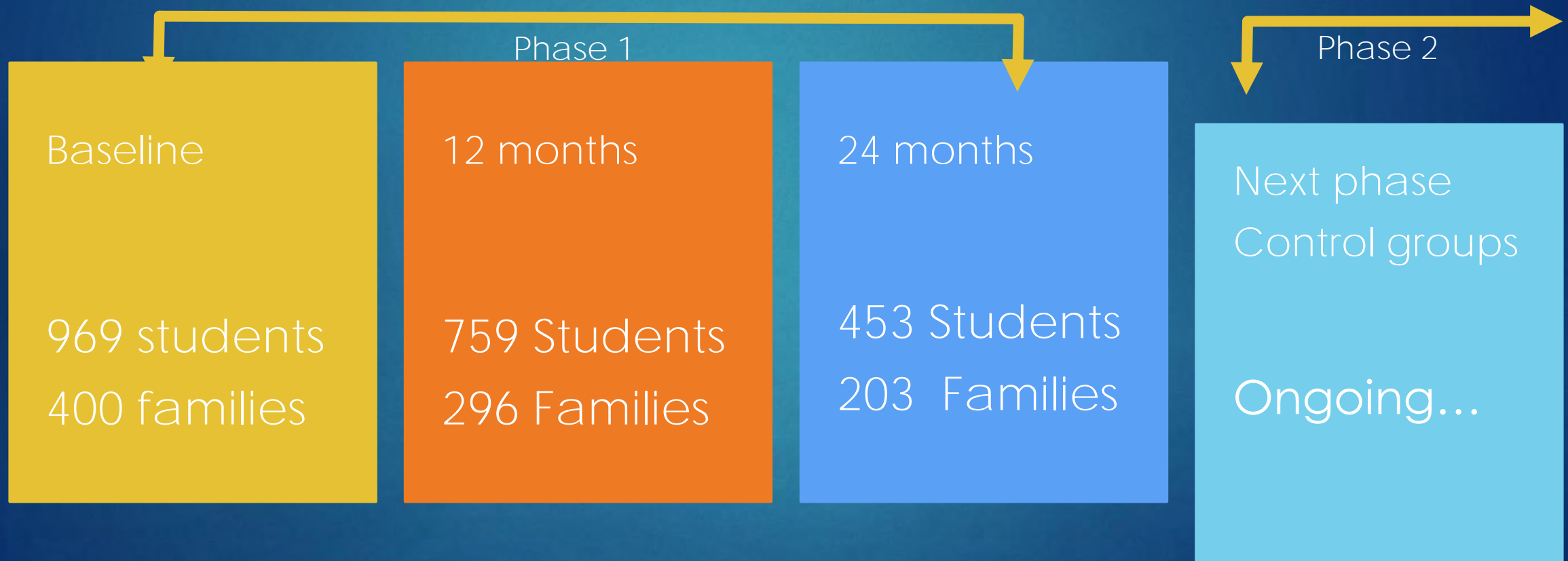


Research study



- Mixed methods evaluation
- Two phases
- Quantitative student measures at baseline, 12 and 24 months
- Student qualitative interviews and focus groups
- Student satisfaction surveys
- PPI Involvement
- Qualitative interviews with person with dementia and their carer
- Family satisfaction surveys & free-text responses
- Quantitative measures – person with dementia and carer

Phase 1: Quantitative Evaluation



Measures

- ▶ **Alzheimer's disease Knowledge Scale** (Carpenter et al., 2009) - a brief 30-item questionnaire designed to assess students' knowledge of AD
- ▶ Dementia Knowledge Questionnaire (Shanahan et al., 2013) - a brief 20-item questionnaire designed to assess dementia knowledge;
- ▶ Approaches to Dementia Questionnaire (Lintern et al., 2000)- a 19-item questionnaire designed to assess attitudes toward dementia patients
- ▶ Dementia Attitude Scale (O'Connor and McFadden, 2010) - a 20-item questionnaire designed to assess attitudes toward dementia;
- ▶ Medical Condition Regard Scale (Christison et al., 2002) - a measure of biases, attitudes and emotions in relation to specific medical conditions
- ▶ Jefferson Scale of Empathy: Health Professional/Medical Student Version (Hojat et al., 2001) - 11 item questionnaire of empathy in healthcare students
- ▶ Student Satisfaction Survey

Student outcomes

Change over two years

Measure	Range	Mean at Baseline	N	Mean at 24M	N	Change in Mean score
Alzheimer's Disease Knowledge Scale	0-30	22.9	692	24.9	302	+ 2.00
Approaches to Dementia Questionnaire	19-95	78.2	699	80.3	299	+2.10
Dementia Knowledge	0-20	15.1	661	16.5	300	+1.40
Medical Condition Regard Scale	11-66	54.2	700	54.8	299	+0.60
Dementia Attitude scale	20-140	112.1	700	118.9	297	+6.80
Jefferson Empathy Scale	20-140	116.0	691	116.5	293	+0.50

Student Experience Qualitative Research

- ▶ Individual in-depth interviews (n=39)
- ▶ 5 focus groups
- ▶ Completed 12 and 24 months
- ▶ 39 medical students, 15 adult and & 10 mental health nursing students and 13 paramedic students
- ▶ Free text satisfaction response surveys 12 (n= 541) and 24 (n= 278) months
- ▶ *Thematic analysis*



Qualitative Themes identified



UNDERSTANDING THE IMPACT OF DEMENTIA

1. Understanding person with dementia and **carer's** perspective
2. Understanding how families view professionals and services
3. Understanding the global impact of dementia

*“the carer felt so lost, although she had been signposted, she felt so alone and so lost in this whole **sea of, you know, internet things and charities**”*

RELATIONAL LEARNING

1. **“Real life” learning is easily absorbed and** retained
2. Relationship with family
3. Benefits to learning in a student partnership

*“Getting to know people experiencing dementia in their own home - **quite a deep learning experience.**”*

CHALLENGING ATTITUDES

1. Changing attitudes towards person with dementia
2. Challenging misunderstandings about dementia/stigma
3. Promoting a positive view of working with patients with dementia

“They have shown me how much the person can still do and enjoy and how they can still develop skills and interests.”

THINKING PSYCHOSOCIALLY

1. Shift in thinking from a medical to psychosocial perspective
2. Person centred care & seeing the person behind the diagnosis
3. Understanding coping

“I previously placed too much emphasis on the medical treatment of dementia. The psychosocial aspects of care may actually have the biggest impact on quality of life and outcomes for the patient.”

ENHANCING DEMENTIA PRACTICE

1. Improvement in clinical skills; e.g. communication & rapport
2. Personal development; e.g. confidence & patience
3. Applying skills to own practice

*'Dementia is a condition which I previously had little exposure to. A year later, I now definitely consider myself to be more empathic, considerate and compassionate. I truly believe that this is a result of the visits, as I was able to understand the importance of both verbal and non-**verbal communication.**'*

One student's experience



When they very first came into Uni and asked us to be part of the study I did think I'm a mature student and I did think

Time for dementia **What's next?**

- ▶ Wider roll-out
- ▶ Publish findings and outcomes
- ▶ Implementation manual
- ▶ Complete phase 2 evaluation
- ▶ Time for Autism
- ▶ REF 202 Impact case

Thank you for listening



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WHOLE SIGHT: New Ways Of Seeing Dementia Resulting From Relational Learning With People Living With Dementia

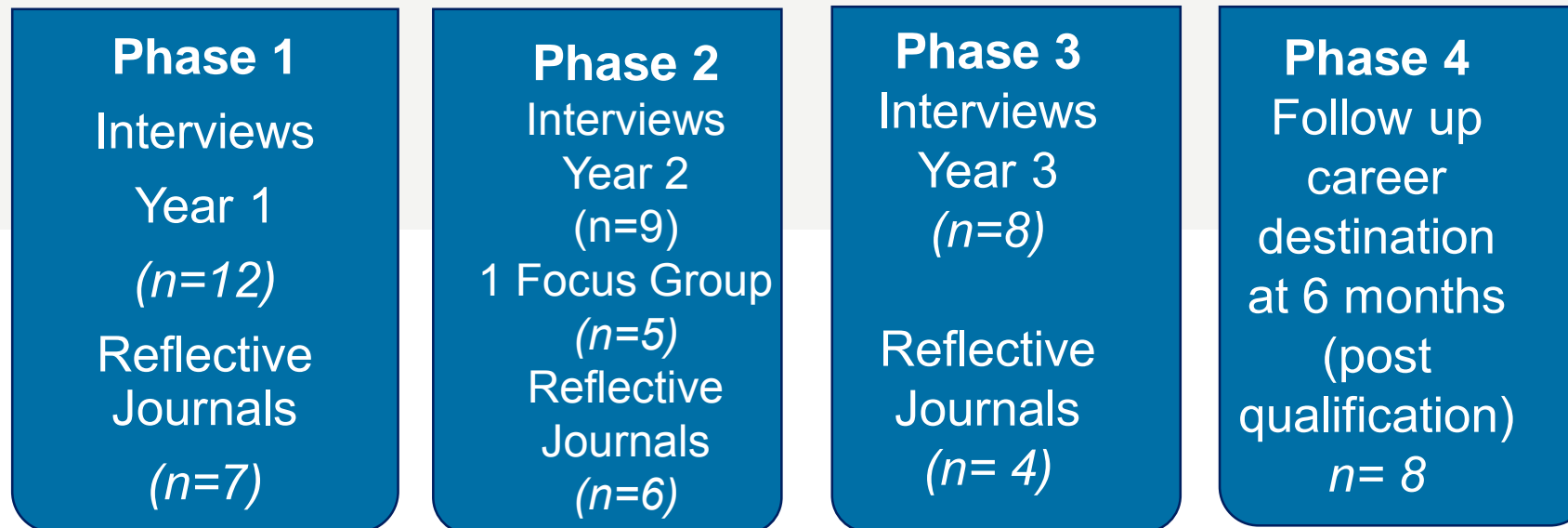
Dr Wendy Grosvenor
Lecturer Older Adult Care



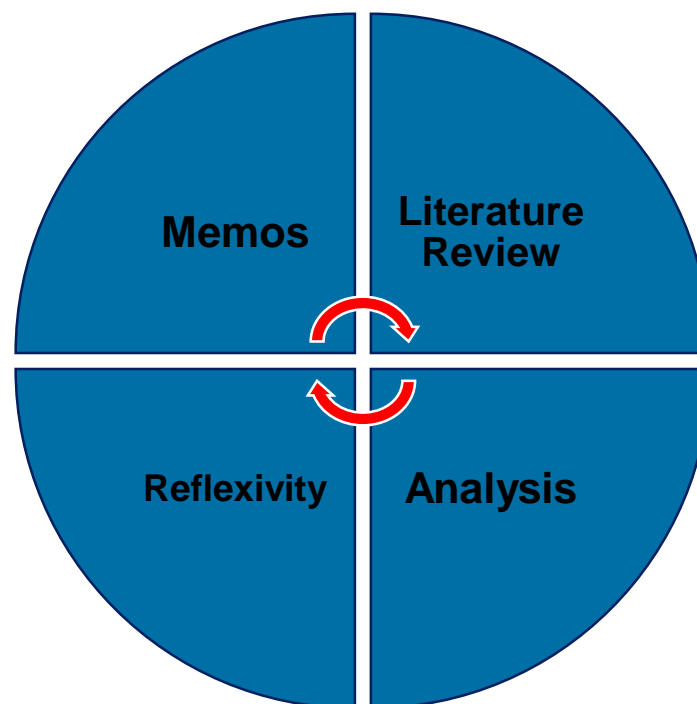
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UNIVERSITY OF
SURREY

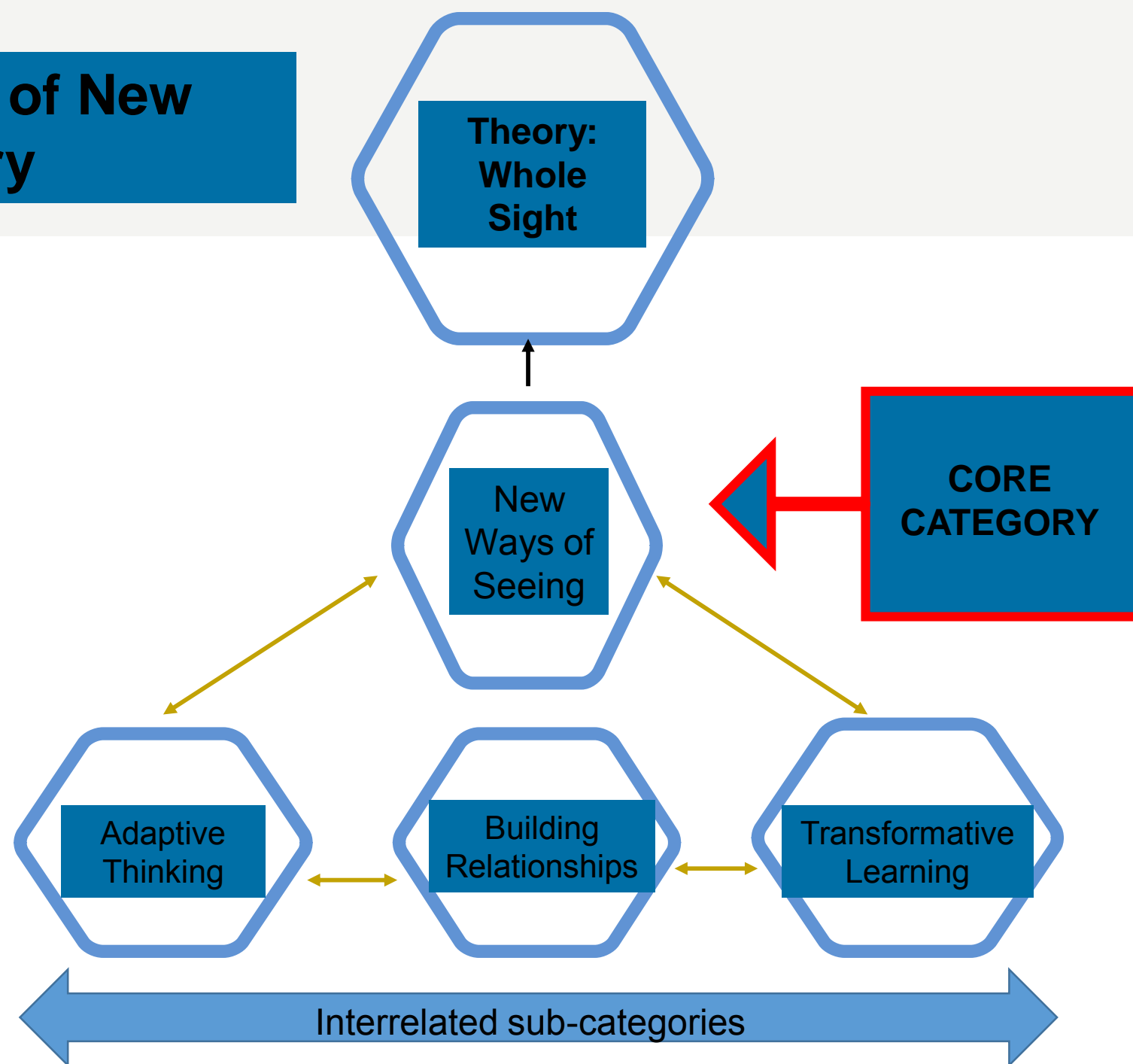


What are student nurse perspectives on the impact of longitudinal home visits to people with dementia and their carers?



**Illustration of
longitudinal phases of
study**

Emergence of New Theory



WHOLE SIGHT

'Person is more than their dementia... Dementia does not define the person'.

(P5, Phase 1)

- Participants' reframed their perceptions of dementia:
 - attention was given to broadening their views of dementia to encompass the person's lives and relationships
- Seeing and treating people with dementia as *wholes*, and not just focusing on their dementia.
- Consequently viewed the person more holistically - resulted in adapting their thinking about dementia.

CORE CATEGORY: NEW WAYS OF SEEING

*New ways of seeing, see dementia
in a different light...experience has
been life changing'.*

(P7, Phase 1

The core category of *New Ways of Seeing*, illustrates the impact of entering the world of a person with dementia.

Visits challenged participants' perceptions and attitudes towards dementia.

ADAPTIVE THINKING.

'Programmes such as this illuminate the experience of dementia... talking about it helps to reduce stigma... gives an opportunity to slowly face our misconceptions and gives the next generation of healthcare professionals a better understanding of how to go about approaching dementia.'

(P12, Phase 3)

- » Participants made frequent references throughout the study to *focusing less on the task and doing.*
- » They spoke of *providing care that focused on the person*; care that prioritised their understanding of a person's experiences; planning and providing care that enabled and affirmed the person, all of which correlates with Kitwood's concept of person-centred.

BUILDING RELATIONSHIPS

'Biggest impact for me has been the realisation...sometime people do not want answers, they just want people who will listen... realisation of how important human interaction is'.

(P1, Phase 2)

- » Participants reflected on the importance of *being with* rather than *doing to* - fundamental to person-centred care.
- » The resulting impact was seen in changes to participants' practice; illustrated by their change of focus from *working on tasks* to *working with*, from *managing patients* to *actively listening to and hearing the person*.
- » Participants' experienced and established presence through these behaviours, resulting in increased empathy and connectedness

TRANSFORMATIVE LEARNING

'We read a lot about caring and dementia but it's when you meet the person and spend time with them that you begin to learn about living with dementia and how we can change our practice to make a difference'.

(P12, P3)

- » Findings from all three phases of this study demonstrate that the impact of visits to people with dementia and their carers were transformational.
- » Participants' perceptions of dementia were challenged and changed

IMPACT...

- » Students questioned and changed their own approaches to people with dementia and their carers
- » Action: Challenged Practice → 'Moral Courage'

'I've seen other people in practice and I don't always agree with how they treat people with dementia...they get cross, but shouting at people and getting cross doesn't do anything does it? There's been a couple of times I have stepped in – I am like, I'll deal with this person. I feel much more confident...not to hold back'.

(P2, Phase 3)

FINAL THOUGHTS...

Dementia is a global challenge of the 21st Century; how well we respond to the projected doubling of the numbers with dementia in the next generation will depend to a large extent on the quality of our future healthcare workforce.

This study offers new insights in developing dementia education that focuses on interconnectedness and caring relationships, promoting a *Whole Sight* focus on the person rather than on their dementia.

Time for Dementia visits created a positive dementia discourse that led to significant changes in practice. This study offers new insights in developing dementia education that focuses on interconnectedness and caring relationships, promoting a *Whole Sight* focus on the person rather than on their dementia.

UNDERSTANDING THE BARRIERS AND FACILITATORS
AFFECTING IMPLEMENTATION OF TIME FOR DEMENTIA INTO
HIGHER EDUCATIONAL INSTITUTE'S (HEI).

Yvonne Feeney

Dr Stephanie Daley

Breda Flaherty

Professor Sube Banerjee

BACKGROUND

- Good quality education provided at undergraduate level is needed to prepare the next generation of healthcare students support people with dementia (1,2)
- Longitudinal programmes can enhance attitudes and understanding of long term conditions (3-5)
- The Time for Dementia programme is now a mandatory component of the curricula at five UK Higher Educational Institutions (HEI's)
- Introducing a longitudinal programme can be a complex task that requires change to established curriculum

SUPPORTING HEI'S IMPLEMENT TIME FOR DEMENTIA

- To facilitate implementation in a new site, a core team supports each HEI
- Core team consists of research staff, the programme lead, an experienced administrator, and Alzheimer's Society Network Manager
- A HEI faculty and pathway lead are identified in each site
- A suite of templates and guidance are provided to new sites
- Longitudinal programmes are not new
- An understanding of the common complexities involved across sites when implementing the programme is essential to support future roll out

STUDY AIMS



Investigate and understand the barriers and facilitators of implementing the Time for Dementia model of education into a HEI



Apply the findings to an implementation manual to guide new sites manage common barriers and facilitators

METHODS



Qualitative design, multi site study



Semi structured interviews with key staff experienced implementing the programme



Data collected between October 2018 – December 2018



Data analysed – an inductive approach using thematic analysis

DEMOGRAPHICS



Participants
(n=12)



Role:
Alzheimer's
Society n=2
HEI faculty Lead
n=3,
HEI pathway lead
n=3
Administrative
n=3
Research n=1



Mean age
46 years



Gender female
(n=12)



Average time
working on Time
for Dementia
17 months

RESULTS

Five key barriers and facilitators were identified

1. Leadership

2. Buy-in

3. Perceived Value

4. Team Coalition

5. Time and Fit

LEADERSHIP FACILITATING FACTORS

Confident leadership with clear understanding of roles and responsibilities

“I think you’d certainly need someone very senior within the School to take the lead on it. You need people in the programmes who are very committed to it...” (Participant 6)

Ability to build trust within the organisation

“I think institutions often what will happen if something happens, what if the patients really confused, what if there’s distress, what if... what if... but actually just being pragmatic about it and I know [NAME 1] was very confident and reassuring and most of those things melted away.” (Participant 5)

Commitment and Enthusiasm

“I was very enthusiastic about it and I wanted to do it. I knew there was going to be challenges and I knew it wasn’t just going to be something easy, but I just thought it had so much potential...” (Participant 12)

Resilience

“...this is an acceptable challenge, because it’s a new project, it’s teething, we’re learning, it’s all part of the experience of dealing with something new, let’s not worry about it, let’s just find the solution.” (Participant 11)

LEADERSHIP BARRIERS

Apprehension due to unfamiliarity

Additional workload for HEI leads

*“sometimes it’s not always an appreciation that it is an add-on rather than a full time job for many people. And if my job was just Time for Dementia it would be very different and I think sometimes it is a challenge”
(Participant 6)*

BUY-IN FACILITATING FACTORS

- **Shared vision for success amongst all partner organisations**

- **Organisational buy-in including influential people i.e. Dean, Head of School**

“It needs to be considered that this is going to be something that the university is going to support, it’s not the kind of quest of one individual, or it’s not an add on to the curriculum...” (Participant 10)

- **Wider faculty awareness to increase student engagement**

“I think it’s that whole buy-in about people championing the project, about championing it for students as well, because ultimately these lecturers will be personal tutors to these students...if the lecturer doesn’t understand what it’s all about...they might send the wrong messages...” (Participant 11)

- **Introduction and preparation sessions, peer to peer student influence**

“I think it also got better because of the introduction from the very beginning, more frequent exposure to what was expected of them and also better resources, which meant that they understood it I think quicker as it was introduced.” (Participant 10)

BUY-IN BARRIERS

- **Student buy-in**

“...look at where it fits in within your curricula, so it makes sense to the students and it engages them.” (Participant 3)

“...introducing it earlier, introducing a family where possible and I think it just takes the abstractness and this mentality, “Oh it’s another thing we have to do”. I think it takes it out of it, because they see there’s actually a family and they really like to meet the students and they like to share their experiences...” (Participant 4)

PERCEIVED VALUE FACILITATING FACTORS

- **Motivation to take part (intrinsic/extrinsic values)**

“...for a long time, dementia ageing has not been particularly valued within education and I think it gave me hope that actually there was that impetus to make a difference and to really kind of make changes around dementia.” (Participant 3)

- **Valuable opportunity**

“I was asked to lead on it, I thought “Oh my god, how on earth am I going to this?” but I thought “Well, I’m going to do this, because it’s so valuable,” and I wasn’t willing to just say no, not interested, haven’t got time, I wanted to do it.” (Participant 12)

- **Positivity and pride**

- **Enhanced learning experiences for students**

- **Value to the organisation**

“I think it’s excellent and it fits very well with our course, which is innovative, it is modern, it does break down some of the traditional barriers...” (Participant 5)

- **Opportunity for networking with peers**

TEAM COALITION FACILITATING FACTORS

- **Supportive environment, team commitment and enthusiasm**

“...the only way this is successful is I think really having a mentality of the team effort, and everyone behind TfD as a programme...” (Participant 10)

- **Core team support and guidance**

“I think they’re key, I couldn’t have done what I did without their support... I would have felt at a loss at times. So, I think they’re absolutely key. And the fact they don’t withdraw from it. So, now we’re still having site meetings...” (Participant 12)

- **Close working relationships**
- **Regular contact – site meetings, phone calls, Sharepoint**

TEAM COALITION BARRIERS

- **Clarity of roles**

“I think some of the ... work that historically has been done by the admin (administrator) at the universities, is that for the university to do, or is it for the Alzheimer’s Society to do? And I think that needs to be a clearer kind of instructions.” (Participant 3)

- **Interorganisational working and logistics**

TIME AND FIT FACILITATING FACTORS

- **Passing of time increased programme stability, student engagement increased, wider faculty awareness increased**
- **Iterative learning**
- **Administrative support**

“I mean once our admin person started, it was like a whole weight had been lifted off my shoulders, because even down to the resources, you know, somebody that can proofread it and format it and do all that sort of stuff and actually sit down and bang ideas out with, was really helpful, and I think having that earlier might be just taking that pressure off a little bit.” (Participant 12)

- **Programme fit – fit within appropriate modules that make sense to students**

TIME AND FIT BARRIERS

- Lack of time – early set up time
- Lack of resources, lack of administrative support
- Timing hotspots
- Programme fit – crowded curriculum
- Sustainability – careful consideration for availability of families

SUMMARY

- Curricular change is a complex task (6) and introducing a longitudinal programme can be daunting
- Leaders need to create a culture prepared to embrace change, they need to have the commitment and enthusiasm to make the change
- There was a **lack** of resistance reported
- A resilient approach
- Participants were motivated by their own core values and beliefs
- Perceived value acted as a major motivational factor influencing participants to implement and remain engaged despite challenges



SUMMARY

- Extrinsic factors were important motivational drivers for participants i.e. value for the organisation
- Buy-in and team coalition are essential to motivate change efforts
- The relationship between intrinsic and extrinsic factors can positively or negatively effect motivation, i.e. pressure, reward, punishment (7)
- Barriers to implementation need to be managed, but importantly, facilitators identified must be nurtured to motivate change





Review

Apply the findings to an implementation manual



Share

Share learning with wider team
Provide manual to new sites to guide effective implementation of the programme

FINAL STEPS

REFERENCES

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THANK
YOU

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- Twitter: @time4dementia



STUDENT NURSE PREFERENCES' FOR WORKING WITH PEOPLE WITH DEMENTIA



Ms Molly Hebditch
Dr Stephanie Daley
Dr Wendy Grosvenor
Ms Gina Sherlock
Professor Sube Banerjee
Professor Juliet Wright

BACKGROUND

Why is it important to understand the career preferences of nurses in relation to dementia?

- Prevalence of dementia (Prince et al., 2013)
- Increased demand for quality care and competency in dementia care (Department of Health, 2013; World Health Organization, 2017)
- Established lack of preference for older adults (Garbrah et al., 2017; Neville et al., 2014), less known but indicated in dementia (Chenoweth et al., 2010; McKenzie & Brown, 2014).

Conclusion

Preferences need to be understood for workforce planning.

BACKGROUND

Systematic Literature Review:

Medical and nursing students' preferences for working with people with dementia; a systematic review

Inclusion
<ol style="list-style-type: none">1. Career preferences AND2. Older adults OR dementia, AND3. Medical or Nursing students
<i>Types of paper:</i>
<ul style="list-style-type: none">• >1995• Empirical papers• Quant , Qual, Mixed methods
<i>Topics:</i>
<ul style="list-style-type: none">• Factors associated with career preferences OR• Career preferences as an outcome of an educational intervention
Exclude
<ul style="list-style-type: none">• Postgraduate training and professionals• Studies that do not measure career preferences related to either older adults or dementia.

BACKGROUND

1. Previous studies suggest preferences towards working with older adults decrease over training (Gould et al., 2012; Happell & Brooker, 2001; Lee et al., 2006; Stevens, 2011; Zisberg et al., 2015).

2. McKenzie and Brown (2014)

Sig factors: Age & Ageism.

Non-significant factors: Aged care placement.

Barriers: emotional personal demands and communication difficulties.

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OBJECTIVES

Objective

To assess student preferences during undergraduate training in relation to working with people with dementia.

Research questions

1. How popular is working with patients with dementia and older adults and do these preferences change over undergraduate training?
2. What factors (including TFD) are associated with a preference for working with people with dementia?
3. What do students report as the reasons for their preferences?

METHODS

Design and Procedure

This is a secondary analysis of data collected from 2014 -2018 as part of the TFD evaluation (Banerjee et al., 2017).

3 Timepoints: T1, T2 & T3.

Study setting and sample

4 cohorts (2 TFD programme, 2 comparison cohorts)



n= 528 TFD
main sample



n= 488

METHODS

Measures

Ranking exercise of career preferences (Stevens, 2011)

1 (their most preferred)  11 (their least preferred).

‘Please explain why your Rank 1 is your most preferred career choice’

‘Please explain why your Rank 11 is your least preferred career choice’

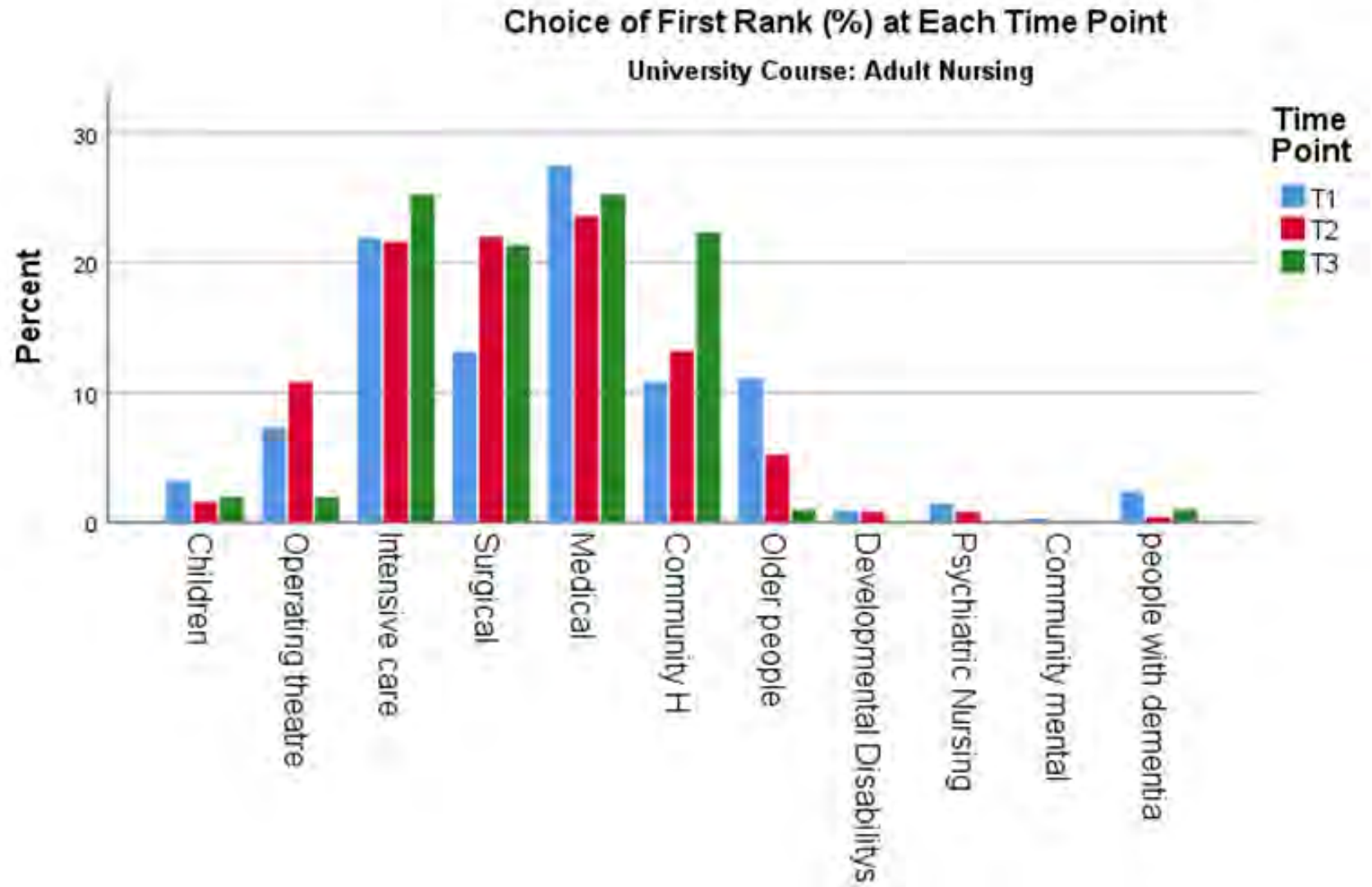
‘Please explain your choice of Rank for a career working with ‘people with dementia’

RESULTS

Research Question 1:

How popular is working with patients with dementia and older adults and do these preferences change over undergraduate training?

RESULTS



RESULTS

Median ranking of working with people with dementia
(1 = Least preferred).

	Median	IQR	Rank
T1 (n=342)	6.0	4.0-8.0	7
T2 (n=250)	7.0	5.8-9.0	7
T3 (n=103)	7.0	5.0-9.0	7

Wilcoxon Matched Pairs Signed-Ranks test.

Comparison	n	P value
T1-T2	210	<0.001
T1-T3	93	0.209

RESULTS

Research Question 2:

What factors (including TFD) are associated with a preference for working with people with dementia

Factors associated with preferences for working with people with dementia in Year 1 (n=396)

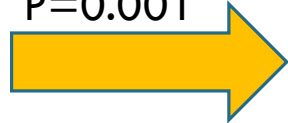
RESULTS

	Mean	Std. Deviation	Pearson correlation	Sig.
T1 People with Dementia (1-11)	5.95	2.63		
University Course (Ad vs MH)	0.21	0.41	-0.17	<0.001
University (UoS vs UoB)	0.16	0.37	0.07	0.700
Student Gender (Female vs Male)	0.11	0.31	-0.01	0.458
Ethnicity (White British/Euro Vs Other)	0.17	0.38	0.06	0.117
Dementia experience (Yes vs No)	0.42	0.49	0.18	<0.001
Student Age	24.88	8.03	-0.08	0.066
ADKS at T1 (0-30)	22.87	3.00	-0.04	0.212
DK at T1 (0-20)	15.19	2.57	-0.12	0.008
MCRS at T1 (11-66)	55.86	6.25	-0.35	<0.001
ADQ at T1 (19-95)	79.70	5.62	-0.21	<0.001
DAS at T1 (20-140)	115.15	13.04	-0.28	<0.001
Jefferson at T1 (20-140)	116.54	10.54	-0.14	0.003

Factors associated with preferences for working with people with dementia in Year 1 (n=396)

RESULTS

P=0.001



Multiple regression:
12 predictors explained
16% of the variance
(R²=.16, F (11,383)
=6.25, p>.001).

P<0.001



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Factors associated with preferences for working with people with dementia in Year 3 (n=106)

RESULTS

	Mean	Std. Deviation	Pearson correlation	Sig.
T3 People with Dementia (1-11)	6.38	2.63		
University Course (Ad vs MH)	0.18	0.39	-0.27	0.003
University (UoS vs UoB)	0.08	0.28	0.00	0.480
Student Gender (Female vs Male)	0.10	0.30	-0.07	0.231
Ethnicity (White British/Euro Vs Other)	0.18	0.39	-0.04	0.336
Dementia experience (Yes vs No)	0.48	0.50	-0.01	0.455
Student Age	28.28	9.14	-0.14	0.080
ADKS at T3 (0-30)	24.74	2.35	-0.09	0.167
DK at T3 (0-20)	16.31	2.28	-0.07	0.242
MCRS at T3 (11-66)	55.28	6.84	-0.48	<0.001
ADQ at T3 (19-95)	80.83	6.54	-0.23	0.008
DAS at T3 (20-140)	120.07	12.21	-0.30	<0.001
Jefferson at T3 (20-140)	116.50	12.08	-0.18	0.027
In Tfd? (Yes vs No)	0.26	0.44	0.19	0.025
T1 People with Dementia	6.04	2.51	0.44	<0.001

Factors associated with preferences for working with people with dementia in Year 3 (n=106)

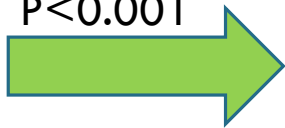
RESULTS

Multiple regression:

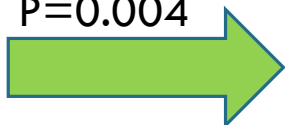
14 predictors explained 40% of the variance ($R^2=.40$, $F(13.108) = 4.45$, $p < .001$).

	Mean	Std. Deviation	Pearson correlation	Sig.
T3 People with Dementia (1-11)	6.38	2.63		
University Course (Ad vs MH)	0.18	0.39	-0.27	0.003
University (UoS vs UoB)	0.08	0.28	0.00	0.480
Student Gender (Female vs Male)	0.10	0.30	-0.07	0.231
Ethnicity (White British/Euro Vs Other)	0.18	0.39	-0.04	0.336
Dementia experience (Yes vs No)	0.48	0.50	-0.01	0.455
Student Age	28.28	9.14	-0.14	0.080
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DAS at T3 (20-140)	120.07	12.21	-0.30	<0.001
Jefferson at T3 (20-140)	116.50	12.08	-0.18	0.027
In Tfd? (Yes vs No)	0.26	0.44	0.19	0.025
T1 People with Dementia	6.04	2.51	0.44	<0.001

P<0.001



P=0.004



RESULTS

Research Question 3:

What do students report as the reasons for their career preferences ?

<p>Aligns with personal skill set (n=10)</p>	<p><i>“I have had experience with dementia hence high rank, I feel confident working with people with dementia”</i></p>
<p>Positive aspects of work (n=12)</p>	<p><i>“I find working with people with dementia are challenging but rewarding. I enjoy building a relationship with them”</i></p> <p><i>“I love being able to empower them to live as independently as possible in their homes”</i></p>
<p>Enjoyment and interest (n=10)</p>	<p><i>“Enjoy working with dementia patients”</i></p> <p><i>“I’m interested in the decline of the mind, especially interested in vascular dementia”</i></p>
<p>Positive past experiences (n=7)</p>	<p><i>“Following placements working in a community mental health team for older people and on an acute elderly specialist dementia ward I’ve grown great interest to work within the field of dementia”</i></p>

<p>Prefer other areas (n=12)</p>	<p>“I'm happy working with people with dementia but I prefer other disciplines”</p>
<p>Negatives characteristics work (n=17)</p>	<p>“I found dementia care understaffed, testing and stressful”</p> <p>Low down on my list because as an illness it tends to deteriorate so I find it more difficult to find the ways to win at work”</p> <p>“I had HCA experience and they have been one of the most difficult people to care of because it's distressing that they don't understand sometimes”</p>
<p>Lack of skills or experience (n=7)</p>	<p>“Minimal experience. Similarly, with rank 1 1 it's a skill set I am not too fond of using.</p> <p>I enjoy working with more active people.”</p> <p>“I am not overly familiar with the appropriate ways to care for people with dementia or the typical symptoms of it”</p>
<p>Personal Experiences (n=2)</p>	<p>“As I have had experience with people with dementia in both professional and personal life, I would find it really difficult to cope with a full-time job in this sector”</p>

CONCLUSIONS

Working with people with dementia is not popular choice, and may decrease

Implication: role of education

MCRS measures what extent students:

‘view patients with a given medical condition as enjoyable, treatable and worthy of medical intervention and resources’ (Christison et al., 2002, p. 257).

Implication: importance of attitudes

Reasons given for a higher preference of working with people with dementia was enhanced skills and knowledge. The most common category of response, regardless of ranking, was negative aspects of the work. This included communication difficulties and the ‘challenging’ nature of the work.

Implication: Perceived competence and work characteristics

THANK YOU!!

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