Setting up a project to improve care of older people in Scotland

AUTHOR Angela Kydd, MSc, PGCE, RGN, RMN, is senior lecturer, School of Health, Nursing and Midwifery, University of Paisley.


This is the first of two articles which describe the ‘Developing as a centre of excellence project’ at the School of Health, Nursing and Midwifery at the University of Paisley. The aim of the project was to enhance good gerontological care by creating a partnership between clinicians and academic staff.

This article charts the progress of the two-year project called ‘Developing as a centre of excellence’. It evolved from a gerontology interest group at the University of Paisley (Kydd, 2002a) that was created to inspire clinicians to improve their practice, and to demonstrate the excellent work that was currently being undertaken. Part two will follow next week and reports on the evaluation of the project.

Background

The nursing unit for gerontology at the University of Paisley offers a range of courses and workshops in gerontology. However, it was felt that it was necessary to foster a culture where academics and clinicians worked together using simple, achievable and effective ways to improve practice.

Murphy (2000) suggests that maintaining a link between practice and education provides advantages for both practitioners and educators in that practitioners can be kept up to date in their practice and educators can retain a focus on the realities of practice. This is particularly pertinent in gerontological nursing – an area of nursing that has now attracted much research-based evidence but remains poorly staffed and undervalued in the clinical setting (Alexander and Eagles, 1990).

The importance of a positive attitude

Attitudes to working with older people have been well documented and many theories have been put forward to explain both positive and negative attitudes. Hope (1994) found that nurses working with older people had a more positive attitude than nurses working in an acute setting. It was concluded that nurses with a positive attitude tend to work in their field of choice, or conversely, all nurses have similar attitudes, but the exposure to the environment and culture of gerontological nursing has a positive influence on nurses’ attitudes.

McAlpine et al (1995) suggest there is a positive relationship between knowledge and attitudes and these findings are substantiated by a study of nurses’ attitudes by Sheffler (1995). Pursey and Luker (1995) found that attitudes towards older people differed from attitudes towards working with older people in a care environment. They concluded that negative attitudes towards working with older people do not result from negative attitudes to older people per se but from not wanting to be in an environment where the work is perceived as routine, busy and demoralising.

Gevers (1990) describes how an interest group in gerontological nursing was established to promote the speciality. In keeping with this philosophy, a gerontology interest group was established at Paisley. This proved to be very successful and received much support from NHS Health Scotland, which commissioned an evaluation with a view to setting up further interest groups in Scotland (Consultancy World, 2003). There are more than 300 people in the group with an average attendance of 110 people at any one meeting. After two years of running the group we felt that we could transfer this idea to a

References


Box 1. First Project Meeting: Ideas for the Way Forward

Why do you want to work on this project?

Why do your staff want to work developing the unit?

What are your own and your team’s expectations and concerns with regard to involvement in the project?

What will help you and your team fulfil expectations, and what can be done to overcome the fears?

Choose two aspects of the SWOT (strengths, weaknesses, opportunities and threats) analysis of your unit – one weakness and one strength. Discuss with your team the restraining forces and the driving forces. What restraining forces can be reduced? What forces can you strengthen? What particular areas will you and your team to choose to work on?
more specific project and this was the start of the ‘Developing as a centre of excellence’ pilot project.

The project
In May 2001 the project leader with the support of the dean of the school of health, nursing and midwifery set up the ‘Developing centres of excellence’ pilot study, believed to be the first of its kind in Scotland. It was intended to help facilitate the implementation of research evidence into nursing practice, leading ultimately to improved care for older people.

In fostering links between higher education and health care providers, a culture was created that promoted clinical effectiveness (McClarey and Duff, 1999). In addition, while the staff involved were committed to working with older people, it was felt that such a project would help to raise the profile of gerontological nursing.

The title of the pilot study was designed to reflect the fact that clinicians and educators would be working towards improvements in selected nursing practices. The word ‘developing’ emphasised that the process would be ongoing. An award would be presented to all successful teams involved in the project.

Recruiting and forming a quality steering group
Clinicians were selected for the project because they had either qualified as specialist nurses in gerontology or were active members of the interest group. Representatives from the major nursing organisations in Scotland were invited to join the team in an advisory capacity. Those who joined included representatives of:
- The National Board for Scotland (NBS, now NHS Education for Scotland);  
- The Scottish Health Advisory Service (SHAS, now NHS Quality);  
- Improvement for Scotland, the Health Education Board for Scotland (HEBS, now NHS Health Scotland);  
- The Nursing and Midwifery Practice Development Unit (NMPDU, now NHS Quality Improvement for Scotland).

These people later became members of the quality steering group to provide external validity to the project.

Academic support was essential and this was provided by the two lecturers currently working in gerontology at the University of Paisley along with the project leader. The dean of school was also a member of the group.

Five months into the project, all the clinicians had been assigned a nurse lecturer from the university to act as a mentor. If there was a need for literature, for example, then this could be secured by the mentor.

Preparation for the project
Before the first meeting in June 2001, the eight clinicians originally involved were sent a set of introductory papers in order that they understood the nature of the project. These included:
- A rationale for the project (www.paisley.ac.uk/gig);  
- A copy of the preliminary aims and objectives of the project (Kydd, 2002b);  
- A handout with a set of questions to pose to their

---

**Box 2. The Criterion for the Award**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Evidence that the cycle of audit is a key part of care delivery</td>
<td>Examining the planning, implementation and evaluation of care; Undertaking action research; Addressing real needs assessment.</td>
</tr>
<tr>
<td>2 Clear evidence of a dissemination strategy</td>
<td>Contacting the NMPDU with evidence of good practice; Publishing articles or writing to relevant journals; Open days; Presentations at conferences.</td>
</tr>
<tr>
<td>3 Evidence of training programmes and communication strategies</td>
<td>In-service training; Utilising free study days from organisations such as HEBS; Multidisciplinary teaching; Communicating with other projects.</td>
</tr>
<tr>
<td>4 Evidence of user involvement</td>
<td>Relatives groups; Thanks and complaints books/systems; Open days.</td>
</tr>
<tr>
<td>5 Evidence of collaborative working within the organisation and the wider community</td>
<td>Appropriate involvement of other agencies; An enquiring approach to the utilisation of care agencies available; Local authority involvement where appropriate.</td>
</tr>
<tr>
<td>6 A statement of commitment from the individual’s organisation</td>
<td></td>
</tr>
</tbody>
</table>

---

**References**


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net
teams (Box 1, p40). This was designed by the project leader in order to provide a structure to the first meeting.

The project leader also stipulated that the group would meet once every two months for two years culminating in a conference, where each clinician would report on their involvement. It was felt that if the aims and objectives were achieved, it would be necessary to disseminate the information as widely as possible.

The award

The group was unanimous that the award would be given purely for completing the project. The group agreed that a wall plaque would be the best form, with every member of each team receiving a personal certificate.

There were concerns that too many arbitrary guidelines would present barriers to development. It was emphasised that the teams should be able to move at a pace that they found acceptable and achievable and that they should be allowed some creativity. The group brainstormed the issues they felt were important to becoming a centre of excellence and the devised criterion for achieving the award (Box 2, p41).

The project meetings

The first meeting

Clinicians were asked to undertake a strengths, weaknesses, opportunities and threats (SWOT) analysis of their workplace and bring this, with their managers’ consent, to the first meeting.

The SWOT analysis was used to help identify an area of weakness for the clinicians to select as their target area to improve. It was important that the clinicians and their teams chose the area of their practice they wished to focus on. Chapman (2001) points out that empowering nurses to develop their practice creates a culture where learning is valued and all team members are involved in making improvements.

Some clinicians brought junior staff members with them and this led to some confusion as to which clinician was going to lead the project for their clinical area.

The conversation at the meeting seemed very open and generated much discussion. It was decided to minute each meeting as accurately as possible. The meetings were scheduled a year in advance to give the maximum amount of notice to all participants. Five of the clinicians attended the first meeting.

Second project meeting

At the second meeting in August 2001, seven clinicians attended, three of whom completed the course. At this meeting much discussion centred on the strengths and weaknesses of the teams.

The project leader suggested that each clinician paired up with another clinician for support purposes. It was felt that a buddy system could provide help the group members, especially as they came from a very wide geographical area.

It was decided that a clear focus was needed and clinicians were asked to select one area on which they wished to concentrate. In order that a positive approach
was maintained, the project leader suggested that the group looked at what was working well and analyse why this particular process worked and how had been sustained. In this way the team could perhaps identify barriers in other areas.

The clinicians were given documents on:
- Developing as a nursing development unit (King’s Fund, 1996);
- The Chartermark Award;
- Literature on sustaining good practice (Bond and Veitch, 2000).

The third meeting

Only three clinicians attended the third meeting, which took place six months into the project.

It was clear that the buddy system was not working. The project leader suggested that a lecturer should be allocated to the clinicians as a source of support and the work was divided geographically among the three nurse lecturers at the university.

A member of the quality steering group attended this meeting and made suggestions to the team on issues that are currently high on the national agenda for older people in Scotland. These included:
- Continence;
- Abuse;
- Nutrition;
- Falls.

The quality steering group member advised that it would be beneficial to contact the people who were currently working on these projects.

Mid-project meetings

Four clinicians attended the fifth meeting, 10 months into the project. There was a feeling of stagnation at this meeting. The project leader had been unsuccessful in attempts to attain funding for the project and the group was poorly attended. There was a feeling that the group had changed dramatically as many of the original members had left.

The project leader discussed the problems that the group had encountered with the dean of school. He had attended most of the meetings and was extremely supportive of the project and offered to supply funding for an evaluation of the project.

Late project meetings

The following meetings were well attended and members of the group were informed that a researcher had been commissioned to start an evaluation of the project. They were enthusiastic about this news and agreed to be interviewed in their workplace.

In November 2002, 16 months into the project, the researcher presented the preliminary results of her findings since starting the evaluation in June 2002. This injected a new lease of life into the project. One finding from the preliminary results was the need for the nurse lecturers to be more involved with the teams on site.

By this time the group was more stable in its membership – there were three original clinicians and five replacement clinicians. At this stage it was felt that there was a goal in sight and there was a much more positive feeling about the project.

By the time of the 10th meeting the director of NHS Quality Improvement for Scotland had offered funding to cover all the expenses of the conference. This was a great psychological bonus to the group as the value of the project had been recognised. It also meant that the conference could be offered to delegates free of charge and was well resourced.

By this time all clinicians had completed their projects (Box 3). Some who had started in 2001 had completed several projects. The focus was now on the conference. The project leader suggested that the last meeting should be used for all participants to present their work.

The final meeting

All members of the quality steering group attended and had come to see the presentations and decide which were worthy of an award.

Some clinicians, mainly those who were co-opted, were extremely nervous about presenting to this group and were terrified of presenting at the conference. They stated that if they had known they were to present their results, they would not have agreed to take on the work.

It was clear that the original people involved had not passed on all the information to their delegates. However, all the clinicians went through the practice successfully and as the conference drew nearer, they all agreed to present.

The quality steering group members were impressed by the quality of the work and had no hesitation in agreeing that all involved deserved an award.

Conclusion

The project boosted the morale of the clinicians and their teams. Several teams expressed the desire to repeat the exercise. There were organisational difficulties due to the changing nature of the group and the late involvement of the lecturers in their role as mentors (Boxes 4–5). It should, however, be noted that this was thought to be the first project of its kind in Scotland and subject to a lot of change in the early stages.

---

**Box 5. Factors with a positive influence on the project’s success**

- Funding for an evaluation
- Presentation of preliminary findings of the evaluation
- Support for the conference
- Input from nurse lecturers

---

**References**

